fiscal 2011-2012 **Q3**

3rd quarter ended December 31, 2011

KGH this quarter

Master Performance Report

Kingston General Hospital

Outstanding care, always

KINGSTON GENERAL HOSPITAL

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KGH Master Performance Report
Q3 Fiscal 2011 - 2012

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Strategy milestone # 1

15 patient experience advisors are integrated into KGH committees

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	Patients are engaged in all aspects of our quality, safety and service improvement initiatives	Integrate patient experience advisors into key KGH activities

Indicator(s)	Status
Number of Patient Experience Advisors on Key Planning/Decision Making Forums	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The target for 2012 was met in Q1, and by end of Q3 32 advisors were participating on 34 standing committees and 19 short term decision making teams. The requests for engagement of advisors is steadily growing and recruitment of advisors is occurring at program and corporate levels to support embedding the patient/family perspective in key KGH activities.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   There is ever-increasing word and awareness of the value of the patient perspective being factored into planning and decision making, resulting in more requests and engagement. Similarly requests for information and site visits by external organizations and associations continues to affirm the strategic direction and work associated with initiative.

3. **Are we on track to meet the milestone by year end?**
   The target for the year has been met and exceeded.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Given that the 2012 milestone has been met, the focus is on ensuring sustainability of current structures and processes, while managing both growth in number of advisors as well as extent and nature of engagement. Internal and external presentations continue, and given interest within the health care system, work is underway on a publication submission.

Kingston General Hospital

Milestone #1

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD1 Transform the patient experience	15 Patient experience advisors are integrated into		Number of Patient Experience Advisors on Key Planning/Decision Making Forums	Y	Y	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

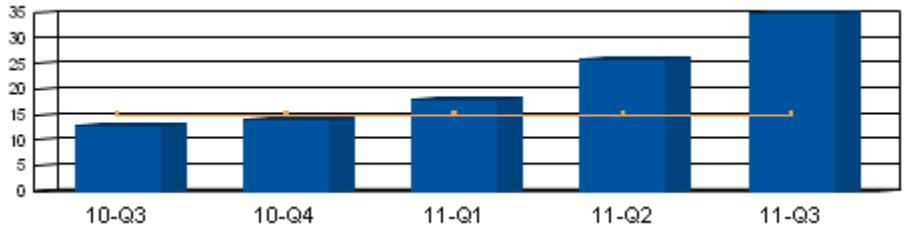
Kingston General Hospital

Milestone #1

SD1 Transform the patient experience through a relentless focus on quality, safety and service

15 Patient experience advisors are integrated into KGH committees

Indicator: Number of Patient Experience Advisors on Key Planning/Decision Making Forums



	Actual	Target
10-Q3	13	**15**
10-Q4	14	**15**
11-Q1	18	**15**
11-Q2	26	**15**
11-Q3	35	**15**

Interpretation - Patient And Business:

35 Patient Experience Advisors now hold positions on councils, committees and working groups throughout the organization. This ensures that the patient voice is being heard where many decisions on patient care are being made.

Actions & Monitoring Underway to Improve Performance:

All Program Councils now have at least one advisor (cardiology has 3) with the exception of SPA which is working towards finding an appropriate advisor. The Regional Cancer Patient and Family Advisory Council is up and running and looking for up to 15 advisors to sit on it. We will continue to interview applicants for the position of advisor and build up a resource pool from which we can fill vacancies as needed.

Definition: KGH is committed to ensuring the patient voice is heard at every level of the organization. To that end Patient Experience Advisors are being recruited and supported for membership on all councils, committees, task forces and working groups which have anything to do with the patient experience.

Target: QIP 11/12 Target: 15

Strategy milestone # 2

Overall patient satisfaction is at or better than the provincial teaching hospital average

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	Patients are engaged in all aspects of our quality, safety and service improvement initiatives	Improve patient satisfaction

Indicator(s)	Status
Overall Acute Inpatient Satisfaction	Green
Overall Emergency Care Patient Satisfaction	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The most recent data remains that for Q4 2011. There was an interruption in the submission of the necessary discharge data to NRC Picker, and thus update on performance will be delayed.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   No update since the past quarter.

3. **Are we on track to meet the milestone by year end?**
   The trending as of Q4 2011 showed downward trends in specific indicators within the milestone, suggesting risk in meeting the milestone. Interruption of data availability has delayed update. Since the most recent data report, the patient experience is being addressed through many corporate, program and patient specific initiatives with view to improvement and improved satisfaction.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The Patient Relations Program and Patient Records have collaborated to resolve the issue with data availability to NRC Picker. All programs are using both formal and informal patient feedback to understand opportunities for improvement, and are engaging patients and family members in planning and decision making with the goal of improving the patient experience. Corporate teams continue to focus on patient safety, patient flow, food services which are associated with patient satisfaction.

Kingston General Hospital

Milestone #2

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3
SD1 Transform the patient experience through a relentless focus on quality, safety and service	Overall patient satisfaction is at or better than the provincial teaching hospital average		Overall Acute Care Patient Satisfaction (%)	G	G	N/A	N/A	N/A
			Overall Emergency Care Patient Satisfaction (%)	G	G	N/A	N/A	N/A
			Percent of Patients Responding "Satisfied" to the Food Patient Discharge Survey	R	R	N/A	N/A	N/A
			Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey	G	G	N/A	N/A	N/A
			Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey (QIP)	Y	Y	N/A	N/A	N/A
			Percent of Patients who Answer "Definitely Yes" to the NRC Picker Question " Would you recommend this Hospital to Your Friends and	Y	R	N/A	N/A	N/A
			Percent of Patients who Answer "Definitely Yes" to the NRC Picker question "Would you Recommend this Hospital to your Friends and	G	Y	N/A	N/A	N/A

Indicates worsening performance to target over the past 5 quarters

Indicates improving performance to target over the past 5 quarters

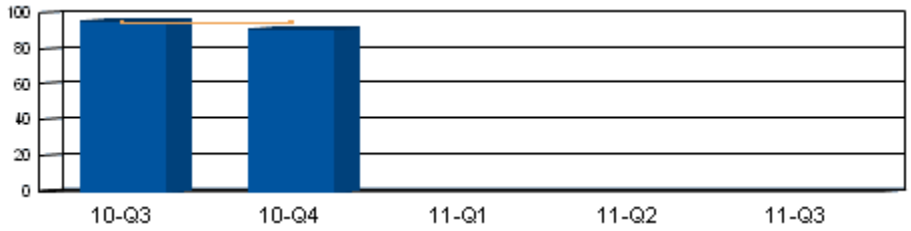
Kingston General Hospital

Milestone #2

SD1 Transform the patient experience through a relentless focus on quality, safety and service

Overall patient satisfaction is at or better than the provincial teaching hospital average

Indicator: Overall Acute Care Patient Satisfaction (%)

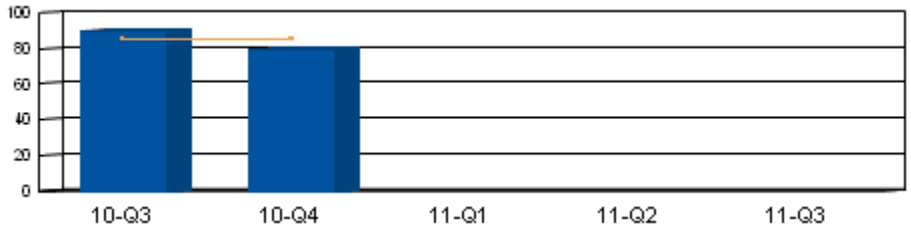


	Actual	Target
10-Q3	95	94
10-Q4	91	94
11-Q1		
11-Q2		
11-Q3		

Definition: The definition is the patient perception of overall care and is based on a single question (#44) on the NRC+ Picker inpatient medical/surgical survey. Pediatric, maternity and ambulatory care visits are excluded from participation. Ambulatory Care is reported elsewhere and is divided between 2 reports, Oncology reported annually and Emergency Care reported quarterly.

Target: Baseline 08/09: 93.3, Target 09/10: 93.8 or Greater, Target 10/11: Provincial Teaching Avg. or Better, Target 11/12: Provincial Teaching Avg. or Better

Indicator: Overall Emergency Care Patient Satisfaction (%)

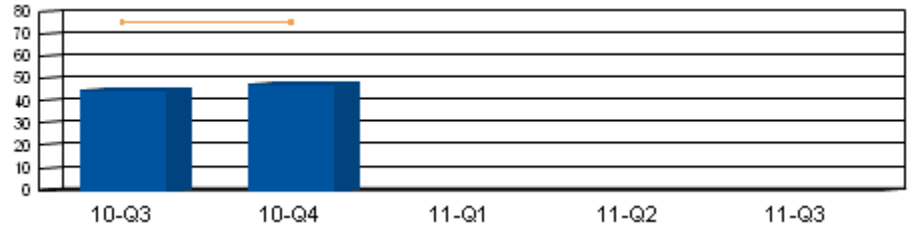


	Actual	Target
10-Q3	90	85
10-Q4	80	85
11-Q1		
11-Q2		
11-Q3		

Definition: This is defined as the patient perception of overall care and is based on the single question (# 46) on the NRC+ Picker survey. The question – Overall, how would you rate the care you received in the Emergency Department? The range is based on a 5 point scale of poor to excellent.

Target: Baseline 08/09: 83.1, Target 09/10: 80.0 or Greater, Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Teaching Avg. Or Better.

Indicator: Percent of Patients Responding "Satisfied" to the Food Patient Discharge Survey



	Actual	Target
10-Q3	44.9	75
10-Q4	47.0	75
11-Q1		
11-Q2		
11-Q3		

Definition: This is one question on the NRC+ Picker patient satisfaction report and can be compared to the Ontario hospital average and the Ontario Teaching Hospital average.

Target: QIP Target 11/12: 75%

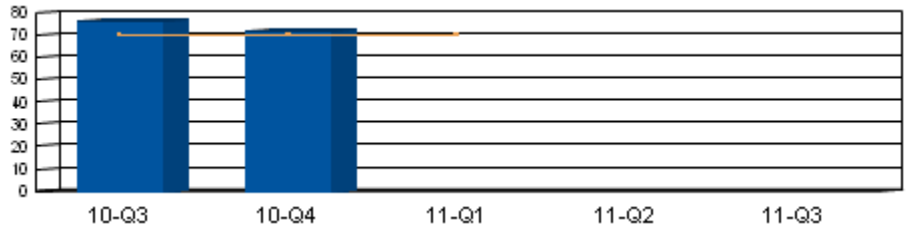
Kingston General Hospital

Milestone #2

SD1 Transform the patient experience through a relentless focus on quality, safety and service

Overall patient satisfaction is at or better than the provincial teaching hospital average

Indicator: Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey

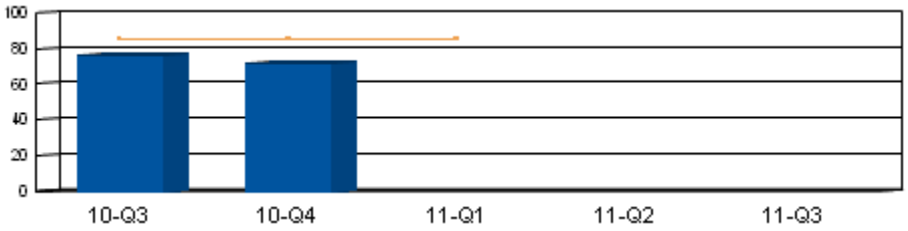


	Actual	Target
10-Q3	76.3	70
10-Q4	72.0	70
11-Q1		70
11-Q2		
11-Q3		

Definition: The NRC + Picker corporate survey following discharge for condition of the room which include cleanliness, temperature and lighting.

Target: SSC 11/12 Target = 70%

Indicator: Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey (QIP)

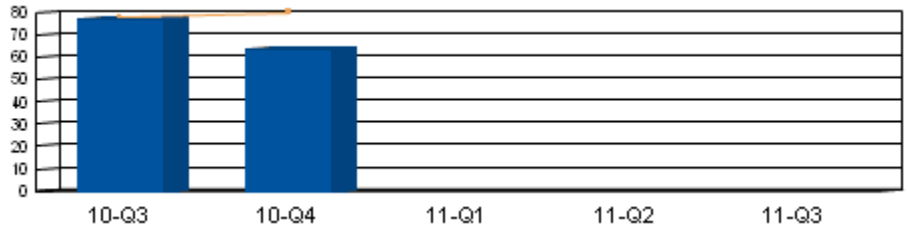


	Actual	Target
10-Q3	76.3	85
10-Q4	72.0	85
11-Q1		85
11-Q2		
11-Q3		

Definition: The NRC + Picker corporate survey following discharge for condition of the room which include cleanliness, temperature and lighting.

Target: QIP Target 11/12: 85%

Indicator: Percent of Patients who Answer "Definitely Yes" to the NRC Picker Question " Would you recommend this Hospital to Your Friends and Family?"



	Actual	Target
10-Q3	77	78
10-Q4	64	80
11-Q1		
11-Q2		
11-Q3		

Definition: This is a single question from the NRC+ Picker patient satisfaction and can be compared to the Ontario Hospital average and the Ontario teaching Hospital average.

Target: 11/12 Target: Prov. Teaching Avg. or Better

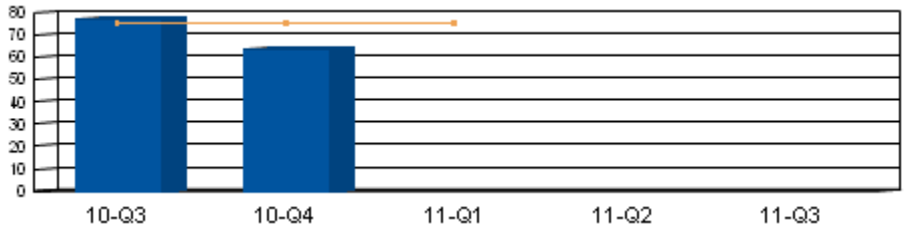
Kingston General Hospital

Milestone #2

SD1 Transform the patient experience through a relentless focus on quality, safety and service

Overall patient satisfaction is at or better than the provincial teaching hospital average

Indicator: Percent of Patients who Answer "Definitely Yes" to the NRC Picker question "Would you Recommend this Hospital to your Friends and Family"? (QIP)



	Actual	Target
10-Q3	77	**75**
10-Q4	64	**75**
11-Q1		**75**
11-Q2		
11-Q3		

Definition: This is a single question from the NRC+ Picker patient satisfaction and can be compared to the Ontario Hospital average and the Ontario teaching Hospital average.

Target: QIP Target 11/12: 75%

Strategy milestone # 3

70% of our people who are surveyed rate us as "excellent" in fostering a patient safety culture

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable harm to patients is eliminated	Improve our patient safety culture

Indicator(s)	Status
Percent of Staff Surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey	Red

1. **What is our actual performance on each of the indicators for this milestone as listed above?**

   The most recent HSMR data is Q4 F10/11 with a value of 101, not significant from the target of 100. The mortality review by clinical departments indicator is above target seeing 100% review completion for the Q4 data for F 10/11. The percent of staff reporting on the Patient Safety Culture survey indicator has not had new data. The next survey is tentative for late Q4.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**

   The MAC Joint Quality Utilization Improvement Committee has taken the lead on HSMR and mortality reviews conducted by the clinical departments. Engagement has been very successful with 100% of mortality reviews completed.

3. **Are we on track to meet the milestone by year end?**

   The milestone will not be on track given the time frame of the next scheduled survey.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   Recruitment for Director of Patient Quality and Safety and Risk is in progress. Organizational links to Patient Safety and Accreditation reinforced. Nursing Professional Practice initiatives enabled with 'Quality of Nursing Environment' funding from the MoH for projects aimed at promoting organizational patient safety awareness.

Kingston General Hospital

Milestone #3

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3
SD1 Transform the patient experience through a relentless focus on quality, safety and service	70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture		Hospital Standardized Mortality Ratio (HSMR)	G	G	N/A	N/A	N/A
			Percent Mortality Reviews Completed with Quarterly Review of Record Level HSMR Data	R	G	N/A	N/A	N/A
			Percent of Staff surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey		R	R	N/A	N/A

Indicates worsening performance to target over the past 5 quarters

Indicates improving performance to target over the past 5 quarters

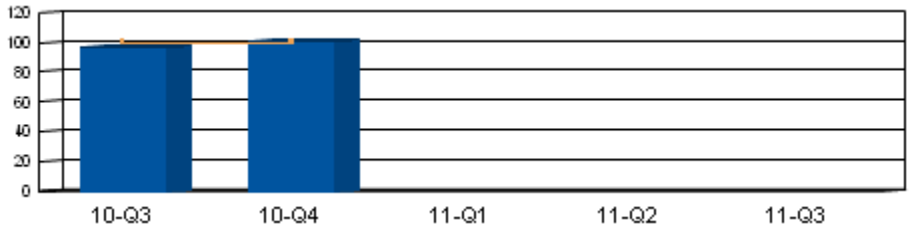
Kingston General Hospital

Milestone #3

SD1 Transform the patient experience through a relentless focus on quality, safety and service

70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture

Indicator: Hospital Standardized Mortality Ratio (HSMR)



	Actual	Target
10-Q3	97	100
10-Q4	101	100
11-Q1		
11-Q2		
11-Q3		

Interpretation - Patient And Business:

The Hospital Standard Mortality Ratio (HSMR) is an important quality of care measurement tool that provides a starting point to assess mortality trends, identify opportunities for improvement and track progress. The HSMR is adjusted for factors affecting mortality, such as age, sex, and length of stay. An HSMR equal to 100 suggests that there is no difference between the hospital's mortality rate and the overall average rate. An HSMR greater than 100 suggests that the local mortality rate is higher than the overall average whereas a HSMR less than 100 suggests that the local mortality rate is lower than the overall average. It is important to note that HSMR is not designed for comparisons between hospitals; it is intended to track a hospital's trend over time.

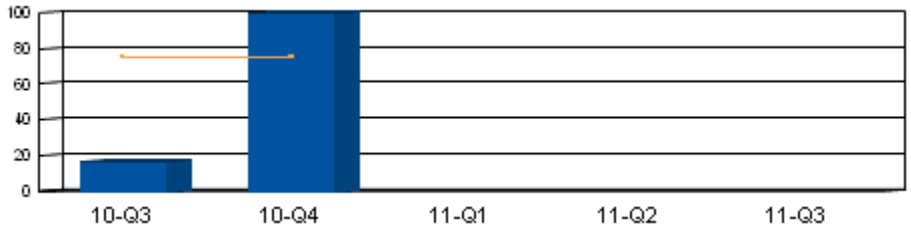
Actions & Monitoring Underway to Improve Performance:

The most recent available data is Q4 fiscal 10/11. The Canadian Institute for Health Information (CIHI) provides the HSMR calculations to all hospitals in Ontario. Because CIHI chooses to provide Q1 and Q2 data together, we do not anticipate receiving these results until Feb 2012. HSMR values will be updated at the time and reported in Q4. Quarterly morality reviews are on-going by the clinical departments. Any concerns or trends are reported to the MAC's Joint Quality and Utilization Committee.

Definition: The Hospital Standardized Mortality Ratio (HSMR) is an overall quality indicator and measurement tool used by all acute care hospitals and regions in Canada (excluding Quebec). HSMR has been used by many hospitals in several countries to help improve quality of care and enhance patient safety. The HSMR is based on diagnosis groups that account for 80% of all deaths in acute care hospitals and is adjusted for factors such as diagnosis group, age, sex, length of hospital stay, admission category, comorbidities (having multiple illnesses at once) and transfers. The Formula for HSMR is equal to the number of observed deaths divided by the number of expected deaths, multiplied by 100.

Target: Baseline 08/09: 111, Target 09/10: 100, Target 10/11: 100, Target 11/12: 106.

Indicator: Percent Mortality Reviews Completed with Quarterly Review of Record Level HSMR Data



	Actual	Target
10-Q3	16	75
10-Q4	100	75
11-Q1		
11-Q2		
11-Q3		

Definition: Mortality reviews completed with quarterly review of record level HSMR data by Departmetn Heads and reported to the Medical Advisory Committee

Target: QIP Target 11/12: 75%

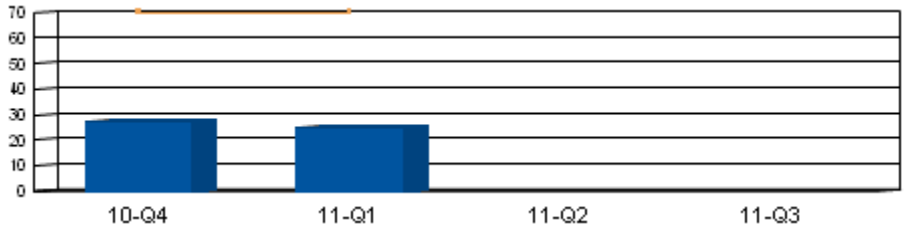
Kingston General Hospital

Milestone #3

SD1 Transform the patient experience through a relentless focus on quality, safety and service

70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture

Indicator: Percent of Staff surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey



	Actual	Target
10-Q4	27.5	**70**
11-Q1	25.1	**70**
11-Q2		
11-Q3		

Definition: The Patient Safety Culture Tool provides insight into staff perceptions of patient safety, allowing us to identify successes and opportunities for improvement, and monitor changes within the organization. It is based on the Modified Stanford Instrument (MSI) Patient Safety Culture Survey developed by Ginsburg et. al. (York University) The tool was recently revised by Ginsburg et. al. to ensure it reflects the most up-to-date patient safety culture research.

The Patient Safety Culture Tool includes 40 items (plus demographic items). Two items assign an overall patient safety grade of the unit and the organization. The remaining 38 items measure the following dimensions:
• Senior leadership support for safety
• Supervisory leadership support for safety
• Patient safety learning culture
• Talking about errors / communication barriers

The question on the Patient Safety Culture Survey reads;

“Please give your unit an overall grade on patient safety”
Staff responses to select from include;
- Excellent
- Very Good
- Acceptable
- Poor
- Failing

Target: Target 11/12: 70%

Strategy milestone # 4

We achieve 100% hand hygiene compliance across all units and categories of staff

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	**All preventable harm to patients is eliminated**	**Reduce hospital-acquired infections**

Indicator(s)	Status
Hand Hygiene Compliance (SSC)	**Yellow**

1. What is our actual performance on each of the indicators for this milestone as listed above?

Hand hygiene compliance is at 90% for the organization , which is the highest is has been in the fiscal year. The indicator status is yellow because a stretch target of 100% has been set for this strategic indicator. It is worth noting that the target set in the Quality Improvement Plan is 90%.

2. What are the contributing factors to the current performance of the indicators for this milestone?

A broad institutional awareness of hand hygiene rates and impact has been in place since Q3 Fiscal 2009. The HandyAudit tool introduction through the CAHO ARTIC project has made data collection and analysis robust. Public reporting, frequent data analysis by all wards and posting on hospital wards and public entrances has maintained visibility on the awareness to meet compliance targets.

3. Are we on track to meet the milestone by year end?

Yes.

4. What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?

Continued executive messaging supporting 100% hand hygiene compliance. Compliance accountability is tied to Infection Control Service and Infection Control Committee. Monthly HandyAudit reports are standing agenda at Infection Control and Patient Safety and Quality Committee meetings.

Kingston General Hospital

Milestone #4

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	We achieve 100% hand hygiene compliance across all units and categories of staff		Hand Hygiene Compliance	Y	G	Y	Y	G	
			Hand Hygiene Compliance (QIP)			Y	Y	G	
			Hand Hygiene Compliance (SSC)			Y	Y	Y	

Indicates worsening performance to target over the past 5 quarters 

Indicates improving performance to target over the past 5 quarters 

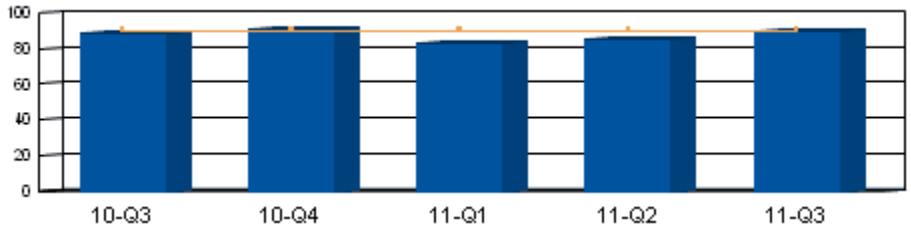
Kingston General Hospital

Milestone #4

SD1 Transform the patient experience through a relentless focus on quality, safety and service

We achieve 100% hand hygiene compliance across all units and categories of staff

Indicator: Hand Hygiene Compliance



	Actual	Target
10-Q3	88	**90**
10-Q4	91	**90**
11-Q1	83	**90**
11-Q2	85	**90**
11-Q3	90	**90**

Interpretation - Patient And Business:

Continued messaging about HH and the use of the HandyAudit tool has had the desired effect on reaching our target for hand hygiene compliance. Continued attention to HH across the institution will be important to reducing the incidence of nosocomal infections overall.

Definition: The single most common way of transferring health care-associated infections (HAIs) in a health care setting is on the hands of health care providers. Health care providers move from patient to patient and room to room while providing care and working in the patient environment. This movement provides many opportunities for the transmission of organisms on hands that can cause infections. Hand hygiene is the act of cleaning one's hands. There are two ways to clean hands; using an alcohol-based hand rub (ABHR) or, when hands are visibly soiled, using soap and running water. Monitoring hand hygiene practices is vital to improving rates and, in turn, reducing HAIs.
Hospitals will post on their web sites, on an annual basis and by hospital site, the compliance rate for: hand hygiene before initial contact with the patient/patient's environment for all health care providers as well as hand hygiene after contact with the patient/patient's environment for all health care providers.

Before Initial Patient/Patient Environment Contact :
# of times hand hygiene performed before initial patient/patient environment contact
---
observed hand hygiene indications before initial patient/patient environment contact x 100

After Patient/Patient Environment Contact :
# of times hand hygiene performed after patient/patient environment contact
---
observed hand hygiene indications after patient/patient environment contact x 100
Hospitals will also report their data to the Ministry of Health and Long-Term Care through an online template captured by a central database. The ministry will post this information on its public website.

