ST. JOSEPH'S HEALTH CENTRE TORONTO

BIG AIM INDICATOR	Q1	Q2	Q3	Q4	Annual
BIG AIM - Right patient to the right bed (90th %tile LOS)					

DRAFT Q1 Corporate SJScorecard
FY 2013-14

Put Patients First					
Indicator	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
BIG AIM - Right patient to right bed (P4R 90%tile LOS)*	36.5 hrs				
C. Difficile per 1000 patient days*	0.2				
Falls with harm*	49				
Pressure Ulcers*	53				
MRSA Incidence Rate per 1000 patient days*	0.12				
VRE Incidence Rate per 1000 patient days*	0.18				
Ventilator-Associated Pneumonia per 1000 device days*	1.4				
Central Line-Associated BSI Rate per 1000 device days*	0.0				
Would you recommend - ER Satisfaction*	56%				
Hospital Standardized Mortality Ratio*	N/A				N/A
90th percentile LOS Non-Admitted High Acuity*	7.1 hrs				
90th percentile LOS Non-Admitted Low Acuity*	3.9 hrs				
Chemotherapy Systemic Treatment*	TBD				TBD
Chronic Obstructive Pulmonary Disease Cases*	77				
Endoscopy*	176				
Non-Cardiac Vascular*	TBD				TBD
Congestive Heart Failure Cases*	125				
Stroke*	54				
Hand Hygiene Compliance	58%				
Surgical Safety Checklist	100.0%				
High Risk Medication Safety Events	N/A				N/A
eCare - Overall Project Status	TBD				TBD
30-Day In-Hospital Mortality Following Acute Myocardial	N/A				N/A
30-Day In-Hospital Mortality Following Stroke	N/A				N/A
5-day In-Hospital Mortality Following Major Surgery	N/A				N/A
In-Hospital Hip Fracture in Elderly Patients	N/A				N/A
Caesarean Section Rate : Excluding Pre-Term and Multiple	N/A				N/A

Enhance the Health of the Communities we Serve					
Indicator	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Hip - Wait Time (Days)*	339				
Knee - Wait Time (Days)*	470				
Cataract - Wait Time (Days)*	99				
Cancer - Wait Time (Days)*	47				
MRI - Wait Time (Days)*	33				
CT - Wait Time (Days)*	29				
Hip - Wait Time (Cases)*	52				
Knee - Wait Time (Cases)*	61				
Cataract - Wait Time (Cases)*	592				
MRI Hours - Wait Time (Hours)*	2,061				
CT Hours - Wait Time (Hours)*	1,699				
General Surgery - Wait Time (Cases)*	297				
Permanent Pacemakers*	31				
% ALC Days*	16.8%				

Create a Culture of Inquiry and Innovation					
Indicator	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Student Learner Satisfaction	82.5%				

Inspire Our People					
Indicator	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Overtime	1.1%				
Sick Time (days)	8.97				
WSIB Lost Time Incidents	4				

Use Resources Wisely					
Indicator	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Current Ratio*	1.7				
Total Margin*	-0.1				
Acute Inpatient Weighted Cases*	7,212				
Ambulatory Visits*	61,446				
ER Weighted Cases*	1,204				
Inpatient Mental Health Weighted Patient Days*	4,454				
Day Surgery Weighted Visits*	757				
Nursing Agency Hours	3.2%				
Full Time RN's	76.5%				

Results:

Metric underperforming benchmark (>10%)
Metric within 10% of benchmark
Metric equal or outperforming benchmark

Legend:

(D) - refers to indicators that are currently in development
(A) - refers to indicators which measure performance on an annual basis

*** Required as part of HSAA & Quality Improvement Plan (QIP)**

CORPORATE PERFORMANCE INDICATOR

BIG AIM - P4R Admitted Patients 90th Percentile LOS in hours

SUCCESS FACTOR:

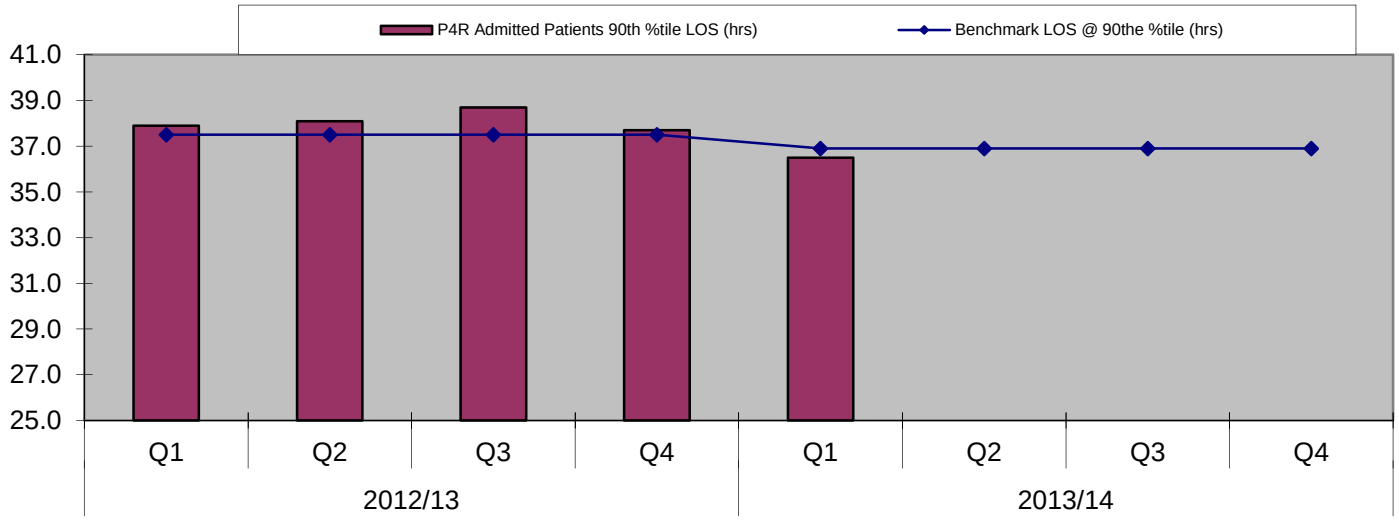
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The total ER LOS where 9 out of 10 admitted patients complete their visit. ER LOS is defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ER.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
P4R Admitted Patients 90th %tile LOS (hrs)	37.9	38.1	38.7	37.7	36.5			
Benchmark LOS @ 90the %tile (hrs)	37.5	37.5	37.5	37.5	36.9	36.9	36.9	36.9

Significance: Part of the MOHLTC ED Pay for Results (P4R) initiative aimed at improving ED treatment time and wait time.

BIG AIM - P4R Admitted Patients 90th Percentile LOS



Analysis: Outperforming to benchmark. Q1 results improved over previous four quarters and better than target (36.3% versus 36.9%), while ED demand remains constant at approximately 8,000 patients per month
Changes to over bed capacity reduced time to inpatient bed and overall ED length of stay for admitted patients
96 patients placed using overcapacity processfrom Apr 29 – Jun 26

Plan for Improvement/Timelines: Continue to increase capacity through: Reducing ALC days;
Increasing interprofessional staffing (OT, PT, RA, SW) on weekends to continue treatment plans 24/7;
Improving access and flow through structural changes;
4M piloting improved admission and discharge process to reduce acute LOS

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Clostridium Difficile

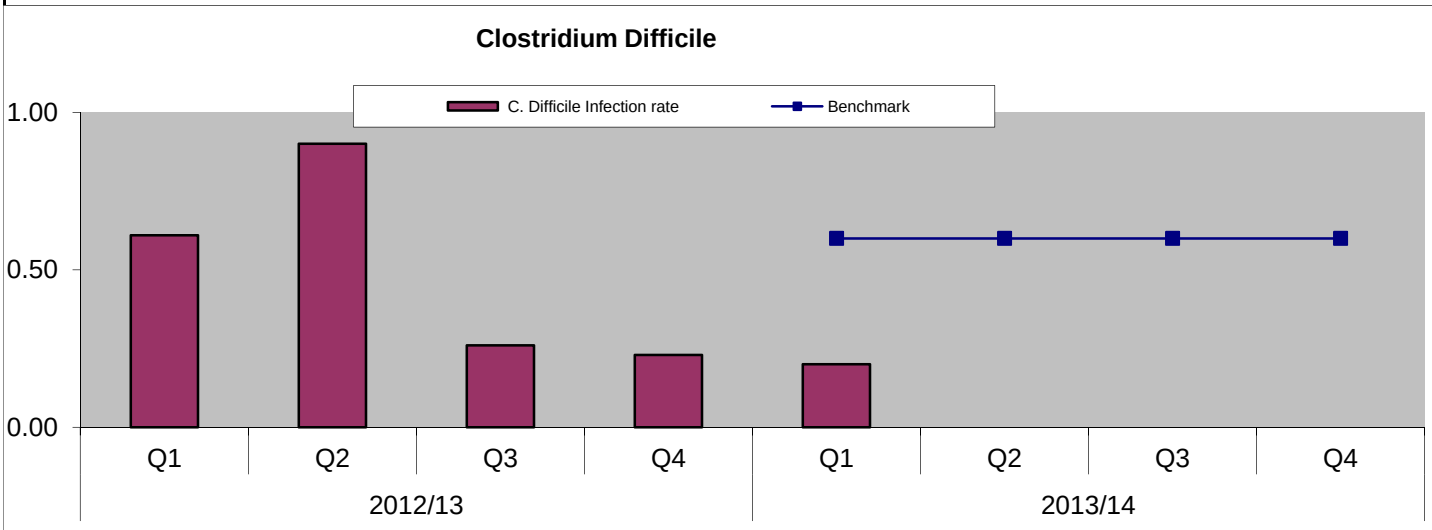
SUCCESS FACTOR:

Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: Number of patients that have developed C. Difficile per 1000 patient days

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
C. Difficile Infection rate	0.61	0.90	0.26	0.23	0.20			
Benchmark					0.60	0.60	0.60	0.60

Significance: C. Difficile is a species of bacteria which causes diarrhea and other intestinal disease when competing bacteria are wiped out by antibiotics. C. difficult is the most serious cause of antibiotic-associated diarrhea (AAD) and can lead to a severe infection of the colon often resulting from eradication of the normal gut flora. C. Difficile contributes to patient co-morbidities and longer length of stays and it can lead to increased mortality and morbidity.



Analysis: Outperforming to benchmark. 6 cases this quarter. April 0; May 4 cases; June 2 cases

Plan for Improvement/Timelines: CQI Reducing C.difficile committee in place with Working Hand Hygiene Group subcommittee. Ongoing eduction to staff. Infection Control resource binder developed and will be distributed to all staff. Emergency Rounds continue and registration triage desk barriers are installed. Clorox company currently reviewing Biomedical Engineering and OR equipment lists to determine if Clorox wipes are safe for use on each equipment type. As well, Clorox company also testing use of Clorox on casings for electronic hand held devices. Antimicrobial Stewardship Program active. Hand Hygiene Products for evaluation pending.

Accountability: L. O'Drowsky (Interim)

CORPORATE PERFORMANCE INDICATOR

Falls With Harm

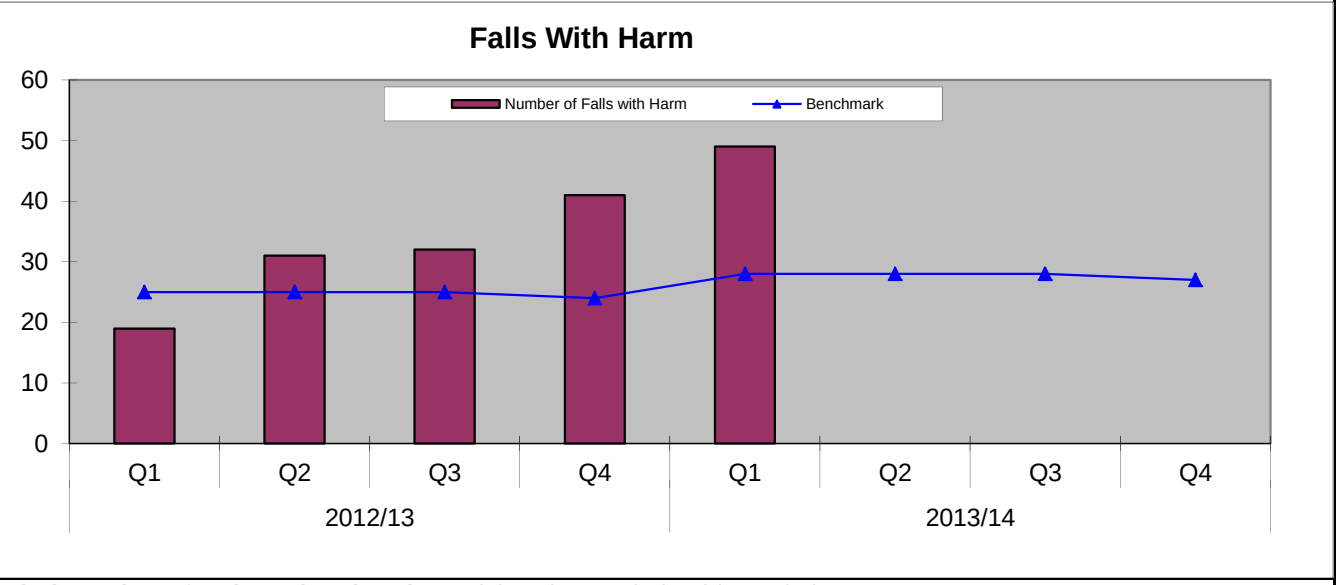
SUCCESS FACTOR:

Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: Number of Falls with Harm as defined by Risk Monitor Pro. Including severity levels 2 (harm - bumps/bruises), 3 (harm - fractures), and 4 (harm - death).

	2012/13				2013/14			
Date	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Falls with Harm	19	31	32	41	49			
Benchmark	25	25	25	24	28	28	28	27

Significance: To reduce number of falls with harm by a magnitude of 10% by March 31, 2014



Analysis: Underperforming to benchmark. Breakdown by severity level (Q1 13/14):
Level 2: 43 (fall result in minor harm/damage, additional follow-up/monitoring required)
Level 3: 5 (fall results in major permanent harm/damage, or major surgical/medical intervention required)
Level 4: 0 (fall results in death, extensive follow-up and investigation required)

Plan for Improvement/Timelines: Initiate 4L trial: q2hourly rounds, to include turning, repositioning, toileting routine by RN and IP staff
Falls Committee co-chairs to meet with each PCM (Medicine/Surgery) to strategize on prevention equipment & activities, conducting safety huddles at daily team talks

Accountability: TBD

CORPORATE PERFORMANCE INDICATOR

Pressure Ulcers

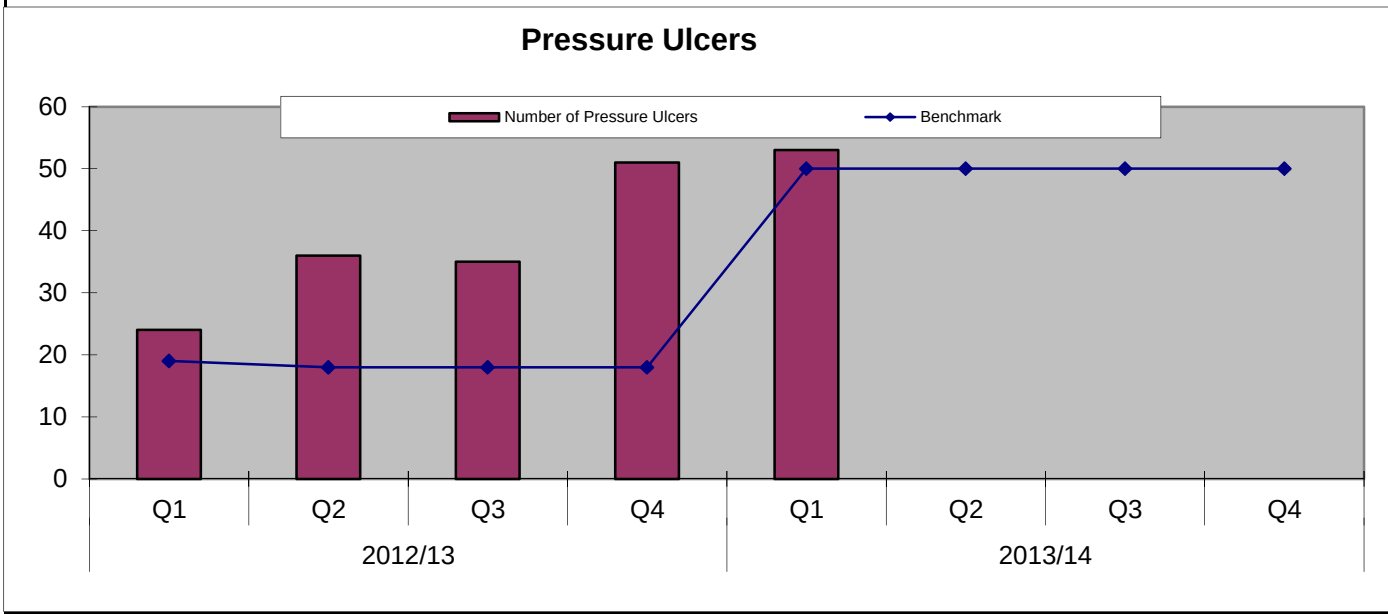
SUCCESS FACTOR:

Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: Number of nosocomial pressure ulcers as defined in Risk Monitor Pro. including severity levels 1, 2, 3, and 4.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Pressure Ulcers	24	36	35	51	53			
Benchmark	19	18	18	18	50	50	50	50

Significance: To reduce number of pressure ulcers by a magnitude of 10% by March 31, 2014. To decrease the length of stay in hospital therefore reduce harm to patient.



Analysis: Within 10% to benchmark. Breakdown by pressure ulcers stages (Q1 13/14):
Stage 1: 13 (area of persistent redness)
Stage 2: 26 (blister/partial loss of skin layers/not purple)
Stage 3 : 3 (deep craters in skin)
Stage 4: 0 (muscle/bone exposed)
Suspected deep tissue injury : 8 (non-blanchable purple base/blister)
Unstageable: 3 (eschar covering visual field of wound bed)

Plan for Improvement/Timelines: Initiate 4L trial: q2hourly rounds, to include turning, repositioning, toileting routine by RN and IP staff
Wound Committee chair to meet with each PCM (Medicine/Surgery) to strategize on prevention equipment & activities, conducting safety huddles at daily team talks

Accountability: L.O'Drowsky (Interim)

CORPORATE PERFORMANCE INDICATOR

MRSA Colonization and Infection Incidence (mandatory)

SUCCESS FACTOR:

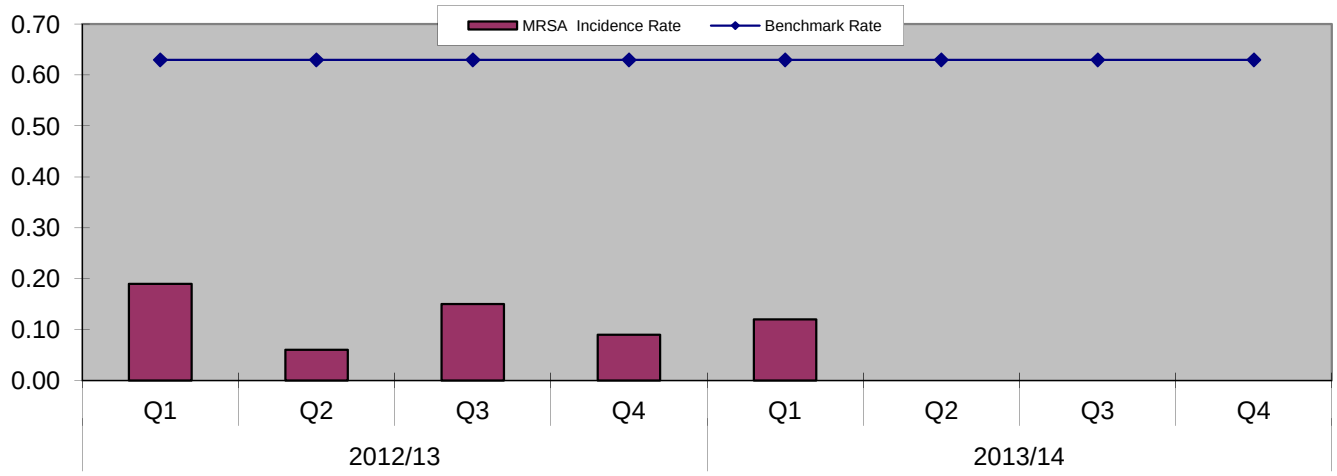
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

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

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
MRSA Incidence Rate	0.19	0.06	0.15	0.09	0.12			
Benchmark Rate	0.63	0.63	0.63	0.63	0.63	0.63	0.63	0.63

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

MRSA Incidence



Analysis: Outperforming to benchmark. Outperforming indicator. 4 cases for the quarter. April 3M(1), May 2L Surg (1), June 4L Med (1), 6M (1).