This indicator is based on the Average compliance for all four moments of Hand Hygiene (Before initial patient/patient environtment contact, Before aseptic procedures, After patient/patient environment contact, After body fluid exposure risk)
- for all professions

Target: Baseline Fiscal 08/09: 44%, Target 09/10: 90%, Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: 90%

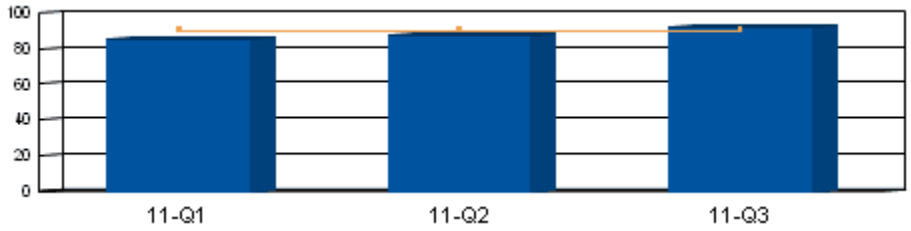
Kingston General Hospital

Milestone #4

SD1 Transform the patient experience through a relentless focus on quality, safety and service

We achieve 100% hand hygiene compliance across all units and categories of staff

Indicator: Hand Hygiene Compliance (QIP)



	Actual	Target
11-Q1	85	**90**
11-Q2	87	**90**
11-Q3	92	**90**

Interpretation - Patient And Business:

Continued messaging about HH and the use of the Handiaudit tool has had the desired effect on reaching our target for hand hygiene compliance. Continued attention to HH across the institution will be important to reducing the incidence of nosocomal infections overall.

Definition: The single most common way of transferring health care-associated infections (HAIs) in a health care setting is on the hands of health care providers. Health care providers move from patient to patient and room to room while providing care and working in the patient environment. This movement provides many opportunities for the transmission of organisms on hands that can cause infections. Hand hygiene is the act of cleaning one's hands. There are two ways to clean hands; using an alcohol-based hand rub (ABHR) or, when hands are visibly soiled, using soap and running water. Monitoring hand hygiene practices is vital to improving rates and, in turn, reducing HAIs.
Hospitals will post on their web sites, on an annual basis and by hospital site, the compliance rate for: hand hygiene before initial contact with the patient/patient's environment for all health care providers as well as hand hygiene after contact with the patient/patient's environment for all health care providers.

Before Initial Patient/Patient Environment Contact :
# of times hand hygiene performed before initial patient/patient environment contact
---
observed hand hygiene indications before initial patient/patient environment contact x 100

After Patient/Patient Environment Contact :
# of times hand hygiene performed after patient/patient environment contact
---
observed hand hygiene indications after patient/patient environment contact x 100
Hospitals will also report their data to the Ministry of Health and Long-Term Care through an online template captured by a central database. The ministry will post this information on its public website.

This indicator is based on the compliance rate for hand hygiene before initial patient / Patient environment contact for all professions

Target: QIP Target 11/12: 90%

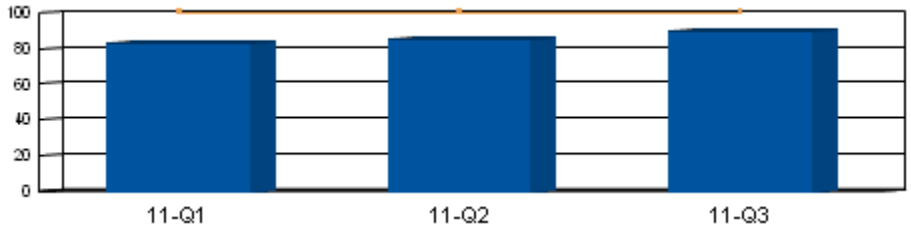
Kingston General Hospital

Milestone #4

SD1 Transform the patient experience through a relentless focus on quality, safety and service

We achieve 100% hand hygiene compliance across all units and categories of staff

Indicator: Hand Hygiene Compliance (SSC)



	Actual	Target
11-Q1	83	**100**
11-Q2	85	**100**
11-Q3	90	**100**

Interpretation - Patient And Business:

Continued messaging about HH and the use of the Handiaudit tool has had the desired effect on moving closer to target for hand hygiene compliance. Continued attention to HH across the institution will be important to reducing the incidence of nosocomal infections overall.

Definition: The single most common way of transferring health care-associated infections (HAIs) in a health care setting is on the hands of health care providers. Health care providers move from patient to patient and room to room while providing care and working in the patient environment. This movement provides many opportunities for the transmission of organisms on hands that can cause infections. Hand hygiene is the act of cleaning one's hands. There are two ways to clean hands; using an alcohol-based hand rub (ABHR) or, when hands are visibly soiled, using soap and running water. Monitoring hand hygiene practices is vital to improving rates and, in turn, reducing HAIs.
Hospitals will post on their web sites, on an annual basis and by hospital site, the compliance rate for: hand hygiene before initial contact with the patient/patient's environment for all health care providers as well as hand hygiene after contact with the patient/patient's environment for all health care providers.

Before Initial Patient/Patient Environment Contact :
# of times hand hygiene performed before initial patient/patient environment contact
---
observed hand hygiene indications before initial patient/patient environment contact x 100

After Patient/Patient Environment Contact :
# of times hand hygiene performed after patient/patient environment contact
---
observed hand hygiene indications after patient/patient environment contact x 100
Hospitals will also report their data to the Ministry of Health and Long-Term Care through an online template captured by a central database. The ministry will post this information on its public website.

This indicator is based on the Average compliance for all four moments of Hand Hygiene (Before initial patient/patient environtment contact, Before aseptic procedures, After patient/patient environment contact, After body fluid exposure risk), for all professions.

Target: SSC Target 11/12: 100%

Strategy milestone # 5

The number of new patients who acquire infections in our hospital is reduced by 10%

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable harm to patients is eliminated	Reduce hospital-acquired infections

Indicator(s)	Status
Number of New Cases of Hospital Acquired Infection	Yellow

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The number of new cases of hospital acquired infections(MRSA, CDI and VRE remains at 36 for Q3 against a target of 31.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   CDI infection rates continues to be the predominate factor in this indicator. KGH has historically seen a seasonal spike in rates for Q3/Q4 with an increased admission of frail elderly patients with pneumonia. Increased antibiotic usage is seen with these admissions (7% increase in Q3).

3. **Are we on track to meet the milestone by year end?**
   The ability to control C. diff. is the sole determinate for meeting the milestone. A brief CDI outbreak in early Q3 has been followed by a subsequent declaration of an outbreak in Q4. Thus there is an identified risk to meeting the milestone.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   Prevention of hospital acquired infections is a complex and multi-faceted problem. There is a predominance of CDI case on carpeted units. KGH continues to remove carpets as quickly as possible (27% complete Q3). Hand hygiene compliance rates continue to climb and KGH rates are leading in our peer group. Environmental audits remain at target of 95%. An antibiotic stewardship program is under evaluation as a method to limit antibiotic usage as known contributor to CDI.

Kingston General Hospital

Milestone #5

			10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	The number of new cases who acquire infections in our hospital is reduced by 10%	Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 patient days	Y	R	R	Y	R	↑
		C-difficile	R	R	R	R	R	↓
		C-difficile (QIP)	R	R	G	R	R	↓
		Central Line Bloodstream Infections	G	G	G	R	G	↑
		Environmental Audits	G	G	Y	G	G	↑
		MRSA (Methicillin-resistant Staphylococcus aureus)	R	Y	Y	Y	G	↑
		Number of New Cases of Hospital Acquired Infection	R	R	G	Y	Y	↑
		Percent of Sepsis Cases Reviewed by Department Head	N/A	N/A	N/A	N/A	N/A	
		Surgical Site Infection (SSI) Prevention	Y	Y	Y	Y	Y	↑
		Ventilator Associated Pneumonia	G	G	G	G	G	↓
		Ventilator Associated Pneumonia (QIP)	G	G	G	G	G	↓
		VRE (Vancomycin-resistant Enterococcus)	Y	G	Y	Y	G	↓

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

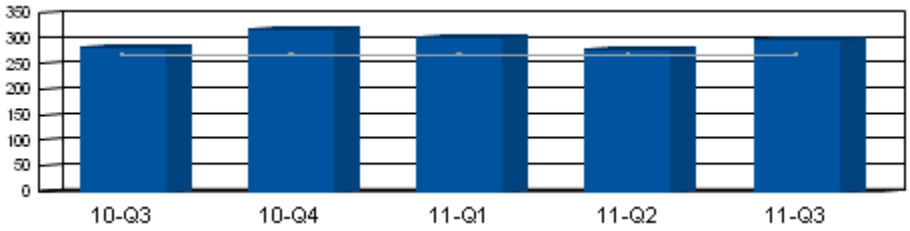
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 patient days



	Actual	Target
10-Q3	281	**267**
10-Q4	317	**267**
11-Q1	303	**267**
11-Q2	278	**267**
11-Q3	299	**267**

Interpretation - Patient And Business:

Antimicrobial resistance is a known major public health issue, and antimicrobial stewardship, the appropriate use of antimicrobial agents, is critical to stemming the continued emergence of antimicrobial-resistant organisms.

The increasing recognition of the health burden associated with hospital-acquired infections in Canada and the increasing evidence that the use of antimicrobials in hospitals is a critical determinant of infection rates due to the most important hospital-acquired pathogens, methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile, emphasize the urgency of developing and facilitating antimicrobial stewardship programs. Literature has shown that appropriate use of antimicrobials can reduce occurrences of antibiotic resistant organisms.

Actions & Monitoring Underway to Improve Performance:

As of Q3, KGH's usage of antibiotics is above target and jumped back up by 7% to 299.. The Infection Prevention and Control Service continues to take the lead in implementation of an antibiotic stewardship program (ABSP) working with and through the Patient Safety and Quality Committee. Curtailing antibiotic usage is expected to have impact by reducing the incidence and frequency of nosocomial infections and outbreaks, especially C. difficile. The introduction of the Anti-biotic Stewardship program is aimed at monitoring and improving anti-biotic utilization.

Definition: The Targeted Antimicrobial Use Indicator is a measure of institutional antimicrobial consumption of broad-spectrum antibacterials. Overuse of antibiotics is associated with the emergence of antimicrobial resistance and selection of some pathogens for example, Clostridium difficile. The indicator permits monitoring using a surrogate marker for institutional trends in overall antimicrobial use. Early warning of increasing patient exposure to antibiotics may become evident with monitoring. Conversely, the impact of interventions aimed at reducing overall patient exposure to antibiotics may become apparent. The total number of defined daily doses (DDD) of targeted antibiotics per 1000 patient-days using the World Health Organization Anatomical Class (WHO ATC) definition of DDD [assumed average maintenance dose per day for a drug used for its main indication in adults].The targeted antibiotics are: carbapenems (ertapenem, imipenem, meropenem, doripenem); third and fourth generation cephalosporins (cefepime, cefixime, cefotaxime, ceftazidime, ceftriaxone); extended-spectrum penicillins (piperacillin, piperacillin-tazobactam, ticarcillin-clavulanate); fluoroquinolones (ciprofloxacin, levofloxacin, moxifloxacin) and clindamycin. The numerator is the total DDDs of targeted antimicrobials, as extracted from GE Centricity Pharmacy Version 8.2 software reports detailing quarterly drug issuance to all patient care units, including Emergency. The denominator is the Quarterly Patient Days Grand Total from the Hospital's Bed Census Report.

Target: 267 DDD/1000 patient-days (based upon 5% reduction from that measured during Fiscal 2011 Q3.

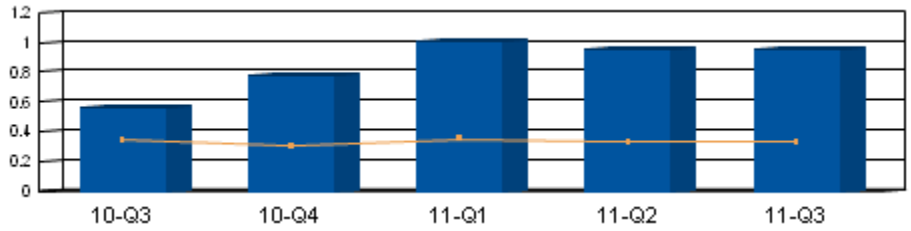
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: C-difficile



	Actual	Target
10-Q3	0.56	**0.34**
10-Q4	0.78	**0.3**
11-Q1	1.01	**0.35**
11-Q2	0.96	**0.33**
11-Q3	0.95	**0.33**

Interpretation - Patient And Business:

The effect of seasonal variation and improved, more sensitive detection testing has resulted in steady CDI rates over the last quarter. Rates remain above targets but are trending downward overall. In the approach to CDI, KGH still lacks an Antibiotic Stewardship Program as a component to controlling CDI incidence. Improved environmental cleaning through auditing has been recently introduced and should prove beneficial. Efforts to direct more resources to CDI and away from other less relevant areas should be considered. IPAC resources remain an issue and speak to the need to bring the team up to its requisite numbers of ICPs. Please note values are monthly (August - December, 2011)

Business perspective: Investment in the Antibiotic Stewardship Program should help to reduce and maintain rates of CDI.

Definition: Clostridium difficile is a spore-forming bacterium that may be present in the environment and can colonize the intestinal tract in up to five per cent of adults in the community without causing symptoms. It can cause an infectious diarrhea in both community and health care settings. It is the single most common cause of antibiotic-associated diarrhea (AAD) accounting for 15-25% of all episodes.

All Ontario hospitals are required to report to the MOHLTC and publicly on the rates and the number of new nosocomial CDI cases associated with the reporting facility.

The CDI count is the number of new nosocomial cases of CDI by month.
The rate of CDI is calculated as follows: The number of new nosocomial cases of CDI associated with the reporting facility multiplied by 1000, then divided by the number of patient days. This rate represents the incidence rate of nosocomial CDI associated with the reporting facility per 1000 patient days.

Target: Target 09/10: 0.26 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

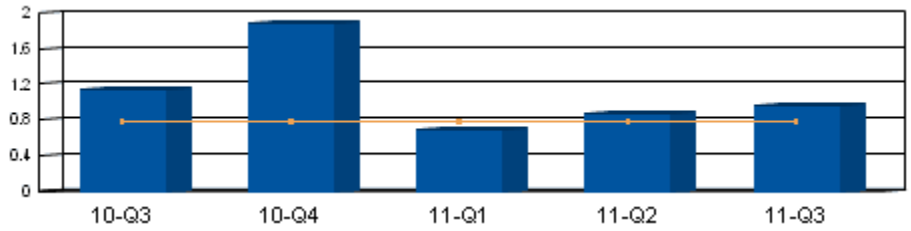
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: C-difficile (QIP)



	Actual	Target
10-Q3	1.15	**0.77**
10-Q4	1.89	**0.77**
11-Q1	0.70	**0.77**
11-Q2	0.87	**0.77**
11-Q3	0.97	**0.77**

Interpretation - Patient And Business:

The effect of seasonal variation and improved, more sensitive detection testing has resulted in a slight upswing of CDI rates over the last quarter. Rates remain above targets. In the approach to CDI, KGH still lacks an Antibiotic Stewardship Program as a component to controlling CDI incidence. Improved environmental cleaning through auditing has been recently introduced and should prove beneficial. Efforts to direct more resources to CDI and away from other less relevant areas should be considered. IPAC resources remain an issue and speak to the need to bring the team up to its requisite numbers of ICPs. Please note values are monthly (August - December, 2011)

Definition: Clostridium difficile is a spore-forming bacterium that may be present in the environment and can colonize the intestinal tract in up to five per cent of adults in the community without causing symptoms. It can cause an infectious diarrhea in both community and health care settings. It is the single most common cause of antibiotic-associated diarrhea (AAD) accounting for 15-25% of all episodes.

All Ontario hospitals are required to report to the MOHLTC and publicly on the rates and the number of new nosocomial CDI cases associated with the reporting facility.

The CDI count is the number of new nosocomial cases of CDI by month.
The rate of CDI is calculated as follows: The number of new nosocomial cases of CDI associated with the reporting facility multiplied by 1000, then divided by the number of patient days. This rate represents the incidence rate of nosocomial CDI associated with the reporting facility per 1000 patient days.

Target: QIP Goal = 0.30, QIP Target For Compensation = 0.77

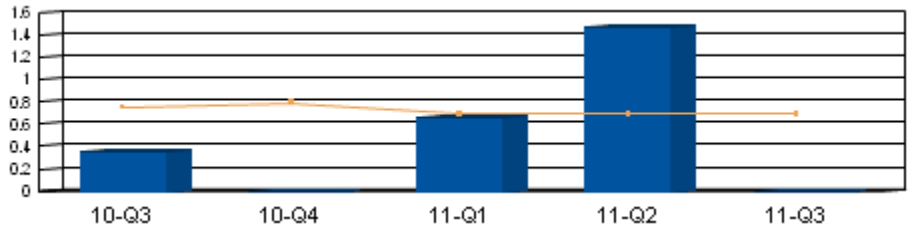
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Central Line Bloodstream Infections



	Actual	Target
10-Q3	0.36	**0.75**
10-Q4	0.00	**0.79**
11-Q1	0.66	**0.69**
11-Q2	1.47	**0.69**
11-Q3	0.00	**0.69**

Interpretation - Patient And Business:

Patient perspective: CLBI poses a significant risk of life threatening infection and increased critical are and hospital length of stay.
Q2 results showed a marked increase. Quarter 3 however shows significant improvement. The use of central line bundle and a patient safety coordinator who works with staff to ensure compliance in all aspects of the bundle have been very effective in changes in practice and maintaining our success. Last quarter appears to be a one-off. The Critical Care program remains vigilant with respect to all infectious disease prevention practices.

Business perspective: Investigation into the cause of the jump in CLBI rates last quarter occurred but were related to only 2 patients on D4ICU.

Actions & Monitoring Underway to Improve Performance:

will continue to monitor and have hired permanently into the Safety Coordinator Position with plans to increase monitoring and implementation of best practice.

Definition: A central line infection (CLI) occurs when a central venous catheter (or "line") placed into a patient's vein becomes infected. A CLI occurs when excessive numbers of bacteria grow on the line, which can lead to blood stream infection. Patients may require a central line when blood, fluid replacement and/or nutrition need to be given to them intravenously. Central lines also allow health care providers to directly monitor fluid status and make determinations about the cardiovascular status of a patient.
A CLI case is defined as an ICU patient who developed a blood stream infection (BSI) a minimum of 48 hours after the insertion of a central line.

The ministry will report and post on its website by hospital site the number of CLI cases that developed in the ICU in each hospital site. Where the number is zero (0) or where the cases total five (5) or more associated with that hospital site, the number will be posted. If the cases are fewer than 5 (i.e., 1 to 4 cases), it will state "<5 cases" and the CLI rate (per 1000 central line days)

The CLI rate is determined by the total number of newly diagnosed CLI cases in the ICU after at least 48 hours of receiving a central line, divided by the number of central line days in that month, multiplied by 1,000. Central line days are the total number of days a central line was used in ICU patients 18 years and older.

Target: Target 09/10: 1.2 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

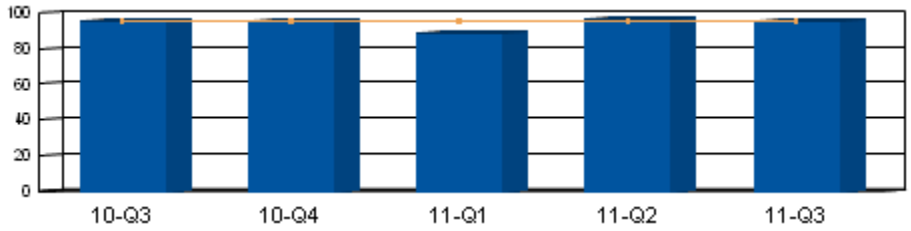
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Environmental Audits



	Actual	Target
10-Q3	95	95
10-Q4	95	95
11-Q1	88	95
11-Q2	96	95
11-Q3	95	95

Interpretation - Patient And Business:

Ongoing staff training on cleaning best practices continues to keep us on target.

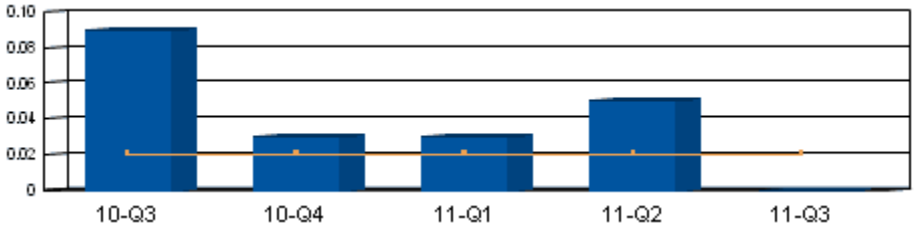
Actions & Monitoring Underway to Improve Performance:

With the addtional new areas all recently hired staff are being included in our formal training.

Definition: The environmental audit indicator evaluates and measures the effectiveness of daily patient room cleaning. The audit identifies opportunities to focus education and training needs. The audit uses a glow germ potion and glow bar UV lamp on frequently touched surfaces in randomly selected patient rooms for an overall representation of cleaning. The percentage is determined on glow germ removed.

Target: QIP Target 11/12: 95%

Indicator: MRSA (Methicillin-resistant Staphylococcus aureus)



	Actual	Target
10-Q3	0.09	0.02
10-Q4	0.03	0.02
11-Q1	0.03	0.02
11-Q2	0.05	0.02
11-Q3	0.00	0.02

Interpretation - Patient And Business:

There were no MRSA bacteremias in the last quarter. This is likely attributable to continued improvement in Hand hygiene rates across the hospital. Colonization rates of MRSA in inpatients is also dropping, again likely a function of better HH rates.

Definition: Staphylococcus aureus is a bacterium that periodically lives on the skin and mucous membranes of healthy people. Occasionally S. aureus can cause an infection. When S. aureus develops resistance to the beta lactam class of antibiotics, it is called methicillin-resistant Staphylococcus aureus, or MRSA.
A case is a patient identified with laboratory confirmed bloodstream infection with MRSA. A bloodstream infection is at least one positive blood culture for MRSA. KGH will post its quarterly rate and new case count of MRSA bacteraemia acquired in its facility on its website.
At the end of each quarter, the ministry will report the previous quarter's data on its website by hospital site including the number of new hospital acquired MRSA bacteraemia cases that is zero (0) or totaling five (5) or more associated with that hospital site, or if this is fewer than 5 cases (i.e. 1 to 4 cases), text reading "< 5 cases", and the hospital acquired MRSA bacteraemia rate.

The total number of new cases of MRSA bacteraemia acquired in the hospital in a quarter is divided by the total number of patient days for that quarter. Patient days are the number of days spent in a hospital for all patients. The results are multiplied by 1000. This represents the rate of hospital acquired associated MRSA bacteraemia associated with the reporting facility per 1000 patient days for that quarter.

Target: Target 09/10: 0.02 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

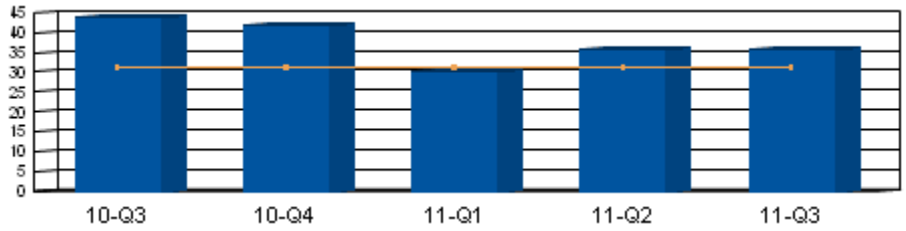
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Number of New Cases of Hospital Acquired Infection



	Actual	Target
10-Q3	44	**31**
10-Q4	42	**31**
11-Q1	30	**31**
11-Q2	36	**31**
11-Q3	36	**31**

Interpretation - Patient And Business:

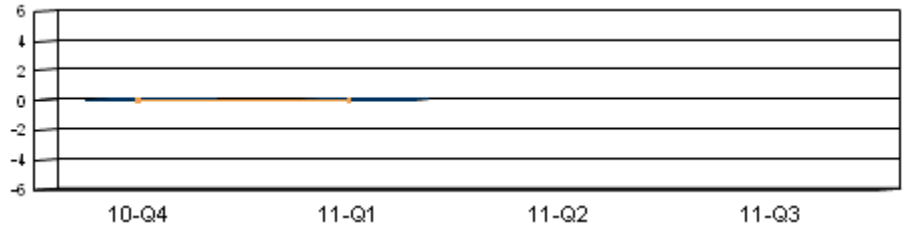
The stability in numbers likely attributable to increased seasonal rates of CDI in the last quarter and a reduction in CLBI in Critical Care and MRSA bacteremias.

Business perspective: Investment in the Antibiotic Stewardship Program should help to reduce and maintain rates of CDI.

Definition: The total number of new cases of hospital-acquired infection is a performance indicator that aggregates new cases of MRSA bacteremia, CDI, and VRE bacteremia into an overall performance measure. This case count excludes colonizations. New cases are tracked on a monthly basis for each category then added and averaged for each fiscal quarter.

Target: Target 11/12: 31

Indicator: Percent of Sepsis Cases Reviewed by Department Head



	Actual	Target
10-Q4	0	**0**
11-Q1	0	**0**
11-Q2		
11-Q3		

Interpretation - Patient And Business:

Not yet being reported. Expectation is in Q4

Definition: Quarterly review of all sepsis cases by Department heads and reported to the Medical Advisory Committee

Target: QIP Target 11/12: 75%

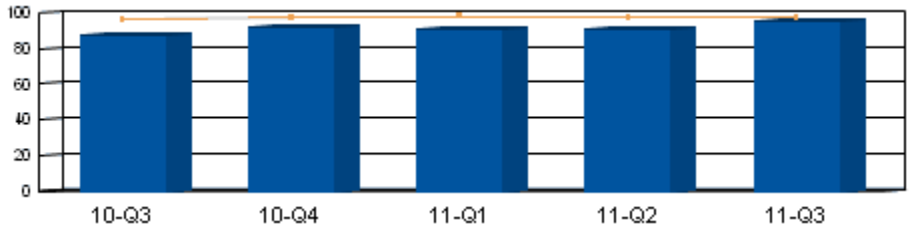
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Surgical Site Infection (SSI) Prevention



	Actual	Target
10-Q3	87	96
10-Q4	92	97
11-Q1	91	98
11-Q2	91	97
11-Q3	95	97

Interpretation - Patient And Business:

Patient perspective: The rates of appropriate timing of prophylactic antibiotic administration for patients undergoing orthopedic procedures are approaching target and are now well above 90%. This is likely attributable to clarifying the process for antibiotic administration in the OR suite. Rates of SSI post arthroplasty remain at acceptable levels.

Business perspective: Identification of any remaining barriers to timely antibiotic administration is being examined by the Surgical Infection Control working group.

Definition: Prevention of surgical site infections (SSI) is multi-faceted. One of the interventions used to reduce the incidence of SSI is the use of pre-operative antibiotics typically administered to patients 0 to 60 minutes (for usual antibiotics) or 0 to 120 minutes (for an antibiotic known as vancomycin) before they undergo surgery. This SSI-prevention indicator will report the percentage of time the health care team gave patients antibiotics within the appropriate time period before the surgery. This will be measured only in patients who are 18 years or older who are about to undergo primary hip or knee joint replacement surgery, including total, partial or hemi-arthoplasty.
Hospitals will post the percentage of hip/knee joint replacement surgical patients who received antibiotics within the appropriate time period before the surgery on their website every three months (quarterly), and will also report their data to the Ministry of Health and Long-Term Care through an online template captured by a central database. The Ministry will post this information on its public website.