Plan for Improvement/Timelines:

Accountability: L. O'Drowsky (Interim)

CORPORATE PERFORMANCE INDICATOR

VRE Colonization and Infection Incidence (mandatory)

SUCCESS FACTOR:

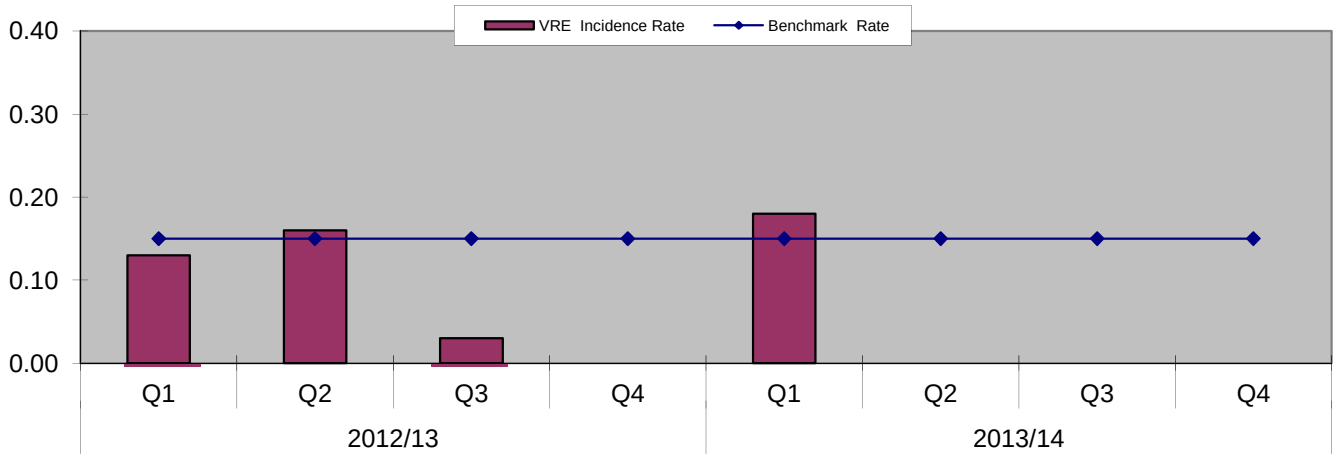
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

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

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
VRE Incidence Rate	0.13	0.16	0.03	0.00	0.18			
Benchmark Rate	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15

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

VRE Incidence



Analysis: Underperforming to benchmark. Over target at 6 cases for this quarter. April 4M (1), May 3M (1), 2L Surg (2); June ICU (1), 4L Med (1). No clusters or outbreaks.

Plan for Improvement/Timelines:

Accountability: L. O'Drowsky (Interim)

CORPORATE PERFORMANCE INDICATOR

Ventilator-Associated Pneumonia (mandatory)

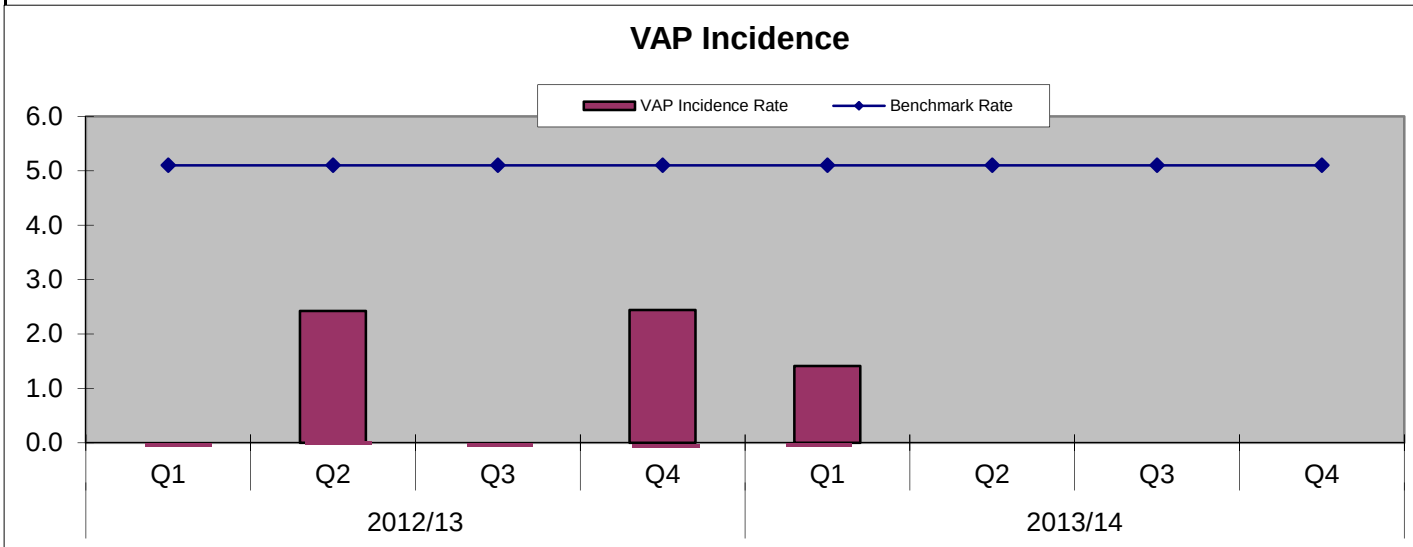
SUCCESS FACTOR:

Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: ICU Ventilator-Associated Pneumonia (VAP) cases per 1000 device days. Benchmark taken from Safer HealthCare Now.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
VAP Incidence Rate	0.0	2.4	0.0	2.4	1.4			
Benchmark Rate	5.1	5.1	5.1	5.1	5.1	5.1	5.1	5.1

Significance: One component of the Safer Healthcare Now reporting initiative and is required reporting by the MOHLTC.



Analysis: Outperforming to benchmark. ICU continues to have a VAP Incidence Rate below our Benchmark Rate. All aspects of the bundle are initiated and in place.

Plan for Improvement/Timelines: ICU continues with the established process to monitor for VAP. Once identified as a VAP, the bundle compliance is reviewed and any learnings are shared with the team. All VAP are reviewed at monthly ICU POCT Meetings as a standing agenda item.

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Central Line-Associated Bloodstream Infection Rate (mandatory)

SUCCESS FACTOR:

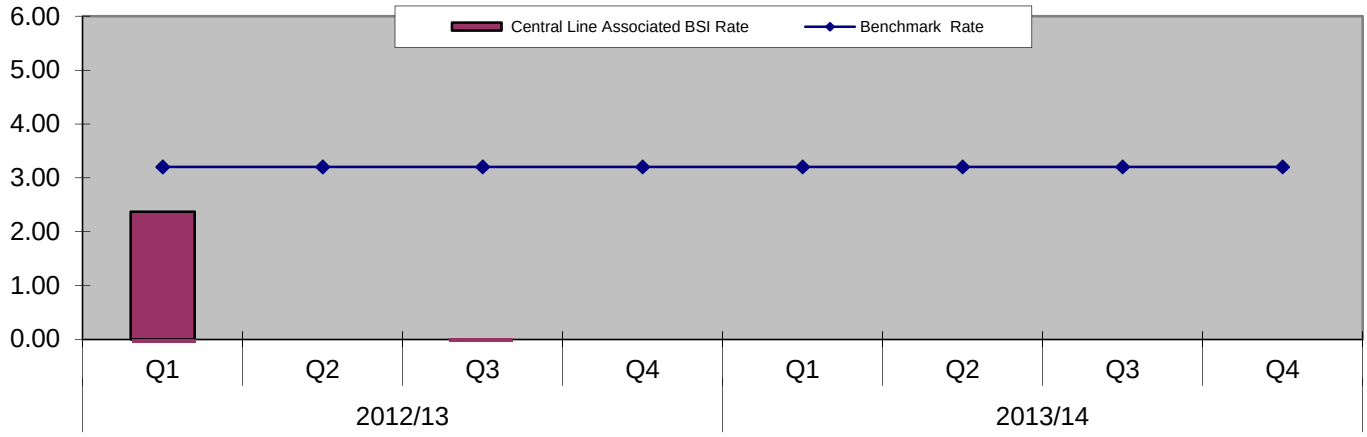
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: ICU central line-associated bloodstream infections per 1000 device days. Benchmark taken from Safer HealthCare Now.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Central Line Associated BSI Rate	2.37	0.00	0.00	0.00	0.00			
Benchmark Rate	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2

Significance: One component of the Safer Healthcare Now reporting initiative and is required reporting by the MOHLTC.

Central Line-Associated BSI Rate



Analysis: Outperforming to benchmark. ICU continue to have a BSI Incidence Rate well below our Benchmark Rate. All aspects of the bundle are initiated and in place.

Plan for Improvement/Timelines: ICU continues with the established process to monitor for BSI. Once identified as a BSI, the bundle compliance is reviewed. All BSI are reviewed at monthly ICU POCT Meetings and any learnings from cases are shared with the team. Changes/improvments with the standard at peer hospitals are reviewed and we are presently considering the acquistion of total body drapes for CVL insertions as is now the standard at most of our peer teaching hospitals.

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Would you recommend - ER Satisfaction

SUCCESS FACTOR:

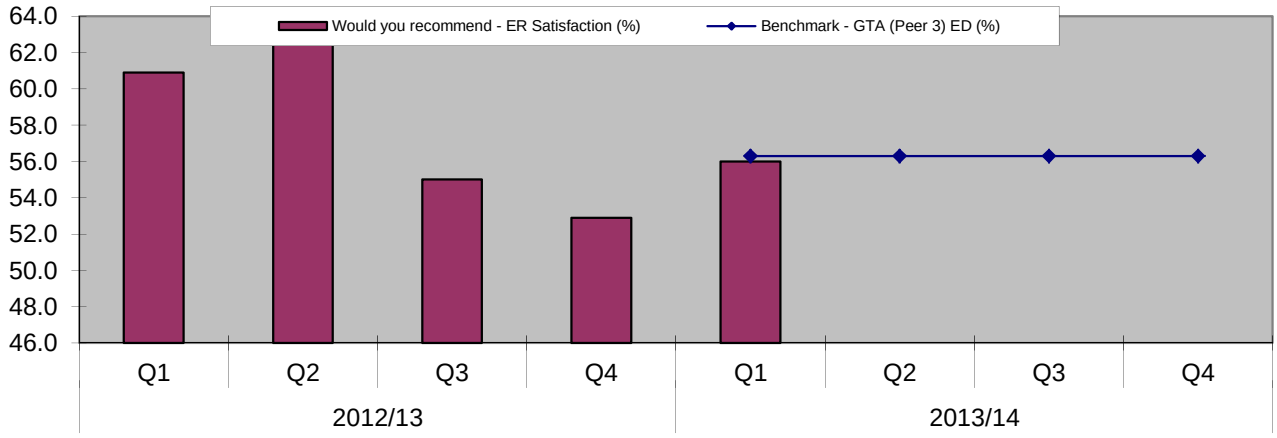
- ☑ **Put Patients First**
- ☐ **Inspire Our People**
- ☐ **Use Resources Wisely**
- ☐ **Enhance the Health of the Communities We Serve**
- ☐ **Create a Culture of Inquiry and Innovation**

Definition: Percentage of positive scores on the question that assesses if patient would recommend ED services to their friends and family

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Would you recommend - ER Satisfaction (%)	60.9	63.1	55.0	52.9	56.0			
Benchmark - GTA (Peer 3) ED (%)					56.3	56.3	56.3	56.3

Significance: A high degree of patient satisfaction is linked with better outcomes for patients. Important knowledge for improving the quality of those aspects of care that are most important to patients

Overall Patient Satisfaction with ER Care Received



Analysis: Underperforming to benchmark. Preliminary results for Q1 are higher compared to previous quarter and slightly lower than target (56.0% versus 56.3%). Among all indicators within the Top Priority of the quadrant for the "Would you recommend question" priority matrix for the last 5 quarters, "Rate amount of time spent in ED" consistently has a low score but a high correlation with patient recommendations for ED services and overall patient satisfaction.

Plan for Improvement/Timelines:

-First e-mail feedback survey report delivered to the ACC Manager for comments.
-Project manager is communicating with Medical and Administrative directors regarding the ED e-mail survey roll out
-Working with ED manager to draft survey
-Anticipate ED patient e-mail survey collection by end of August 2013

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Hospital Standardized Mortality Ratio - All Cases (mandatory)

SUCCESS FACTOR:

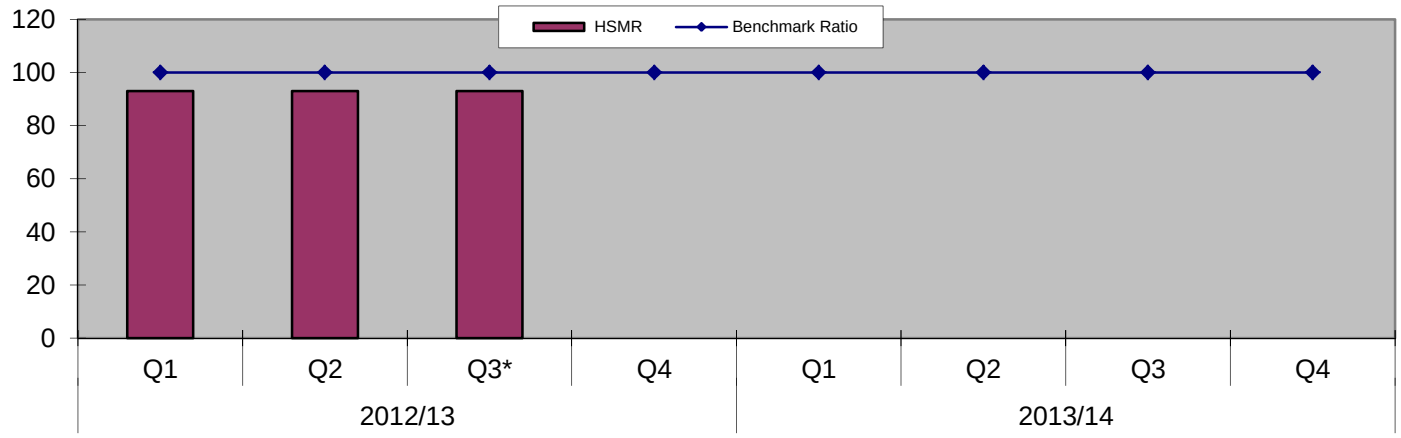
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The HSMR is based on ICD-10 diagnosis groups that account for 80% of all deaths in acute care hospitals. It is a ratio of the actual number of deaths to the expected number of deaths; adjusted for age, sex and length of stay. Baseline was adjusted from 2004-05 to 2009-10, therefore all historical values have been restated

	2012/13				2013/14			
	Q1	Q2	Q3*	Q4	Q1	Q2	Q3	Q4
HSMR	93	93	93	N/A	N/A			
Benchmark Ratio	100	100	100	100	100	100	100	100

Significance: An HSMR greater than 100 suggests that the local mortality rate is higher than the overall average; less than 100 suggests the local mortality rate is lower than average. Included as part of the Quality Improvement Plan (QIP)

HSMR



Analysis:

Plan for Improvement/Timelines:

Accountability: Dr. Rogovein

CORPORATE PERFORMANCE INDICATOR

90th Percentile LOS for Non-admitted High Acuity

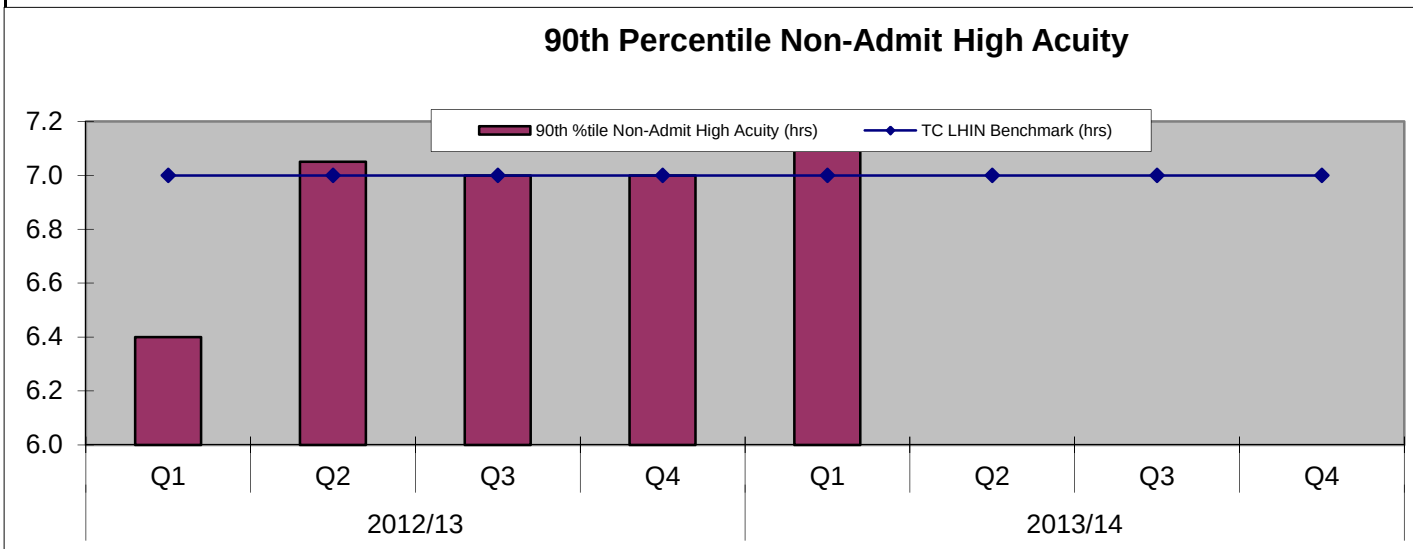
SUCCESS FACTOR:

Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The total ER LOS where 9 out of 10 non-admitted complex (Canadian Triage & Acuity Scale (CTAS) levels I, II, and III) patients complete their visit. ER LOS is defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ER.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
90th %tile Non-Admit High Acuity (hrs)	6.4	7.1	7.0	7.0	7.1			
TC LHIN Benchmark (hrs)	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0

Significance: Included as part of the HSAA Supplementary Request from the TC LHIN.



Analysis: Within 10% to benchmark.

Plan for Improvement/Timelines: Increased by 2 extra assessment areas. Continue with enhanced strategies to improve flow particularly in the Ambulatory Area of ED, shifts in nursing assignments, Pt. Navigator project. Have increased to 3 scribes per day as of Q4 - will increase to 4 PN's daily as of May 2013. Recommendations from ED Operational Review will add strategies to support continued improvement.. Portering initiative in planning stage - should assist with flow.

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

90th Percentile LOS for Non-admitted Low Acuity

SUCCESS FACTOR:

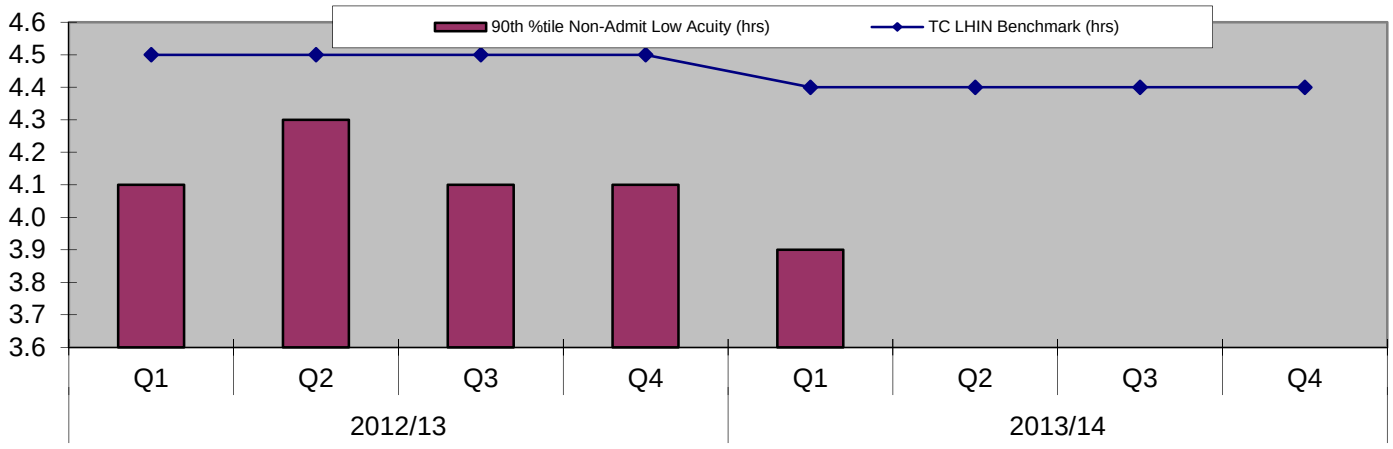
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The total ER LOS where 9 out of 10 non-admitted minor/uncomplicated (Canadian Triage & Acuity Scale (CTAS) levels IV and V) patients complete their visit. ER LOS is defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ER.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
90th %tile Non-Admit Low Acuity (hrs)	4.1	4.3	4.1	4.1	3.9			
TC LHIN Benchmark (hrs)	4.5	4.5	4.5	4.5	4.4	4.4	4.4	4.4

Significance: Included as part of the HSAA Supplementary Request from the TC LHIN.

90th Percentile LOS for Non-Admitted Low Acuity



Analysis: Outperforming to benchmark.

Plan for Improvement/Timelines: Increased by 2 extra assessment areas. Continue with enhanced strategies to improve flow particularly in the Ambulatory Area of ED, shifts in nursing assignments, Pt. Navigator project. Have increased to 3 scribes per day as of Q4 - will increase to 4 PN's daily as of May 2013. Recommendations from ED Operational Review will add strategies to support continued improvement.