Target: Target 09/10: 91.95%, Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

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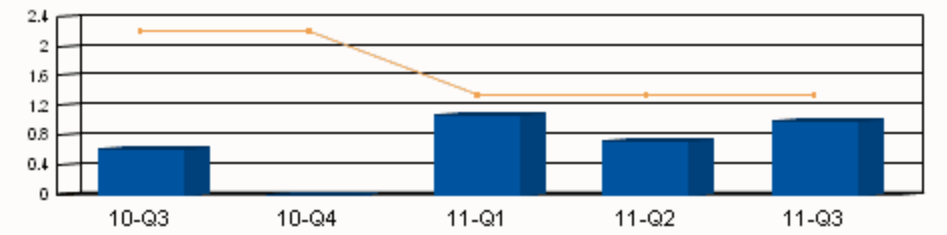
Indicator: Ventilator Associated Pneumonia



	Actual	Target
10-Q3	0.60	2.20
10-Q4	0.00	2.20
11-Q1	1.06	1.33
11-Q2	0.71	1.33
11-Q3	1.00	1.33

Interpretation - Patient And Business:

Consistently below target for 6 quarters with recent rise. Multi-pronged approach by ICU staff using VAP bundle and best practices monitored by a Patient Safety Coordinator continues to show success.

Actions & Monitoring Underway to Improve Performance:

Continue to monitor and educate at point of care by Patient Safety Coordinator

Definition: Ventilator associated pneumonia (VAP) can occur in patients, specifically those in Intensive Care Units (ICU) who need assistance breathing with a mechanical ventilator for at least 48 hours. VAP case is defined as ICU patients 18 years and older who are on ventilators (occasionally or continuously) where Pneumonia appears at least 48 hours after the patient was placed on a ventilator.
Patients are at risk of acquiring VAP if they have been on a ventilator for more than 5 days, have been recently hospitalized, had prior use of antibiotics (within the last 90 days), had dialysis treatment in a clinic or resided in a nursing home.
The ministry will publicly report and post on its website by hospital site the number of VAP cases. Where the number is zero (0) or cases total five (5) or more associated with that hospital site, the number will be posted. If the cases are fewer than 5 (i.e., 1 to 4 cases), it will state “<5 cases”, and the VAP rate (per 1000 ventilator days).

Target: Target 09/10: 3.01 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

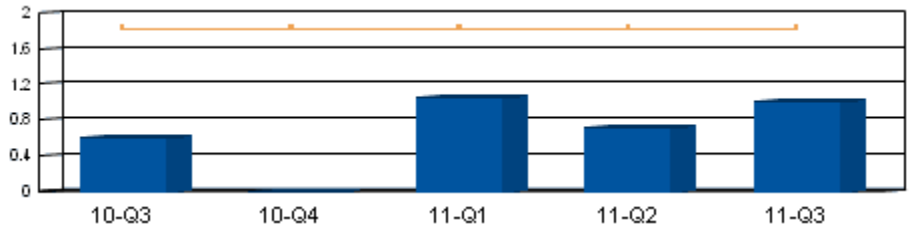
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Ventilator Associated Pneumonia (QIP)



	Actual	Target
10-Q3	0.60	1.82
10-Q4	0.00	1.82
11-Q1	1.06	1.82
11-Q2	0.71	1.82
11-Q3	1.00	1.82

Interpretation - Patient And Business:

Consistently below target for 6 quarters with recent rise. Multi-pronged approach by ICU staff using VAP bundle and best practices monitored by a Patient Safety Coordinator continues to show success.

Actions & Monitoring Underway to Improve Performance:

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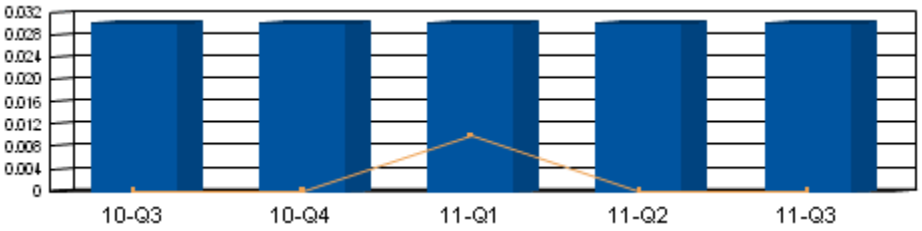
Patients are at risk of acquiring VAP if they have been on a ventilator for more than 5 days, have been recently hospitalized, had prior use of antibiotics (within the last 90 days), had dialysis treatment in a clinic or resided in a nursing home.
The ministry will publicly report and post on its website by hospital site the number of VAP cases. Where the number is zero (0) or cases total five (5) or more associated with that hospital site, the number will be posted. If the cases are fewer than 5 (i.e., 1 to 4 cases), it will state “<5 cases”, and the VAP rate (per 1000 ventilator days).

Target: QIP Goal = 1.82, QIP Target For Compensation = 1.82

Indicator: VRE (Vancomycin-resistant Enterococcus)



	Actual	Target
10-Q3	0.03	0.00
10-Q4	0.03	0.00
11-Q1	0.03	0.01
11-Q2	0.03	0.00
11-Q3	0.03	0.00

Interpretation - Patient And Business:

Patient perspective: Very low rates of clinically relevant infection and no attributable mortality.

Business perspective: Main impact is on need to isolate patients who are colonized. Attendant isolation rates may have a direct impact on patient flow. No appreciable change in colonization rates for over 2 years suggests that VRE colonization is endemic in the community rather than solely the hospital.

Definition: Enterococci are bacteria that live in the gastrointestinal tract of most individuals and generally do not cause harm. Vancomycin-resistant enterococci (VRE) are strains of enterococci that are resistant to the antibiotic vancomycin. If a person has an infection caused by VRE, such as a blood infection, it may be more difficult to treat due to the availability of antibiotics active against VRE.

KGH will post its quarterly rate and new case count of VRE bacteremia.
At the end of each quarter, the ministry will report the previous quarter's data on its website by hospital site including the number of new hospital acquired VRE bacteremia cases that is zero (0) or totaling five (5) or more associated with that hospital site, or if this is fewer than 5 cases (i.e. 1 to 4 cases), text reading "< 5 cases", and the hospital acquired VRE bacteremia rate.

The total number of new cases of VRE bacteremia acquired in the hospital in a quarter is divided by the total number of patient days for that quarter. Patient days are the number of days spent in a hospital for all patients. The results are multiplied by 1000. This represents the rate of hospital acquired VRE bacteraemia associated with the reporting facility per 1000 patient days for that quarter.

Target: Target 09/10: 0.0 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

Strategy milestone # 6

100% of our clinical services discharge patients at their expected LOS

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable delays in the patient journey to, within, and from KGH are eliminated	Actively manage patient flow

Indicator(s)	Status
Overall - Acute Average Length of Stay vs. ELOS (Variance)	Green
Percent ALC Days	Yellow
Percent of Clinical Services Meeting ELOS Target	Red

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Three of the five indicators reviewed in this milestone are green and all trending favourably. Overall average length of stay is exceeding the ELOS by 0.5 of a day. Of the 18 clinical services targeting to meet ELOS, 11 have met this in Q2 and early Q3 has 13 at or better than target (72%). Percent ALC days is only 1% above a target of 10% for the most recent Q2 data. The average number of ALC patients per day for Q3 has decreased by 6 from Q2 now at 23 patients with a target of 26. Thus the percent ALC days for Q3 data should fall to or below target with analysis available.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   ELOS is dependent upon both intrinsic and extrinsic resources. While patent flow initiatives and physician engagement have created much of the gains on this indicator, CCAC resources and external supports such as rehabilitation beds are limited.

3. **Are we on track to meet the milestone by year end?**
   The indicators are all on track for target at end of Q4. One or two clinical services with identified manpower issues put the ELOS target at risk.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Patient and process review committees analyze roadblocks and focus on resolution. Patient Flow Task Force, Joint Program Council and the Most Responsible Physician Program are focused on these indicators and promoting engagement in ELOS targets.

Kingston General Hospital

Milestone #6

			10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	100% of our clinical services discharge patients at their expected LOS	Average # ALC Patients per Day	G	G	R	R	G	↑
		Overall - Acute Average Length of Stay Days (Based on HSAA)	Y	Y	Y	G	N/A	↑
		Overall - Acute Average Length of Stay vs. ELOS (Variance)	G	G	G	G	N/A	↑
		Percent ALC Days	R	R	Y	Y	N/A	↑
		Percent of Clinical Services Meeting ELOS Target	R	R	R	R	N/A	↑
		Readmission rate Within 30 Days for Selected CMG's	R	R	N/A	N/A	N/A	

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

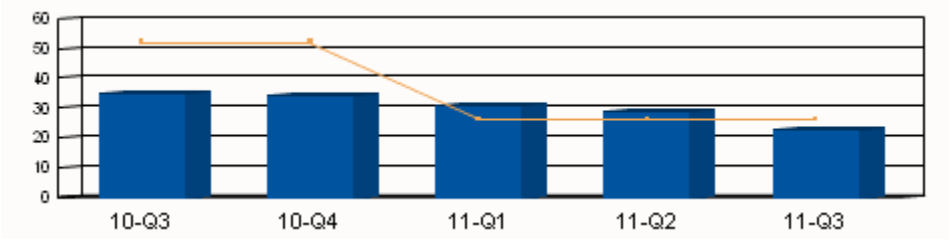
Kingston General Hospital

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Average # ALC Patients per Day



	Actual	Target
10-Q3	35	52
10-Q4	34	52
11-Q1	31	26
11-Q2	29	26
11-Q3	23	26

Interpretation - Patient And Business:

Target has been achieved. Focus will be on sustaining the impact of changes in internal processes and in process improvements with community partners that support transitions to home or alternate settings.

Actions & Monitoring Underway to Improve Performance:

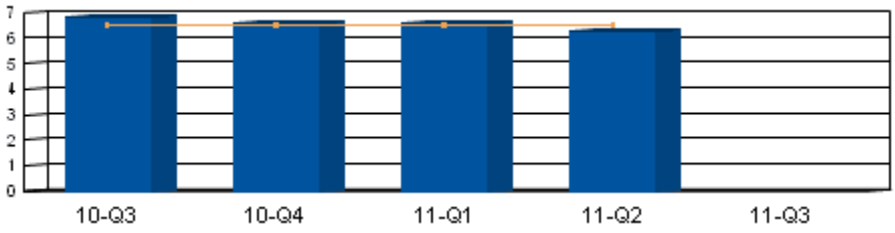
The Patient Flow Task Force will continue with oversight of the indicator. The Home First program remains a focus in all clinical areas with evidence of higher numbers of transfer to home. ALC rates, conversion rates and Home First trends are reviewed monthly with consideration of opportunities for improvement.

Partnering with Providence Care continues to enable assessment/designation of ALC in complex continuing care and rehab categories. Similar work is occurring with a focus on the mental health population (with Providence Care and Frontenac Community Mental Health and Addiction Services) and has been initiated with the long term care homes. Focus is on improvements with admission avoidance, transfer planning and communication at transition points.

Definition: When a patient occupies a bed in a hospital and does not require the intensity of resources/services provided in the acute care setting, the patient must be designated Alternate Level of Care (ALC) by the physician or his/her delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination, or when the patient's needs or condition changes and the designation of ALC no longer applies.

Target: Baseline 08/09: 60 patients, Target 09/10: 57 patients, Target 10/11: 52 patients, Target 11/12: 26 patients.

Indicator: Overall - Acute Average Length of Stay Days (Based on HSAA)



	Actual	Target
10-Q3	6.8	6.5
10-Q4	6.6	6.5
11-Q1	6.6	6.5
11-Q2	6.3	6.5
11-Q3		

Interpretation - Patient And Business:

The average length of stay for Q2 has trended downward to 6.3 which puts us below target (by .2 of a day) for the first in the last3 1/2 years. There have been tremendous efforts placed on this achieving this target though the implementation of a variety of initiatives lead by a variety of disciplines. This is significant accomplishment.

Actions & Monitoring Underway to Improve Performance:

ALOS is the focus of work within programs, in the Patient Flow Task Force and at MAC. In addition, all programs are tasked with achieving the target of ELOS for their patient populations (ELOS is what would be expected length of stay for the type of patients at KGH).

Definition: This indicator is a measure of how long inpatients stay in-hospital. By measuring the "acute" length of stay, all alternate level of Care (ALC) days and any days of stay assigned to newborns are removed form the calculation. This is in keeping with MoH methodology and in support of comparing and benchmarking length of stay performance across hospitals. The length of stay is calculated by subtracting the day of admission from the day of discharge from hospital. For example if a patient is admitted on a Monday and discharged on a Friday, the length of stay would be 4 days. Length of stay a crude measure of efficiency as it relates the use of inpatient beds.

Target: Baseline 08/09: 6.8 days, Target 09/10: 6.5 days, Target 10/11: 6.5 days, Target 11/12: 6.5 days.

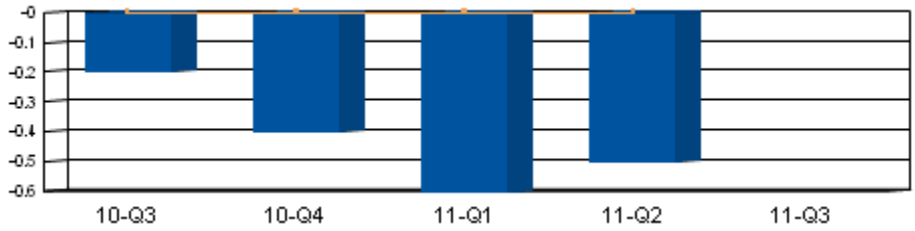
Kingston General Hospital

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Overall - Acute Average Length of Stay vs. ELOS (Variance)



	Actual	Target
10-Q3	-0.2	**0**
10-Q4	-0.4	**0**
11-Q1	-0.6	**0**
11-Q2	-0.5	**0**
11-Q3		

Interpretation - Patient And Business:

Because this indicator is calculated using coded and abstracted medical record data, Q2 results are the latest complete fiscal quarter. A positive trend in overall performance continues although there has been some slight leveling off in Q2. The -0.5 variance for Q2 (fiscal 11/12) indicates that overall our actual length of stay remains below or better than our expected length of by 0.5 of a day. However, it is important to note that this is calculated on an overall basis. There remains opportunity to achieve expected length of stay in the services of Nephrology, Neurology, Neurosurgery, Obs/Gyn, Otolaryngology, Plastic Surgery, and Vascular Surgery.

Actions & Monitoring Underway to Improve Performance:

Meetings through the Chief of Staff's office continue with individual Departments for the purpose of explaining these data and exploring opportunities for improvement. These data are also shared with all Program leadership for the purpose of exploring opportunities to improve length of stay.

Definition: This indicator is a measure of how long inpatients stay in-hospital. By measuring the “acute” length of stay, all alternate level of Care (ALC) days and any days of stay assigned to newborns are removed from the calculation. This is in keeping with MOH methodology and in support of comparing and benchmarking length of stay performance across acute care hospitals. The length of stay is calculated by subtracting the day of admission from the day of discharge from hospital. For example if a patient is admitted on a Monday and discharged on a Friday, the length of stay would be 4 days. Length of stay is a crude measure of efficiency as it relates the use of inpatient beds.
The expected length of stay (ELOS) is calculated on typical patients taking into account the reason for hospitalization, age, comorbidity, and complications. Typical cases exclude deaths, transfers, voluntary sign-outs, and cases where the actual length of stay is greater than the ""trim point"" established by CIHI. For this measure, a positive variance indicates actual days stay was longer than expected while a negative value suggests the average actual stay was shorter than expected.

Target: 11/12 Target: 0

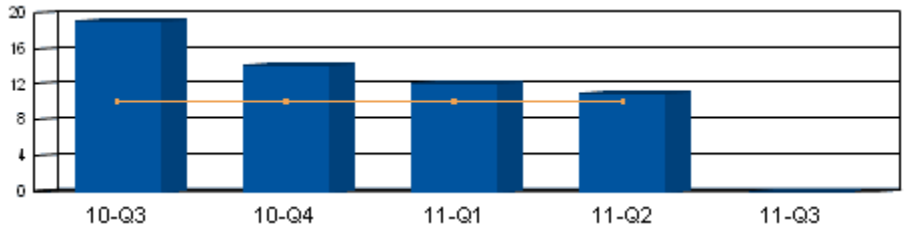
Kingston General Hospital

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Percent ALC Days



	Actual	Target
10-Q3	19	**10**
10-Q4	14	**10**
11-Q1	12	**10**
11-Q2	11	**10**
11-Q3	0	

Interpretation - Patient And Business:

Although the reduced target has not yet been achieved on a consistent basis, the number of patients designated as ALC continues to decrease on a month by month basis, and the target for average number of ALC patients per day has been met in Q3. Focus remains on internal processes and process improvements with community partners that support transitions to home or alternate settings.

Actions & Monitoring Underway to Improve Performance:

The Patient Flow Task Force will continue with oversight of the indicator. The Home First program remains a focus in all clinical areas with evidence of higher numbers of transfer to home. ALC rates, conversion rates and Home First trends are reviewed monthly with consideration of opportunities for improvement.

Partnering with Providence Care continues to enable assessment/designation of ALC in complex continuing care and rehab categories. Similar work is occurring with a focus on the mental health population (with Providence Care and Frontenac Community Mental Health and Addiction Services) and has been initiated with the long term care homes. Focus is on improvements with admission avoidance, transfer planning and communication at transition points.

Definition: When a patient occupies a hospital bed and does not require the intensity of resources/services provided in the acute care setting, the patient must be designated alternate level of care (ALC) by the physician or his/her delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination, or when the patient's needs or condition changes and the designation of ALC no longer applies. The percent of ALC days (total ALC days/total inpatient days) is calculated to better understand the proportion of ALC days for a given period of time.

Target: 11/12 Target: 10%

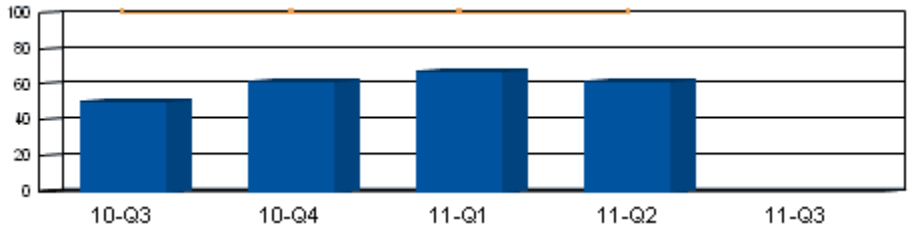
Kingston General Hospital

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Percent of Clinical Services Meeting ELOS Target



	Actual	Target
10-Q3	50	**100**
10-Q4	61	**100**
11-Q1	67	**100**
11-Q2	61	**100**
11-Q3		

Interpretation - Patient And Business:

Because this indicator is calculated using coded and abstracted medical record data, Q2 results are the latest complete fiscal quarter. A positive trend over the last four fiscal quarters continues however 7 clinical services as Q2 were above their ELOS. The 61 percent of services achieving their expected length of stay for Q1 (fiscal 11/12) translates to 11 of 18 services achieving expected length of stay or better. The services not currently at expected length of stay are Nephrology, Neurology, Neurosurgery, Obs/Gyn, Otolaryngology, Plastic Surgery, and Vascular Surgery.

Actions & Monitoring Underway to Improve Performance:

Meetings through the Chief of Staff's office continue with individual Departments on explaining these data and exploring opportunities for improvement. These data are also shared with all Program leadership for the purpose of exploring opportunities to improve length of stay.

Definition: This indicator is a measure of how long inpatients stay in-hospital. By measuring the “acute” length of stay, all alternate level of Care (ALC) days and any days of stay assigned to newborns are removed from the calculation. This is in keeping with MOH methodology and in support of comparing and benchmarking length of stay performance across acute care hospitals. The length of stay is calculated by subtracting the day of admission from the day of discharge from hospital. For example if a patient is admitted on a Monday and discharged on a Friday, the length of stay would be 4 days. Length of stay is a crude measure of efficiency as it relates the use of inpatient beds.
The expected length of stay (ELOS) is calculated on typical patients taking into account the reason for hospitalization, age, comorbidity, and complications. Typical cases exclude deaths, transfers, voluntary sign-outs, and cases where the actual length of stay is greater than the ""trim point"" established by CIHI. For this measure, average acute length of stay is compared to ELOS at the clinical service level (e.g. cardiology, general surgery etc.). The services with a negative variance are tallied and divided by the total number of services expressed as a percent.

Target: QIP Target 11/12: 100%

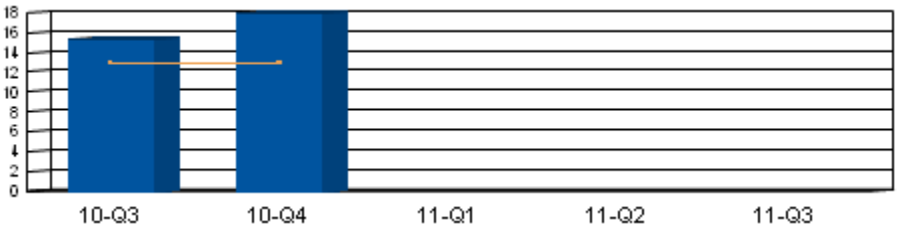
Kingston General Hospital

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Readmission rate Within 30 Days for Selected CMG's



	Actual	Target
10-Q3	15.3	**12.9**
10-Q4	17.9	**12.9**
11-Q1		
11-Q2		
11-Q3		

Interpretation - Patient And Business:

30 day readmission rates in part reflects that patients received appropriate, timely care from physicians, nurses and other healthcare providers. Another factor that may contribute to lower 30-day readmission rates is well-prepared instructions for discharge from the hospital. Examples include instructions on proper medication use, diet, wound care management and follow up instructions. Availability and access to CCAC/home care will play an additional role. This indicator represents the readmission rate for selected CMGs to ANY facility within the SE LHIN. A low rate of readmission would therefore be reflective of quality of care by the discharging institution and care provided in the community.

Actions & Monitoring Underway to Improve Performance:

The data is supplied to KGH from the MOH and generally will be 3 quarters behind. The current rate is above target. An in-depth analysis of each CMG group will be reviewed by MAC Joint Quality and Utilization Committee and the Patient Safety and Quality Committee. It is also worth noting that this indicator will be part of the KGH QIP for fiscal 12/13

Definition: This indicator is calculated by the MOH and supplied to KGH via the Ministry LHIN Performance agreement (MLPA – a performance agreement that focuses on system performance and financial accountabilities. This indicator is best described as the number of patients readmitted to any facility for non-elective inpatient care, compared to the number of expected non-elective readmissions using data from all Ontario acute hospitals. The number of patients readmitted to any facility for non-elective inpatient care is defined as the observed number of patients, discharged with specific CMG's within calendar year, readmitted to any facility for any non-elective patient care within the specified number days of discharge for index admission.

Target: QIP Goal 11/12= 12.9%

Strategy milestone # 7

The Emergency Department wait time for admitted patients is less than 8 hours for 100% of patients

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable delays in the patient journey to, within, and from KGH are eliminated	Reduce wait times

Indicator(s)	Status
Percent of Patients Admitted (from the Emergency Department) Within a Wait Time Target of< 8 hrs (SSC)	Red

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   While the stretch target of all patients being admitted within 8 hours has not and will not be met by fiscal year end, there is improvement in 5 of the 7 indicators with 3 of those 5 meeting or exceeding the target. Two indicators, related to wait times for non-admitted minor conditions and non-admitted low acuity patients, did not meet the target and showed decrease.
2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   With oversight by a corporate task force, patient flow remains the focus of each clinical program and support areas such as Admitting, Environmental Services. The indicators not meeting target and showing decline are those with the lower acuity and typically managed with the emergency fast track. Increased ED volumes, presence of admitted inpatients, and presence of greater number of mental health patients are factors in increased delay.
3. **Are we on track to meet the milestone by year end?**
   No, and we will not meet the milestone by fiscal year end. There is however general upward trending with the ED indicators. The indicators for 90th Percentile ED Wait time for all patients, the non-admitted high acuity patient wait time; and the percent of patients admitted within the ministry wait time target have all been met and show improvements. The indicators for non-admitted minor condition/low acuity patients were not met, and the decline in the past quarter is linked to increased volumes.
4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The task force has overseen changes with the bed map, the bed allocation process, a gridlock protocol to address clinical congestion in ED, critical care and inpatient units. Data extracted from the EDIS system is enabling focus on consultation times. The discharge prediction process is focus in Q4.

Kingston General Hospital

Milestone #7

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	The ED wait time for admitted patients is less than 8 hrs for 100% of patients		90th Percentile ED Wait Time (All Admitted Patients)	R	R	G	G	G	↑
			Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th percentile wait time (hrs)	R	R	R	R	R	↓
			Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)	R	R	R	R	R	↑
			Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)	Y	R	G	G	G	↑
			Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs	Y	R	R	R	R	↓
			Percent of Patients Admitted (from the Emergency Department) within a wait time target of <8 hrs	Y	Y	G	Y	G	↑
			Percent of Patients Admitted (from the Emergency Department) within a Wait Time Target of <8Hrs (SSC)	R	R	R	R	R	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

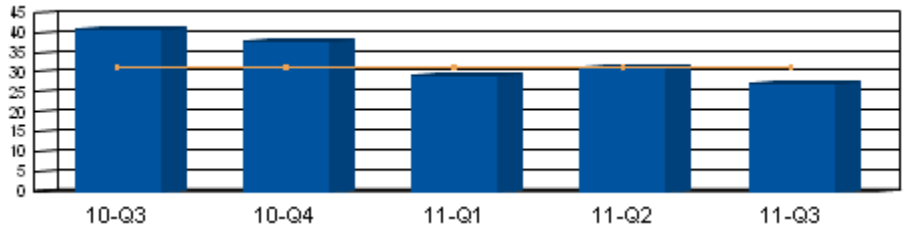
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: 90th Percentile ED Wait Time (All Admitted Patients)



	Actual	Target
10-Q3	41	**31**
10-Q4	38	**31**
11-Q1	29	**31**
11-Q2	31	**31**
11-Q3	27	**31**

Interpretation - Patient And Business:

The target of 9/10 patients spending less than 31 hours in the Emergency Department waiting for an inpatient bed has been met for the past 3 quarters. This is an improvement of 14 hours from Q3 last fiscal. At the end of Q3, 10% of admitted patients waited longer than 27 hours for an inpatient bed. This is a significant improvement given the increase in activity this year relative to last resulting in 300 more admissions in Q3 F12 than in Q3 F11.

Note: Year 4 Pay for Results target for this indicator is 33.2 hours & at Q2 the SE LHIN imposed an HSAA target of 25 hrs

Actions & Monitoring Underway to Improve Performance:

LOS in the ED is continuously monitored in real time with EDIS, and supports timely and factual communication with inpatient units to support planning.

A number of initiatives are in progress as part of the Ministry wait time project (Pay for Results) - ie Medical Short Stay Unit, additional express beds, Surgical Short Stay beds and a medicine nurse to coordinate patient flow to medicine units.
Consultant times are also being monitored from time of consult request to arrival in the ED and time of consult request to disposition decision. Changes with bed assignment process, ie Bed Allocator role and reporting/communication tools, continue to be monitored and improved.

Definition: This indicator measures the amount of time 9 out of 10 patients (90th percentile) spend in an ED being diagnosed, receiving treatment and waiting for admission to a hospital bed. Most patients spend less time, while 1 out of 10 patients will spend more time. The time being measured is defined as when a patient registers until the time when the patient is admitted to an inpatient hospital bed. For this indicator, 9 out of 10 patients (for all admitted patients at all levels of complexity) will spend no more than 31 hours within the ER from the time they arrive and register to the time they leave the ED.

Target: QIP Target 11/12: 31 Hours

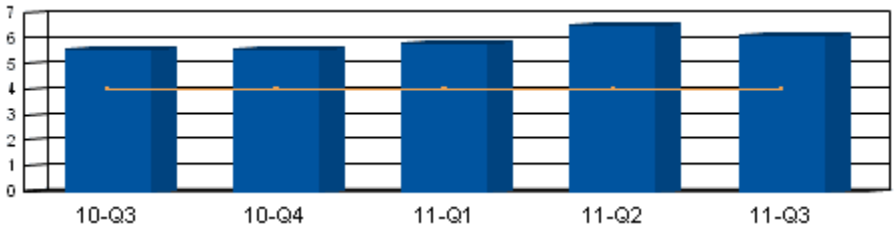
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th percentile wait time (hrs)



	Actual	Target
10-Q3	5.6	4
10-Q4	5.6	4
11-Q1	5.8	4
11-Q2	6.5	4
11-Q3	6.1	4

Interpretation - Patient And Business:

Patient Perspective: Based on the Q3 results, KGH is failing to meet the ED 90th percentile wait time target of 4hrs for patients presenting with minor or uncomplicated conditions. Ten percent of patients in this category had a total length of stay longer than 6.1 hours, a slight improvement over last quarter. The move of the MH inpatient unit in June (Q2) had a significant impact on the ED and at times limited our ability to see patients in fast track given the volumes patients requiring MH assessment and/or admission occupying the space used for fast track.

Visit volumes were significantly higher during Q3 with a higher proportion of high acuity patients requiring more urgent assessment and intervention (53% of all ED visits). Visits in this category (non-admit, low acuity) made up 24% of all ED visits.

Business Perspective: This is an indicator in the provincial Pay for Results program with a target of 4:52 hours at the 90th percentile. Funding is at risk of clawback if targets are not met. In addition, there is incentive pay through the provincial Pay for Results program for each patient in this low acuity non-admitted category seen and treated within the 4 hour target ($100 for each patient discharged within 4 hours over last year's baseline).

Actions & Monitoring Underway to Improve Performance:

Volumes have increased in the higher acuity category which means less acute patients may be waiting longer to be seen due to physician availability as they are busy with more urgent patients. In January, a new physician schedule will start with additional coverage and overlap during peak times to help with Initial Physician Assessment times and to address wait times for patients in this category.

EDIS is helping to monitor turn-around times and alert physicians when results are ready for review.

Definition: This indicator measures the amount of time 9 out of 10 patients (90th percentile) spend in an ED being diagnosed, receiving treatment and being discharged from the ED. Most patients spend less time, while 1 out of 10 patients will spend more time. The time being measured is defined as when a patient registers until the time when the patient is discharged from the ED. 9 out of 10 patients whose conditions are minor or uncomplicated and require less time for treatment, diagnosis or observation will spend no more than 4 hours within the ER from the time they arrive and register to the time their visit is complete and they are discharged. CTAS (Canadian Triage & Acuity Scale) 4 or 5 are used to describe 'Minor or Uncomplicated'.

Target: Baseline 08/09: 7.0hrs, Target 09/10: 4hrs, Target 10/11: 4hrs, Target 11/12: 4hrs.

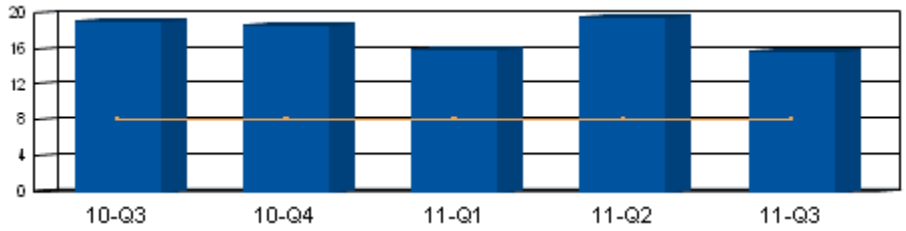
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)



	Actual	Target
10-Q3	19.1	8
10-Q4	18.7	8
11-Q1	15.8	8
11-Q2	19.6	8
11-Q3	15.7	8

Interpretation - Patient And Business:

Patient Perspective: Based on the Q3 results, KGH is failing to meet the 90th percentile total ED LOS target of 8 hours for admitted patients with complex conditions. There are quality of care and patient satisfaction concerns when patients inpatient beds are not available once the decision to admit has been made. LOS in ED have reached over 3 days in this quarter. Nine of 10 patients were admitted to an inpatient bed within 15.7 hours which is an improvement of 4 hours over last quarter. Delays in moving patients include a high demand for critical care beds, particularly level 2 beds and increased isolation requirements.

Business Perspective: With increasing volumes and high acuity of patients presenting to the ED, the extended LOS of patients once admitted has a negative impact on the ED's ability to see patients within target times. Volumes of admitted patients were 578 higher this quarter than expected and higher than in previous quarters particularly in the high acuity categories. Admitted patient volumes were 392 more than Q3 last fiscal. Overall visit volumes were 1161 higher than the same quarter last fiscal. Admission rates average between 17.3 and 19.3% creating a surge in Medicine which was running at over 140% occupancy at times. Inefficiencies are created that have a negative financial impact on the hospital (e.g. caring for admitted patients in the Emergency Department during the most expensive part of their stay).
7 short stay medicine beds were opened in July as well as surgical short stay beds to help decant patients out of the ED quicker. Additional express beds were opened to help manage higher volumes. The funding for these beds comes from the provincial Pay for Results program and funding is at risk of claw back if targets are not met.

Actions & Monitoring Underway to Improve Performance:

Initiatives throughout the hospital and within each program are in progress to improve performance. e.g. medicine short stay unit, surgical short stay unit, express beds, offload nurse, EDIS, improved process for lab result notification, reduce bed empty time, medicine bed manager, and a change in process for placing patients with responsibility shifting to the Bed Allocators.

The Patient Flow Task Force (PFTF) meets every two weeks.

A drop in weekend discharges contributes to a bottleneck in the ED on Monday mornings and then the early part of the week is spent "catching up".

Often, patients do not get admitted until they have been in the ED longer than 8 hours meaning the breach occurs before the time of conversion from outpatient to inpatient. This often occurs when consults are not done in a timely fashion or there is a delay in the decision to admit. Consult times are now being tracked at 2 time stamps: time from consult request to the arrival of consultant service is the first time stamp and time from consult request to disposition decision is the second. These results are publicly reported.

Definition: This indicator measures the amount of time 9 out of 10 patients (90th percentile) spend in an ED being diagnosed, receiving treatment and waiting for admission to a hospital bed. Most patients spend less time, while 1 out of 10 patients will spend more time. The time being measured is defined as when a patient registers until the time when the patient is admitted to a hospital bed. 9 out of 10 patients with complex conditions that may require more time for treatment, diagnosis or admission to a hospital bed will spend no more then eight hours within the ER from the time they arrive and register to the time they leave the ER. CTAS (Canadian Triage & Acuity Scale) 1, 2 or 3 are used to describe 'Complex'.

Target: Baseline 08/09: 22.4hrs, Target 09/10: 8hrs, Target 10/11: 8hrs, Target 11/12: 8hrs.

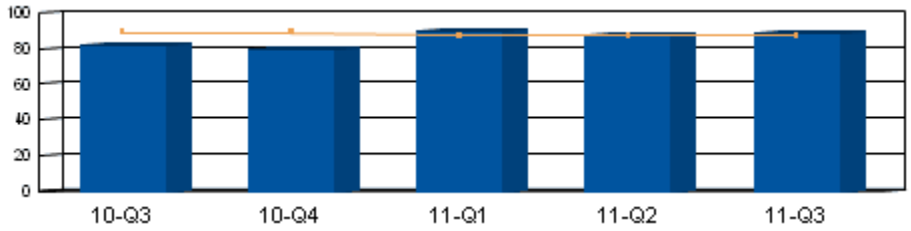
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)



	Actual	Target
10-Q3	82	**89**
10-Q4	80	**89**
11-Q1	90	**87**
11-Q2	87	**87**
11-Q3	88	**87**

Interpretation - Patient And Business:

Patient Perspective: Based on the Q3 results, the ED has improved the ED wait time surpassing the 87% target for non admitted, high acuity patients. Fewer non-admitted high acuity patients are waiting in the ED longer than the 8 and 6 hour targets compared to same time last year. This target has been achieved for the past 3 quarters.

Business Perspective: Year 4 Pay for Results funding enables us to implement initiatives to help with patient flow. This funding is at risk of claw back if targets are not met.

Note: The description of this indicator states CTAS 1 and 2 have an 8 hour target, while CTAS 3 has a 6 hour target. Under Pay for Results, this indicator has been changed to 7 hours for non-admitted high acuity. KGH has a target of 7:50 at the 90th percentile based on a ten per cent improvement over last year's baseline.

Actions & Monitoring Underway to Improve Performance:

Initiatives are in progress to meet this target e.g. improved lab result notification, improvement of the Fast Track to include ambulatory CTAS 3 patients, realignment of medical coverage in the ED to patient arrival times as well as additional physician hours with overlapping shifts to cover busier times. A triage transition nurse assignment supports 90 second straight back triage and will help to ensure triage is quick and patients in this category are brought to a stretcher for more rapid assessment and treatment.

A dedicated off-load nurse helps to ensure patients arriving by ambulance do not wait to be "off-loaded" and are assessed by this nurse upon arrival. Average off-load time this quarter is 8 minutes.

In Q3 of last fiscal, a virtual Clinical Decision Unit (CDU) was implemented. This 6 bed virtual allows us to "admit" patients within the ED who we know in advance will breach the 8 hour target but do not need to be admitted. There are predetermined criteria as to which patients can be admitted to the CDU. The CDU LOS at the 90th percentile is 18 hours and the admission rate is 25% (allowed up to 30%).
Colour coding on EDIS alerts staff if patients are approaching target time.

Definition: There are three Emergency Department (ED) wait time metrics that are directly tied to the Provincial ED Pay for Results initiative which is focused on reducing ED wait times. Each metric is designed to focus on a particular cohort of patients that present to the ED and each one has been assigned a target. The MOH provided selected hospital with funding to support initiatives aimed at improving patient flow. This measure represents the percentage of non-admitted high acuity patients treated within a wait time target of less than 8hrs (CTAS 1-2) and less than6hrs (CTAS 3). The 8 and 6 hour wait time targets are measured from the time of registration in ED to the time the patient leaves the ED.

(Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level 1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 77%, Target 09/10: 87%, Target 10/11: 89%, Target 11/12: 87%

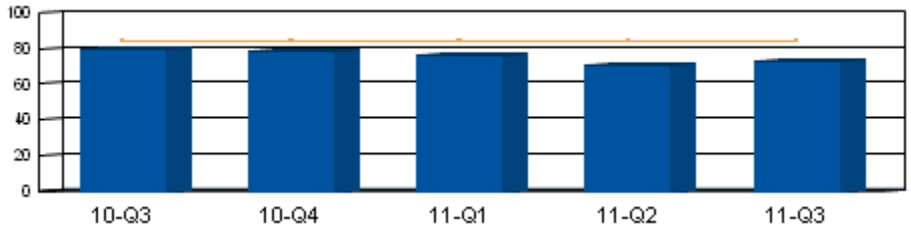
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs



	Actual	Target
10-Q3	80	**84**
10-Q4	78	**84**
11-Q1	76	**84**
11-Q2	71	**84**
11-Q3	73	**84**

Interpretation - Patient And Business:

Patient Perspective: Based on Q3 results the ED is failing to meet the target wait time for the non-admitted low acuity patients. 27% of patients in this category have an ED total LOS greater than 4 hours. However, Physician Initial Assessment time is under the 2.42 hour target which indicates delays in meeting the target for some patients is turn-around time for test results, time needed for treatment and delays in reassessment. Infrequently, patients are in the waiting room waiting for an available space to be further assessed after triage. This is due to the large volumes of higher acuity patients and number of ambulances. Many of the patients in this category could be seen in the fast track area which sometimes is full with other patients requiring this space. I.e., because the rooms in this section have doors, they are often used for patients requiring mental health assessment.

High volumes of patients with higher acuity means that patients in this category wait longer for physician assessment.

Business Perspective: This target is associated with Pay for Results funding but funding is not solely dependent on this indicator.

Implementation of the EDIS in March is helping to monitor turn-around time for test results and promote more timely reassessment.

Volumes in this category were slightly higher than planned.

Actions & Monitoring Underway to Improve Performance:

The creation of an e-track in section E was open daily from 0800 to 2000. Most days 50% of all patients presenting to the ED were seen in etrack which had significantly contributed to the trend toward meeting this target. When the inpatient Mental Health Program moved to KGH in June, Section E was modified to be used for MH patients. The fast-track was then moved to Section B. At first this was successful, however, after MH volumes started to increase, there was an overflow of patients from section E to B. As well, Section E is only staffed 8 hours a day. This has had a negative impact on our ability to see patients in this category due to lack of space. An increase in higher acuity volumes combined with the number of admitted patients waiting for beds has forced more patients to wait in the waiting room for a space to become available for further assessment and treatment.

The implementation of the Emergency Department Information System (EDIS) will help us to continuously monitor ED wait times in real time.

Definition: There are three ED wait time metrics that are directly tied to the Provincial ED Pay for Results initiative which is focused on reducing ED wait times. The MOH provides financial support to select hospitals to improve on ED wait times – decreasing ED demand, increasing ED capacity and improving bed utilization.
This measure represents the percentage of non-admitted low acuity patients treated within a wait time target of less than 4hrs (CTAS 4 & 5). The 4 hour wait time target is measured from the time of registration in ED to the time the patient leaves the ED.

(Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 66%, Target 09/10: 76%, Target 10/11: 84%, Target 11/12: 84%.

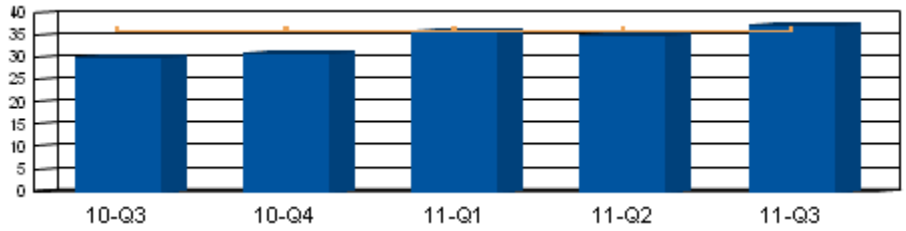
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Percent of Patients Admitted (from the Emergency Department) within a wait time target of <8 hrs



	Actual	Target
10-Q3	30	**36**
10-Q4	31	**36**
11-Q1	36	**36**
11-Q2	35	**36**
11-Q3	37	**36**

Interpretation - Patient And Business:

Patient Perspective: Based on Q3 results, improvements to patient flow have been made over this past year and this target has been met in Q1 and Q3 and missed by 1 percentage point in Q2. While many patients are waiting longer than 8 hours before reaching their inpatient bed, 37% are moving within the 8 hour target.

Those that wait longer than 8 hours are waiting 15.7 hours at the 90th percentile. Inpatient days in ED this quarter were 712 days which is 136 days less than the previous quarter. Inpatient days in December were 199 which is the lowest number of inpatient days in the previous 21 months.

Business Perspective: When the ED becomes backed up with admitted patients it negatively impacts the ability to see and treat emergency patients from a space and resource perspective. The number of patients admitted requiring specialized services, i.e. isolation, critical care and mental health, limits the ability to quickly move these patients to an inpatient bed if these specialized beds are not available.

Funding from the provincial Pay for Results program will enable us to continue with initiatives in place to sustain gains made and continue to improve patient flow. This target is now measured at the 90th percentile under the provincial program with a target of 33.2 hours based on a 10% improvement over last year's baseline.

Actions & Monitoring Underway to Improve Performance:

KGH continues to be part of the Provincial Pay for Results Program for the 4th consecutive year. Additional flex capacity has been built in with the opening of 7 new short stay medicine beds in July (express beds). These beds are funded under the provincial pay for results program. Funding is at risk if targets are not met.

Clinical teams are engaged in planning discharges from the point of admission; and making changes with prediction of discharge dates and activation of conditional discharge orders at earliest point in the day with goal of having discharges occur as quickly as possible after the order is written.

Some patients do not get admitted until after the 8 hour target has passed for various reasons including long waits for consult or a delay in the decision to admit. This time from consult request to consultant arrival in ED as well as the time from consultant request to disposition decision is now being measured, monitored and publicly reported.

A drop in the number of discharges occurring on the weekends causes predictable bottlenecks in ED on Monday mornings. The early part of the week is spent "catching up".

Definition: This is the length of time a patient admitted to hospital is in the ED waiting for an inpatient bed The MOH provides financial support to select hospitals to improve on ED wait times – decreasing ED demand, increasing ED capacity and improving bed utilization. This measure represents the percentage of admitted patients (from the ED) with a length of stay LOS of <8 hrs. The 8 hours is measured from the time the patient is registered in the ED to the time that the patient is moved into an inpatient bed.

Target: Baseline 08/09: 27%, Target 09/10: 37%, Target 10/11: 36%, Target 11/12: 36%.

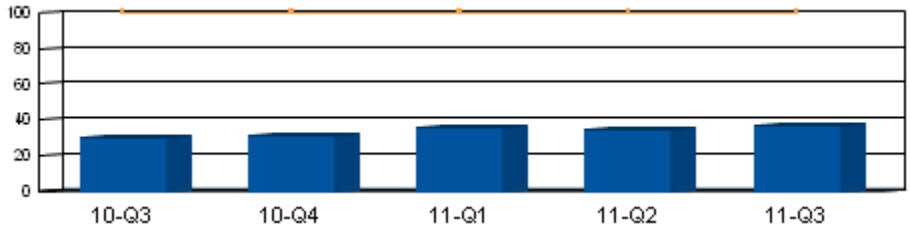
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Percent of Patients Admitted (from the Emergency Department) within a Wait Time Target of <8Hrs (SSC)



	Actual	Target
10-Q3	30	**100**
10-Q4	31	**100**
11-Q1	36	**100**
11-Q2	35	**100**
11-Q3	37	**100**

Interpretation - Patient And Business:

KGH is not meeting the 100 percent target set by KGH. In order to meet this target significant improvements in the movement of admitted patients from the ED to inpatient units must occur.
Many patients require longer than 8 hours for assessment, consultation and decision to admit. For these patients, a virtual CDU was created to avoid breeching the 7 hour target for non-admitted patients. In this model, it is acceptable to admit 30% of patients from CDU. These patients can be in CDU for up to 24 hours but will necessarily breech the 8 hour target.
Having the option of CDU allows more time for diagnosis and treatment and possible admission avoidance.

Actions & Monitoring Underway to Improve Performance:

All additionally funded beds have been opened included short stay beds in both Medicine and Surgery, express beds and flex capacity has been created.
Surgery has closed appropriate beds reflective of LOS targets. LOS continues to be monitored.
Staffing the flex beds and overcapacity beds has been challenging and has contributed to delays in moving patients to these beds. Surges in Medicine, Critical Care (level 2) and Mental Health all contribute to challenges with bed availability.

Definition: This is the length of time a patient admitted to hospital is in the ED waiting for an inpatient bed The MOH provides financial support to select hospitals to improve on ED wait times – decreasing ED demand, increasing ED capacity and improving bed utilization. This measure represents the percentage of admitted patients (from the ED) with a length of stay LOS of <8 hrs. The 8 hours is measured from the time the patient is registered in the ED to the time that the patient is moved into an inpatient bed.

Target: SSC Target 100%

Strategy milestone # 8

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable delays in the patient journey to, within, and from KGH are eliminated	Reduce wait times

Indicator(s)	Status
Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	Red

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   At Q3, 33 of 44 or 75% of surgical wait times followed meet or exceed the 90th percentile wait time target.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The 11 areas currently off target are General Surgery (2), Gynecology (1), Oral/maxilofacial surgery (3), Orthopedics (3) and Urology (2). Orthopedic surgeries (non joint) have seen a significant rise in the 90th percentile wait times. Others are generally low volume or trending to target.

3. **Are we on track to meet the milestone by year end?**
   Although we are trending well and will see improvement on most surgical programs, there are issues in a few that will not be solved in the current fiscal year. Surgical recruitment and competing priorities challenges the 90% target in Pediatric ENT surgery and non joint orthopedic surgeries. MRI access is trending well with the new recruitment of technicians.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The Wait Times Strategy Committee with Decision Support will continue to support the Surgical Program Leadership in monitoring progress and opportunities to improve access. Despite the challenges of working with 90th percentile wait times, average and median wait times have shown a significant improvement in the larger programs (non joint orthopedic surgery). Adjustments to the operating room schedule to improve access to general emergency time and orthopedic trauma room time especially on weekends will help significantly to address waiting times.

Kingston General Hospital

Milestone #8

			10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	90% of patients receive their elective surgery within or faster than the provincially targeted wait time	All Cancer Surgery Wait time - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
		All Paediatric Surgery - 90th Percentile Wait Time (Days)	R	R	R	R	R	↓
		Cardiac Bypass Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
		Coronary Angiography - 90th Percentile Wait Time (Days)	G	G	G	G	N/A	↓
		Coronary Angioplasty - 90th Percentile Wait Time (hrs)	G	G	G	G	G	↑
		Diagnostic Imaging - CT – 90th Percentile Wait time (Days)	G	G	G	G	G	↑
		Diagnostic Imaging- MRI – 90th Percentile Wait time (Days)	R	R	R	R	R	↓
		General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)	G	G	G	G	R	↓
		Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)	R	G	G	G	G	↑
		Orthopedic Surgery (excluding total hip and knee replacements) - 90th Percentile Wait Time (Days)	R	R	R	R	R	↑
		Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	N/A	R	R	R	R	↑
		Radiation Wait time (Referral-Consult) Percent seen within 14 days	G	G	G	R	N/A	↓

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

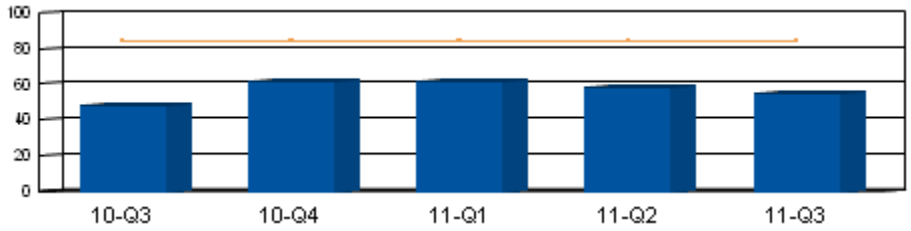
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: All Cancer Surgery Wait time - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q3	48	84
10-Q4	62	84
11-Q1	61	84
11-Q2	58	84
11-Q3	55	84

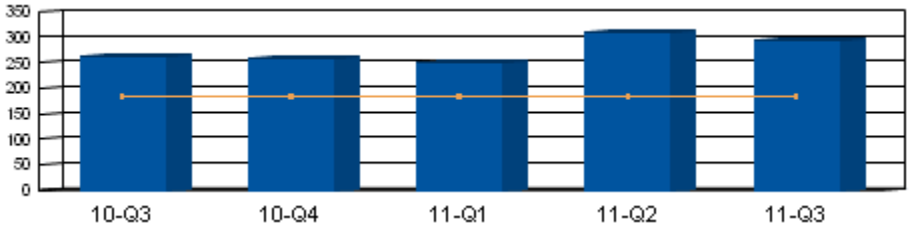
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: For all confirmed and suspected cancer surgical procedures, Cancer Care Ontario and the Ontario WTS measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery or exam ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 64 days, Target 09/10: 84 days, Target 10/11: 84 days, Target 11/12: 84 days.

Indicator: All Paediatric Surgery - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q3	263	182
10-Q4	258	182
11-Q1	250	182
11-Q2	310	182
11-Q3	293	182

Interpretation - Patient And Business:

KGH has not achieved the 90th percentile wait time provincial target for Q3.although the 90th percentile wait has decreased slightly to 293 days from 310 days in Q2. The 90% For Q3, October ENT had the highest wait time in October with 558 days which decreased to 361 days in December. The ENT service average median is 132 days in Q3 which is an increase of 40 days from Q2. There continually is challenges with the reduced physician resources for this service which impacts the number of Otolaryngology patient with long waits receiving surgery.

Pediatric general surgery does not impact this data as the case volumes remain small for the 2 part-time physicians currently in place.

Actions & Monitoring Underway to Improve Performance:

Program management is meeting quarterly with service to plan out strategies on improving and managing current waiting lists.