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Chemotherapy Systemic Treatment - Quality Based Procedure (Cases)

SUCCESS FACTOR:

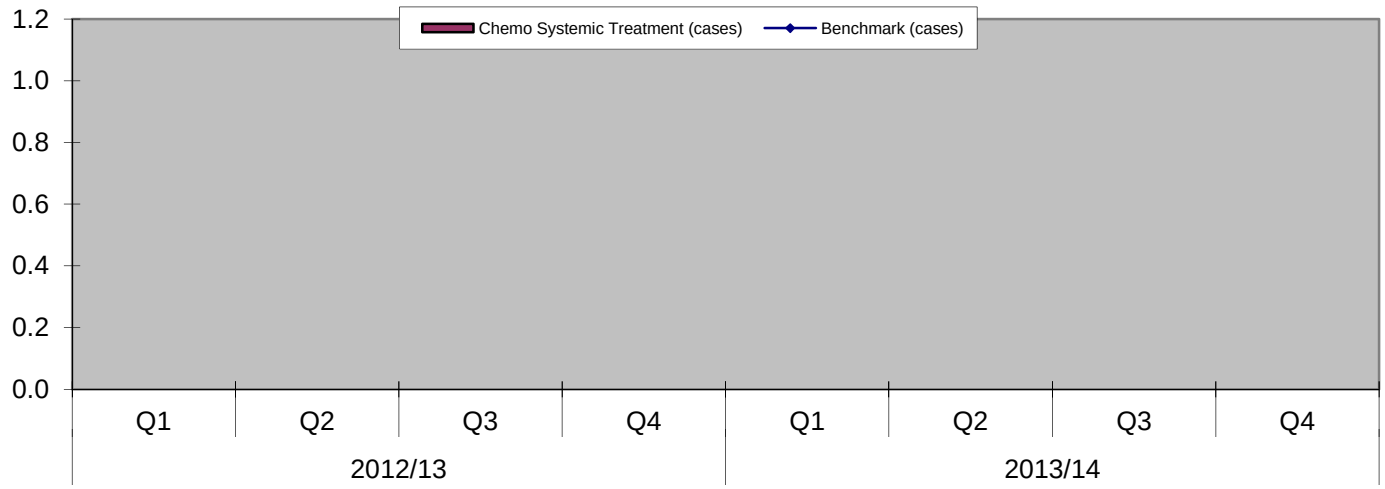
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: TBD

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Chemo Systemic Treatment (cases)								
Benchmark (cases)								

Significance:

Chemotherapy Systemic Treatment - Quality Based Procedure (Cases)



Analysis: New QBP - Work underway with TC LHIN to establish indicator targets.

Plan for Improvement/Timelines:

Accountability:

CORPORATE PERFORMANCE INDICATOR

Chronic Obstructive Pulmonary Disease - Quality Based Procedure (Cases)

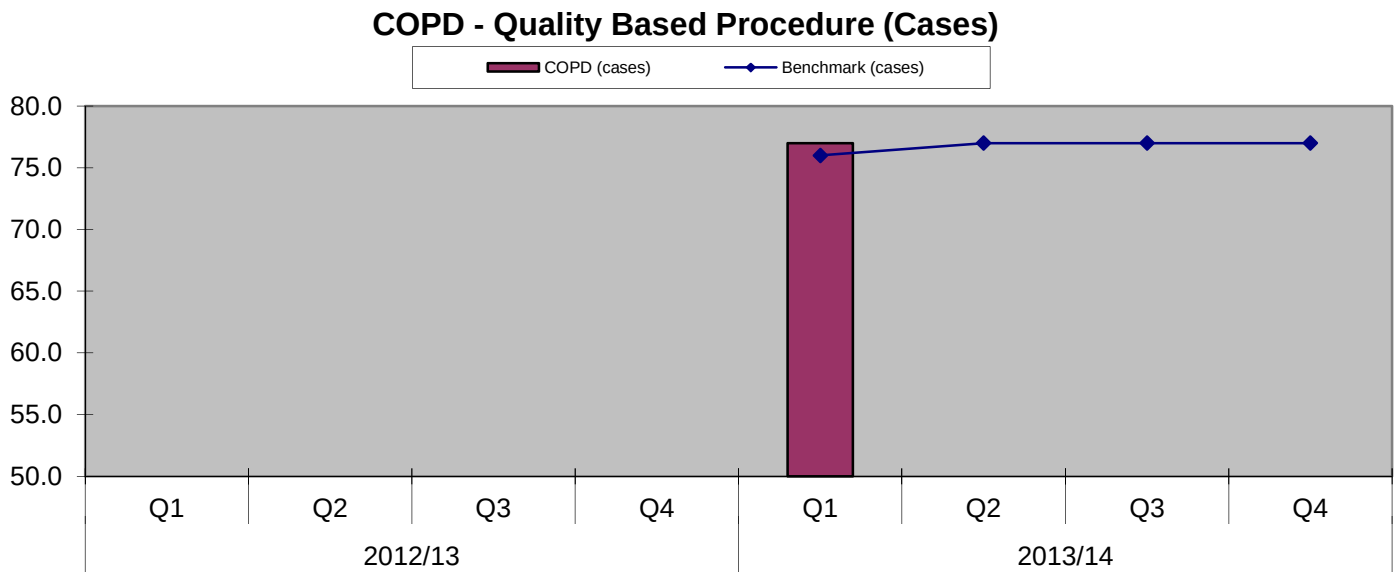
SUCCESS FACTOR:

Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: New QBP - Indicator capture the number of Chronic Obstructive Pulmonary Disease cases.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
COPD (cases)					77			
Benchmark (cases)					76	77	77	77

Significance:



Analysis: Outperforming to benchmark.

Plan for Improvement/Timelines:

Accountability:

CORPORATE PERFORMANCE INDICATOR

Endoscopy - Quality Based Procedure (Cases)

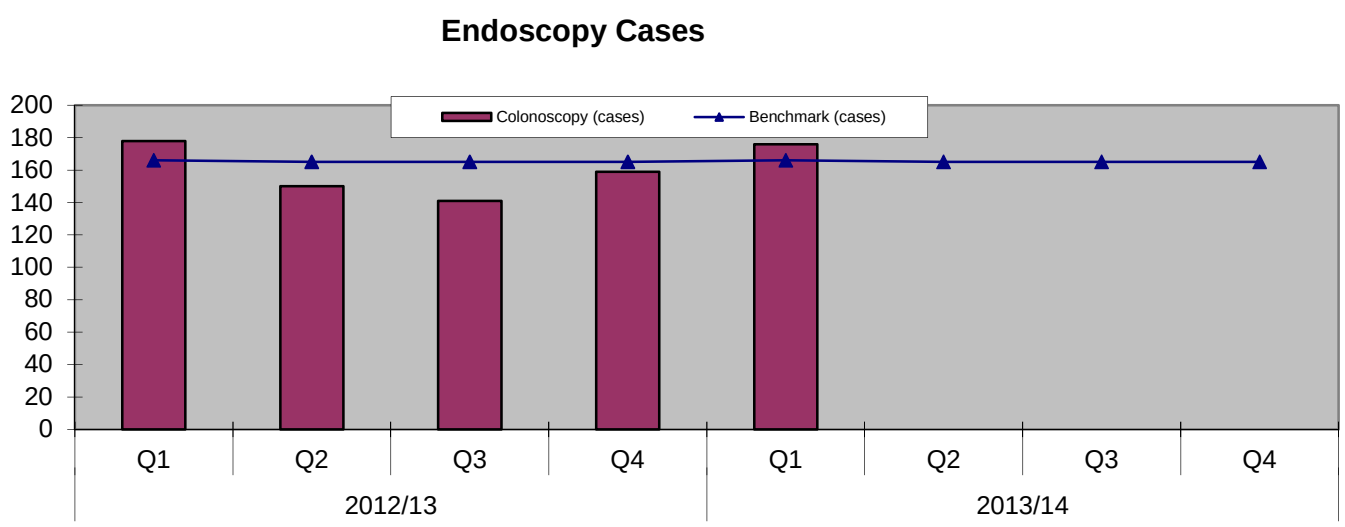
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of patients who have had a colonoscopy and have either a first degree family member with the disease, or a positive Fecal Occult Blood Test (FOBT).

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Colonoscopy (cases)	178	150	141	159	176			
Benchmark (cases)	166	165	165	165	166	165	165	165

Significance: The allocation of volumes will support Ontario's Wait Time Strategy, which includes the development of a comprehensive system to monitor wait times and help ensure that Ontarians receive timely and appropriate access to five select services: cancer surgery, cataract surgery, hip and knee replacements, and MRI and CT exams. The volumes will support this goal and are to assist organizations in reducing waiting times for surgical cases and/or diagnostic imaging.



Analysis: Outperforming to benchmark. The total number of colonoscopy cases has increased this quarter, 10 more than benchmark cases and 17 cases more than last quarter.

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Non-Cardiac Vascular - Quality Based Procedure (Cases)

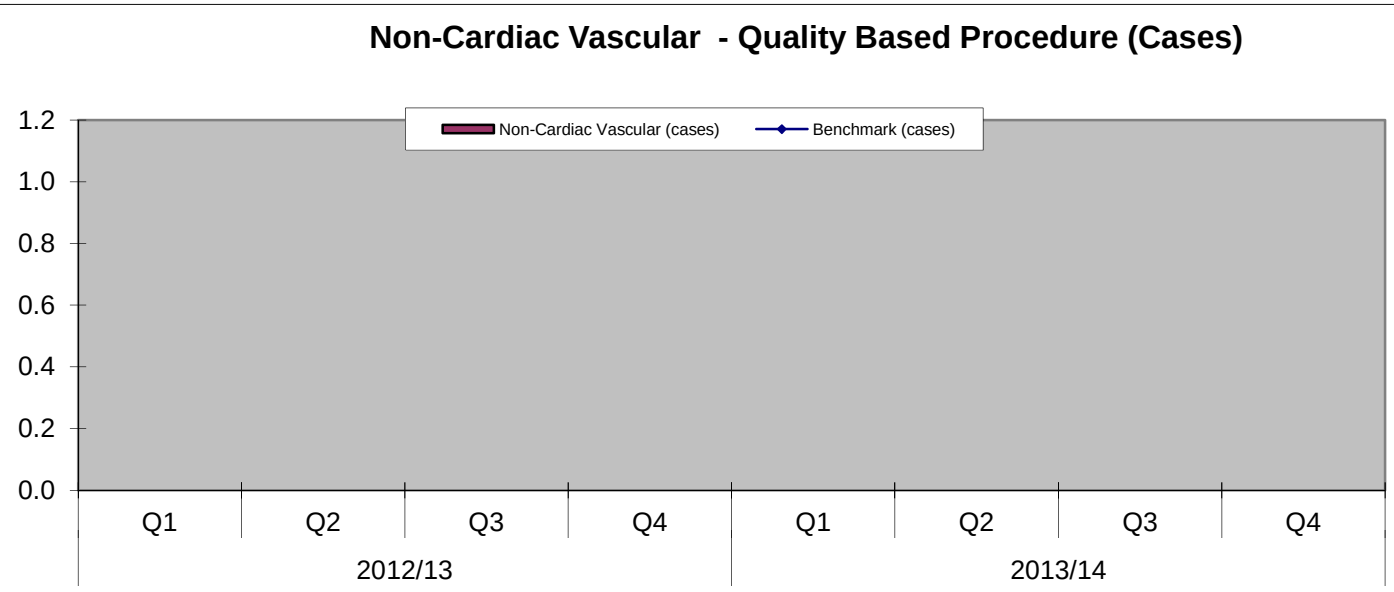
SUCCESS FACTOR:

Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: TBD

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Cardiac Vascular (cases)								
Benchmark (cases)								

Significance:



Analysis: TBD - New QBP

Plan for Improvement/Timelines:

Accountability:

CORPORATE PERFORMANCE INDICATOR

Congestive Heart Failure - Quality Based Procedure (Cases)

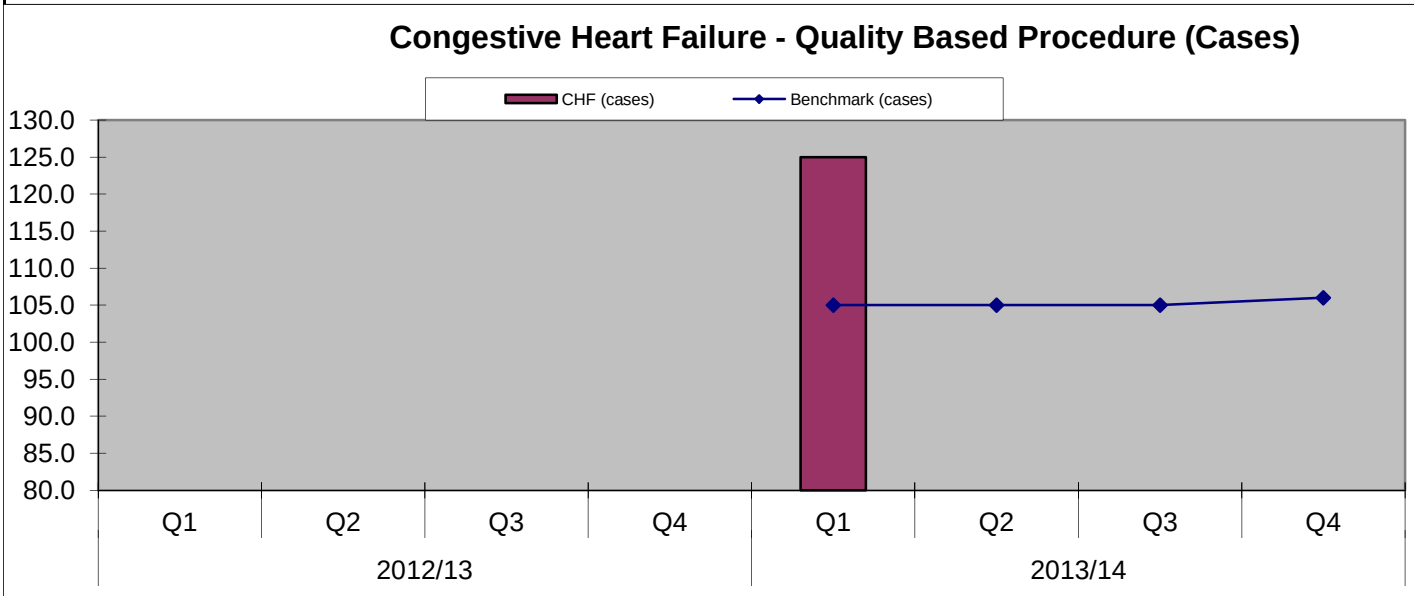
SUCCESS FACTOR:

Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: New QBP - indicator captures the number of Congestive Heart Failure cases.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CHF (cases)					125			
Benchmark (cases)					105	105	105	106

Significance:



Analysis:

Plan for Improvement/Timelines:

Accountability:

CORPORATE PERFORMANCE INDICATOR

Stroke - Quality Based Procedure (Cases)

SUCCESS FACTOR:

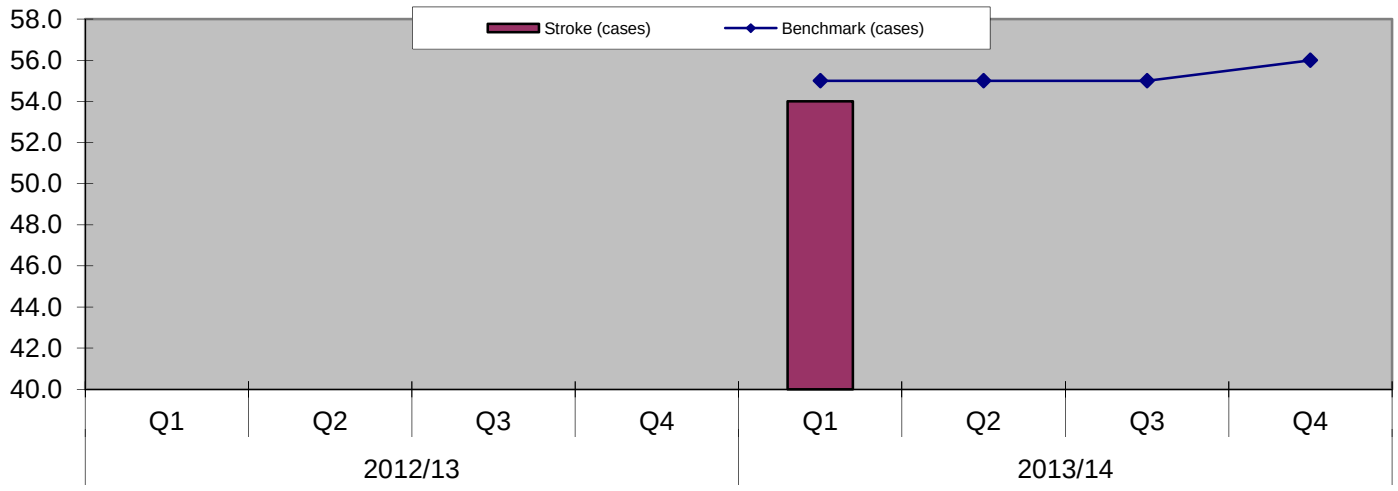
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: New QBP - indicator captures three types of stoke for inpatients: Hemorrhagic, Ischemic or unspecified and Transient Ischemic Attack (TIA).

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Stroke (cases)					54			
Benchmark (cases)					55	55	55	56

Significance:

Stroke - Quality Based Procedure (Cases)



Analysis: Within 10% of benchmark.

Plan for Improvement/Timelines:

Accountability:

CORPORATE PERFORMANCE INDICATOR

Hand Hygiene Compliance (mandatory)

SUCCESS FACTOR:

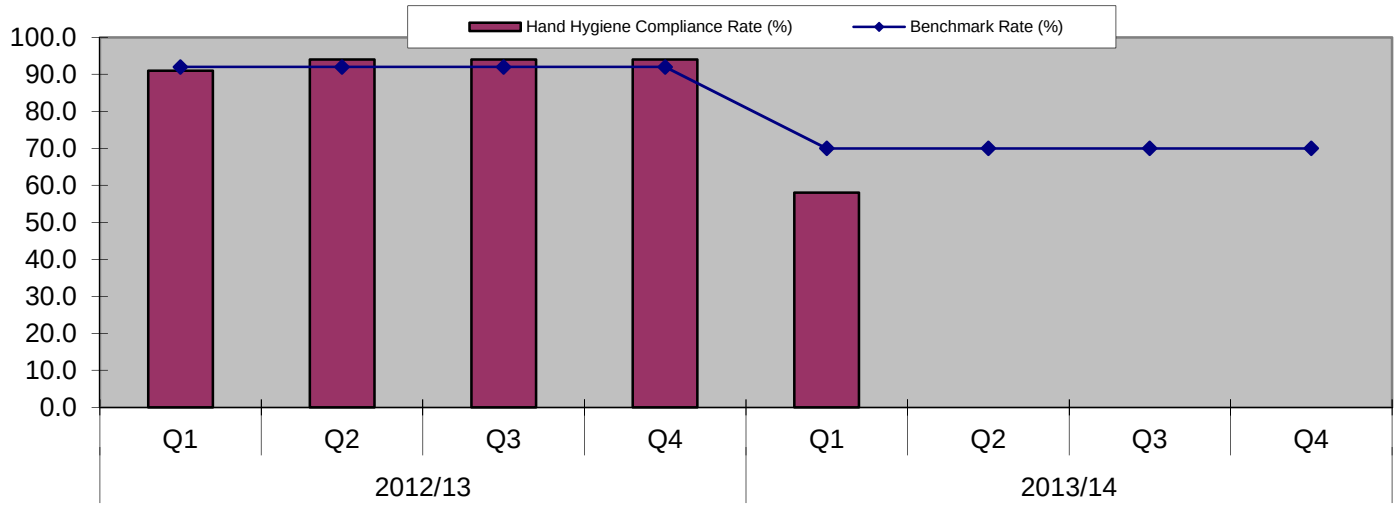
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The percentage compliance for before and after patient / patient environment contact by combined categories of health care practitioners. (i.e.. # of times hand hygiene performed before and after contact as a percentage of the # observed hand hygiene indications before and after contact.)

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Hand Hygiene Compliance Rate (%)	91.0	94.0	94.0	94.0	58.0			
Benchmark Rate (%)	92.0	92.0	92.0	92.0	70.0	70.0	70.0	70.0

Significance: One component of the Safer Healthcare Now reporting initiative and is required reporting by the MOHLTC.

Hand Hygiene Compliance Rate



Analysis: Underperforming to benchmark. An entirely new process for collecting and measuring HH is underway.

Plan for Improvement/Timelines: April 2013 self auditing ceased and hand hygiene audits conducted by trained observers with inter-related reliability testing. Hand hygiene Working Group a subcommittee of CQI Reducing C. difficile committee. Electronic based auditing system has gone to tender and is expected to be completed by end of July. Educational Road Show is underway.