Definition: For children 18 years and under having surgical procedures, the Ontario WTS measures the wait time from when a patient and a surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

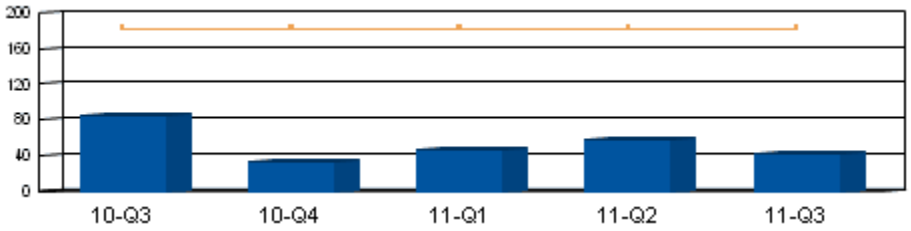
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Cardiac Bypass Surgery - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q3	85	182
10-Q4	33	182
11-Q1	46	182
11-Q2	57	182
11-Q3	43	182

Definition: For cardiac surgeries, the Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 78 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days

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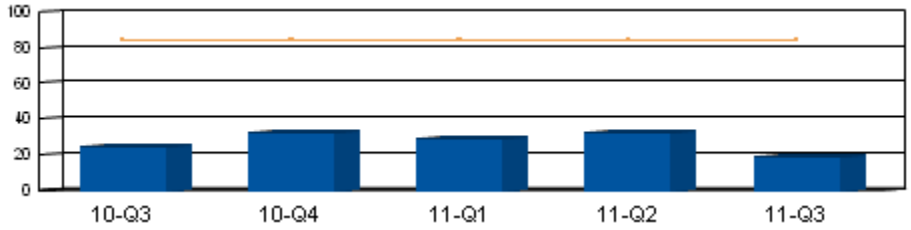
Indicator: Coronary Angiography - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q3	24	84
10-Q4	32	84
11-Q1	29	84
11-Q2	32	84
11-Q3	19	84

Definition: Coronary angiography means taking pictures of blood vessels in the heart. Angiography involves injecting a dye that is visible to x-rays. The physician, a cardiology interventionalist, uses an x-ray machine to guide him or her through the procedure and record the pictures. For coronary angiography procedures, the Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and interventionalist decide to proceed with the procedure, until the time when the actual procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the procedure or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait time is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of10 patients have completed the treatment. .
Note: Wait Time information is shown only for referrals where the primary indication is coronary artery disease. These account for >85% of total angiography referrals.

Target: Baseline 08/09: 39 days, Target 09/10: 84 days, Target 10/11: 84 days, Target 11/12: 84 days.

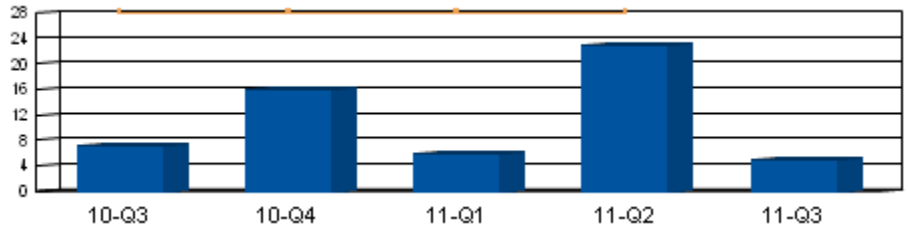
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Coronary Angioplasty - 90th Percentile Wait Time (hrs)

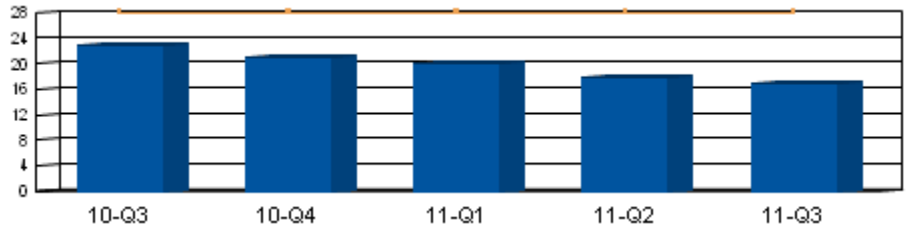


	Actual	Target
10-Q3	7	28
10-Q4	16	28
11-Q1	6	28
11-Q2	23	28
11-Q3	5	

Definition: Coronary angioplasty is a procedure which unblocks narrowed arteries by inserting a small balloon into each artery and inflating the balloon at the site of the blockage. Often, a small metal tube (stent) is permanently placed in the artery to help keep the artery open. This allows blood to flow freely through the artery. For coronary angioplasty procedures, the Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and interventional cardiologist decide to proceed with the procedure, until the time when the actual procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the procedure or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of10 patients have completed the treatment.

Target: Baseline 08/09: 12 days, Target 09/10: 28 days, Target 10/11: 28 days, Target 11/12: 28 days.

Indicator: Diagnostic Imaging - CT – 90th Percentile Wait time (Days)



	Actual	Target
10-Q3	23	28
10-Q4	21	28
11-Q1	20	28
11-Q2	18	28
11-Q3	17	28

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: For diagnostic CT scans, the Ontario Wait Time Strategy measures the wait time from when a CT scan is ordered, until when the actual exam is completed. This interval is typically referred to as from "decision to treat" to "treatment". A patient with an existing condition may be pre-booked for a follow-up exam or a series of follow-up exams at a later date, resulting in apparently long wait times for those particular exams. Please note, as of January 1st, 2008 these cases are excluded from publically reported CT wait time data as well scans done on an emergency basis. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed the exam.

Target: Baseline 08/09: 26 days, Target 09/10: 28 days, Target 10/11: 28 days, Target 11/12: 28 days.

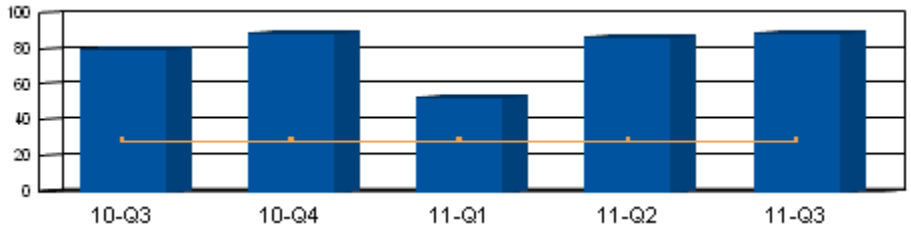
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Diagnostic Imaging- MRI – 90th Percentile Wait time (Days)



	Actual	Target
10-Q3	80	**28**
10-Q4	89	**28**
11-Q1	53	**28**
11-Q2	86	**28**
11-Q3	88	**28**

Interpretation - Patient And Business:

The provincial average of 28 days is the overarching goal. The LHIN target for the end of this fiscal year is 72 days for KGH.

The current demand on the single hospital based magnet at KGH far overwhelms the resources. Particularly in the area of the complex studies requires by the cancer center as well as specialized areas such as cardiac MRI and pediatric conscious sedation studies. These studies significantly exceed wait times unless they are identified as an urgent priority based on clinical history.

The other factor that elongates our wait times are the studies that are less urgent. These studies get bumped further and further out for booking to accommodate the urgent demands that come to the MRI department every day.

We have had some resource challenges in filling a MRT vacancy in Q2 that resulted in the department decreasing hours and therefore bumping bookings into Q3. In Q3 the department was able to complete a great number of these longstanding cases. Though this is a positive from a patient perspective it does result in the appearance of longer wait times when these cases where closed off in Q3.

Actions & Monitoring Underway to Improve Performance:

Continued efforts to improve efficiency and perform more cases a day. Recruitment of another experienced skilled MRI technologist so that we ensure that we run full hours every week.
Weekly monitoring of wait times as well as the number of requisitions to be booked.

Definition: For diagnostic MRI scans, the Ontario Wait Time Strategy measures the wait time from when a diagnostic scan is ordered, until when the actual exam is completed. This interval is typically referred to as from "decision to treat" to "treatment". A patient with an existing condition may be pre-booked for a follow-up exam or a series of follow-up exams at a later date, resulting in apparently long wait times for those particular exams. Please note, as of January 1st, 2008 these cases are excluded from publically reported MRI wait time data as well scans done on an emergency basis. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed the exam.

Target: Baseline 08/09: 120 days, Target 09/10: 28 days, Target 10/11: 28 days, Target 11/12: 28 days

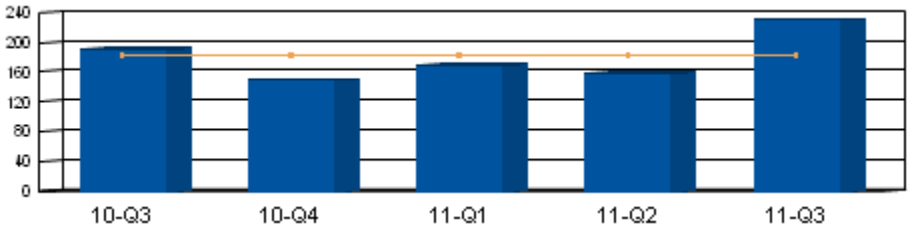
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q3	192	**182**
10-Q4	149	**182**
11-Q1	169	**182**
11-Q2	159	**182**
11-Q3	230	**182**

Interpretation - Patient And Business:

The 90th percentile wait increased by 92 days this quarter, The median wait for Q3 was 58.6 days which increased from 53 days from Q2. Currently this service has access to additional OR time during the evening and on weekends to add any elective cases once the trauma cases are addressed.

The contributing factor to this sudden increase in wait days after being green for "4 " quarters was the completion of 21 surgeries that were done in this quarter which ranged from 231 days to 1,659 days. It is predicted there will be an improvement seen in the next quarter.

Actions & Monitoring Underway to Improve Performance:

Meeting planned with decision support to examine strategies on how to build capacity in the OR program to monitor the wait time lists to ensure that patient wait days are being managed more effectively to reflect patient availability and booking times which have a substantial influence on documented wait times.

Definition: For all general surgical procedures (excluding confirmed and suspected cancer surgeries), the Ontario WTS measures the wait time from when a patient and a surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 306 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

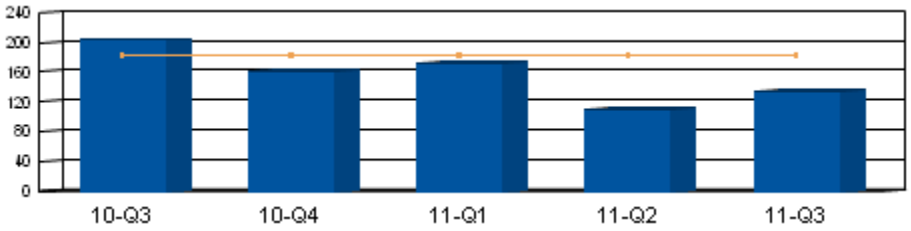
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q3	203	182
10-Q4	161	182
11-Q1	173	182
11-Q2	111	182
11-Q3	135	182

Interpretation - Patient And Business:

This KPI indicator continues to maintain its green target status. For Q3 there was a slight increase in the median days of 2 days from Q2. The beginning of the quarter had recorded 132 days waiting with a small increase to 145 days by the end of December. Contributing to the wait time increase was the impact on the operating room schedule having to close 4 operating rooms in order to facilitate a planned maintenance renovation.

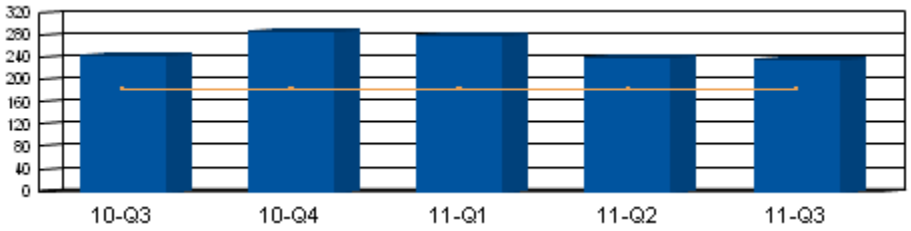
Actions & Monitoring Underway to Improve Performance:

Constant monitoring of additional ortho trauma time during the weekday is being conducted by program management and the Operating room committee. Opportunity to add additional ortho elective cases during unutilized general emergency time or ortho trauma operating is being implemented.

Definition: For all total hip and knee replacement procedures, the Ontario WTS measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 403 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

Indicator: Orthopedic Surgery (excluding total hip and knee replacements) - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q3	242	182
10-Q4	286	182
11-Q1	281	182
11-Q2	240	182
11-Q3	235	182

Actions & Monitoring Underway to Improve Performance:

Wait times will continue to be monitored at the joint KGH/HDH Wait list committee meetings. With the additional ortho trauma operative time allocated to KGH is anticipated that the wait times will continue to improve.

Definition: For orthopedic surgery (excluding total hip and knee replacements) procedures, the Ontario WTS measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 183 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

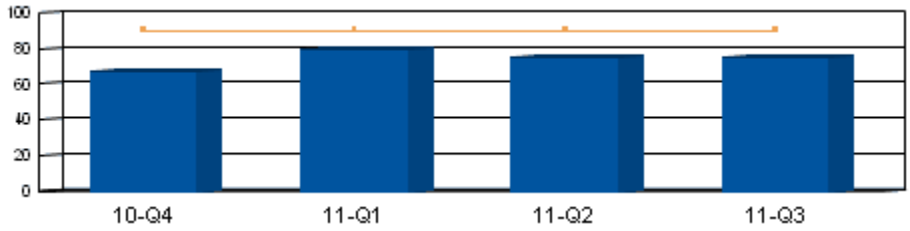
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets



	Actual	Target
10-Q4	67	**90**
11-Q1	80	**90**
11-Q2	75	**90**
11-Q3	75	**90**

Interpretation - Patient And Business:

The Ontario government has put a plan in place to increase access and reduce wait times for most surgeries. Ontario's plan has a goal to significantly increase the number of procedures to reduce the backlog that has developed over the last decade, standardize best practices for both surgical and administrative functions in order to improve patient flow and efficiency and collect and report accurate and up-to-date data on wait times to allow better decision making and increase accountability.

Actions & Monitoring Underway to Improve Performance:

The Q3 results indicate that the target of 90% has still not been reached and we remain at 75% of clinical meeting the 90th percentile. As of Q3, 33 out of 44 Surgical wait categories were meeting the MOH 90th percentile wait time target. The 11 areas currently off target are 2 in General Surgery, 1 in Gynecology, 3 in Oral/maxillofacial surgery, 3 in Orthopedics, and 2 in Urology. The surgical program leadership closely monitors wait times in conjunction with the Wait Times Committee. Departments and Divisions are informed of their rates and encouraged to look at means to improve wait times.

Definition: The Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from ""decision to treat"" to ""treatment"". For wait times that are reported for the specific time period, calculations include all cases where the surgery or (""treatment"") was completed during that time period. The wait times are calculated by subtracting the ""decision to treat"" date from the ""treatment"" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.
The KGH is mandated to report 90th percentile wait times in 40 unique categories to the MOH on a monthly basis. This performance indicator simply counts the number of those unique categories meeting the 90th percentile target and dividing that by the total number of unique categories expressed as a percentage. It is intended to provide an overall view of progress with respect to meeting MOH wait time targets.

Target: Target 11/12: 90%

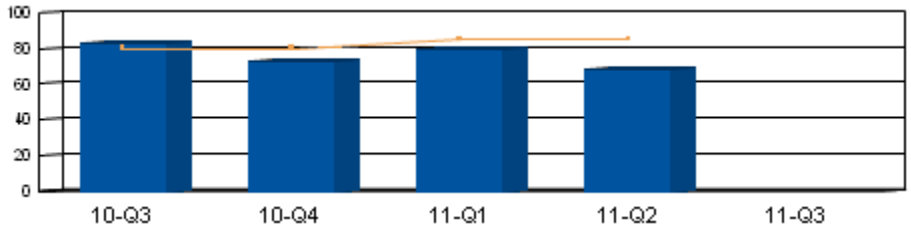
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Radiation Wait time (Referral-Consult) Percent seen within 14 days



	Actual	Target
10-Q3	83	**80**
10-Q4	73	**80**
11-Q1	80	**85**
11-Q2	68	**85**
11-Q3		

Interpretation - Patient And Business:

Q3 Radiation Wait Time referral-consult data not yet available. Results are expected by mid-February 2012

Actions & Monitoring Underway to Improve Performance:

Q3 data not yet available

Definition: Cancer Care Ontario (CCO) reports the proportion of patients who are being seen or receiving radiation treatment within the recommended timeframe or target. Referral to Consult: The time between a referral to radiation oncologist to the time that oncologist consults with the patient. This is based on the waiting period from the time a regional cancer centre receives a referral for a patient to have their initial consultation appointment with the oncologist. KGH's 2009/10 target is 75%. The provincial target/benchmark for radiation referral to consult is 80% of patients are seen within 14 days of receipt of the referral to the regional cancer centre. This region specific target is established on an annual basis with CCO before the end of Q4 of the previous year.

Target: Target 09/10: 80%, Target 10/11: 80%, Target 11/12: 80%.

Strategy milestone # 9

100% of our clinical areas have implemented ICPM

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Bring to life new models of interprofessional care and education	Our Interprofessional Collaborative Practice Model (ICPM) is implemented in every clinical area with high ratings from patients, staff and learners	Roll out the KGH model of interprofessional collaborative practice in every clinical area

Indicator(s)	Status
Implementation of ICPM in all inpatient units and extended to ambulatory settings by March 2012	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The majority of ambulatory areas included for roll out in Q3 have been launched according to plan. These areas include the Renal Unit, Satellite Dialysis units in Kingston, Belleville, Picton, Bancroft, Perth and Smiths Falls, Diagnostic Imaging and Surgical Suites. The laboratories which were originally slated for Q3 will instead be launched with the Cancer Program in Q4.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The project charter, oversight by the ICPM Steering Committee and project manager have been instrumental in successfully launching ICPM in the ambulatory areas.

3. **Are we on track to meet the milestone by year end?**
   Yes – KGH based Clinics (primarily FAPC) and Ventilator Equipment Pool, laboratories, Cancer Centre and Emergency Department have been or are on track for launch in Q4.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The project team continues with the role reviews, process redesign, documentation and education for the remaining areas. With the full roll out of the ICPM into all clinical areas, all efforts will be directed to utilizing the evaluation process and outcomes to support sustainability and continuous improvement. The Cancer Program, which is completing its strategic planning process, is optimizing the ICPM as a tool to support delivering on both the KGH 2015 Strategy as well as the CCO provincial strategy.

Kingston General Hospital

Milestone #9

				10-Q4	11-Q1	11-Q2	11-Q3	
SD2 Bring to life new models of interprofessional	100% of our clinical areas have implemented ICPM		Implementation of ICPM in All Inpatient Units and Extended to Ambulatory Setting by March 2012	N/A	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

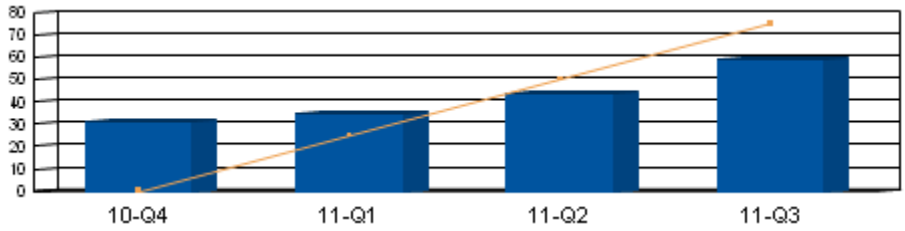
Kingston General Hospital

Milestone #9

SD2 Bring to life new models of interprofessional care and education

100% of our clinical areas have implemented ICPM

Indicator: Implementation of ICPM in All Inpatient Units and Extended to Ambulatory Setting by March 2012



	Actual	Target
10-Q4	31	**0**
11-Q1	35	**25**
11-Q2	44	**50**
11-Q3	59	**75**

Interpretation - Patient And Business:

The target is set at100 percent. By Q3, 30 of 51 (59 percent) of patient care areas have implemented ICPM and implementation is on track.

In Q3, ICPM was implemented in 8 patient care areas including the Renal Unit, Satellite Dialysis units in Kingston, Belleville, Picton, Bancroft, Perth & Smiths Falls, Diagnostic Imaging and Surgical Suites.

The Human Resources Team has reviewed 7 provider and support roles in the ambulatory areas listed above, ensuring that everyone is working to their full scope of practice.

The Process Redesign Team has worked with each individual unit during the pre-implementation planning phase to identify process issues specific to those areas. The team continues to work with Transportation Services to resolve issues with delays related to patient transport.

The Documentation Team implemented the consolidated patient record project where the complete record including flowsheet and medication administration record is housed in wall desks outside patient rooms on Kidd 3.

The Education Team facilitated education sessions for 214 staff from the ambulatory care areas listed above during this quarter. As of Q3, 1,504 staff have attended ICPM education sessions.

Actions & Monitoring Underway to Improve Performance:

Pre-ICPM patient and provider satisfaction surveys have been distributed in the Cardiovascular Laboratory and provider surveys have been distributed in the Clinical Laboratories, This data will serve as a baseline with which we will compare post survey data to see if the changes made with ICPM have been effective in these areas.

Evaluation continues post implementation on 5 inpatient care units. Success to date continues to be monitored for sustainability and advancement. Action plans have been developed for each satisfaction survey item that has a negative trend from pre-ICPM to 16 months post-ICPM implementation.

KGH is sharing the ICPM information internally and externally. In Q3, ICPM was presented at the Registered Nurses' Association of Ontario Excellent Care for All Act Conference, the Professional Practice Network of Ontario Conference, Queen's University Office of Interprofessional Education and Practice Lunch Series and the Quality of Patient Care Committee meeting.

Staff from the Children's Hospital of Eastern Ontario visited KGH to learn about ICPM and in addition, ICPM teleconferences have occurred with representatives from both the Credit Valley Hospital and the District Health Authorities in Nova Scotia.

Definition: Percent completion of ICPM implementation in 51 patient care areas. ICPM implementation is defined as putting into action all role, process improvement, documentation, technology and staffing changes following stakeholder engagement and completion of staff and physician education. The evaluation strategy is approved and in progress.

Target: Target 11/12: 100%

Strategy milestone # 10

The KGH Interprofessional Education Steering Committee and workplan is in place

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Bring to life new models of interprofessional care and education	KGH is recognized as a centre of excellence in interprofessional education	Establish an Interprofessional Education Steering Committee

Indicator(s)	Status
IPE Work Plan Launched	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The IPE Workplan has been approved by the Operations Committee and is guiding the activities of the steering committee and support teams (Accreditation Alignment, Environmental Factors and Support, Interprofessional Events Planning, Evaluation and Communication).

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The replication of the change management approach used with ICPM (infrastructure of charter, project lead, task teams) are assets in working toward this 2015 outcome. There is also an alignment with the ICPM, patient and family centred care and patient safety initiatives.

3. **Are we on track to meet the milestone by year end?**
   Milestone has been met as workplan has been launched.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The IPE support teams are primarily focused on assessments and environmental scans at this time to inform future work. There is planning underway for two interprofessional educational events in F2013 focused on resuscitation skills (Simulation Olympics) and patient safety. Consultation is occurring with other academic centres with more history and experience with interprofessional education to help with planning and concrete, measurable improvements. Focus is turning from assessment and identification of opportunities to detailed action planning (i.e. organizational competencies to support professional learning).

Kingston General Hospital

Milestone #10

				10-Q4	11-Q1	11-Q2	11-Q3	
SD2 Bring to life new models of interprofessional	The KGH Interprofessional education council		IPE Work Plan Launched	G	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

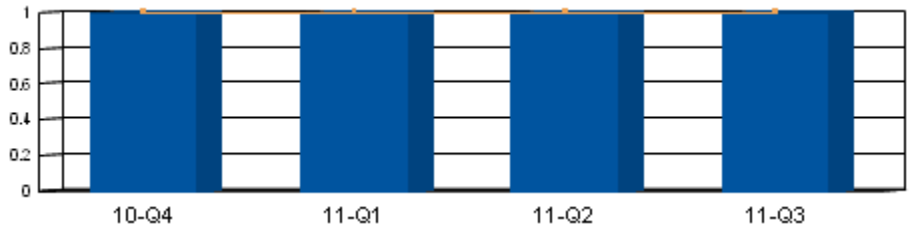
Kingston General Hospital

Milestone #10

SD2 Bring to life new models of interprofessional care and education

The KGH Interprofessional education council and work plan is in place

Indicator: IPE Work Plan Launched



	Actual	Target
10-Q4	1	**1**
11-Q1	1	**1**
11-Q2	1	**1**
11-Q3	1	**1**

Interpretation - Patient And Business:

The Interprofessional Education Steering Committee meets monthly and there is active interest and engagement of all members in delivering on the expectations outlined in the strategy.

The support teams and the Evaluation Committee have been meeting regularly to implement their individual work plans.

Actions & Monitoring Underway to Improve Performance:

The Interprofessional Education Steering Committee reports to the Operations Committee and provided an update in 2011 November.

The work is at a very early stage and there is deliberate attention on maintaining focus on the plans and alignment to the KGH Strategy and Action Plan. Broad communication and a higher profile of the initiative within the organization are being planned for early 2012.

The executive sponsor presented an update to the Research and Education Committee in 2011 November.

Definition: The IPE project charter forms the basis of the IPE work plan. The work plan includes establishment of working groups with defined terms of reference, objectives and deliverables, initiative timelines, project milestones, and the IPE communication and evaluation strategies.

Target: Target 11/12: Yes

Strategy milestone # 11

Externally funded research at KGH has increased by 10% and our clinician scientist program expands

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Cultivate patient oriented research	Externally funded research at KGH has increased by 50%	Expand the number of clinician scientists conducting research at KGH

Indicator(s)	Status
Expand Number of Clinician Scientists	Green
Percent Increase of Externally Funded Research Dollars at KGH	Green
Research Institute Business and Operating Plan Delivered	N/A

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Our efforts to build upon a culture of patient-oriented research at KGH continue to expand through the creation of the KGH Research Institute (KGHRI), the recruitment of four clinician scientists to date (*Emergency Medicine, Pathology & Molecular Medicine, Respirology, and Neurosurgery*), and through ongoing planning for clinical research space, increasing research personnel, and creating a strategic plan for research at KGH. As of Q3, both the clinician scientist program and percent increase of externally funded research at KGH have a status of green. A Needs Assessment for the KGHRI has been completed and disseminated to EMC. It includes a draft floor plan for a new Clinical Investigation Unit and a marketing/communication strategy for the KGHRI.
2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Our success has been fostered through KGH's commitment to providing Research infrastructure (i.e. space, personnel) and the cooperation of SEAMO and the Queen's University Faculty of Health Sciences on our common quest to establish leadership in the Canadian health research domain.
3. **Are we on track to meet the milestone by year end?**
   Yes. We have already exceeded our target of one new clinician scientist recruited and externally-funded research has increased 32% by fiscal year end. The research institute business and operating plan are currently underway and will be delivered by year end.
4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   There is no requirement for corrective actions at this time as our milestone is on track to be met by year end.