Accountability: L. O'Drowsky (Interim)

CORPORATE PERFORMANCE INDICATOR

Surgical Safety Checklist Compliance

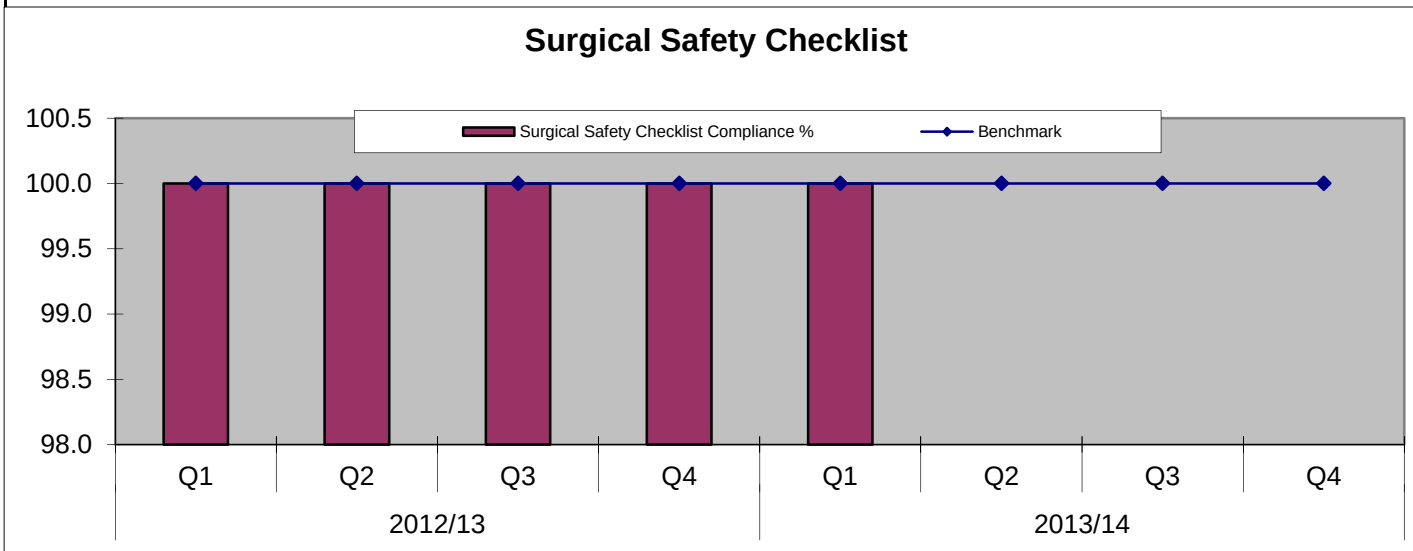
SUCCESS FACTOR:

Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of cases where all three phases of the surgical safety checklist were performed as a percentage of total number of surgeries performed

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Surgical Safety Checklist Compliance %	100.0	100.0	100.0	100.0	100.0			
Benchmark	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Significance: Included as part of the Quality Improvement Plan (QIP). To improve the reliability of care through the use of Surgical Safety Checklist



Analysis: Outperforming to benchmark.

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

HIGH RISK MEDICATION SAFETY EVENTS

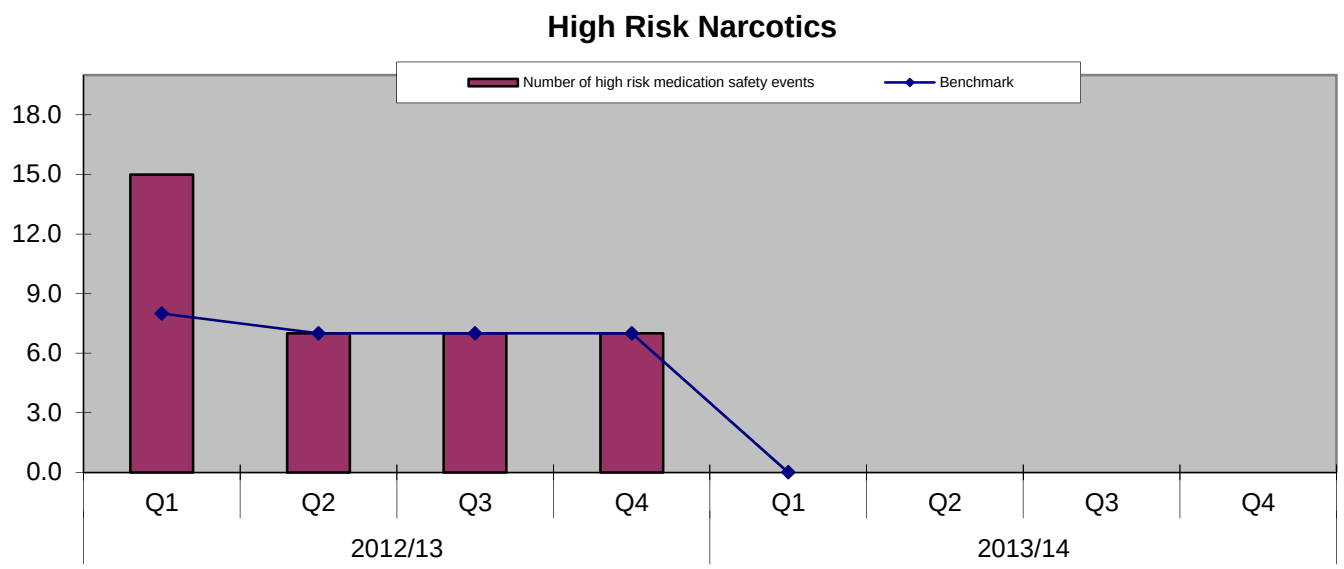
SUCCESS FACTOR:

Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of safety events involving the three narcotics; hydromorphone, morphine and oxycodone.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of high risk medication safety events	15	7	7	7	N/A			
Benchmark	8	7	7	7	N/A			

Significance: Medication errors contribute to patient harm, the aim is to reduce the number of safety events resulting from high risk medications - narcotics and opioids. Included as part of the Quality Improvement Plan (QIP)



Analysis: N/A

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

eCare - Project Plan Compliance

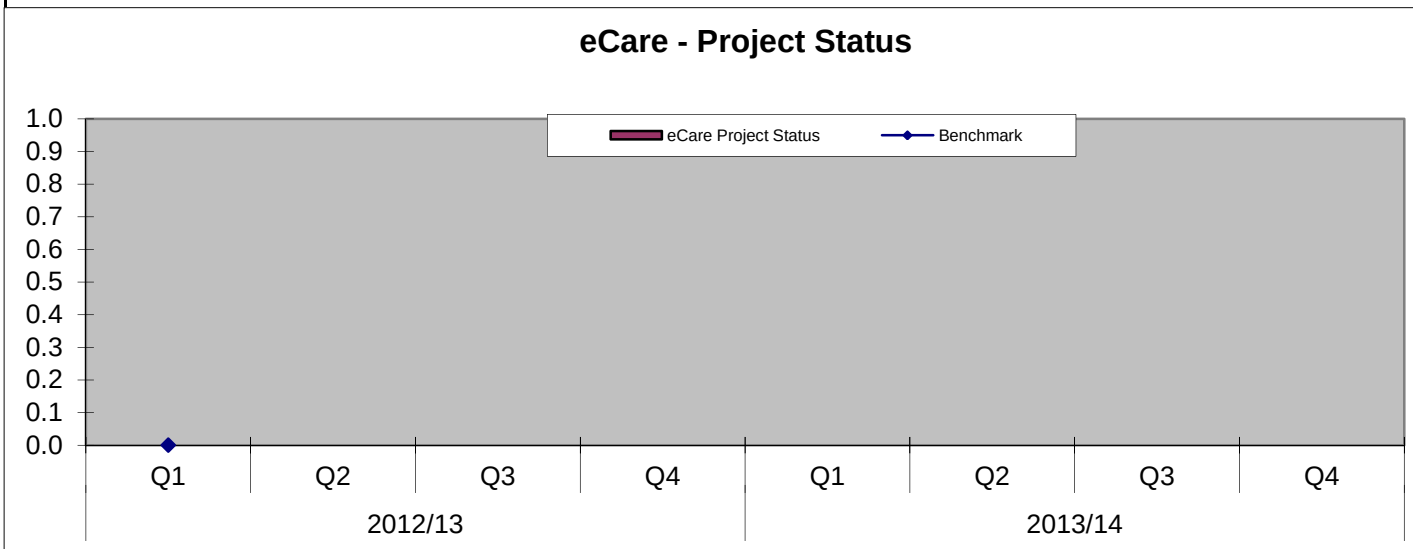
SUCCESS FACTOR:

Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: Base on the eCare Executive Milestone Status Report, this metric measures progress on Actual Percentage Completed of activities compared to the Planned Percentage of Completion activities for all plan deliverables.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
eCare Project Status			Yellow	Yellow	TBD			
Benchmark	Base on eCare Executive Milestone Status Report							

Significance: To determine if the project is progressing as planned therefore being able to act proactively to improve performance.



Accountability: M. Vimr

CORPORATE PERFORMANCE INDICATOR

30 Day In-Hospital Mortality Following Acute Myocardial Infraction (rate per 100)

SUCCESS FACTOR:

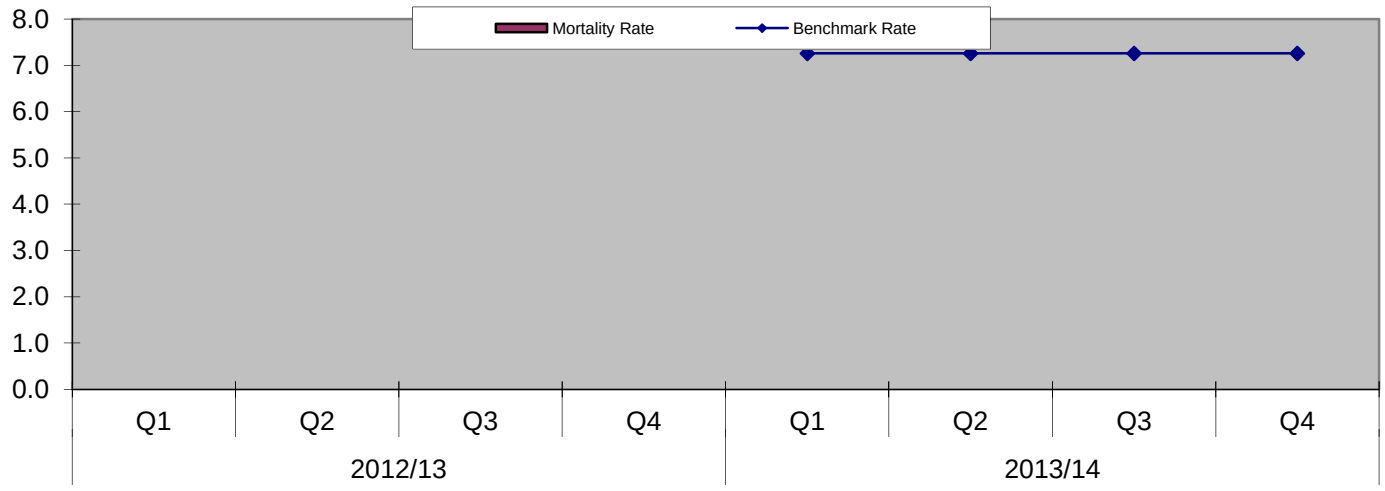
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The rate of in-hospital deaths due to all causes occurring within 30 days after the first acute myocardial infarction (AMI) admission to an acute care hospital.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Mortality Rate					N/A			
Benchmark Rate					7.26	7.26	7.26	7.26

Significance:

30 Day In-Hospital Mortality Following Acute Myocardial Infraction



Analysis: Q1 coded data not available until September 2013.

Plan for Improvement/Timelines:

Accountability:

CORPORATE PERFORMANCE INDICATOR

30 Day In-Hospital Mortality Following Stroke (rate per 100)

SUCCESS FACTOR:

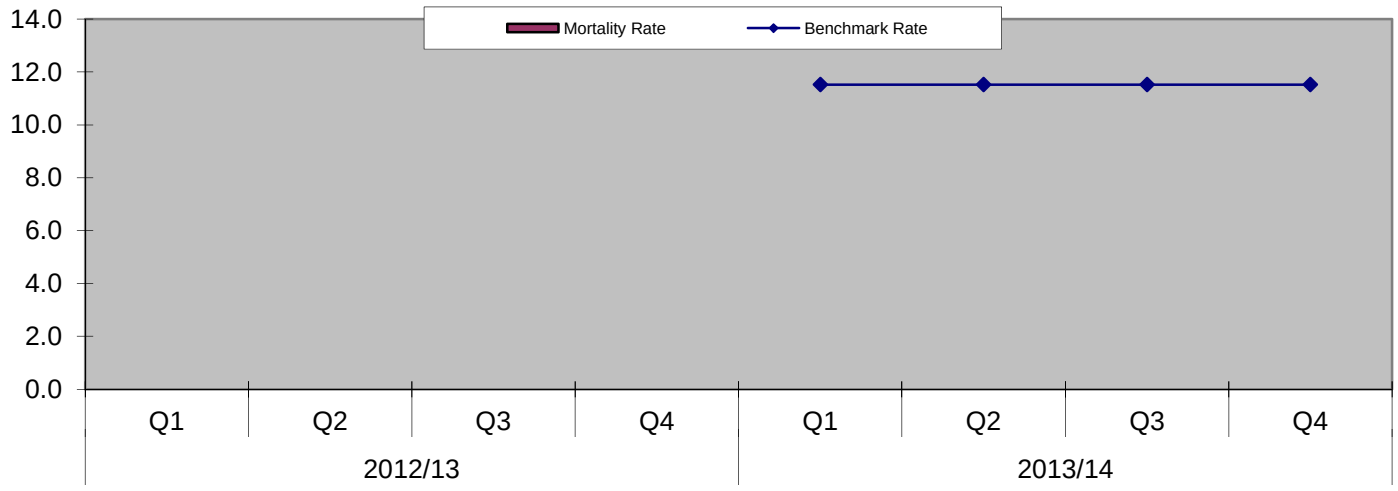
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The rate of in-hospital deaths due to all causes occurring within 30 days after the first stroke admission to an acute care hospital.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Mortality Rate					N/A			
Benchmark Rate					11.52	11.52	11.52	11.52

Significance:

30 Day In-Hospital Mortality Following Stroke (rate per 100)



Analysis: Q1 coded data not available until September 2013.

Plan for Improvement/Timelines:

Accountability:

CORPORATE PERFORMANCE INDICATOR

5 Day In-Hospital Mortality Following Major Surgery (rate per 1000)

SUCCESS FACTOR:

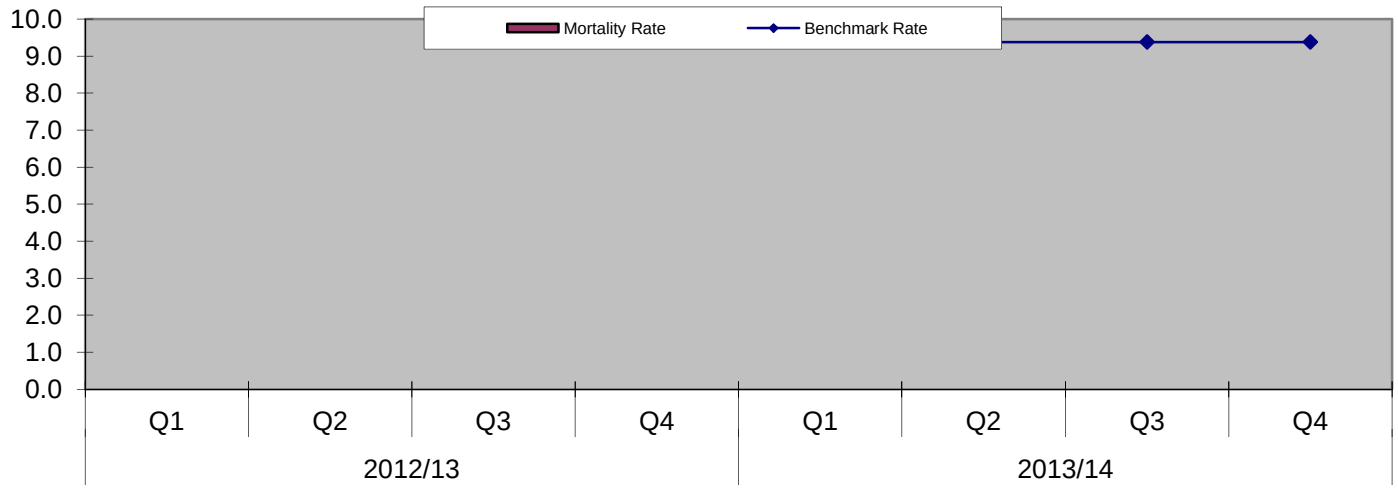
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The rate of in-hospital deaths due to all causes occurring within five days of major surgery

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Mortality Rate					N/A			
Benchmark Rate					9.38	9.38	9.38	9.38

Significance:

5 Day In-Hospital Mortality Following Major Surgery



Analysis: Q1 coded data not available until September 2013.

Plan for Improvement/Timelines:

Accountability:

CORPORATE PERFORMANCE INDICATOR

In-Hospital Hip Fracture in Elderly (65+) Patients (rate per 1000)

SUCCESS FACTOR:

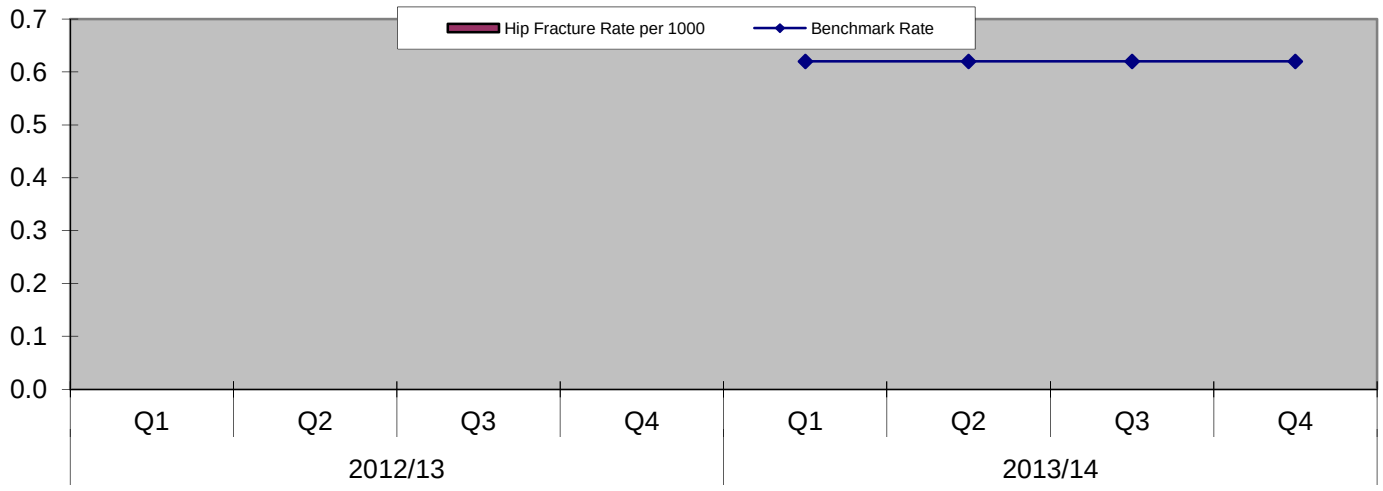
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The rate of in-hospital hip fractures among acute care inpatients age 65 and older

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Hip Fracture Rate per 1000					N/A			
Benchmark Rate					0.62	0.62	0.62	0.62

Significance:

In-Hospital Hip Fracture in Elderly (65+) Patients



Analysis: Q1 coded data not available until September 2013.

Plan for Improvement/Timelines:

Accountability:

CORPORATE PERFORMANCE INDICATOR

Caesarean Section Rate :Excluding Pre-Term and Multiple

SUCCESS FACTOR:

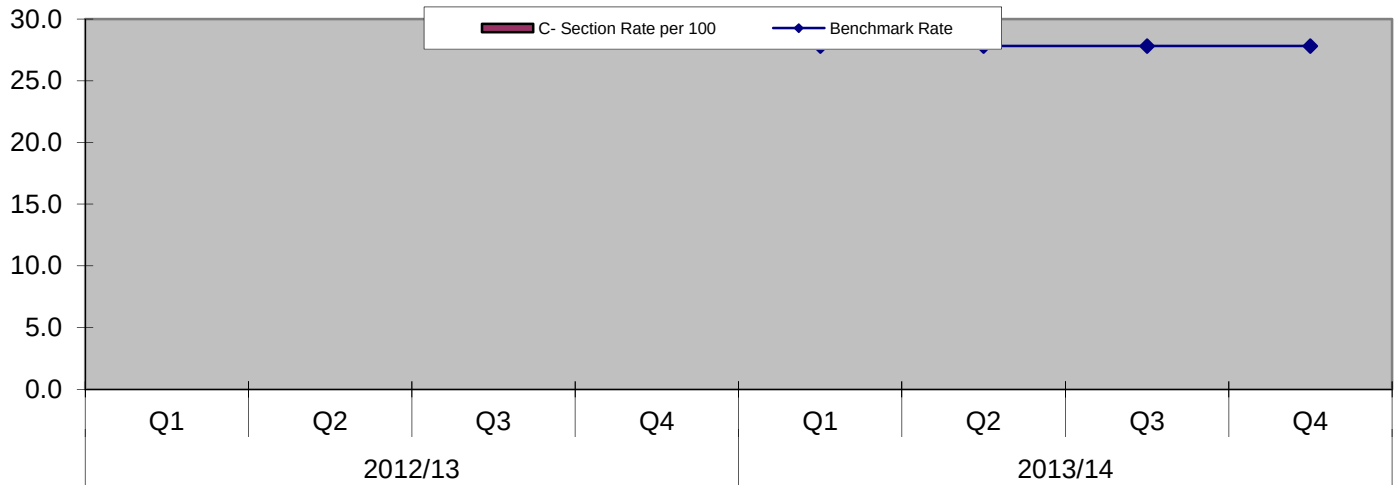
Put Patients First	☑	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The rate of deliveries via Caesarean section , excluding pre-term and multiple -gestation pregnancies

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
C- Section Rate per 100					N/A			
Benchmark Rate					27.8	27.8	27.8	27.8

Significance:

Caesarean Section Rate :Excluding Pre-Term and Multiple



Analysis: Q1 coded data not available until September 2013.