Kingston General Hospital

Milestone #11

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD3 Cultivate patient oriented research	Externally funded research at KGH has increased by 10% and our clinician scientist program expands		Active Clinical Trials	G	G	G	G	G	↑
			Clinical Trials Generating Revenue	Y	G	G	G	G	↑
			Expand Number of Clinician Scientists			G	G	G	↑
			New Clinical Trials	G	G	G	R	R	↑
			Percent Increase of Externally Funded Research Dollars at KGH			N/A	G	G	
			Research Institute Business and Operating Plan Delivered			N/A	N/A	N/A	

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

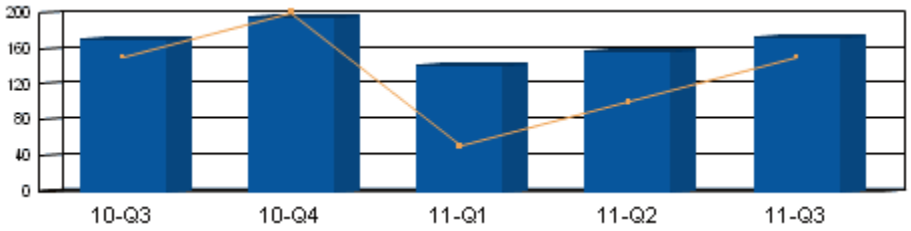
Kingston General Hospital

Milestone #11

SD3 Cultivate patient oriented research

Externally funded research at KGH has increased by 10% and our clinician scientist program expands

Indicator: Active Clinical Trials



	Actual	Target
10-Q3	170	150
10-Q4	196	200
11-Q1	140	50
11-Q2	157	100
11-Q3	172	150

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q3.

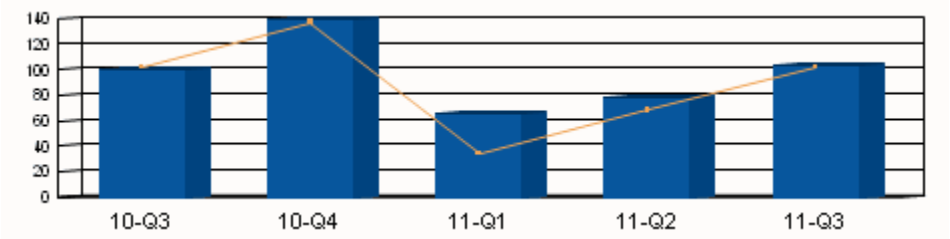
Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the third quarter (Q3).

Definition: The Council of Academic Hospitals of Ontario (CAHO) is moving to adopt research as the defining characteristic of an academic hospital. Research attracts the most highly qualified staff, it helps to build public and patient confidence, it drives evidence based care, and it provides local access to clinical trials, new treatment modalities and technologies. In order to be considered an academic hospital under the CAHO definition, total research funding attributable to the hospital must exceed $10M. In depth reporting on research activity and funding at KGH is provided annually in the 'Annual Research Report' in the Fall of the subsequent fiscal year. However, various indicators related to clinical trials activity can and will be provided on a quarterly basis.

The majority of clinical trials within KGH are funded through external granting agencies (i.e. CIHR) or industry/corporation sponsors.

Target: Baseline 08/09: 195 Trials, Target 09/10: 200 Trials (2.5% increase), Target 10/11: 200 Trials. Target 11/12: 200 Trials.

Indicator: Clinical Trials Generating Revenue



	Actual	Target
10-Q3	100	102
10-Q4	139	137
11-Q1	66	34
11-Q2	79	68
11-Q3	103	102

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q3.

Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the third quarter (Q3).

Definition: The Council of Academic Hospitals of Ontario (CAHO) is moving to adopt research as the defining characteristic of an academic hospital. Research attracts the most highly qualified staff, it helps to build public and patient confidence, it drives evidence based care, and it provides local access to clinical trials, new treatment modalities and technologies. In order to be considered an academic hospital under the CAHO definition total research funding attributable to the hospital must exceed $10M. In depth reporting on research activity and funding at KGH is provided annually in the 'Annual Research Report' in the Fall of the subsequent fiscal year. However, various indicators related to clinical trials activity can and will be provided on a quarterly basis.

The majority of clinical trials within KGH are funded through external granting agencies (i.e. CIHR) or industry/corporation sponsors.

Target: Baseline 08/09: 125 Trials, Target 09/10: 137 Trials (10% increase), Target 10/11: 137 Trials. Target 11/12: 137 Trials.

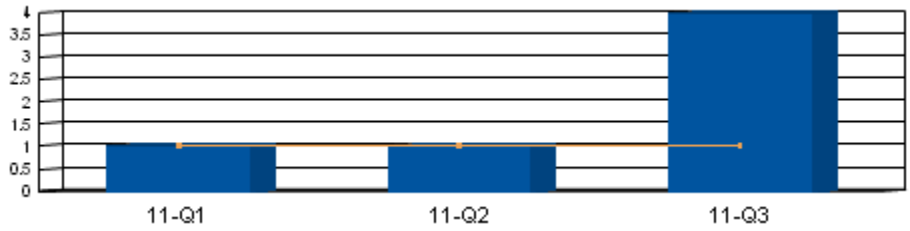
Kingston General Hospital

Milestone #11

SD3 Cultivate patient oriented research

Externally funded research at KGH has increased by 10% and our clinician scientist program expands

Indicator: Expand Number of Clinician Scientists



	Actual	Target
11-Q1	1	1
11-Q2	1	1
11-Q3	4	1

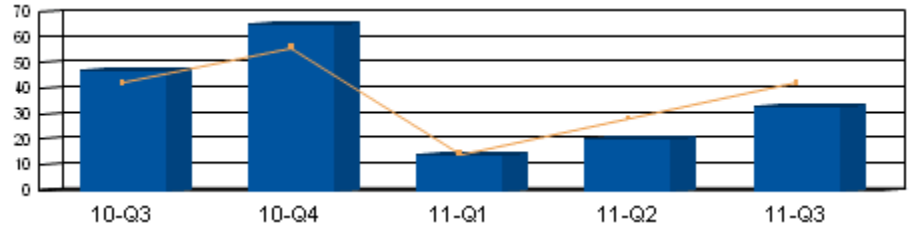
Interpretation - Patient And Business:

First and second competitions of the SEAMO Clinician Scientists Recruitment Program were held in spring and fall 2011. Four (4) clinician scientists will be coming to KGH conditional upon Hospital impact analysis (Emergency Medicine, Pathology, Respirology, and Neurosurgery).

Definition: Commencing in the 2011-12 fiscal year, $3.6 million dollars will be capitalized annually to fund 2 to 3 new clinician scientist positions of 5 years duration within the Queen's Faculty of Health Sciences, creating over a 5 year period 10-15 new clinician scientist positions. Some of these clinician scientists will reside in KGH. The new SEAMO Clinician Scientists Recruitment Program supports SEAMO's objective of significantly expanding its clinical research enterprise by increasing SEAMO's clinical scientist research capacity. A clinician scientist is defined as a physician who leads, or is deemed to have the potential to lead, a research program that is supported by sustained funding from external agencies.

Target: Target = 1 or greater in 11/12

Indicator: New Clinical Trials



	Actual	Target
10-Q3	47	42
10-Q4	65	56
11-Q1	14	14
11-Q2	20	28
11-Q3	33	42

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to new clinical trials at KGH during Q3.

Business Perspective: Based on the fiscal year to date, KGH is behind its target by the end of the third quarter (Q3). As per our Affiliation Agreement with Queen's University, clinical trial contracts, agreements and grants are administered primarily by the Queen's Office of Research Services' Contracts Office.
ACAHO/CIHR/RX&D have created a model Clinical Trial Agreement (CTA) template for phase 2 and 3 clinical drug trials. Queen's has agreed to participate in the pilot of this model CTA for negotiating new clinical trials. This will hopefully help to expediate the start up of new trials in the years to come.

Definition: The Council of Academic Hospitals of Ontario (CAHO) is moving to adopt research as the defining characteristic of an academic hospital. Research attracts the most highly qualified staff, it helps to build public and patient confidence, it drives evidence based care, and it provides local access to clinical trials, new treatment modalities and technologies. In order to be considered an academic hospital under the CAHO definition total research funding attributable to the hospital must exceed $10M. In depth reporting on research activity and funding at KGH is provided annually in the 'Annual Research Report' in the Fall of the subsequent fiscal year. However, various indicators related to clinical trials activity can and will be provided on a quarterly basis.

The majority of clinical trials within KGH are funded through external granting agencies (i.e. CIHR) or industry/corporation sponsors.

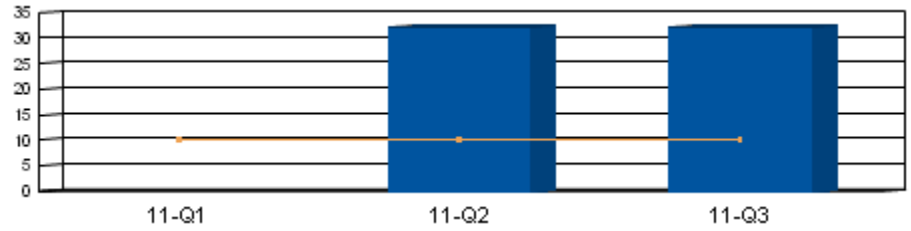
Target: Baseline 08/09: 53 Trials, Target 09/10: 56 Trials (5% increase), Target 10/11: 56 Trials. Target 11/12: 56 Trials.

Milestone #11

SD3 Cultivate patient oriented research

Externally funded research at KGH has increased by 10% and our clinician scientist program expands

Indicator: Percent Increase of Externally Funded Research Dollars at KGH



	Actual	Target
11-Q1		10
11-Q2	32	10
11-Q3	32	10

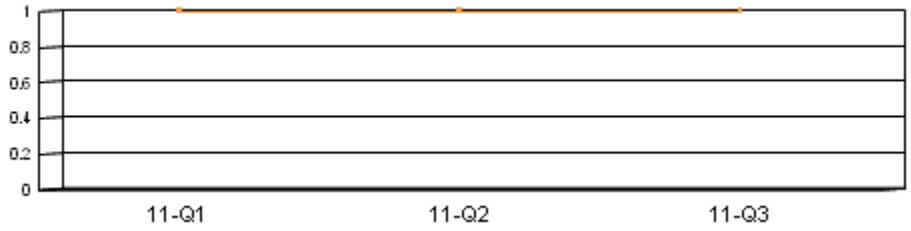
Interpretation - Patient And Business:

Real F2011 data will be used for reporting of F2012 data for this performance indicator since real figures for F2012 will not be available until September 2012. 95% of the data is obtained from external sources and is not available on a quarterly basis for reporting.

Definition: The KGH 2015 Strategy Plan calls for externally-funded research at KGH to increase by 50% by the end of F2015. Researchers at KGH received $15.6 and $16.3 million dollars in external funding from government sources, foundations, societies and agencies, industry, and other sources in F2009 and F2010 respectively.

Target: Target 11/12: 10% increase from 08/09

Indicator: Research Institute Business and Operating Plan Delivered



	Actual	Target
11-Q1		1
11-Q2		1
11-Q3		1

Interpretation - Patient And Business:

Performance indicator is only available on an annual basis and will be reported in Q4.

Definition: Kingston General Hospital (KGH) Research Institute (KGHRI) is the research arm of KGH, a teaching hospital fully affiliated with Queen's University. We have already moved forward in a deliberate way with the establishment of the KGHRI entity in F2011, which will provide a platform to help create an environment where patient-oriented research will flourish. The next steps involve the creation of the KGHRI business and operating plans in F2012 for the next 5-10 years.

Target: Plans completed by Q4 in 11/12

Strategy milestone # 12

KGH services align with our role as the region's complex-acute and specialty care provider and the Cancer Care at KGH strategic plan is in place

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Increase our focus on complex-acute and specialty care	KGH services are well aligned and integrated with the broader health care system	Participate in the South East LHIN's Clinical Services Roadmap project and create a Cancer Care at KGH strategy

Indicator(s)	Status
KGH Cancer Care Plan in Place	Green
KGH Participation in Clinical Services Roadmap Initiatives	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The Oncology Program has been active in developing a strategic direction for the program aligned to the KGH 2015 strategy. It has engaged all stakeholders and encompasses clinical, academic and research domains.
   KGH continues to participate in the SE LHIN Clinical Services Roadmap (CSR) initiative. The process in currently assessing feasibility of the initiatives.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The Oncology Program has taken ownership in the development of the KGH Cancer Care Plan with the Regional RVP (Brenda Carter) as lead. The CSR has shown good progress over the last quarter with a greater understanding by the SE LHIN and partners on resource issues and feasibility.

3. **Are we on track to meet the milestone by year end?**
   Yes. The KGH Cancer Care Plan is tracking for finalization by the end of Q4. The KGH will continue to participate and lead as appropriate with its regional partners.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Strategy and Steering Committee planning days are set out to meet the Q4 deadline ensuring engagement of all stakeholders.

Kingston General Hospital

Milestone #12

				11-Q1	11-Q2	11-Q3	
SD4 Increase our focus on complex-acute and specialty care	KGH services align with our role as the region's complex-acute and specialty care provider and the Cancer Care at KGH strategic plan		KGH Cancer Care Plan	G	G	G	↑
			KGH Participation in Clinical Services Roadmap Initiatives	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

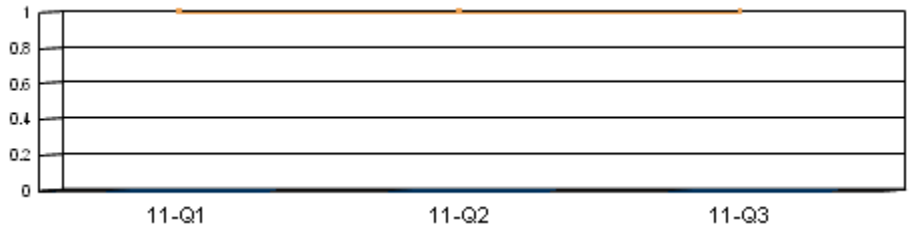
Kingston General Hospital

Milestone #12

SD4 Increase our focus on complex-acute and specialty care

KGH services align with our role as the region's complex-acute and specialty care provider and the Cancer Care at KGH strategic plan is in place

Indicator: KGH Cancer Care Plan



	Actual	Target
11-Q1	0	1
11-Q2	0	1
11-Q3	0	1

Interpretation - Patient And Business:

The process to develop the Cancer Care Strategy for KGH is on track. Target completion - end of Q4 F12.

Actions & Monitoring Underway to Improve Performance:

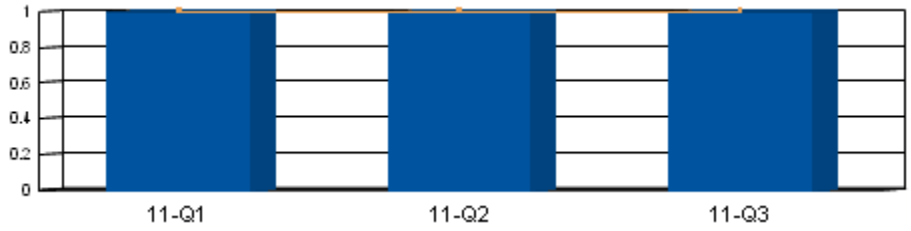
Extensive enterprise-wide engagement is underway in developing the Cancer Care Strategy for KGH. Finalization of the strategy and action plan will happen in Q4.

As we move through the process, we will be documenting our approach and lessons learned to facilitate the development of strategies for other clinical programs at KGH.

Definition: A plan for Cancer Care at KGH will be in place by the end of March 2012 as articulated in the KGH 2015 Action plan for achieving Outstanding Care, Always. The cancer care plan will consider the strategic directions in the KGH 2015 strategy as well as the priorities articulated in Cancer Care Ontario's Ontario Cancer Plan III and the South East Regional Cancer Program plan. As a guide to the strategic development, choices and investments in cancer care, research and education to 2015, this plan will be instrumental in achieving Outstanding Cancer Care, Always at KGH. The process used to develop the cancer care plan will serve as an example of clinical planning that can be used by others within KGH to map their efforts to the 2015 strategy and action plan.

Target: Target 11/12: Yes

Indicator: KGH Participation in Clinical Services Roadmap Initiatives



	Actual	Target
11-Q1	1	1
11-Q2	1	1
11-Q3	1	1

Interpretation - Patient And Business:

The SE LHIN and the regional hospitals with CCAC have embarked upon a critical examination of current hospital services within seven clinical areas. The goal is to improve service provision, reduce program duplication and improve access, efficiency and effectiveness. Working groups with representation from all partners have focused on the clinical area of cardiovascular disease, emergency department wait times, healthcare acquired infections, maternal/high risk newborn, mental health and addictions services, restorative care and surgery.

Actions & Monitoring Underway to Improve Performance:

KGH's clinical programs and leadership continue to actively participate in the development of the roadmap.

Definition: KGH's ability to fulfill its role as the academic tertiary care center to the region in part requires an integrated, strategic approach to health care in the SE LHIN. Regional partners working to their scope, rely on KGH to provide the complex-acute and specialty level care. KGH's participation and leadership within the clinical services roadmap will help meet this objective. The similar alignment of the Cancer Care strategic plan will similarly meet the same objective for this complex group of patients.

Target: Target 11/12: Yes

Strategy milestone # 13

100% of target service volumes are met

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Increase our focus on complex-acute and specialty care	KGH services are well aligned and integrated with the broader health care system	Deliver on MOH volume contracts

Indicator(s)	Status
Percent of Wait Time Contracted Volumes Achieved	Yellow

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   As of Q3, there were 2 incremental volume contracts that were not on target (intestinal and ventral hernia general surgery). Not achieving volume targets by year end poses the risk of these volumes being adjusted downward and permanently reassigned to other hospitals. This carries a financial risk to the organization. (For F2012: Intestinal IP, Groin Hernia, Ventral Hernia, Oral Maxiofascial (Dental), Scoliosis, MRI, CT Total Joints, Cancer Surgery, Cardiac)

2. **What are the contributing factors to the current performance of the indicator for this milestone?**
   The intestinal and ventral hernia were acquisition related issues as opposed to resource related.

3. **Are we on track to meet the milestone by year end?**
   This milestone at risk of not being achieved in full. Of the 16 supporting volume indicators to the milestone, 15 are green and 1 is yellow. It is of note that some of the green indicator s are an overachievement of targeted volume and therefore require a discussion around resource utilization. In some instances, revenue or reallocation within a portfolio can offset these overages.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The Wait List Committee in conjunction with the SPA Program continue to closely monitor volumes. Increased operating capacity and efficiencies will assist in the optimization of meeting volume obligations and Wait Times.

Kingston General Hospital

Milestone #13

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met		Stem Cell Transplants	Y	G	G	G	G	↑
			Ambulatory Care Volumes	G	G	G	G	G	↑
			Cardiac - Angiography Volumes	G	G	G	G	G	↑
			Cardiac - Angioplasty Volumes	G	G	G	G	G	↑
			Cardiac - Bypass Volumes	G	G	G	G	G	↓
			Chronic Kidney Disease Program- Weighted Units	G	G	G	G	Y	↓
			CT Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑
			Emergency Department Admitted Patient Volumes – All Levels of Acuity	G	G	G	G	G	↑
			Emergency Department Non-Admitted Low Acuity (CTAS 4&5) volumes	G	G	G	G	G	↑
			Emergency Department Non-Admitted Patient Visits – High Acuity	G	G	G	G	G	↑
			Hip and Knee Replacement Volume (Wait Time Strategy Allocation)	G	G	Y	Y	G	↑
			Kidney Transplants	Y	Y	G	R	R	↓
			MRI Hours (Wait Time Strategy Allocation)	G	R	G	Y	G	↑
			OR Cases (Inpatient and Outpatient))	G	G	G	G	G	↑

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met		OR Hours (Inpatient & Outpatient)	Y	Y	G	G	G	↑
			Percent of Wait Time Contracted Volumes Achieved	N/A	N/A	R	Y	Y	↑
			Total Inpatient Admissions	G	G	G	G	G	↑
			Total Inpatient Weighted Cases	G	G	G	G	N/A	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

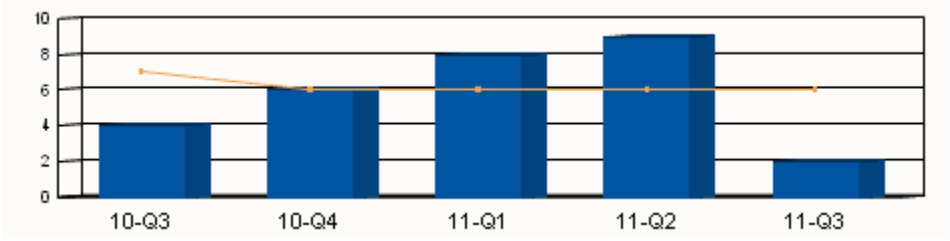
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Stem Cell Transplants



	Actual	Target
10-Q3	4	7
10-Q4	6	6
11-Q1	8	6
11-Q2	9	6
11-Q3	2	6

Interpretation - Patient And Business:

KGH has established its 2011/12 annual stem cell transplant volume at 25 (13 cases included in the Hospital's base budget and 12 incremental cases funded by Cancer Care Ontario).

In Q3 2011/12, 2 stem cell transplants were completed, bringing the YTD total to 19. One transplant in Q1 was federally funded. Therefore in Q4, capacity remains for 7 incremental CCO-funded transplants.

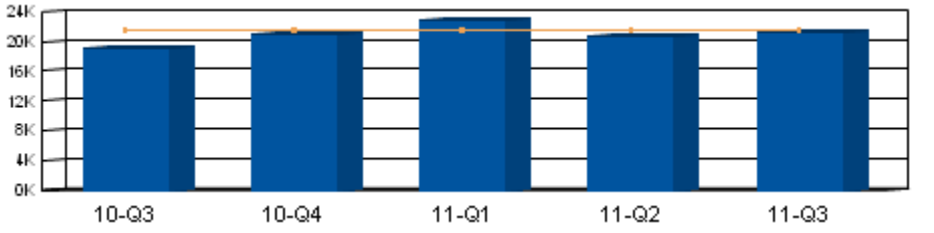
Actions & Monitoring Underway to Improve Performance:

In line with KGH's strategic direction for complex and specialty care, KGH is the only provider of autologous stem cell transplants in the SE region. Timely access to this important cancer treatment modality to patients referred to KGH continues to be provided. KGH maximizes incremental funding available from Cancer Care Ontario to offer this treatment closer to home.

Definition: Number of Stem Cell Transplants (SCT) is a volume funded program that is currently being monitored by the Ministry of Health and Long Term Care/LHIN and Cancer Care Ontario. Stem Cell Transplants (autologous) require the harvesting of the patient's own stems cells prior to the delivery of high doses of chemotherapy that is intended to target and kill cancer cells present in the blood. Once the chemotherapy has been administered, the patient's own stem cells (previously harvested) are reintroduced into the patient to allow for the generation of new healthy, cancer free stem cells. This is a highly intensive treatment requiring extended hospital stays and specific expertise. Autologous SCTs are known to be effective for patients with myeloma, non-Hodgkin's Lymphoma, Hodgkin's disease and on the rare occasion testicular cancer. The hospital is funded based on the total workload achieved by the program within contracted volumes outlined in the Hospital Services Accountability Agreement (HSAA).

Target: Baseline 08/09: 8, Target 09/10: 44, Target 10/11: 44, Target 11/12: 25

Indicator: Ambulatory Care Volumes



	Actual	Target
10-Q3	19067	21400
10-Q4	21050	21400
11-Q1	22878	21400
11-Q2	20797	21400
11-Q3	21184	21400

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Total number of ambulatory care visits to the hospital

Target: Baseline 08/09: 85594, Target 09/10: 85594, Target 10/11: 85594, Target 11/12: 85292

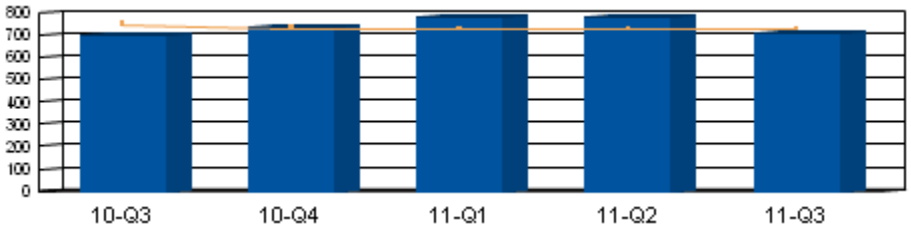
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Cardiac - Angiography Volumes



	Actual	Target
10-Q3	700	748
10-Q4	731	729
11-Q1	779	725
11-Q2	777	725
11-Q3	705	725

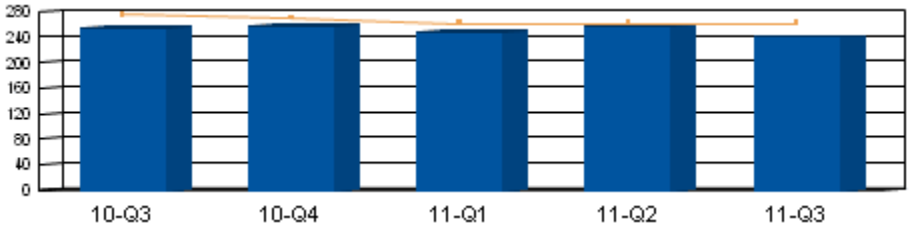
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. Angiography procedures are one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the Base Volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is Base volumes plus WTS Incremental cases plus any additional in-year SE LHIN volume adjustments. Coronary angiography means taking pictures of blood vessels in the heart. Angiography involves injecting a dye that is visible to x-rays. The physician uses an x-ray machine to guide him or her through the procedure and record the pictures to determine whether or not there is adequate blood flow through the vessels.

Target: Baseline 08/09: 1709, Target 09/10: 3100 , Target 10/11: 3100, Target 11/12: 2900

Indicator: Cardiac - Angioplasty Volumes



	Actual	Target
10-Q3	255	275
10-Q4	257	270
11-Q1	249	262
11-Q2	256	262
11-Q3	240	262

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. Angioplasty procedures are one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the Base Volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is Base volumes plus WTS Incremental cases plus any additional in-year LHIN volume adjustments. Coronary angioplasty is a procedure which unblocks narrowed arteries by inserting a small balloon into each artery and inflating the balloon at the site of the blockage. Often, a small metal tube (stent) is permanently placed in the artery to help keep the artery open. This allows blood to flow freely through the artery.

Target: Baseline 08/09: 1084, Target 09/10: 1150, Target 10/11: 1150, Target 11/12: 1050

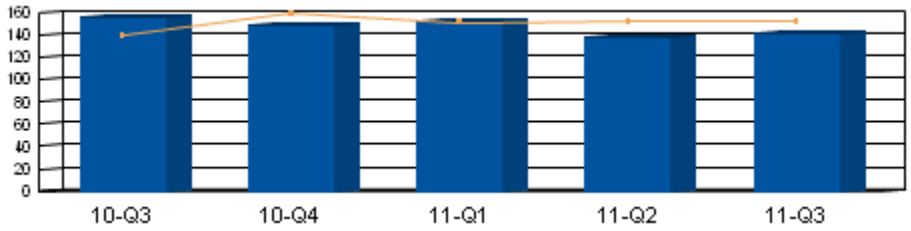
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Cardiac - Bypass Volumes



	Actual	Target
10-Q3	156	139
10-Q4	148	159
11-Q1	153	151
11-Q2	138	152
11-Q3	141	152

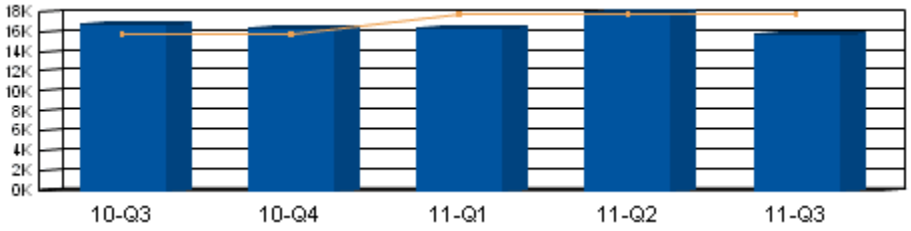
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Wait Time Strategy (WTS) Allocation: In order to strategically increase service in select clinical services, the Province has provided funds to support expanded volumes in some key areas - cardiac bypass procedures are one of the selected areas. For the past few years the province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the base volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is base volumes plus WTS incremental cases plus any additional in-year LHIN volume adjustments.

Target: Target 10/11: 580, Target 11/12: 606

Indicator: Chronic Kidney Disease Program- Weighted Units



	Actual	Target
10-Q3	16723	15655
10-Q4	16290	15655
11-Q1	16265	17707
11-Q2	17888	17707
11-Q3	15792	17707

Interpretation - Patient And Business:

Total dialysis activity is up against plan, activity shifts between modalities (hemodialysis and peritoneal dialysis) and this is within normal limits

Actions & Monitoring Underway to Improve Performance:

The increase in total activity is supportable within available physical capacity and is met with appropriate funding via the Ontario Renal Network.

Definition: Chronic Kidney Disease (CKD) services is a volume funded service that is currently being monitored by Ontario Renal Network (an subdivision of Cancer Care Ontario) on behalf of the Ministry of Health and Long Term Care. The hospital is funded based on the total workload achieved by the service within contracted volumes outlined in the Hospital Services Accountability Agreement (HSAA). Activities specified by the HSAA are multiplied by MoH weighted units and then used for funding. Examples of weights: pre dialysis clinic visit = 1.21; level 1 dialysis treatment = 0.68; level 2 dialysis treatment = 1.00. The renal service (within the Medicine Program) delivers care across over 30 measured service points that together comprise the continuum of care for patients with Chronic Kidney Disease. The most familiar care element is that of dialysis.

Target: Baseline 08/09: 65240, Target 09/10: 69992, Target 10/11: 69992, Target 11/12: 70828

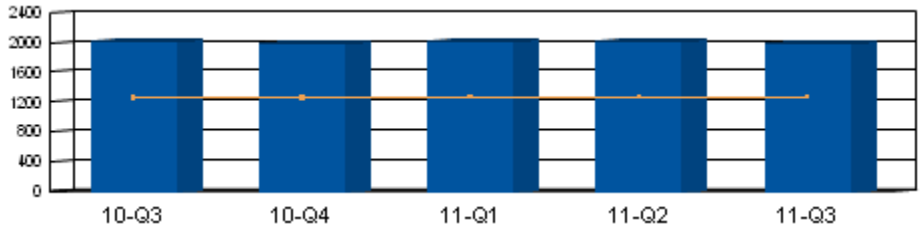
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: CT Hours (Wait Time Strategy Allocation)



	Actual	Target
10-Q3	2009	1247
10-Q4	1987	1247
11-Q1	2012	1263
11-Q2	2015	1263
11-Q3	1979	1263

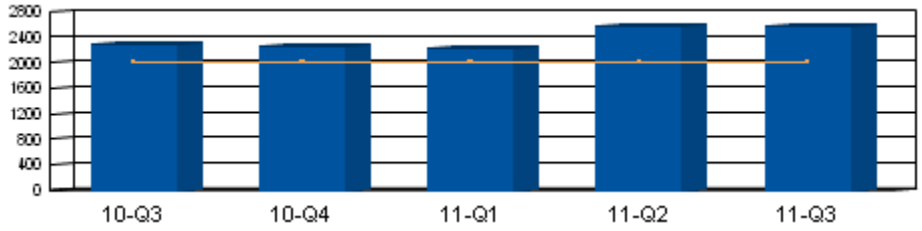
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Wait Time Strategy (WTS) Allocation: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. CT Hours is one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the base volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is base volumes plus WTS Incremental cases plus any additional in-year SE LHIN volume adjustments.

Target: Baseline 08/09: 8039 hrs, Target 09/10: 4888 hrs, Target 10/11: 4888 hrs, Target 11/12: 5050 hrs.

Indicator: Emergency Department Admitted Patient Volumes – All Levels of Acuity



	Actual	Target
10-Q3	2288	2002
10-Q4	2250	2002
11-Q1	2234	2002
11-Q2	2576	2002
11-Q3	2580	2002

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: This is the number of patients in the Emergency Department (ED) (all levels of CTAS acuity) who are admitted and waiting for inpatient bed. (Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 8163, Target 09/10: 8163, Target 10/11: 8163, Target 11/12: 8008

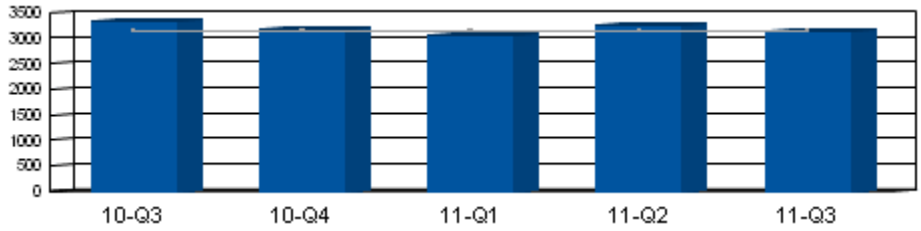
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Emergency Department Non-Admitted Low Acuity (CTAS 4&5) volumes



	Actual	Target
10-Q3	3351	3138
10-Q4	3175	3138
11-Q1	3058	3138
11-Q2	3250	3138
11-Q3	3145	3138

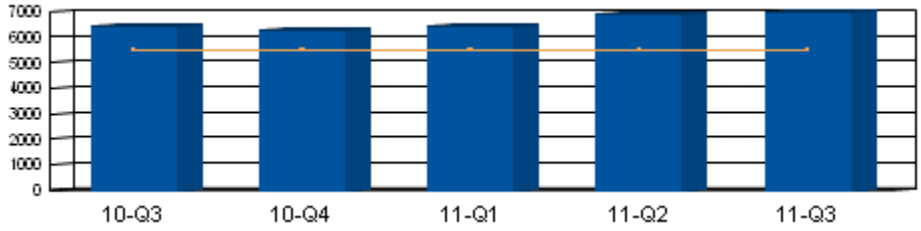
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: This is the number of Emergency Department (ED) patient visits, low acuity (CTAS 4 & 5) that are seen in the ED and discharged from the ED.
(Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 14270, Target 09/10: 14270, Target 10/11: 14270, Target 11/12: 12552

Indicator: Emergency Department Non-Admitted Patient Visits – High Acuity



	Actual	Target
10-Q3	6421	5481
10-Q4	6243	5481
11-Q1	6398	5481
11-Q2	6936	5481
11-Q3	6988	5481

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: This is the number of Emergency Department (ED) patient visits (high acuity) CTAS (Canadian Triage & Acuity Scale 1, 2 or 3) that are seen in the ED and discharged from the ED.
(Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 22823, Target 09/10: 22823, Target 10/11: 22823, Target 11/12: 21924

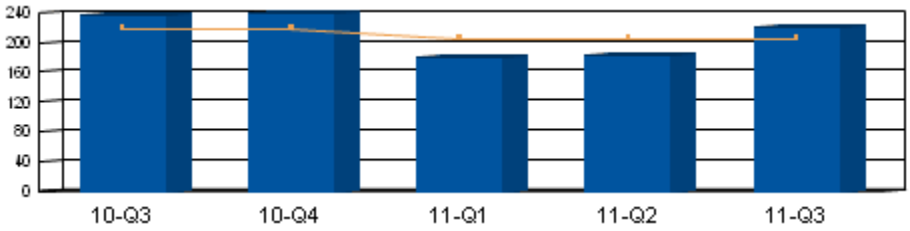
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Hip and Knee Replacement Volume (Wait Time Strategy Allocation)



	Actual	Target
10-Q3	238	219
10-Q4	239	219
11-Q1	180	205
11-Q2	183	205
11-Q3	221	205

Interpretation - Patient And Business:

For this KPI the revised target volume of 784 has contributed to this indicator being within the green zone.

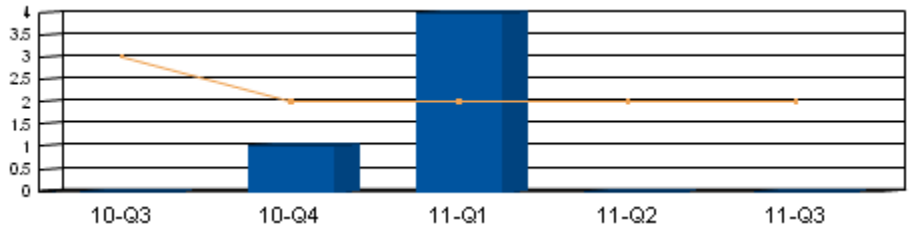
Actions & Monitoring Underway to Improve Performance:

Volumes continue to be monitored closely by Program management and the Surgical, Perioperative & Anaesthesia Program Council.

Definition: Wait Time Strategy (WTS) Allocation: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. Hip and Knee replacements are one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the Base Volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is Base volumes plus WTS Incremental cases plus any additional in-year LHIN volume adjustments.
The hospital is funded based on the total workload achieved by the program within contracted volumes outlined in the Hospital Services Accountability Agreement (HSAA).

Target: Baseline 08/09: 878, Target 09/10: 876, Target 10/11: 876, Target 11/12: 819

Indicator: Kidney Transplants



	Actual	Target
10-Q3	0	3
10-Q4	1	2
11-Q1	4	2
11-Q2	0	2
11-Q3	0	2

Interpretation - Patient And Business:

The indicator is driven by available donor organs; no organs have been available for transplantation.

Actions & Monitoring Underway to Improve Performance:

Population donor rates are not variant in our region. The variation seen in the fiscal year, is therefore not outside of the reasonable norm.

Definition: Kidney transplant is at KGH is cadaveric only, and can only occur when a donor is presented and a patient match (within catchment area) is found. If there is no organ match then the organ is made available to the province and beyond. The activity is measured by the case (transplanted kidney). The cadaveric (deceased donor) transplantation of Kidney's is supported by the Trillium gift of life network, the provincial organ and tissue donation agency.

Target: Baseline 08/09: 10, Target 09/10: 9, Target 10/11: 9, Target 11/12: 9

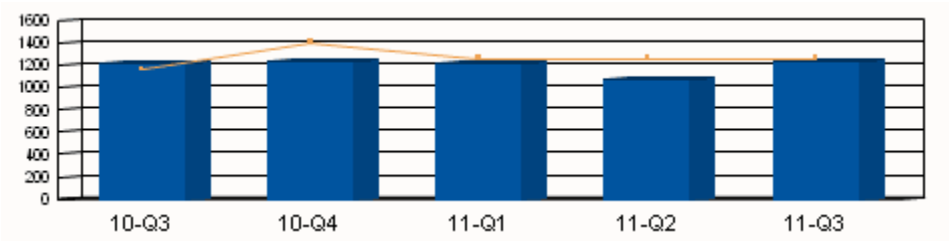
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: MRI Hours (Wait Time Strategy Allocation)



	Actual	Target
10-Q3	1225	1165
10-Q4	1232	1405
11-Q1	1212	1259
11-Q2	1071	1259
11-Q3	1239	1259

Interpretation - Patient And Business:

KGH has achieved more MRI hours this fiscal year than any year previously. KGH was also allotted more incremental hours than any year previously. Not all of the hours will be achieved due to staffing challenges however considerable effort and success has been achieved with the resources available.

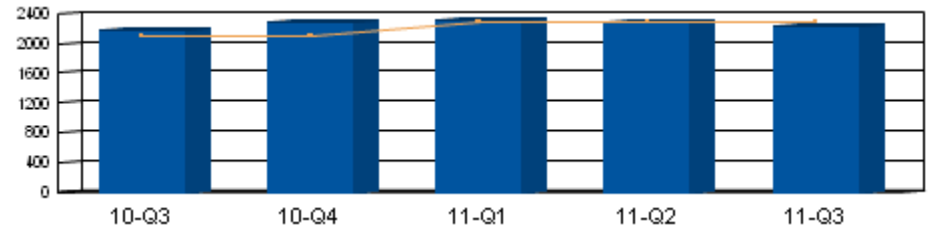
Actions & Monitoring Underway to Improve Performance:

Approval for an additional MRI technologist has been granted by the senior leadership team. Recruitment will start shortly. Having these additional resources will pretty much guarantee that we reach our targeted hours.

Definition: Wait Time Strategy (WTS) Allocation: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. MRI Hours is one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the base volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is base volumes plus WTS Incremental cases plus any additional in-year SE LHIN volume adjustments.

Target: Baseline 08/09: 4627 hrs, Target 09/10: 4700 hrs, Target 10/11: 4700 hrs, Target 11/12: 5035 hrs.

Indicator: OR Cases (Inpatient and Outpatient))



	Actual	Target
10-Q3	2175	2098
10-Q4	2296	2098
11-Q1	2318	2286
11-Q2	2274	2286
11-Q3	2234	2286

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Described as the total number of inpatient and outpatient cases in the operating room (OR).

Target: Baseline 08/09: 8488, Target 09/10: 8390, Target 10/11: 8390, Target 11/12: 9145

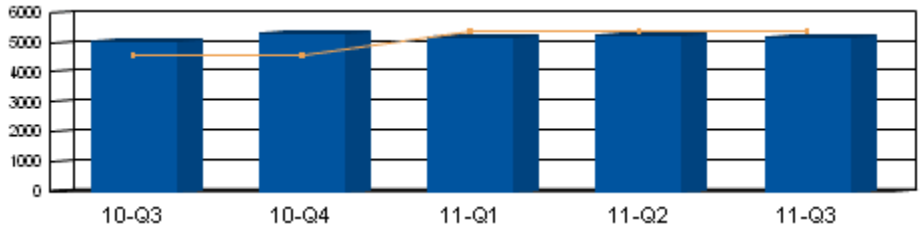
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: OR Hours (Inpatient & Outpatient)



	Actual	Target
10-Q3	5042	4537
10-Q4	5279	4537
11-Q1	5191	5345
11-Q2	5233	5345
11-Q3	5203	5345

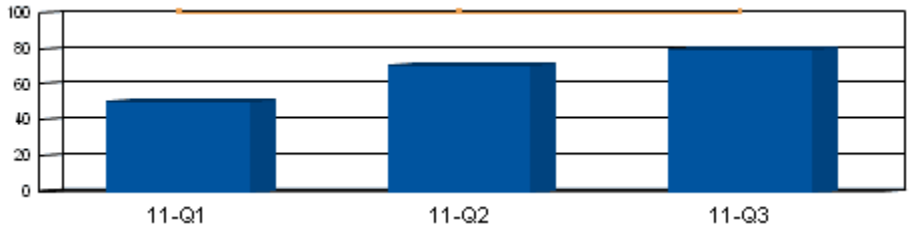
Interpretation - Patient And Business:

The additional evening general emergency and ortho trauma weekend operative hours continue to assist in keeping this indicator in a green status.

Definition: Operating room (OR) hours is described as the total inpatient and outpatient operating room hours staffed and available in the operating room.

Target: Baseline 08/09: 21143, Target 09/10: 18148, Target 10/11: 18148, Target 11/12: 21378

Indicator: Percent of Wait Time Contracted Volumes Achieved



	Actual	Target
11-Q1	50	100
11-Q2	70	100
11-Q3	80	100

Interpretation - Patient And Business:

As of Q3, there were 2 incremental volume contracts that were not on target (intestinal and ventral hernia general surgery). Not achieving volume targets by year end poses the risk of these volumes being adjusted downward and permanently reassigned to other hospitals. This carries a financial risk to the organization.

Actions & Monitoring Underway to Improve Performance:

The Wait List Management Committee and the Surgical Program are closely monitoring these issues. A realignment of OR time scheduled across the 7 day week for the fall of 2011 will help with optimizing OR utilization and therefore case throughput.

Definition: In order to strategically increase service in select clinical services, the Province has provided incremental funds to support expanded volumes. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond these base volumes. Given that KGH has been selected to provide additional volumes in many different areas, our definition of this performance indicator is dividing the number of incremental volume contracts on target by the total number of contracts expressed as a percent. It is intended to provide an overall view of progress with respect to meeting MOH volume contracts.

For F2012: Intestinal IP, Groin Hernia, Ventral Hernia,Oral Maxiofascial (Dental), Scoliosis,MRI, CT,Total Joints, Cancer Surgery, Cardiac

Target: Target 11/12: 100%

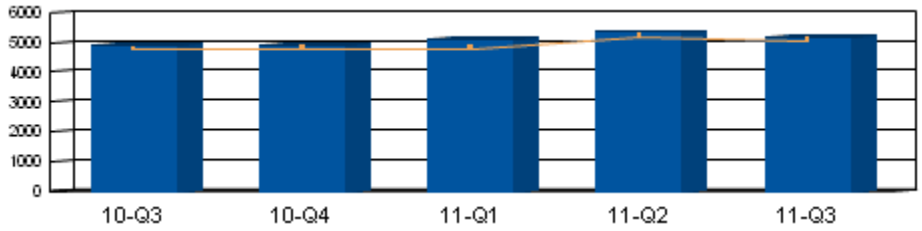
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Total Inpatient Admissions



	Actual	Target
10-Q3	4878	4779
10-Q4	4925	4782
11-Q1	5082	4782
11-Q2	5345	5195
11-Q3	5204	5055

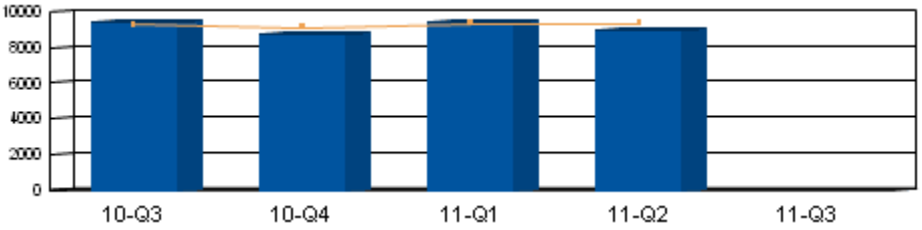
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Total number of admissions to inpatient wards is a measure of total inpatient activity in the hospital.

Target: Baseline 08/09: 19464, Target 09/10: 19400, Target 10/11: 19400, Target 11/12: 20,500

Indicator: Total Inpatient Weighted Cases



	Actual	Target
10-Q3	9369	9284
10-Q4	8710	9103
11-Q1	9363	9326
11-Q2	9014	9326
11-Q3		

Interpretation - Patient And Business:

Inpatient weighted case volumes for Q2 are within planned levels which has a positive benefit to both maintaining the level and mix of services (primary, secondary, tertiary) provided to the population of South Eastern Ontario. Achieving the desired volume of targeted weighted cases could ultimately have a positive financial impact on the hospital.
Q2 total weighted case results are slightly below target but well within the 10% corridor of performance.

Definition: Total Inpatient Weighted Cases is a measure of total inpatient output of the hospital. By converting cases to a normalized measure using case Resource Intensity Weights (RIW) a common overall measure of output is produced.

RIW methodology is a relative resource allocation tool for estimating a hospital's inpatient-specific resource consumption. RIWs are used to standardize the expression of hospital case resource consumption, recognizing that not all patients require the same health care resources. Total resource consumption is then expressed as "weighted cases".

Target: Baseline 08/09: 35291, Target 09/10: 35300, Target 10/11: 35300, Target 11/12: 34616

Strategy milestone # 14

KGH clinical staff adopt evidence-based guidelines in 6 clinical areas

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Increase our focus on complex-acute and specialty care	Best evidence used to guide practice	Increase adoption of clinical practice guidelines

Indicator(s)	Status
Number of Clinical Areas That Have Implemented Open Source Order (OS)	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?**

   The indicator is at target of 4 clinical services having implemented the Order Sets.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**

   The Order Set Committee has been active in recruiting programs and clinical services in development of order sets.

3. **Are we on track to meet the milestone by year end?**

   Yes

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   The Order Set Committee will guide the programs in development and process to implement order set throughout most services.

Kingston General Hospital

Milestone #14

				10-Q4	11-Q1	11-Q2	11-Q3	
SD4 Increase our focus on complex-acute care	KGH clinical staff adopt evidence-based guidelines		Number of Clinical Areas that have Implemented Open Source (OS)	N/A	G	R	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

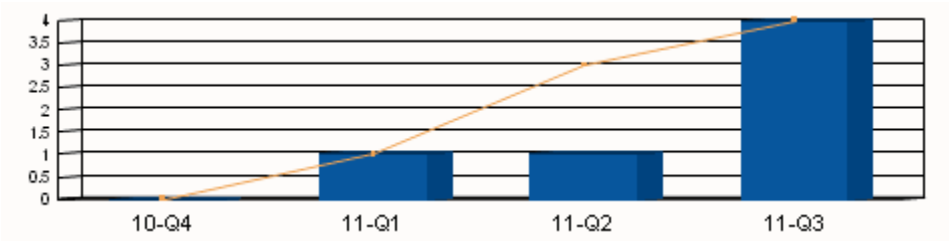
Kingston General Hospital

Milestone #14

SD4 Increase our focus on complex-acute and specialty care

KGH clinical staff adopt evidence-based guidelines in 6 clinical areas

Indicator: Number of Clinical Areas that have Implemented Open Source (OS)



	Actual	Target
10-Q4	0	**0**
11-Q1	1	**1**
11-Q2	1	**3**
11-Q3	4	**4**

Interpretation - Patient And Business:

An order set is a group of comprehensive, best practice/evidence-based practitioner orders that assist healthcare providers to manage common healthcare issues and interventions/procedures in a variety of patient populations. The benefits to patient safety and quality of care are expected by using best practice/evidence based templates to ensure appropriate treatments, medications and investigations. Reduced length of stay and readmission rates are also expected to be supported with use of Order Sets.

Actions & Monitoring Underway to Improve Performance:

As of Q3, 4 of the 6 planned clinical areas had achieved Implementation (ICU, Cardio-vasc surg, Gen surg, Obs/Gyn). The remaining two targeted clinical areas (Emerg and Urology) are on target for completion in Q4.

Definition: Clinical Areas - Generally defined as the programs. However, SPA and Medicine are too large. These programs will be divided by service areas. Several areas fall outside of the program structure and these will be defined by group e.g. Allied Health, Diagnostic Imaging

Adoption – order set development and approval by MAC

Target: Target 11/12: 6

Strategy milestone # 15

Average sick days per KGH employee are reduced to 10.5

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
People	KGH is designated as one of the best places to work	Launch our staff scheduling system

Indicator(s)	Status
Launch a Staff Scheduling Project	Red
Average sick days per eligible employee per year	Yellow

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   At the end of Q3, Launch of the Scheduling Project was red despite continued recruitment activities, RFP to obtain contract support, and exploration to commence a component of the project (joint endeavour with the nurses union to modify master schedules for 2012). While sick time usage during Q3 dropped, the rolling 12 month average rose due to increased sick time usage in the spring and summer 2011.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Lack of project manager to lead the Scheduling project. The rolling 12 month average for sick time was impacted by the increase in usage over 2011 spring and summer. However, the actual usage in Q3 was on a downward trend.

3. **Are we on track to meet the milestone by year end?**
   With the focus on alternatives to commence the Scheduling project, it should still be launched in Q4, which would meet the milestone. The target of a rolling 12 month average of 10.5 days will not be met, however, downward usage of usage and historical pattern from 2011 Q4, i.e. sick time usage hit this target in that quarter, it may be possible to achieve in Q4.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Focus efforts on the recruitment for a Project Manager; and explore possibilities of an internal secondments. Continue with Attendance Management Program and introduce a new practice to review areas with continued high sick time and assess other metric trends, such as turnover and overtime to address systemic issues causing the continued high sick time usage.

Kingston General Hospital

Milestone #15

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
E1 People	Average sick days per KGH employee are reduced to 10.5		Average Sick Days per Eligible Employee Per Year	Y	Y	Y	Y	Y	↑
			Launch the Staff Scheduling Project			G	R	N/A	
			Percent of Overtime Hours	Y	Y	Y	Y	Y	↓
			Percent Sick Time Hours	G	G	Y	Y	Y	↓
			Total Full Time Equivalents (FTE's)	Y	Y	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

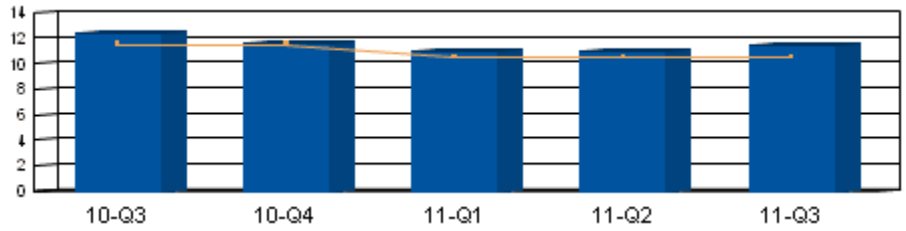
Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Average Sick Days per Eligible Employee Per Year



	Actual	Target
10-Q3	12.35	11.5
10-Q4	11.6	11.5
11-Q1	10.9	10.5
11-Q2	10.9	10.5
11-Q3	11.4	10.5

Interpretation - Patient And Business:

The rolling average increased again to 11.36 as at the end of December. We are not on track for achieving the 10.5 rolling average since our lowest months experienced one year ago for the November to February time period will begin to drop off, without new comparable numbers, pushing up the average. Despite the rolling average increase, we continue to trend downwards on a month to month basis for our largest groups (ONA, CUPE, OPSEU) since the summer. The monthly statistic for December was 0.97. It is noted that CUPE continues on the downward trend over the past 5 months, and is lower than it has been in the previous 7 months. ONA had also been trending upward this past summer, now reversing that trend for the quarter, posting similar numbers (1.16) to a year ago in December.

KGH participated in the OHA Absence Survey which captured information as of March 31, 2011. The report was based on KGH average of 11.92 at the time, placing us at the 21st percentile of participants up from the 13th percentile the previous year. The overall OHA average was 10.52 days per employee, up slightly from the previous year (10.49).