Plan for Improvement/Timelines:

Accountability:

CORPORATE PERFORMANCE INDICATOR

Hip Wait Time Days (mandatory)

SUCCESS FACTOR:

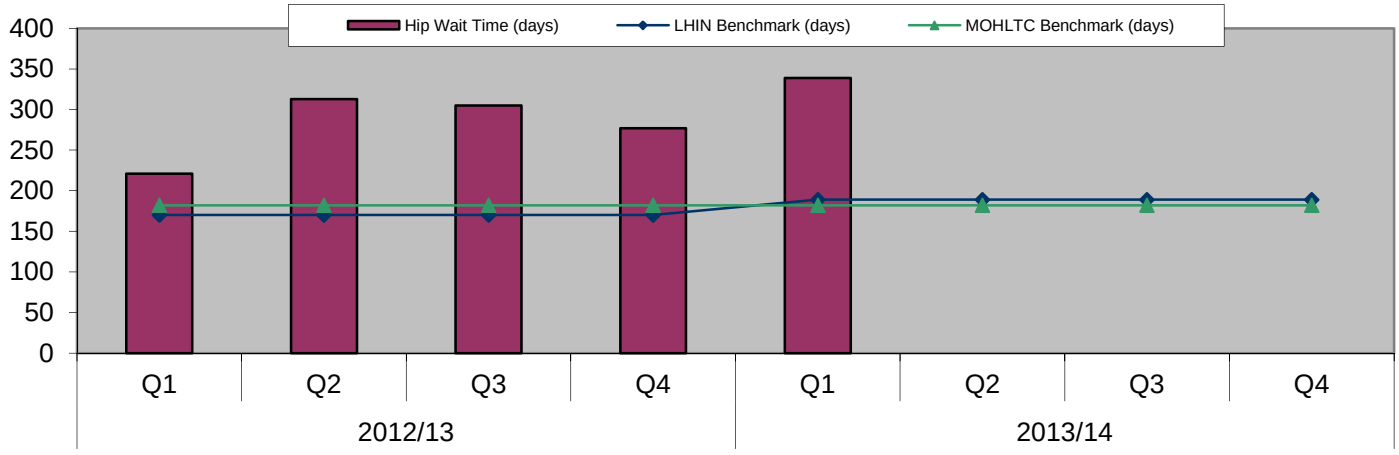
Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of days 9 out of 10 patients (90th percentile) wait for a hip replacement from the date of decision to treat to day of surgery. Current Wait Time targets are measured by TC LHIN at 170 days

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Hip Wait Time (days)	221	313	305	277	339			
LHIN Benchmark (days)	170	170	170	170	189	189	189	189
MOHLTC Benchmark (days)	182	182	182	182	182	182	182	182

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

Hip Wait Time (days)



Analysis: Underperforming to benchmark. Wait time performance in Q1 continues to exceed both LHIN and MOHLTC targets. Hip replacement wait times, at the 90th percentile, by month were as follows: April (402 days), May (368 days), June (308 days). A total of 4 patients exceeded the 182 day MOHLTC benchmark in Q1. In comparison to previous periods, the wait time increased by 62 days from last quarter and increased by 118 days from Q1 2012/13.

Plan for Improvement/Timelines: Wait Time Coordinator along with VP Quality and Chief of Ortho are developing a strategy to improve performance.

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Knee Wait Time Days (mandatory)

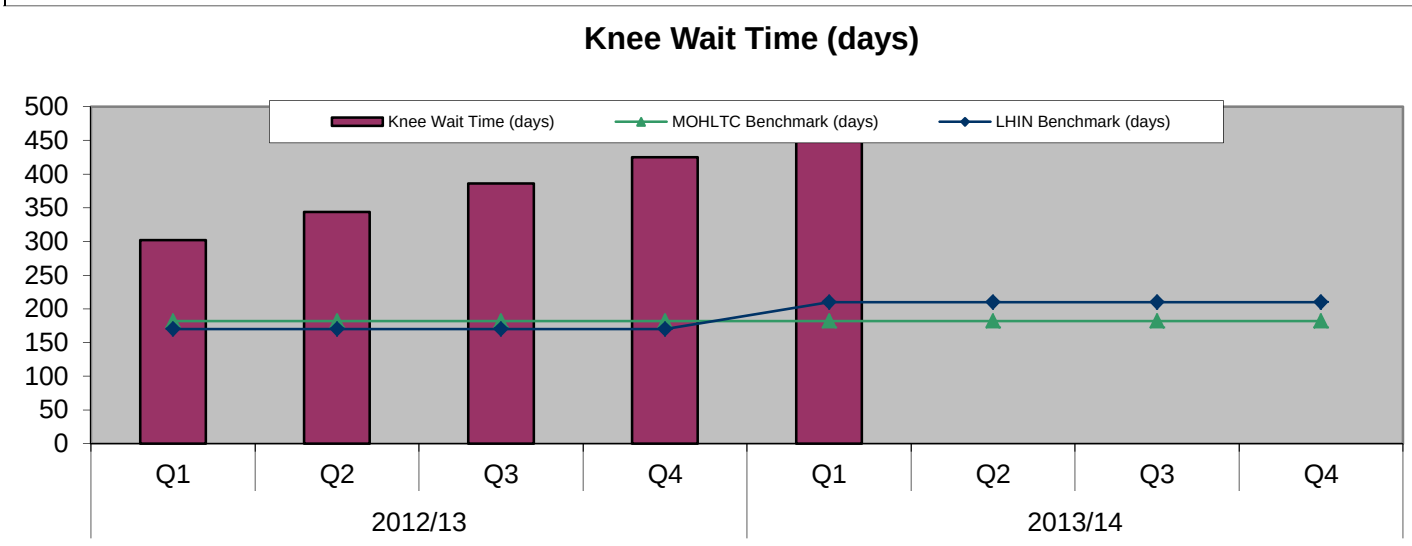
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of days 9 out of 10 patients (90th percentile) wait for a knee replacement from the date of decision to treat to day of surgery. Current Wait Time targets are measured by TC LHIN at 170 days

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Knee Wait Time (days)	302	344	386	425	470			
LHIN Benchmark (days)	170	170	170	170	210	210	210	210
MOHLTC Benchmark (days)	182	182	182	182	182	182	182	182

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



Analysis: Underperforming to benchmark. Wait time performance continues to climb and has surpassed both LHIN and MOHLTC targets. Knee replacement wait times, at the 90th percentile, by month were as follows: April (526), May (439), June (410). A total of 7 patients exceeded the 182 day MOHLTC benchmark in Q1. In comparison to previous periods, the wait time has grown by 45 days from last quarter and 168 days from Q1 2012/13, reaching its highest level since Q1 2012/13.

Plan for Improvement/Timelines: Wait Time Coordinator along with VP Quality and Chief of Ortho are developing a strategy to improve performance.

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Cataract Wait Time Days (mandatory)

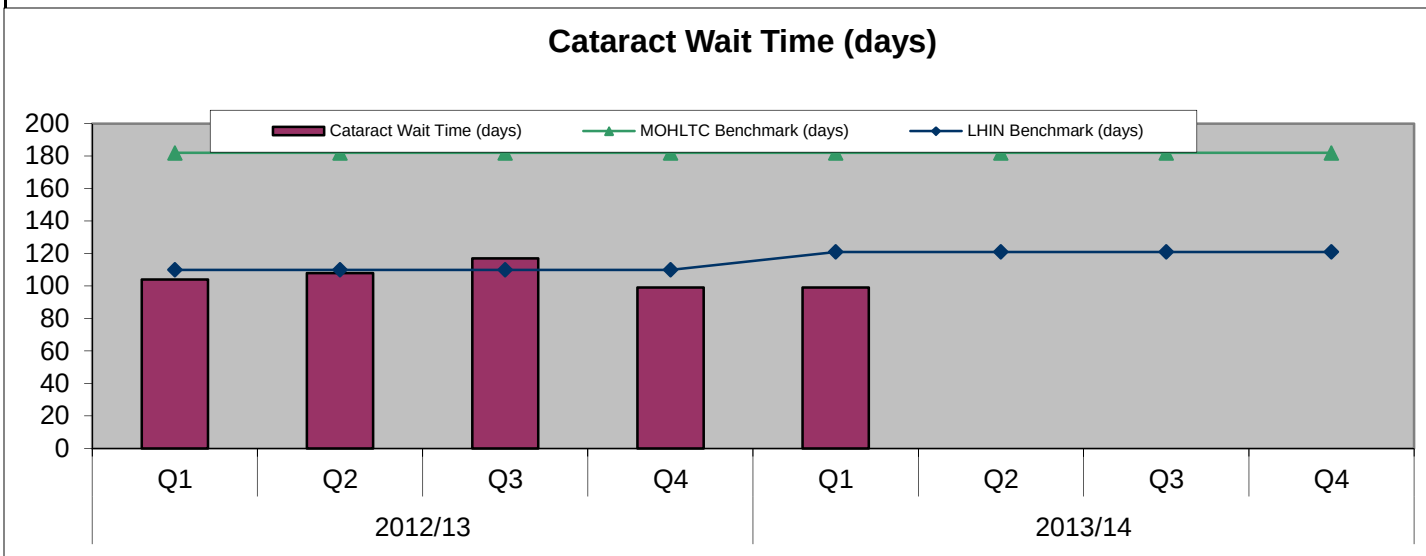
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of days 9 out of 10 patients (90th percentile) wait for cataract surgery from the date of decision to treat to day of surgery. Current Wait Time targets are measured by TC LHIN at 100 days

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cataract Wait Time (days)	104	108	117	99	99			
LHIN Benchmark (days)	110	110	110	110	121	121	121	121
MOHLTC Benchmark (days)	182	182	182	182	182	182	182	182

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



Analysis: Outperforming to benchmark. The 90th percentile wait time performance was the same as last quarter and sit below the LHIN benchmark, reaching its lowest level since Q1 2012/13 . Metric continues to sit well below the MOHLTC target of 182 days. Cataract surgery wait times by month were as follows: April (107), May(89), June (80). In comparison to previous periods, the wait time was same as last quarter and has dropped by 5 days from Q1 2012/13. (Note: LHIN benchmark was changed to 121 days)

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Cancer Wait Time Days (mandatory)

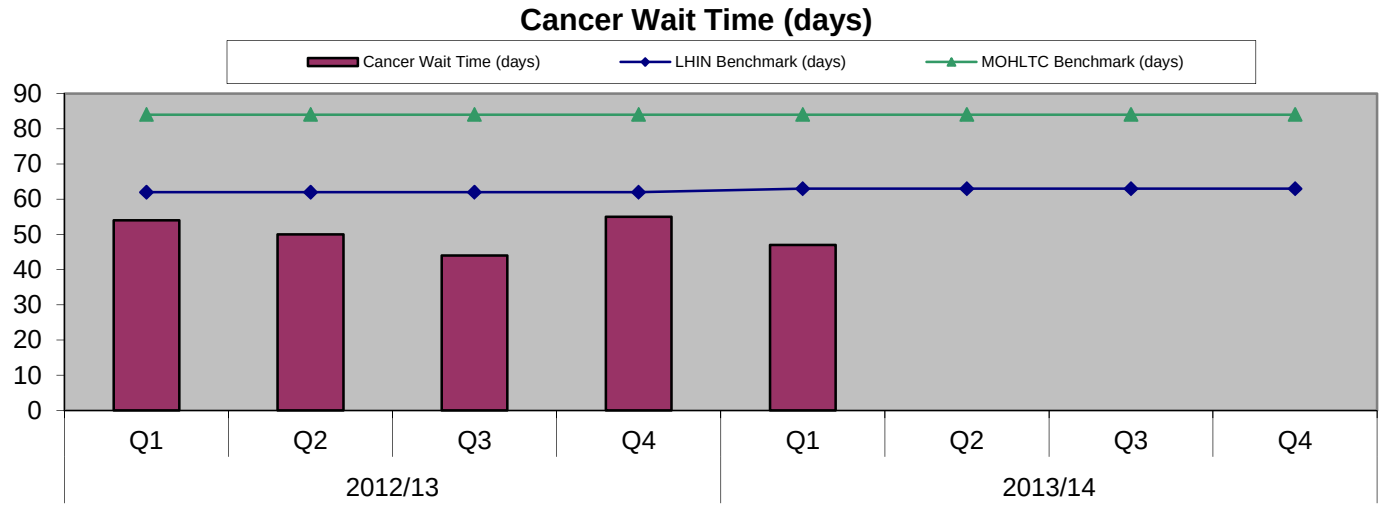
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of days 9 out of 10 patients (90th percentile) wait for cancer surgery from the date of decision to treat to day of surgery. Current wait time targets are measured by TC LHIN at 70 days

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cancer Wait Time (days)	54	50	44	55	47			
LHIN Benchmark (days)	62	62	62	62	63	63	63	63
MOHLTC Benchmark (days)	84	84	84	84	84	84	84	84

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.



Analysis: Outperforming to benchmark. Wait time performance has improved and continues to sit below both LHIN and MOHLTC benchmarks. In comparison to previous periods, wait times have dropped by 8 days from last quarter and declined by 7 days from the same quarter last year.

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

MRI Wait Time Days (mandatory)

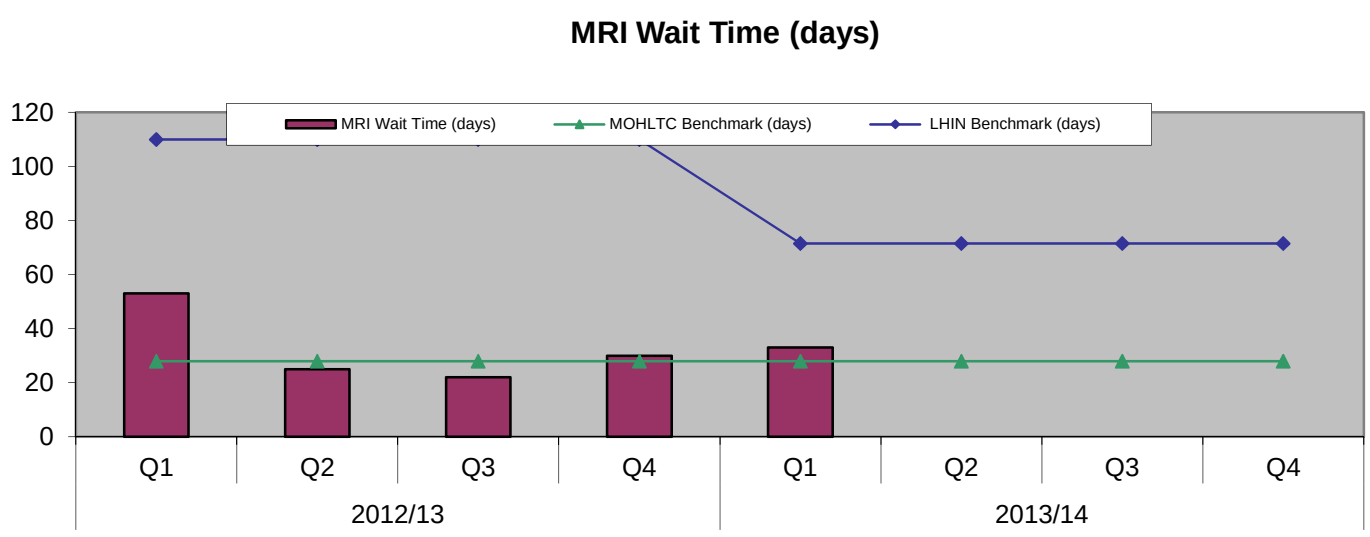
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of days 9 out of 10 patients (90th percentile) wait for an MRI from time the scan is ordered to time until the actual scan is completed. Performance is measured against LHIN benchmark at 115 days.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
MRI Wait Time (days)	53	25	22	30	33			
LHIN Benchmark (days)	110	110	110	110	72	72	72	72
MOHLTC Benchmark (days)	28	28	28	28	28	28	28	28

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



Analysis: Outperforming to benchmark.

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

CT Wait Time Days (mandatory)

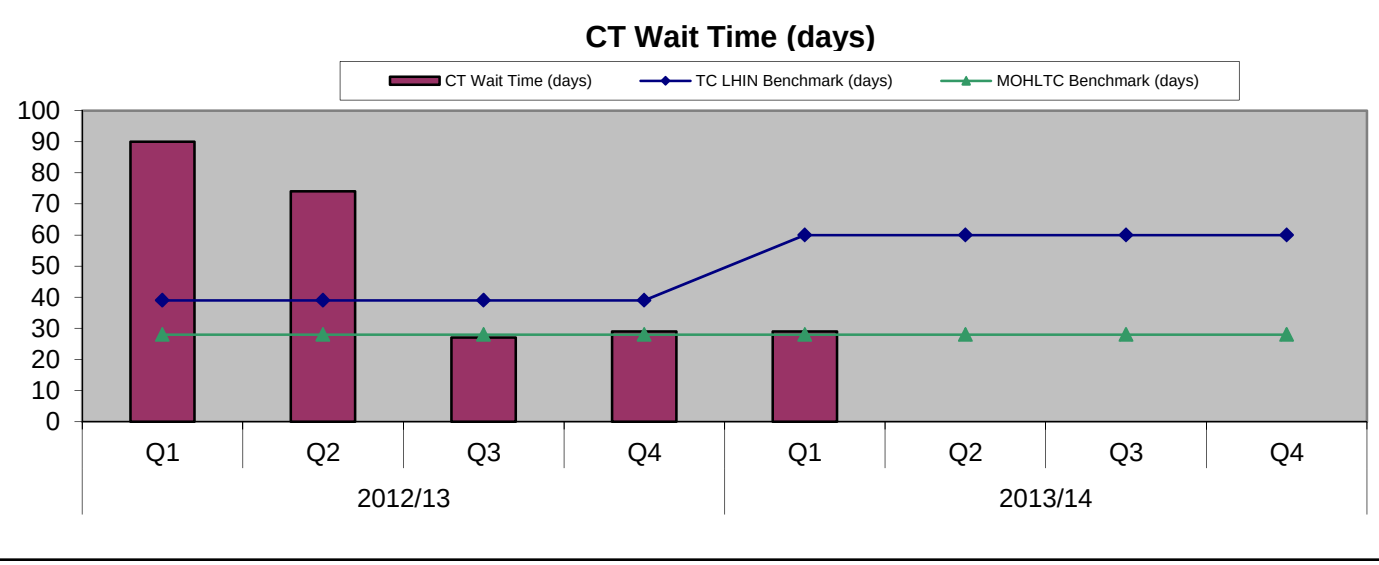
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of days 9 out of 10 patients (90th percentile) wait for a CT from time the scan is ordered to time until the actual scan is completed. Performance is measured against LHIN benchmark at 28 days.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CT Wait Time (days)	90	74	27	29	29			
TC LHIN Benchmark (days)	39	39	39	39	60	60	60	60
MOHLTC Benchmark (days)	28	28	28	28	28	28	28	28

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



Analysis: Outperforming to benchmark.

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Hip Replacement Wait Time Cases (mandatory)

SUCCESS FACTOR:

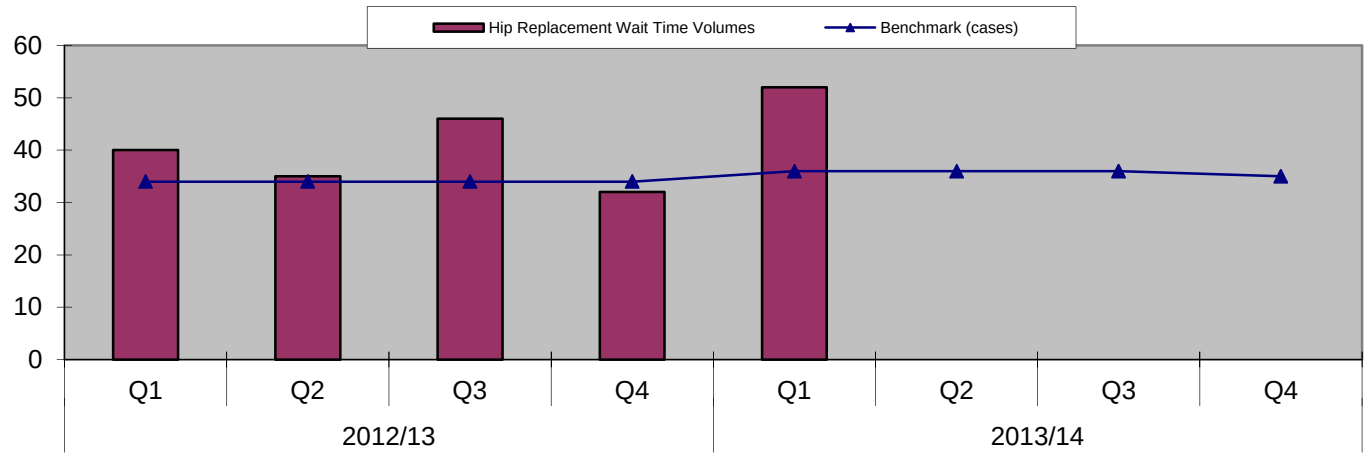
Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of primary hip replacements performed to meet the volume allocated through Ontario's Wait Time Strategy / Quality Based Procedures (QBP)

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Hip Replacement Wait Time Volumes	40	35	46	32	52			
Benchmark (cases)	34	34	34	34	36	36	36	35

Significance: The allocation of volumes will support Ontario's Wait Time Strategy, which includes the development of a comprehensive system to monitor wait times and help ensure that Ontarians receive timely and appropriate access to five select services: cancer surgery, cataract surgery, hip and knee replacements, and MRI and CT exams. The volumes will support this goal and are to assist organizations in reducing waiting times for surgical cases and/or diagnostic imaging.

Hip Replacement Cases



Analysis: Outperforming to benchmark. Q1 actual volume represents 36.36% of the annual Wait Time Strategy / QBP draft target of 143 cases, indicating SJHC is on track to meeting and exceeding the 2013/14 volume allocation. Year-to-date comparison shows hip replacement volumes are up by 30% (12 cases).

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Knee Replacement Wait Time Cases (mandatory)

SUCCESS FACTOR:

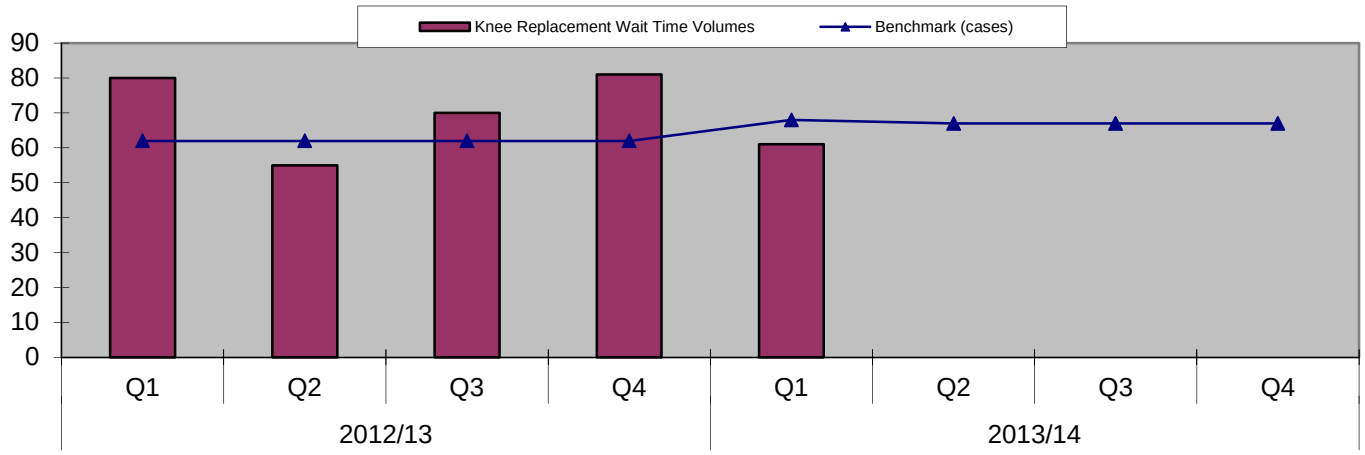
Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of primary knee replacements performed to meet the volume allocated through Ontario's Wait Time Strategy / Quality Based Procedures (QBP) .

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Knee Replacement Wait Time Volumes	80	55	70	81	61			
Benchmark (cases)	62	62	62	62	68	67	67	67

Significance: The allocation of volumes will support Ontario's Wait Time Strategy, which includes the development of a comprehensive system to monitor wait times and help ensure that Ontarians receive timely and appropriate access to five select services: cancer surgery, cataract surgery, hip and knee replacements, and MRI and CT exams. The volumes will support this goal and are to assist organizations in reducing waiting times for surgical cases and/or diagnostic imaging.

Knee Replacement Cases



Analysis: Within 10% of benchmark. Q1 actual volume represents 22.76% of the annual Wait Time Strategy / QBP draft target of 268 cases, indicating SJHC is on track to meeting and exceeding the 2013/14 volume allocation. Year-to-date comparison shows knee replacement volumes are down by 23.75% (or 19 cases).

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Cataract Wait Time Cases (mandatory)

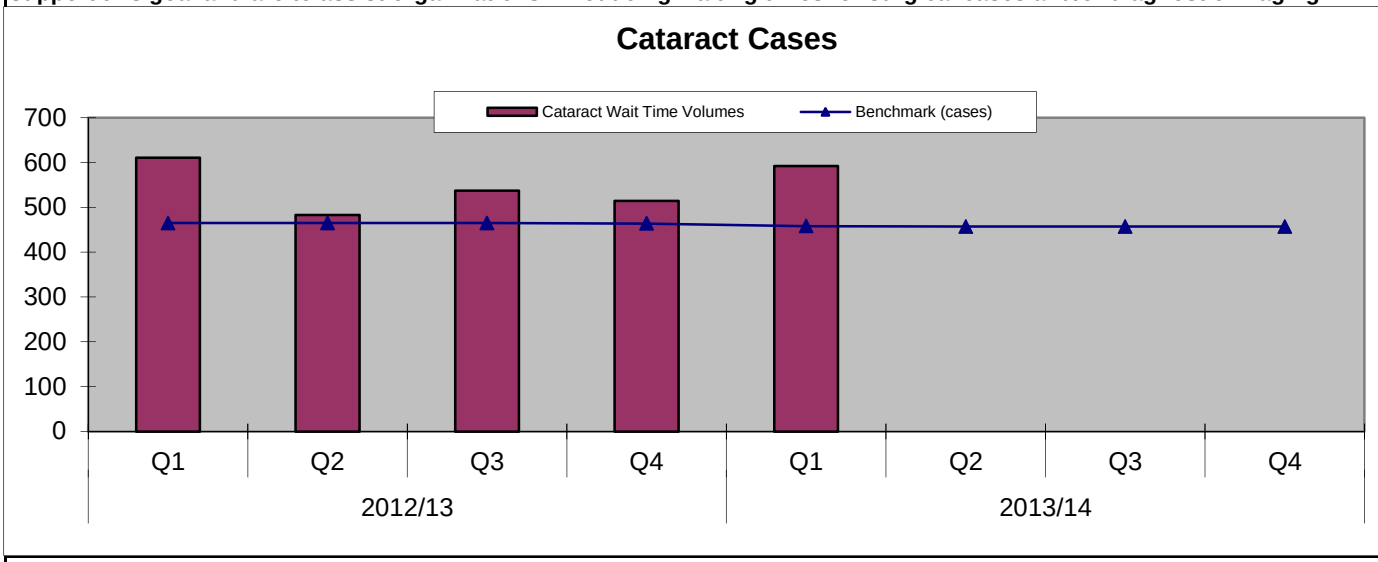
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of cataract procedures performed to meet the volume allocated through Ontario's Wait Time Strategy/ Quality Based Procedures (QBP) .

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cataract Wait Time Volumes	611	483	537	514	592			
Benchmark (cases)	465	465	465	464	458	457	457	457

Significance: The allocation of volumes will support Ontario's Wait Time Strategy, which includes the development of a comprehensive system to monitor wait times and help ensure that Ontarians receive timely and appropriate access to five select services: cancer surgery, cataract surgery, hip and knee replacements, and MRI and CT exams. The volumes will support this goal and are to assist organizations in reducing waiting times for surgical cases and/or diagnostic imaging.



Analysis: Outperforming to benchmark. Q1 actual volume represents 32.4% of the annual Wait Time Strategy / QBP target of 1829 cases. This indicates SJHC is on track to meeting and exceeding the 2013/14 volume allocation.

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

MRI Wait Time Hours (mandatory)

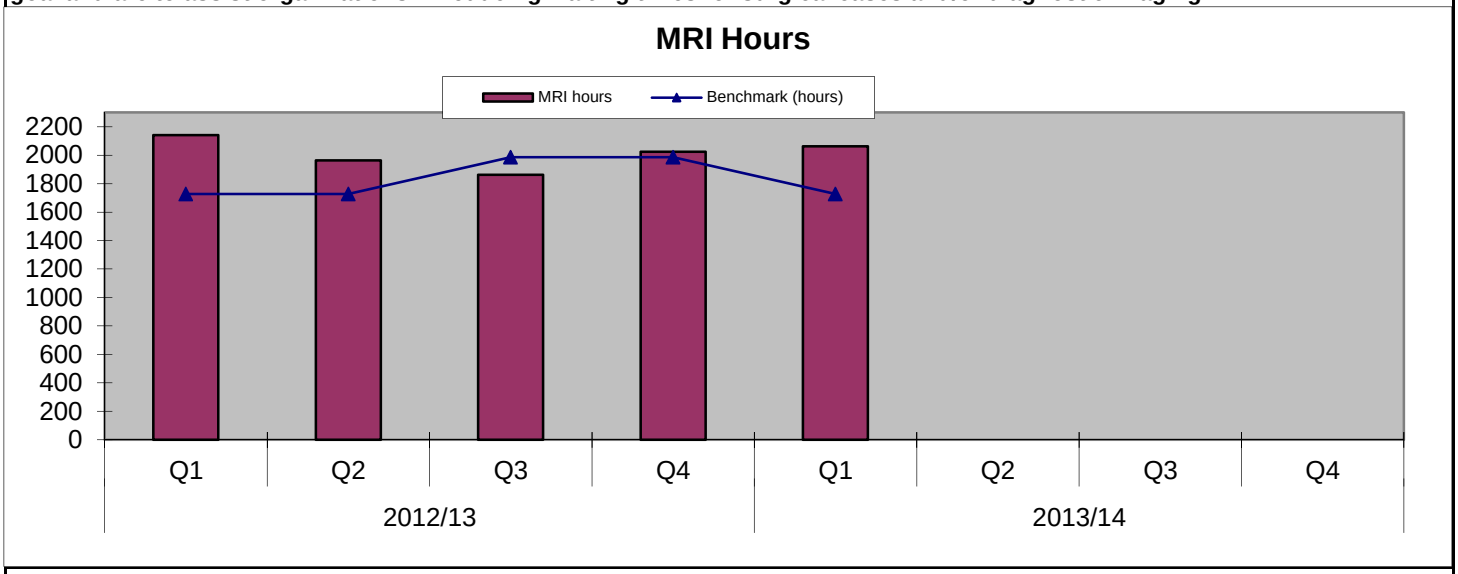
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of MRI hours performed to meet the volume allocated through Ontario's Wait Time Strategy.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
MRI hours	2141	1963	1862	2024	2061			
Benchmark (hours)	1727	1727	1986	1986	1727			

Significance: The allocation of volumes will support Ontario's Wait Time Strategy, which includes the development of a comprehensive system to monitor wait times and help ensure that Ontarians receive timely and appropriate access to five select services: cancer surgery, cataract surgery, hip and knee replacements, and MRI and CT exams. The volumes will support this goal and are to assist organizations in reducing waiting times for surgical cases and/or diagnostic imaging.



Analysis: Outperforming to benchmark.

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

CT Wait Time Hours (mandatory)

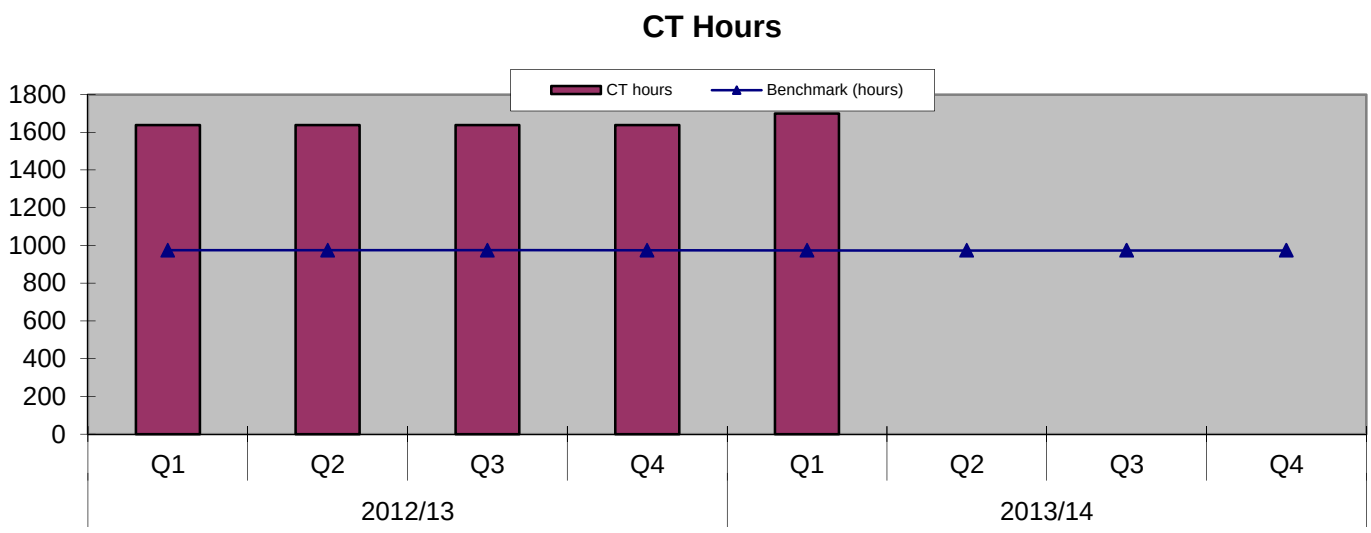
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of CT hours performed to meet the volume allocated through Ontario's Wait Time Strategy.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CT hours	1638	1638	1638	1638	1699			
Benchmark (hours)	974	974	974	974	974	974	974	974

Significance: The allocation of volumes will support Ontario's Wait Time Strategy, which includes the development of a comprehensive system to monitor wait times and help ensure that Ontarians receive timely and appropriate access to five select services: cancer surgery, cataract surgery, hip and knee replacements, and MRI and CT exams. The volumes will support this goal and are to assist organizations in reducing waiting times for surgical cases and/or diagnostic imaging.



Analysis: Outperforming to benchmark. CT consistently exceeds the Ministry benchmark as the target is based on one scanner and we operate two.

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

General Surgery - Wait Time (Cases)

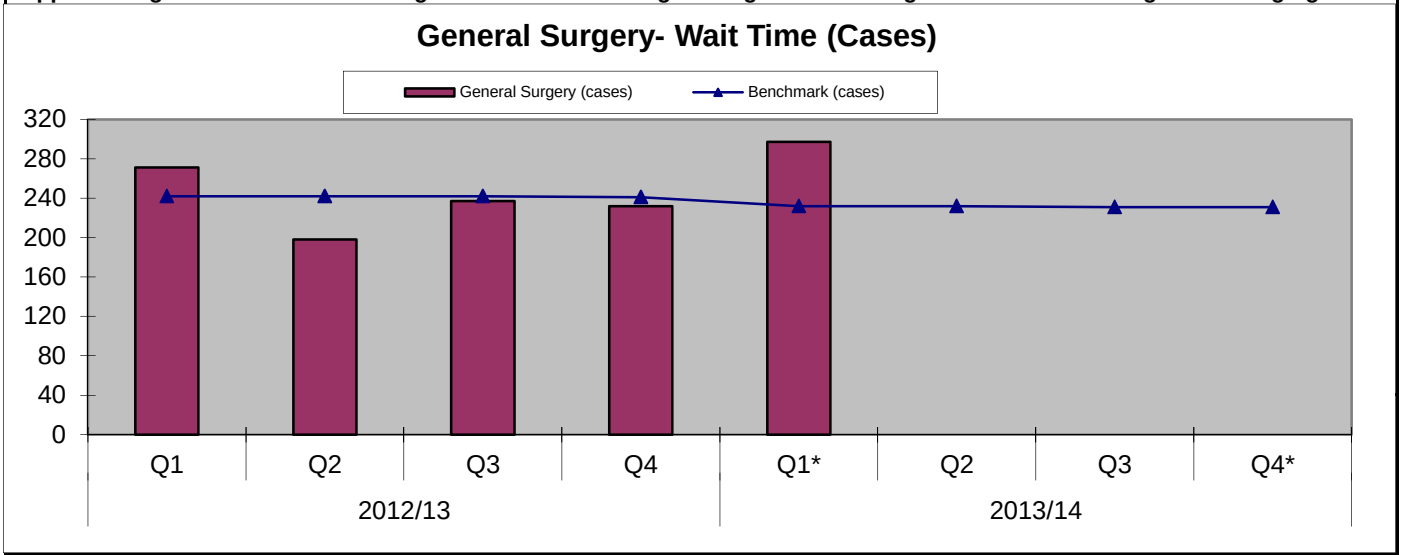
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of select General Surgery Cases performed to meet the volume allocated through Ontario's Wait Time Strategy. Types of surgeries included in the count are: Anorectal surgery, Cholecystectomy, Intestinal surgery, Groin Hernia Repair and Ventral Hernia Repair.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1*	Q2	Q3	Q4*
General Surgery (cases)	271	198	237	232	297			
Benchmark (cases)	242	242	242	241	232	232	231	231

Significance: The allocation of volumes will support Ontario's Wait Time Strategy, which includes the development of a comprehensive system to monitor wait times and help ensure that Ontarians receive timely and appropriate access to five select services: cancer surgery, cataract surgery, hip and knee replacements, and MRI and CT exams. The volumes will support this goal and are to assist organizations in reducing waiting times for surgical cases and/or diagnostic imaging.



Analysis: Outperforming to benchmark. Q1 estimated volume represents 32% of the Wait Time Strategy annual target of 926 cases, indicating SJHC is on track to meeting the 2013/14 volume allocation. Year-to-date comparison shows cancer surgery volumes are up by 9.6% (or 26 cases). Final Q1 numbers will be confirmed once June 2013 patient charts are coded and abstracted . MOHLTC deadline for coding of first quarter data is August 31, 2013.

**Q1 data is an estimate based on single month data (99 x 3 =297)*

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Cardiac Services - Permanent Pacemakers

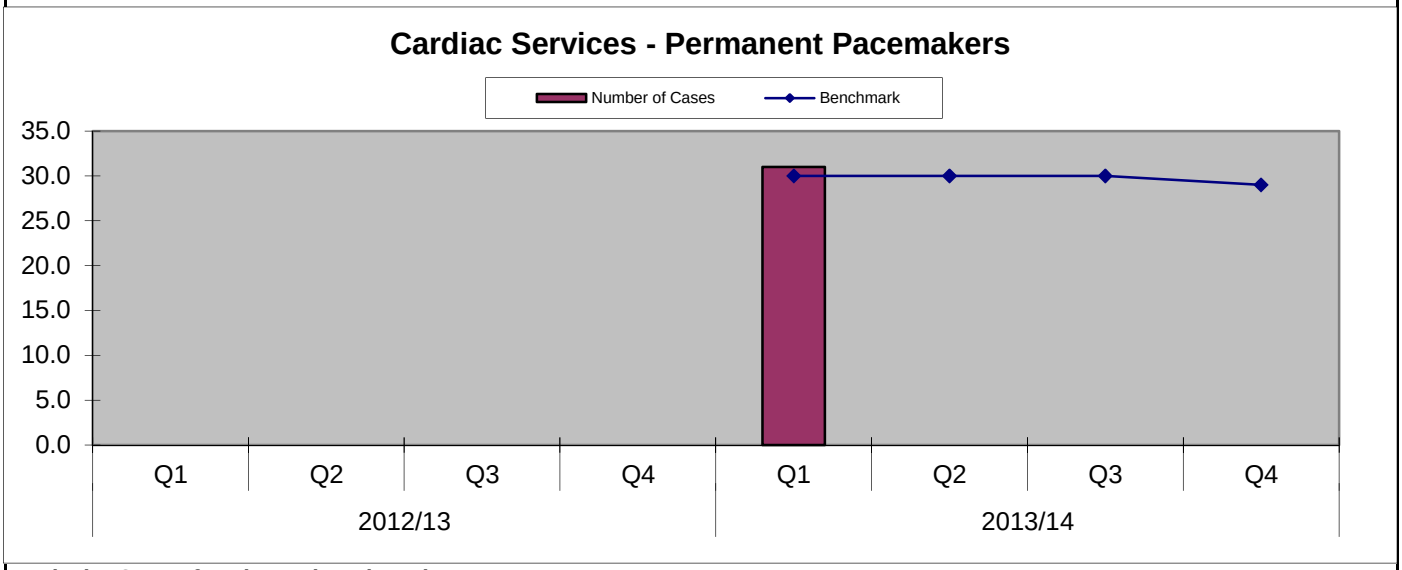
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: Indicator captures the number of Pacemaker cases performed.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Cases					31			
Benchmark					30	30	30	29

Significance:



Analysis: Outperforming to benchmark.

Plan for Improvement/Timelines:

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Percent ALC Days

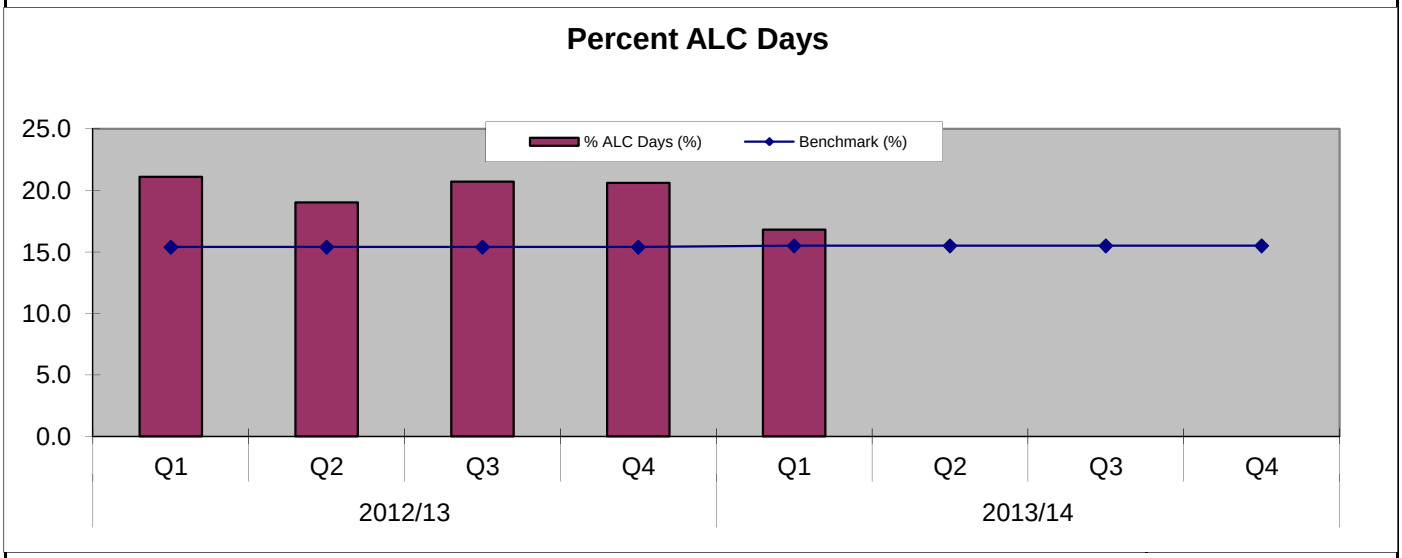
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☑
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: Percentage of inpatient days that are designated Alternate Level of Care (ALC), which indicates that Acute level care is no longer required.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
% ALC Days (%)	21.1	19.0	20.7	20.6	16.8			
Benchmark (%)	15.4	15.4	15.4	15.4	15.5	15.5	15.5	15.5
LHIN Target (%)	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0

Significance: Indicates the hospitals ability to access appropriate level of care within health system. (Benchmark is based on our Quality Plan for 2012-13. Target is based on TC LHIN target for 2011-12 as stated in the MLPA.)



Analysis: Within 10% of benchmark. A marked improvement in performance in Q1 with an absolute decrease in ALC by 3.8%.

Plan for Improvement/Timelines: The MASH Program continues to work with its community partners and the TC CCAC to capitalize on all "Home First" and Aging at Home strategies for ALC patients. During late Q3, a new role was introduced (ALC Strategy Lead) to attempt to better understand ALC pressures (internally and externally) and to develop strategies to reduce ALC volumes and days. The Discharge Operations Team began its work at the start of Q4 to provide oversight to all ALC patient discharge planning.

Accountability: Dr. Harmantas/M. Vimr

CORPORATE PERFORMANCE INDICATOR

Overtime

SUCCESS FACTOR:

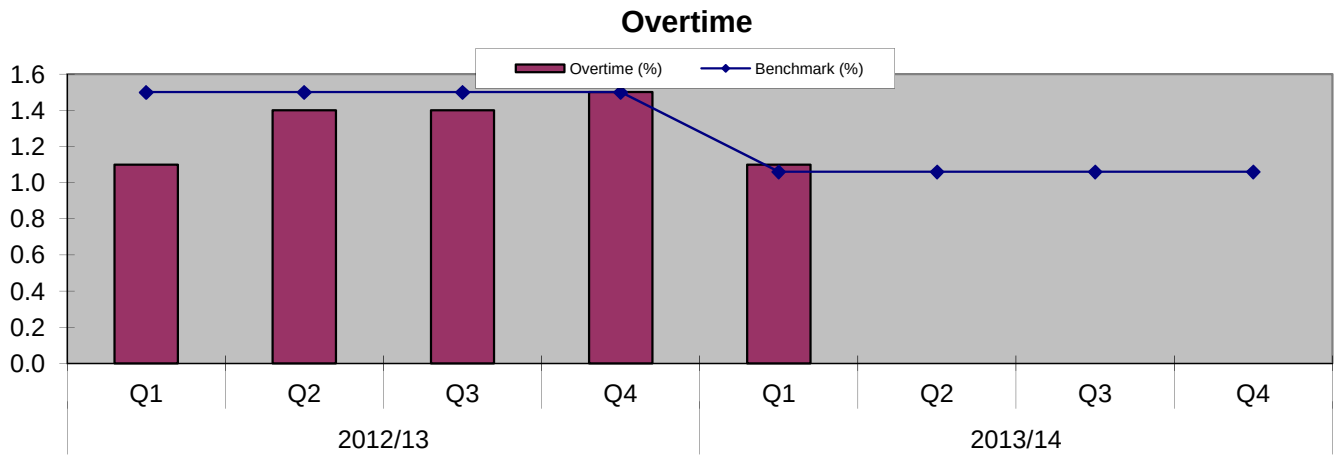
Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☑	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The number of overtime hours as a percentage of the total paid hours.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overtime (%)	1.1	1.4	1.4	1.5	1.10			
Benchmark (%)	1.5	1.5	1.5	1.5	1.06	1.06	1.06	1.06
Target (%)	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0

Significance: A higher rate of overtime results in a higher cost burden to the hospital. It may indicate staffing shortages and can lead to employee dissatisfaction.

Benchmark source: 2012 -OHA HR Benchmarking Survey Report - Region #3 Weighted Average



Analysis: Within 10% of benchmark.

Plan for Improvement/Timelines:

Accountability: W. Steele

CORPORATE PERFORMANCE INDICATOR

Employee Sick Time

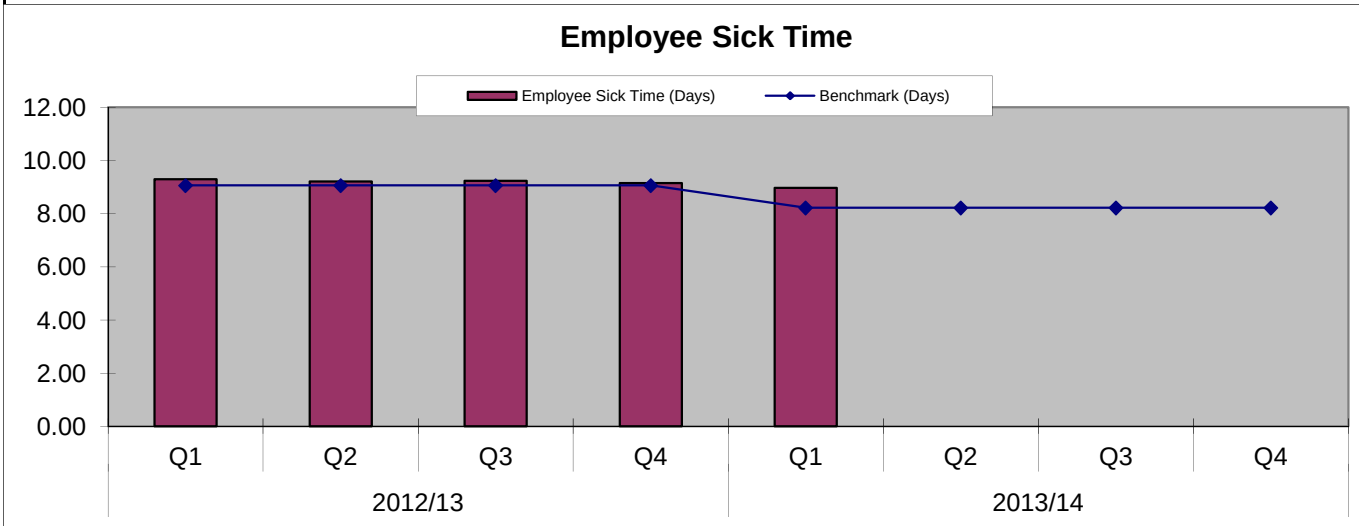
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☑	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: Average number of sick leave days per full-time employee across the Health Centre.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Employee Sick Time (Days)	9.29	9.21	9.23	9.15	8.97			
Benchmark (Days)	9.06	9.06	9.06	9.06	8.22	8.22	8.22	8.22
Target (Days)	7.20	7.20	7.20	7.20	7.20	7.20	7.20	7.20

Significance:
Benchmark source: 2012 -OHA HR Benchmarking Survey Report - Region #3 Weighted Average



Analysis: Within 10% of benchmark. Sick days are now below 9 days on average.

Plan for Improvement/Timelines: Continue to monitor the compliance of the Attendance Management Program (AMP) with respect to Managers meeting with identified employees regarding the application of the AMP Policy.

Accountability: W. Steele

CORPORATE PERFORMANCE INDICATOR

WSIB Lost Time Incidents

SUCCESS FACTOR:

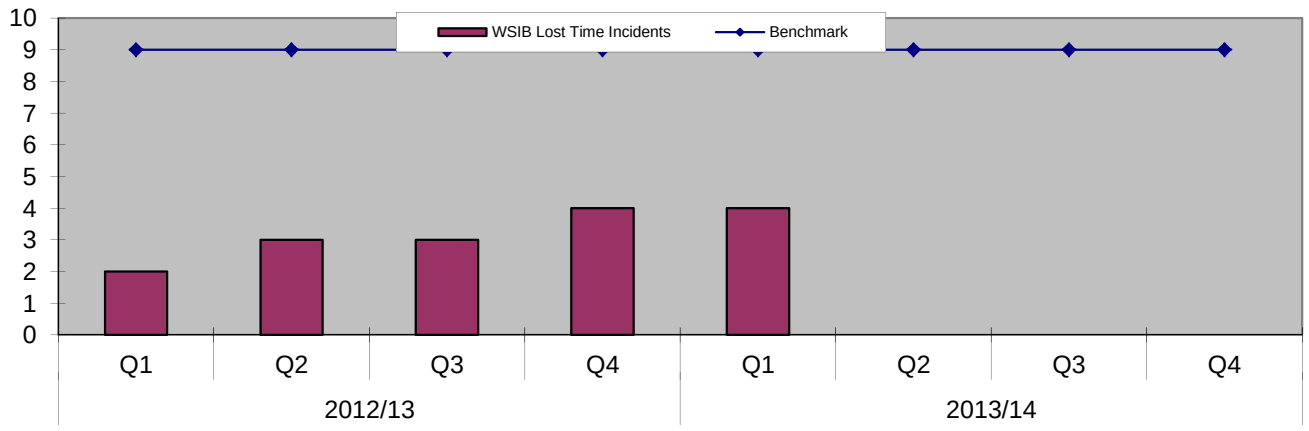
Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☑	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☐		

Definition: The total number of WSIB lost time incidents per quarter for SJHC staff.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
WSIB Lost Time Incidents	2	3	3	4	4			
Benchmark	9	9	9	9	9	9	9	9

Significance: An employer of choice is dedicated to the safety of its employees

WSIB Lost Time Incidents



Analysis: Outperforming to benchmark. There were a total of 4 lost time incidents that occurred in Q1

Plan for Improvement/Timelines:

Accountability: W. Steele

CORPORATE PERFORMANCE INDICATOR

Student Learner Satisfaction

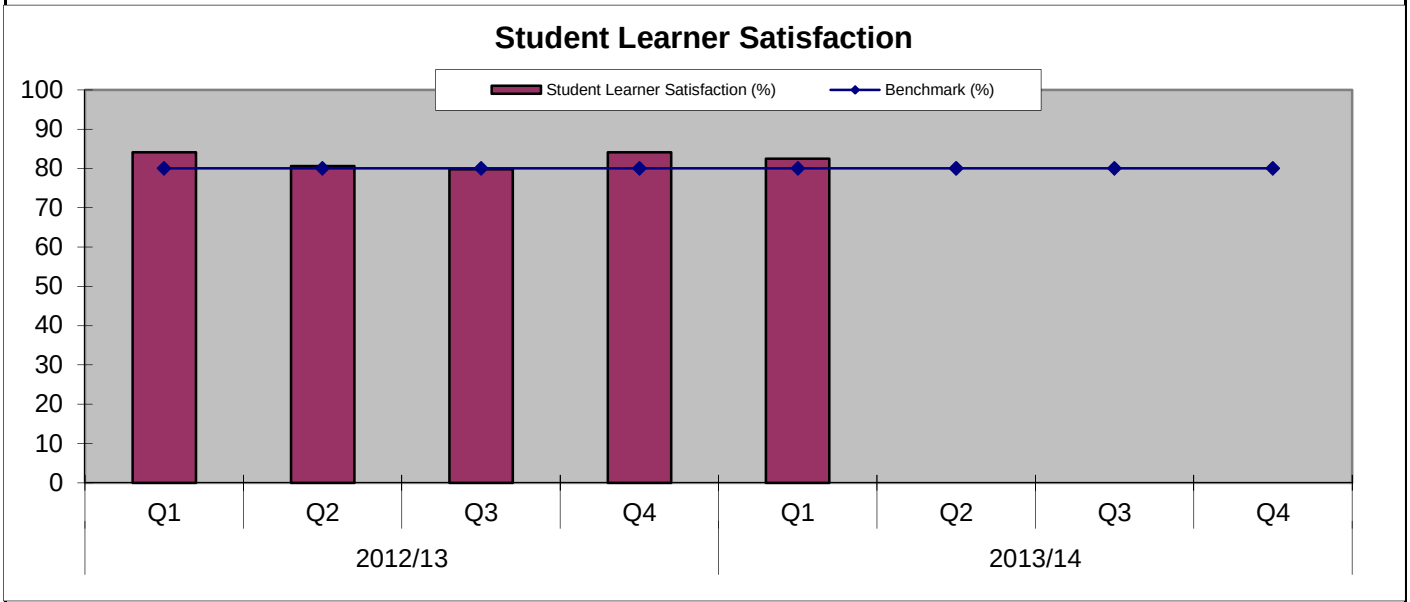
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☑
Use Resources Wisely	☐		

Definition: Student satisfaction with learning experience at St. Joseph's Health Centre. Students from all professions are included in the evaluation.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Student Learner Satisfaction (%)	84.1	80.6	79.8	84.1	82.5			
Benchmark (%)	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0

Significance: Timely review of post placement evaluations allows SJHC to respond immediately to student concerns thus ensuring a high quality student experience.



Analysis: Outperforming to benchmark.

*For medical education, 91.8% of learners who responded rated their overall satisfaction with their learning experience at SJHC as excellent or very good.
*For the students that go through myself & Susan, 69.5% of learners who responded rated their overall satisfaction with their learning experience at SJHC as excellent or very good.

Plan for Improvement/Timelines: There is a slight downward trend in overall learner satisfaction and the score remains above the benchmark. In analyzing the scores, it may be noted that while learner satisfaction improved for medical trainees, it decreased for learners in other professions. Feedback has been provided by the Interprofessional Education & Collaboration Department to units where performance is low. Ongoing work continues to support the student experience. This quarter we celebrated our second annual Academic Achievement Day - an event created to support recognition around excellence in teaching and learning.

Accountability: Dr. Rogovein/W. Steele

CORPORATE PERFORMANCE INDICATOR

Current Ratio (mandatory)

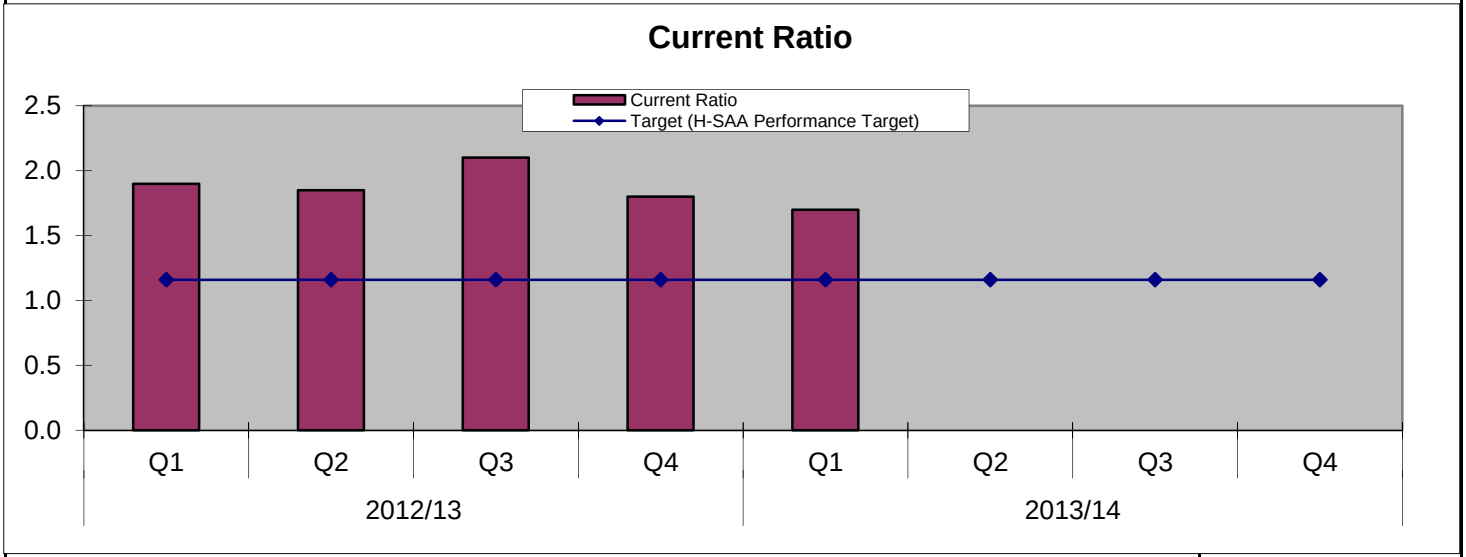
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☑		

Definition: The number of times the hospital's short-term obligations can be paid using the hospital's short-term assets.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Current Ratio	1.9	1.9	2.1	1.8	1.7			
Target (H-SAA Performance Target)	1.16	1.16	1.16	1.16	1.16	1.16	1.16	1.16
Benchmark (H-SAA Performance Standard Minimum)	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80

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



Analysis: Outperforming to benchmark.

Plan for Improvement/Timelines:

Accountability: D. McGregor

CORPORATE PERFORMANCE INDICATOR

Total Margin (mandatory)

SUCCESS FACTOR:

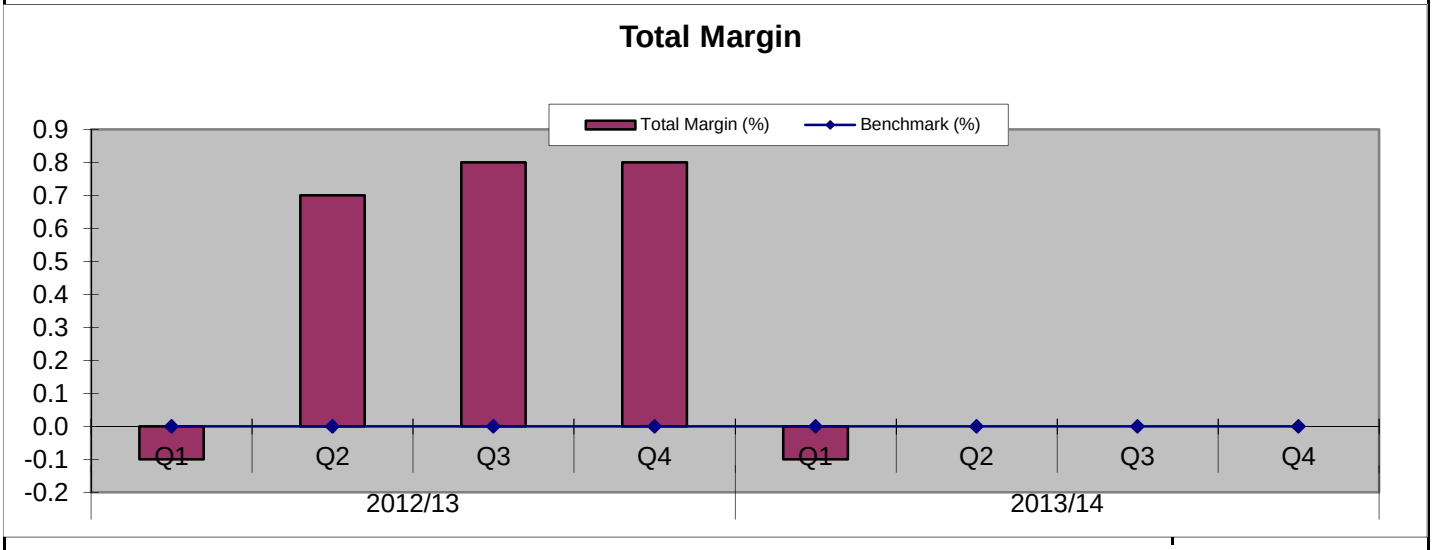
Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☑		

Definition: The percentage by which total revenues exceed total expenses (includes the hospital's global operating funds, other votes funds and equipment amortization; it excludes commercial operations).

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total Margin (%)	-0.1	0.7	0.8	0.8	-0.1			
Benchmark (%)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

***A negative value indicates that expenses have exceeded revenues and a positive value indicates an excess of revenues over expenses.**

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



Analysis: Within 10% of benchmark.

Plan for Improvement/Timelines:

Accountability: D. McGregor

CORPORATE PERFORMANCE INDICATOR

Acute Inpatient Weighted Cases (mandatory)

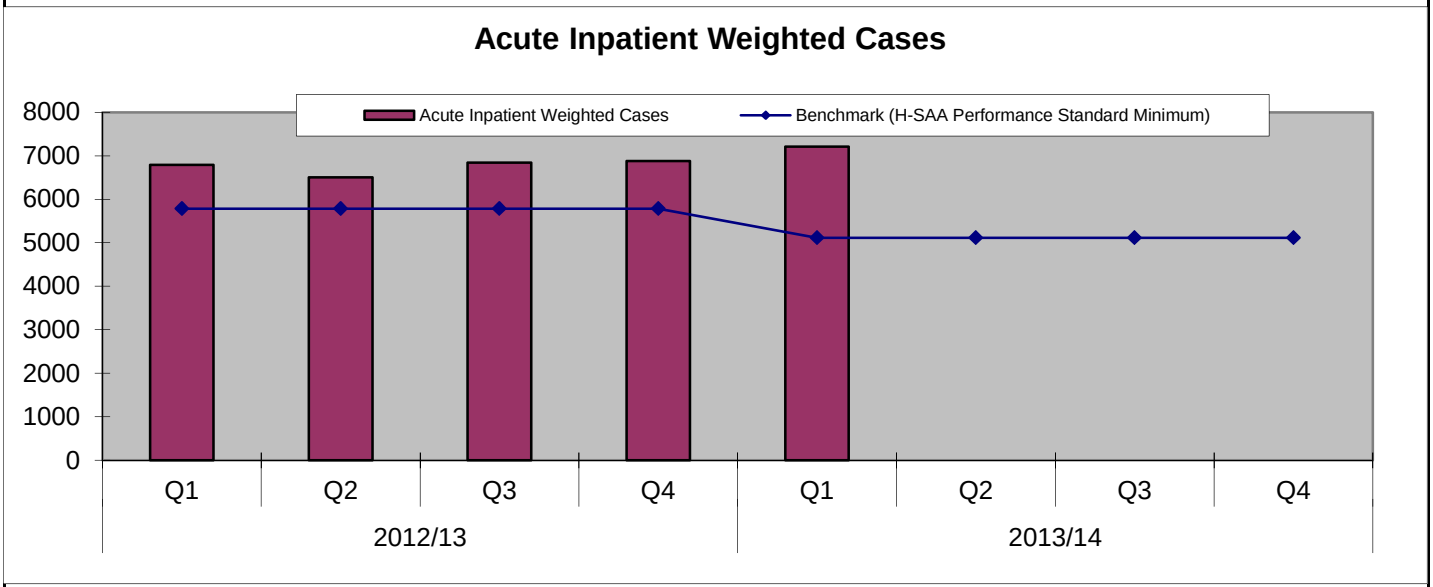
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☑		

Definition: The sum of resource intensity weights (RIW) per patient using CIHI's CMG+ grouping methodology. The hospital total weighted cases is used as the denominator in the cost per weighted case calculation.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Acute Inpatient Weighted Cases	6794	6504	6845	6879	7212			
Benchmark (H-SAA Performance Standard Minimum)	5786	5786	5786	5786	5117	5116	5116	5116
Target (H-SAA Performance Target)	6429	6429	6429	6429	5685	5685	5685	5684

Significance: Resource intensity weights are a relative measure of resource use and one component in cost recovery.



Analysis: Outperforming to benchmark.

Plan for Improvement/Timelines:

Accountability: D. McGregor

CORPORATE PERFORMANCE INDICATOR

Ambulatory Visits (mandatory)

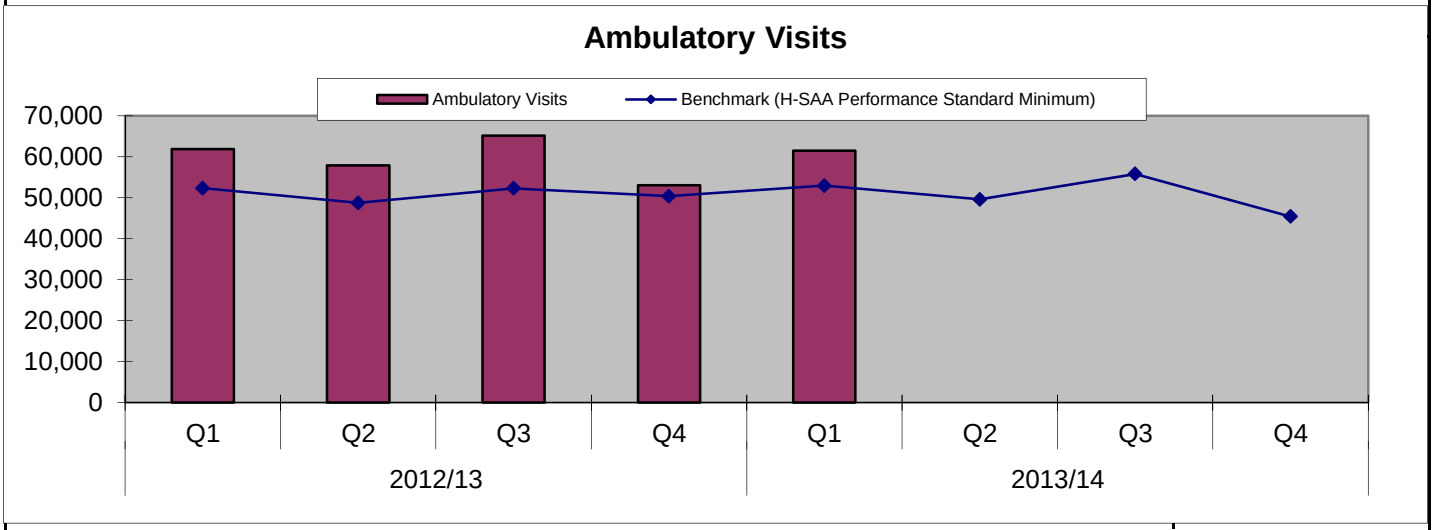
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☑		

Definition: Scheduled/ non-scheduled IP and OP clinic visits and visits in non surgical Day/ Night functional centres, excluding Emergency Department visits and Other Votes.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Ambulatory Visits	61,837	57,898	65,169	53,043	61,446			
Benchmark (H-SAA Performance Standard Minimum)	52,312	48,751	52,283	50,354	52,937	49,565	55,789	45,409
Target (H-SAA Performance Standard)	58,124	54,168	58,092	55,949	58,811	55,065	61,980	50,448

Significance: Health care services provided in an ambulatory care setting can greatly reduce the resource requirements on acute inpatient care, resulting in improved quality of patient care.



Analysis: Outperforming to benchmark.

Plan for Improvement/Timelines:

Accountability: D. McGregor

CORPORATE PERFORMANCE INDICATOR

Emergency Department Weighted Cases (New)

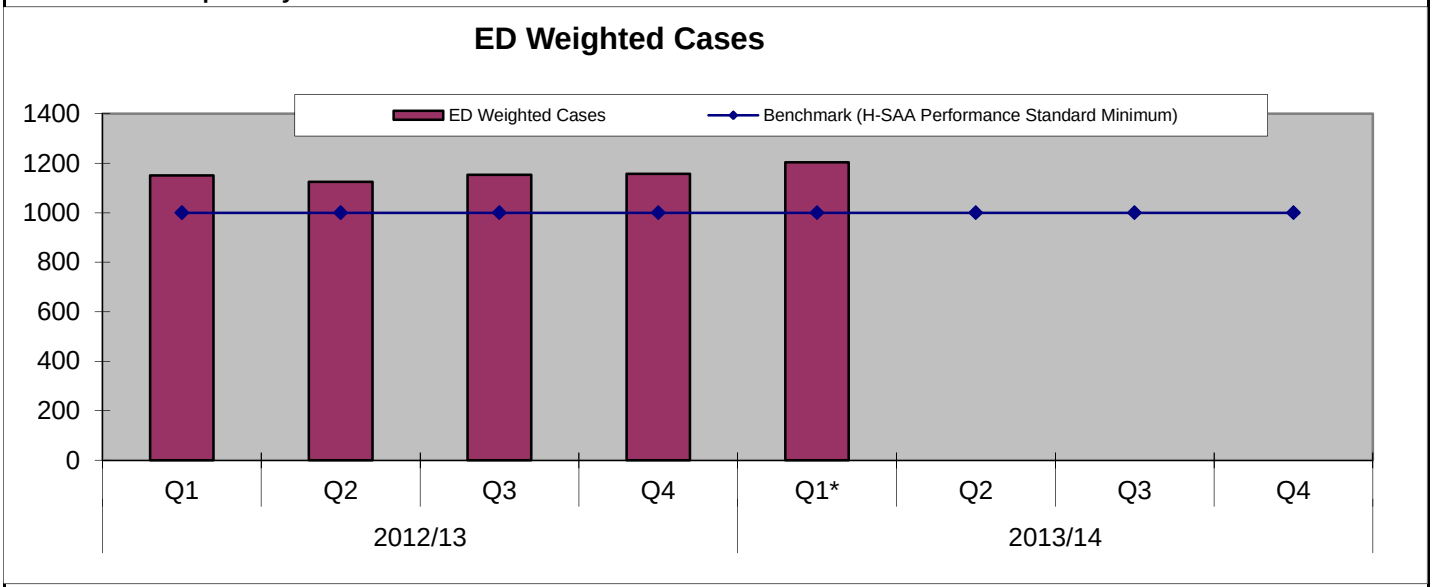
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☑		

Definition: Total emergency visits adjusted for resource intensity using the Comprehensive Ambulatory Care Classification System (CACS), the methodology that is applied to ambulatory care data.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1*	Q2	Q3	Q4
ED Weighted Cases	1151	1125	1154	1158	1204			
Benchmark (H-SAA Performance Standard Minimum)	1000	1000	1000	1000	1000	1000	1000	1000
Target (H-SAA Performance Target)	1111	1111	1111	1111	1111	1111	1111	1111

Significance: CACS weights are a relative measure of resource use. Data using CACS is released annually on May 31; interim data is available quarterly.



Analysis: Outperforming to benchmark. *Q1 data is based on an estimate of data up to April until verified with Health Records.

Plan for Improvement/Timelines:

Accountability: D. McGregor

CORPORATE PERFORMANCE INDICATOR

Inpatient Mental Health Weighted Patient Days (New)

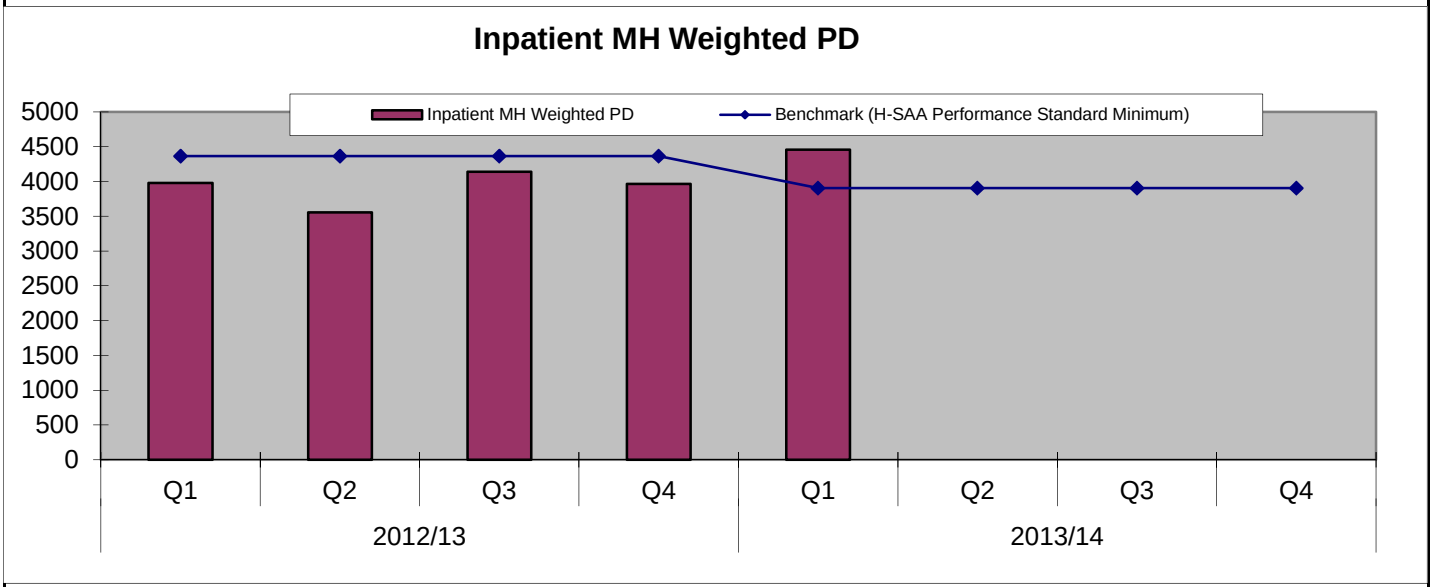
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☑		

Definition: Measures adult MH total inpatient weighted days of activity using the System for Classification of Inpatient Psychiatry (SCIPP) weighted patient days (SWPD).

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Inpatient MH Weighted PD	3980	3555	4139	3962	4454			
Benchmark (H-SAA Performance Standard Minimum)	4363	4363	4363	4363	3903	3903	3904	3904
Target (H-SAA Performance Target)	4593	4593	4593	4593	4593	4593	4593	4593

Significance: SCIPP weights are a relative measure of resource use. Information is submitted through the Ontario MH Reporting System (OMHRS) and Q1, Q2 & Q3 data is two (2) quarters delayed, while Q4 is four (4) months delayed.



Analysis: Outperforming to benchmark.

Plan for Improvement/Timelines:

Accountability: D. McGregor

CORPORATE PERFORMANCE INDICATOR

Day Surgery Weighted Visits (New)

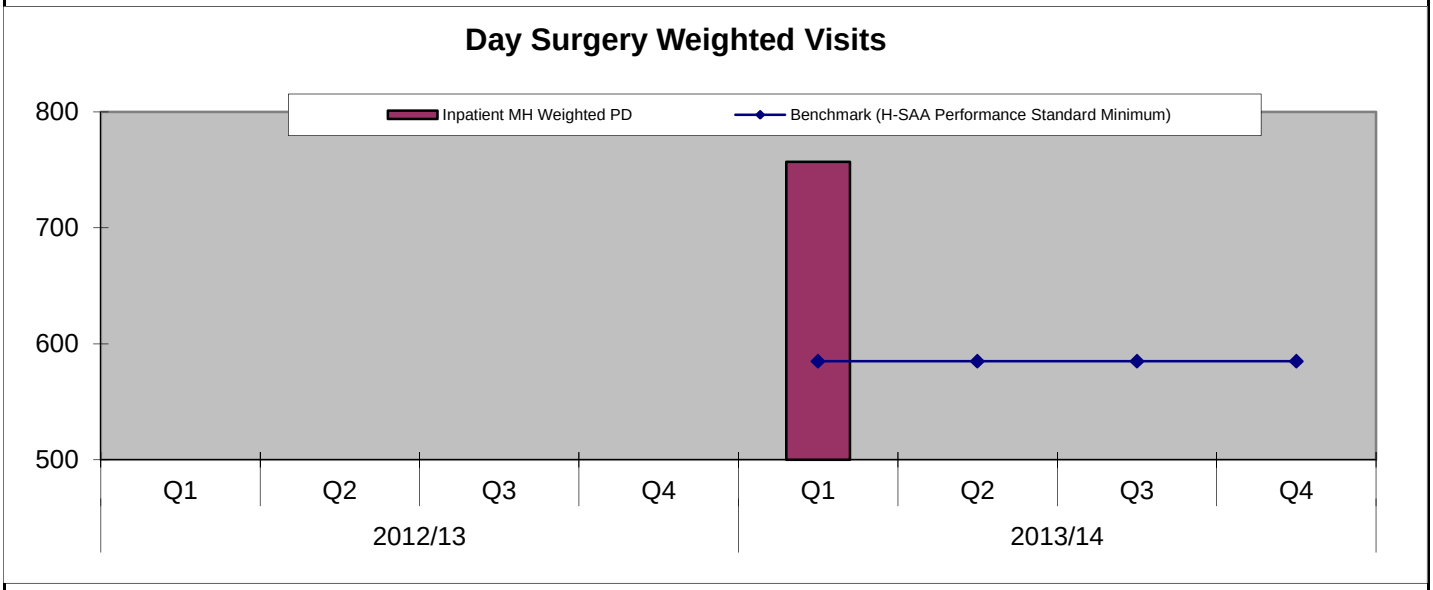
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☑		

Definition: The sum of resource intensity weights (RIW) per Day surgery patient using CIHI's CMG+ grouping methodology. The hospital total weighted cases is used as the denominator in the cost per weighted case calculation.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Inpatient MH Weighted PD					757			
Benchmark (H-SAA Performance Standard Minimum)					585	585	585	585
Target (H-SAA Performance Target)					650	650	650	650

Significance: Resource intensity weights are a relative measure of resource use and one component in cost recovery.



Analysis: Outperforming to benchmark.

Plan for Improvement/Timelines:

Accountability: D. McGregor

CORPORATE PERFORMANCE INDICATOR

Nursing Agency Hours

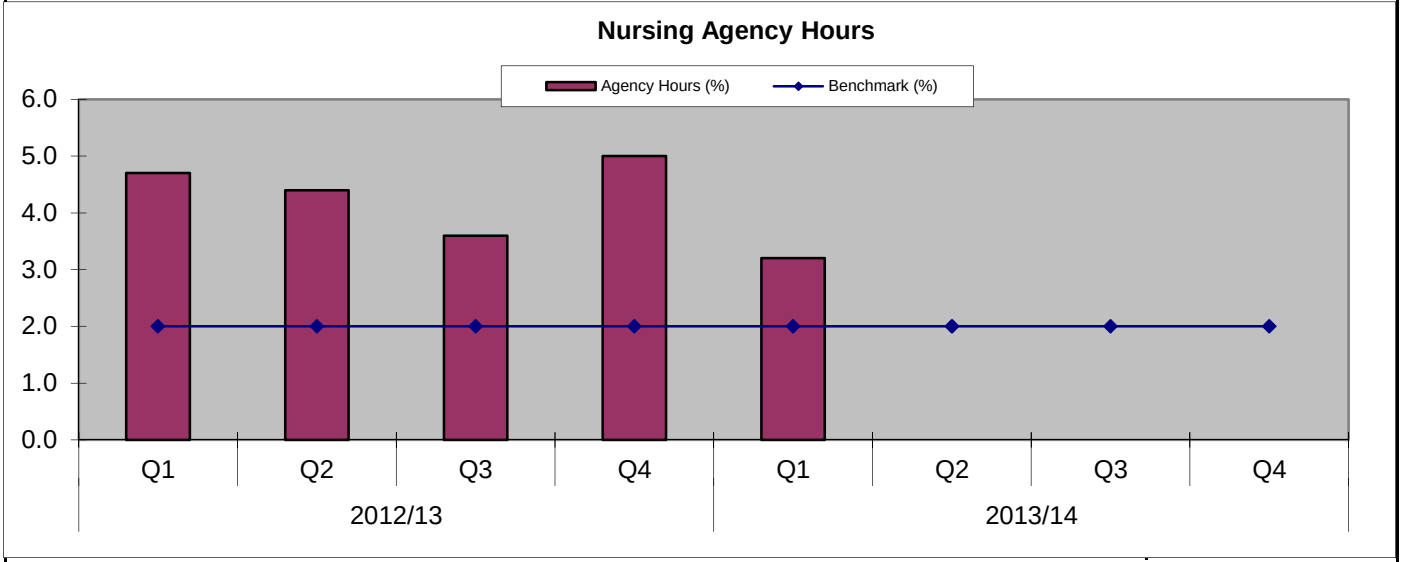
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☑		

Definition: Inpatient nursing unit and ambulatory care units purchased service hours per inpatient & ambulatory care units total hrs.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Agency Hours (%)	4.7	4.4	3.6	5.0	3.2			
Benchmark (%)	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Target (%)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Significance: A high degree of patient satisfaction is linked with consistent staff.



Analysis: Underperforming to benchmark. All programs continue to utilize agency. Medicine (3933 hrs) , Surgery (3742 hrs) and ED (1934 hrs) use the most hours, followed closely by WCFH (1736 hrs). MH used the fewest hours at 589.

Plan for Improvement/Timelines:

Accountability: D. McGregor

CORPORATE PERFORMANCE INDICATOR

Full Time RN's (mandatory)

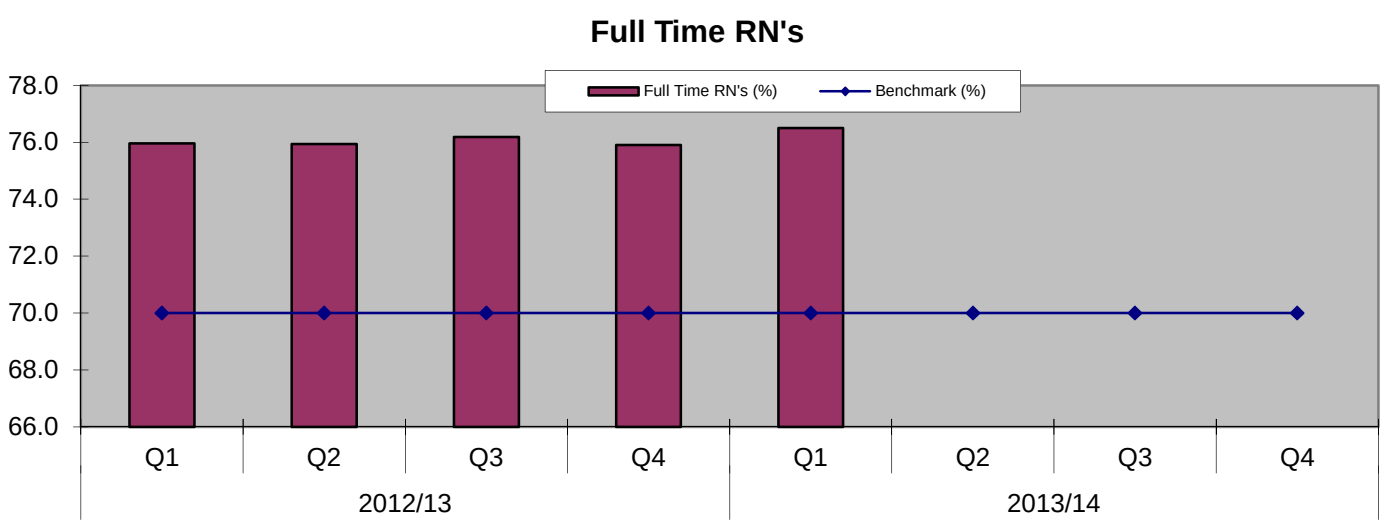
SUCCESS FACTOR:

Put Patients First	☐	**Enhance the Health of the Communities We Serve**	☐
Inspire Our People	☐	**Create a Culture of Inquiry and Innovation**	☐
Use Resources Wisely	☑		

Definition: The number of full time nurses (Registered Nurse) as a percentage of the total nurses employed within the health centre.

	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Full Time RN's (%)	76.0	75.9	76.2	75.9	76.5			
Benchmark (%)	70.0	70.0	70.0	70.0	70.0	70.0	70.0	70.0
Target (%)	75.0	75.0	75.0	75.0	75.0	75.0	75.0	75.0

Significance: The MOHLTC set the ratio of full-time RN's to be maintained at >70% (corridor floor 1%). This promotes the optimal quality of care for patients.



Analysis: Outperforming to benchmark.

Plan for Improvement/Timelines:

Accountability: D. McGregor