In the category of non-accumulating plans and comparing with acute teaching hospitals only, for the unionized employee groups, the combined OHA average is 13.22, with KGH at 13.00, and for the administrative non union group, it was 5.80 with KGH at 4.68. KGH is below the comparable hospital average which was not the case in the prior year.

Actions & Monitoring Underway to Improve Performance:

The nature of the illnesses for comparable hospitals was 1. Musculoskeletal, 2. Infectious and 3. Mental health/Pyschological. Surgery was not listed as a stand alone category. We did not submit data from KGH given our challenges and manual processes in the collection and reproduction of reports. We are working on data collection that would assist us with a full year analysis for the next survey. Based on data collected over the last six months, the ranking of illness appears to be in line with the OHA survey.

With the changes to the collective agreements in OPSEU and ONA regarding the 6th and subsequent incident not being paid, it caused us to review our practices and compliance with the HOODIP plan. Partial absence days are now configured and implemented in SAP where they do not count as an incident of sick time. Previously we were counting these which elevated our sick time marginally. This change allows us to be in alignment with the OHA direction and the HOODIP plan.

A poster outlining various departmental/organization units and their sick time, a successful method of communicating to staff will go up. Health, Safety & Wellness unit bulletin boards will roll out to more departments throughout January. These boards have a place for monthly departmental sick time average which will be updated by the manager. Learning sessions for leaders that include the safety boards, and sick time average will occur. Other activities planned include in unit information sessions for staff starting with 2 nursing units with high sick time. Further statistical analysis will be undertaken to assist in root causes that may be impacting on sick time. Under discussion is participating in the Your Health Matters pilot and Food Services/Nutrition promotion for healthy eating. Communications and development of these activities remains a challenge.

Definition: The average sick days per eligible employee tracks all sick time of an employee on a twelve month rolling basis. Employees included are all active employees, eligible for paid sick time, as at the last day of the last calendar month of the twelve month period. Active employees include employees on leave of absence. It does not include employees who have terminated, retired or transferred to part-time positions during the twelve month period reported. The average is calculated based on total sick hours for all employees eligible for paid sick time divided by the total number of active employees, eligible for paid sick time as at the last day of the month. A day is based on 7.50 hours. The corporate goal is to reduce the average sick time to the Human Resources Benchmarking Network (HRBN) average for the healthcare sector in Ontario.

Target: Baseline 08/09: 14.03, Target 09/10: 12, Target 10/11: 11.5, Target 11/12: 10.5

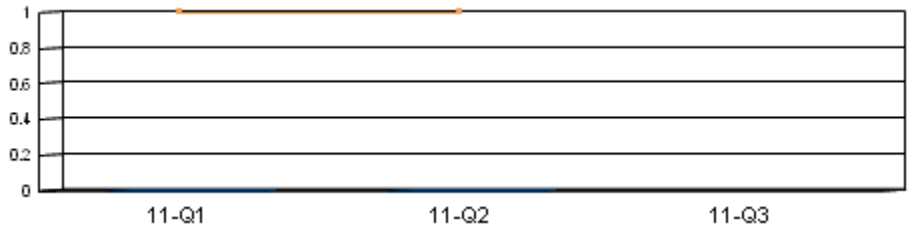
Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Launch the Staff Scheduling Project

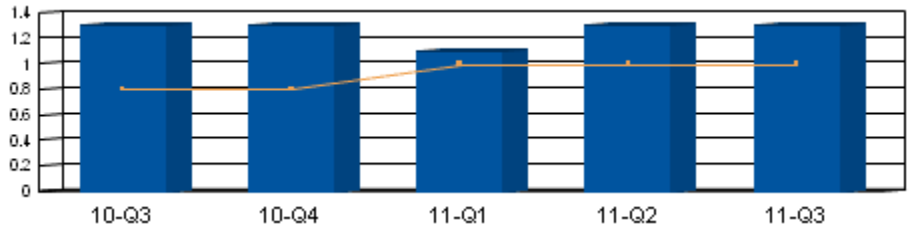


	Actual	Target
11-Q1	0	1
11-Q2	0	1
11-Q3		

Definition: The purpose of the scheduling project is to increase efficiencies through standard processes, centralized scheduling and deployment of updated technologies to create capacity for frontline managers and staff. The improvement of staff scheduling against union contracts across the hospital will decrease sick time and overtime payments. This project will leverage the current workforce scheduling software that has already been procured at the hospital to gain these efficiencies. The measurement is that the project will be in its configuration stage by March 2011.

Target: Target 11/12: Yes

Indicator: Percent of Overtime Hours



	Actual	Target
10-Q3	1.30	0.80
10-Q4	1.30	0.80
11-Q1	1.10	0.99
11-Q2	1.30	0.99
11-Q3	1.30	0.99

Interpretation - Patient And Business:

After the significant spike in both sick time and overtime hours in July, overtime has remained stable for the past 3 months with little variation. The number of sick time hours which could effect overtime has reduced since July also stabilizing the number of staff who are away from work due to illness.

Actions & Monitoring Underway to Improve Performance:

The changes in the collective agreements through settlements last summer and fall for ONA and OPSEU may impact on sick time. Vacation carryover was another change and the scheduling of vacations were also new provisions which could impact on other worked and not worked time during the summer. The scheduling project will have the potential to impact overtime once implemented.

Definition: This is a Hospital Annual Planning Submission (HAPS) indicator that covers full-time staff. This indicator measures the percentage of overtime hours worked by all employees (i.e. not including purchased services) compared to the total hours worked.

Target: Baseline 08/09: 1.9%, Target 09/10: 0.8%, Target 10/11: 0.8%, Target 11/12 0.99%

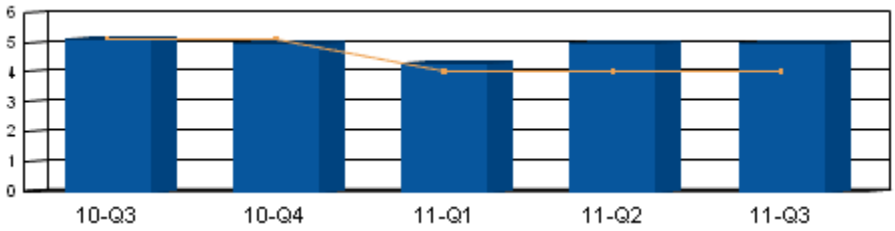
Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Percent Sick Time Hours



	Actual	Target
10-Q3	5.1	**5.1**
10-Q4	5.0	**5.1**
11-Q1	4.3	**4.0**
11-Q2	5.0	**4.0**
11-Q3	5.0	**4.0**

Interpretation - Patient And Business:

After the significant spike in both sick time and overtime hours in July, the actual number of sick time hours continues to be less (16,130.70) however, still higher than planned.
The rolling average increased again to 11.36 as at the end of December. We are not on track for achieving the 10.5 rolling average since our lowest months experienced one year ago for the November to February time period will begin to drop off, without new comparable numbers, pushing up the average. Despite the rolling average increase, we continue to trend downwards on a month to month basis for our largest groups (ONA, CUPE, OPSEU) since the summer. The monthly statistic for December was 0.97. It is noted that CUPE continues on the downward trend over the past 5 months, and is lower than it has been in the previous 7 months. ONA had also been trending upward this past summer, now reversing that trend for the quarter, posting similar numbers (1.16) to a year ago in December. Although a small group, non union sick time has been trending upward, with an increase in December to 0.58 for the month. It is noted that the non union monthly information is about the same as the month where there was H1N1 in October 2009.

Actions & Monitoring Underway to Improve Performance:

The nature of the illnesses for comparable hospitals was 1. Musculoskeletal, 2. Infectious and 3. Mental health/Psychological. Surgery was not listed as a stand alone category. We did not submit data from KGH given our challenges and manual processes in the collection and reproduction of reports. We are working on data collection that would assist us with a full year analysis for the next survey. Based on data collected over the last six months, the ranking of illness appears to be in line with the OHA survey.

With the changes to the collective agreements in OPSEU and ONA regarding the 6th and subsequent incident not being paid, it caused us to review our practices and compliance with the HOODIP plan. Partial absence days are now configured and implemented in SAP where they do not count as an incident of sick time. Previously we were counting these which elevated our sick time marginally. This change allows us to be in alignment with the OHA direction and the HOODIP plan.

Definition: This is a Hospital Annual Planning Submission (HAPS) indicator that measures the percentage of sick time provided by full-time employees. Full-time employees are defined as those employment statuses that are full-time, part time temporary full-time or job sharing, and casual temporary full time. Occupational groups include Management & Operational Support (M&OS), Unit Producing Personnel (UPP), and Nurse Practitioner (NP).

Target: Baseline 08/09: 6.6%, Target 09/10: 5.2%, Target 10/11: 5.1%, Target 11/12 4.0%

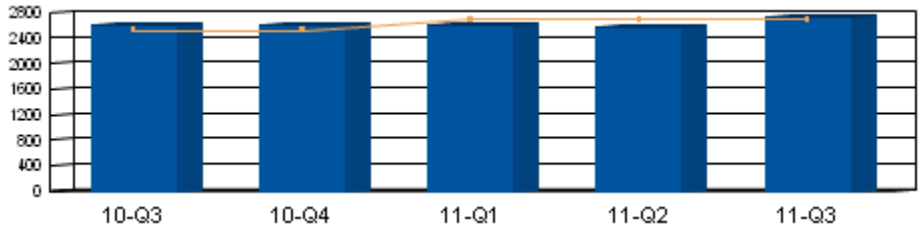
Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Total Full Time Equivalents (FTE's)



	Actual	Target
10-Q3	2618	**2515**
10-Q4	2601	**2515**
11-Q1	2613	**2687**
11-Q2	2566	**2687**
11-Q3	2718	**2687**

Interpretation - Patient And Business:

While slightly over target, the differential has dropped from 4.7% over target in Q2 to 1.2% in Q3. Overtime remains constant at 30% above target as does sick time remain at 25% over target both of which have a direct impact on FTE hours due to replacement requirements for a major portion of the staff.

Actions & Monitoring Underway to Improve Performance:

Continue to move forward with the corporate scheduling project to ensure baselines are met; continue to focus on healthy workplace initiatives to reduce sick time.

Definition: This is a Hospital Annual Planning Submission (HAPS) indicator. This indicator measures the average number of unit-producing and management operational & support full-time equivalents (FTEs) in the facility in a given period. FTEs are calculated by total earned hours divided by FTE hours (1950 hours). FTE counts provide a common denominator in which to measure total hours e.g. KGH could have 4000 employees but they equate to only 3200 FTEs while another hospital may have only 3700 employees but their total FTEs equals 3100 employees.

Target: Baseline 08/09: 2648, Target 09/10: 2566 , Target 10/11: 2515, Target 11/12: 2687

Strategy milestone # 16

Lost time injury claims are reduced by 10%

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
People	All preventable harm to staff is eliminated	Improve workplace safety

Indicator(s)	Status
Lost time injury claims	Yellow

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Lost time injury claims was 6 and this was similar to previous quarters; it is near the target.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The Hospital was successful on challenging claims submitted to WSIB and the provision of modified work reduced some possible lost time injury claims. Of the 6 approved claims, 3 were related to gastrointestinal (noro-virus like) illness; 12 claims had been submitted by staff as a result of the breakout at KGH, however, only 3 claims were accepted by WSIB and 3 claims are pending. Note that the 12 staff submissions required notification to the Ministry of Labour. Managers incident investigations were at the highest quarterly level to date at 90%.

3. **Are we on track to meet the milestone by year end?**
   We are on track to achieve the reduction of lost time injury claims, however, a number of other metrics under this category are not on track. Needlestick and musculoskeletal injuries continues to run high and are not on track.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Business case for conversion to a safer butterfly device that is easier to activate and a different IV catheter that eliminates the potential for exposure to blood are in development. Online training regarding needlestick awareness and usage. Proposal submitted to utilize the Fiscal 2013 Safety Program Rebate for backfill for MSI Safety Champions and Coaches (reinstate program that had been funded through Healthforce Ontario grant in Fiscal 2010).

Kingston General Hospital

Milestone #16

			10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
E1 People	Lost time injury claims are reduced by 10%	Lost Time Injury Claims	N/A	N/A	Y	Y	Y	↓
		Musculoskeletal Injuries (MSIs)	G	R	G	R	R	↓
		Percent Completion of Incident Investigations	R	R	R	R	Y	↑
		Reduction in Lost Time Injury Claims due to Musculoskeletal Injuries	N/A	N/A	R	R	Y	↑
		Reduction in Needle Stick Injuries	N/A	N/A	R	Y	R	↓

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

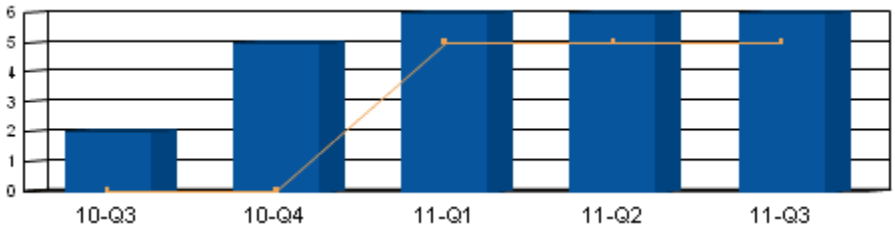
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Lost Time Injury Claims



	Actual	Target
10-Q3	2	**0**
10-Q4	5	**0**
11-Q1	6	**5**
11-Q2	6	**5**
11-Q3	6	**5**

Interpretation - Patient And Business:

The number of Q3 LTIs is the same as previous 2 quarters as is approaching the target. It is important to note that all LTIs occurred in the month of December and 3 of the 6 claims were related to gastrointestinal (norovirus?) illness that staff reported as being work-related. Another 8 gastrointestinal claims were reported to the WSIB as per the employee's request to do so however WSIB has not yet adjudicated these claims. The LTI rate for this quarter will change based on the decisions made by the WSIB.

Excluding the GI claims, the remaining 3 LTIs were all due to musculoskeletal injury and resulted in a total of 10 days of lost work. .

Additional lost time injuries were avoided through the provision of modified work- 28 employees were on modified work during Q3 which equated to a total of 290 modified work days.

Actions & Monitoring Underway to Improve Performance:

The "Hazard Recognition, Control & Management Inspection Program," which is intended to assist in the proactive identification and resolution of hazards thereby reducing the incidence of injury and potential for lost time, was rolled out in Q3 with 100 leaders attending the training sessions. Upcoming Leadership Update sessions in February will reinforce the need for timely communication & immediate offers of modified work to avoid lost time injury claims.

Definition: Workplace injuries that result in a worker being unable to report to work, even in a modified capacity, are a measure of the severity of injury incurred. Hospitals are benchmarked against one another by the WSIB according to lost time injury (LTI) frequencies. LTI frequency and severity (total days per claim) are the key metrics used for selecting organizations to participate in health & safety improvement initiatives such as workwell audits and targeted intervention by the Ministry of Labour (MOL). It is LTI's that result in the majority of our WSIB claim costs. Reducing LTI's means substantial savings on the NEER statement and the potential for year end rebates rather than surcharges.

Target: Target 11/12: 19 (10% reduction from fiscal 10/11)

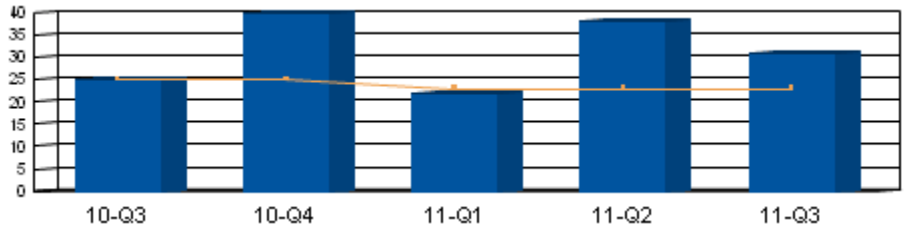
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Musculoskeletal Injuries (MSIs)



	Actual	Target
10-Q3	25	**25**
10-Q4	40	**25**
11-Q1	22	**23**
11-Q2	38	**23**
11-Q3	31	**23**

Interpretation - Patient And Business:

Q3 reported MSI incidents stats continue to surpass the quarterly goal. Of the 31 incidents, 35% (N= 11) were related to patient handling activities (lifting, transferring, repositioning), and 65% (N= 20) were due to all other causes (MSI -Other). The causes of these incidents were as follows:

For MSI Other- 7 involved the pushing, pulling, or lifting of equipment, 2 were ergonomic related, 2 were musculoskeletal injuries related to patient action. 35% of MSI-Other incidents occurred in Environmental Services (7 incidents).

For MSI- Patient Handling- 45% of these MSIs occurred during repositioning, 36% during transfers, and 18% during patient lifting. The highest incidence of MSIs due to patient handling occurred in the Cardiac and Critical Care Programs.

Actions & Monitoring Underway to Improve Performance:

The new unit/dept monthly management health & safety inspections will provide the opportunity for leaders to identify MSI hazards and address/resolve issues. As well, conducting root causes analysis as part of the incident investigation process will assist ensure y reduction. OHSW continues to follow up with managers where there are MSI events to ensure underlying cause(s) and appropriate corrective measures are being taken

Definition: MSI rate is a measure of health & safety performance and linked to Ministry of Labour (MOL) involvement and Workplace Safety & Insurance Board (WSIB) costs. The MSI measure is divided into 1-MSI's related to patient handling and 2- MSI's other. MSI's are tracked monthly. Based on the premise that workplace injuries are preventable, they are unacceptable and our long term goal should be "zero" MSIs. MSIs are the type of injury that most often result in delayed recovery & permanent limitations.

Target: Baseline Fiscal 08/09: 150, Target 09/10: 100, Target 10/11: 100, Target 11/12: 90

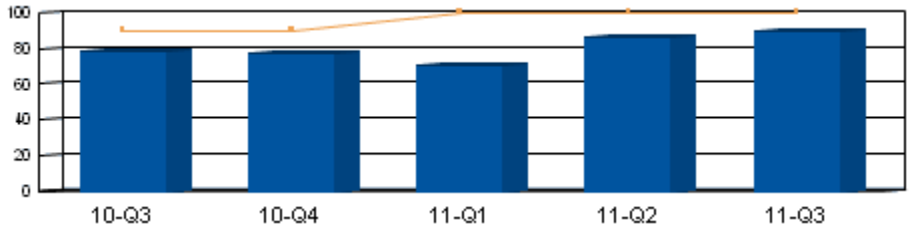
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Percent Completion of Incident Investigations



	Actual	Target
10-Q3	78	90
10-Q4	77	90
11-Q1	70	100
11-Q2	86	100
11-Q3	90	100

Interpretation - Patient And Business:

Continued improvement in completion rate with highest completion rate to date. OHSW process includes automatic reminders & instructions at day 4 if investigation incomplete.

Actions & Monitoring Underway to Improve Performance:

OHSW working with managers to ensure investigations identify root causes and that appropriate corrective actions are being implemented. 73 leaders trained to date (Nov & Dec) in Incident Investigation requirements/Root Cause Analysis; additional training sessions being planned for Feb 2002 for leaders who have not yet attended.

Definition: Investigating workplace incidents ensures due diligence in terms of identifying and resolving hazards that contribute to injuries. This is a legislative requirement under the Occupational Health & Safety Act (OH&S Act) and demonstrates our commitment as an organization in managing hazards and creating a work environment that is safe for staff and patients. Collecting & analyzing the underlying causes and putting in place correction actions/improvements is a key strategy in the elimination of all preventable harm. Calculation is based on the percentage of investigations completed as compared to those that were required. The goal for 2011 is for 100% of employee/affiliate general safety events submitted in Safe Reporting to be investigated by managers/supervisors.

Target: Baseline Fiscal 08/09: Between 20-30% of investigations are completed,Target Fiscal 09/10: 90% completion, Target Fiscal 10/11: 90% completion, Target 11/12: 100% completion

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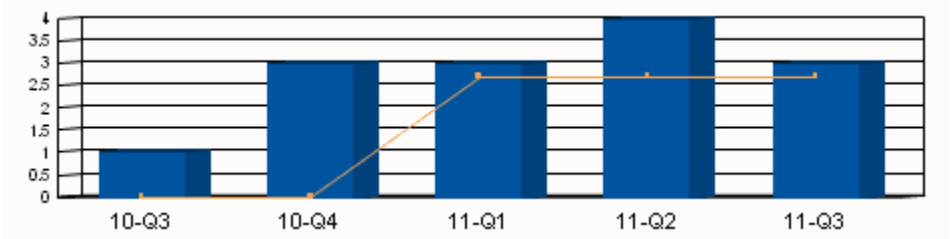
Indicator: Reduction in Lost Time Injury Claims due to Musculoskeletal Injuries



	Actual	Target
10-Q3	1	0
10-Q4	3	0
11-Q1	3	2.7
11-Q2	4	2.7
11-Q3	3	2.7

Interpretation - Patient And Business:

Despite a relatively high overall incidence of MSIs this quarter (N=31), we were able to limit our LTI's due to MSI to 3 and are closely approaching our target. Two (2) of these were patient handling related. A total of 10 days were lost related to these 3 claims.

Actions & Monitoring Underway to Improve Performance:

2 focus groups (clinical and non-clinical) have been formed to review strategies by which we can improve our existing MSI prevention program, ensure compliance, and reduce MSIs. The plan is for a MSI Phase 2 program to be rolled out in the spring/early summer based with input from these focus groups. A business case for conversion to disposable transfer board sleeves will be developed in Q4.

Definition: Musculoskeletal Injuries (MSIs), as a main cause of lost time injuries, result in the highest workplace injury costs. MSIs often result in dealyed recovery, long periods of modified/alternate work, permanent accommodation, or an inability to return to employement at the hosptial. Redcution in MSI's that result in lost time will reduce the hosptial's injury costs and avoid the negative repercussions to the employee & their unit/dept that are associated with a reduced ability to function in the workplace.

Target: Target 11/12: 10.8

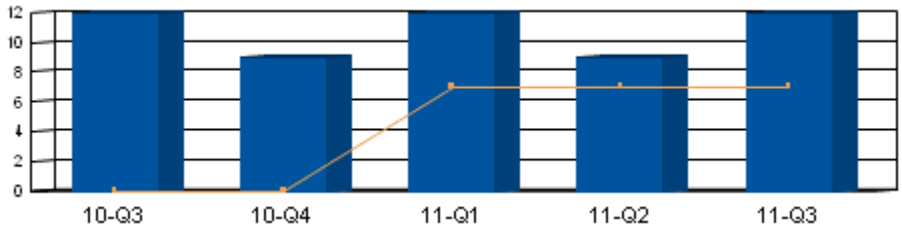
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Reduction in Needle Stick Injuries



	Actual	Target
10-Q3	12	**0**
10-Q4	9	**0**
11-Q1	12	**7**
11-Q2	9	**7**
11-Q3	12	**7**

Interpretation - Patient And Business:

Of the 12 NSIs that occurred in Q3, 8 occurred in Nursing, 1 in Autopsy, 2 in Environmental Services Assistants, and 1 in a Resident. One third of NSIs occurred in the Medicine Program. The devices involved were as follows:

Non-safety blood gas needle (1), suture needle (3), insulin safety needle (2), safety butterfly (1) used for venipuncture, safety hypodermic needles (2), unknown (2) and vacationer (1).

Improper activation of safety needles and unsafe disposal continue to be common contributing factors.

Actions & Monitoring Underway to Improve Performance:

Needle Safety Awareness training will be developed and rolled out through the LMS to all clinical staff using needles. Business cases for conversion to a safer butterfly device (push button) that is easier to activate, and to a different IV catheter (Nexiva) that eliminates the potential for exposure to blood, are in development.

Definition: Needlestick injuries are one of the indicators used to measure the success of KGH's sharps management program. The incidence is also used by the Ministry of Labour to determine whether the hospital is putting in place adequate controls to protect workers from the risk of blood-borne pathogens. Each year thousands of health care workers sustain needlestick injuries in Canada; each one of these injuries carries the risk of exposure to serious and even potentially fatal infections with bloodborne pathogens such as HBV, HCV or HIV. Analysis of needlestick injruy data, investigation of all needlestick injuries, and implementation of corrective measures/improvements will result in safer use of medical sharps and a reduced risk of serious occupational disease claims.

Target: Target 11/12: 26

Strategy milestone # 17

100% of our staff complete mandatory online training

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
People	**Staff are engaged in all aspects of our quality, safety and service improvement initiatives**	**Enhance our leadership and learning programs**

Indicator(s)	Status
Percent of Staff that Complete Mandatory Online Training Programs	**Yellow**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The performance continues to improve at over 91%, at the same time that new staff are hired and are required to complete the training and others are required to renew.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Follow-up with managers and notification during orientation of requirement to complete.

3. **Are we on track to meet the milestone by year end?** It is unlikely to hit 100% in each category due to the continued recruitment of external staff and timing for completion of the training within the first month of start.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   Upgrade and roll-out of licenses in December 2011 for all staff to utilize the Learning Management System (LMS). The system generates reminders to staff and eliminates the manual tracking of training. Working group established to assess the designation of mandatory training and create a sustainment plan. Medical residents notification that privileges will be removed for non-compliance of mandatory training.

Kingston General Hospital

Milestone #17

				10-Q4	11-Q1	11-Q2	11-Q3	
E1 People	100% of our staff complete mandatory online training		Percent of Staff that Complete Mandatory Online Training Programs	N/A	R	Y	Y	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

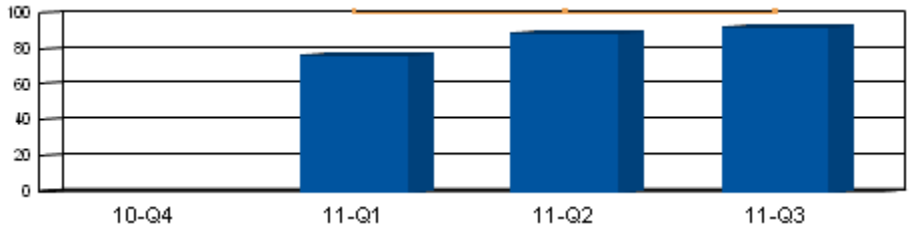
Kingston General Hospital

Milestone #17

E1 People

100% of our staff complete mandatory online training

Indicator: Percent of Staff that Complete Mandatory Online Training Programs



	Actual	Target
10-Q4		
11-Q1	76	**100**
11-Q2	88.4	**100**
11-Q3	91.5	**100**

Definition: Currently, mandatory training includes Incident Reporting, Accessibility, WHIMS and Musculoskeletal Injury reporting. The Learning Management System (LMS) is being upgraded and enhanced to allow all staff access to mandatory training on-line. Functionality is such that managers can obtain timely reports on the status of compliance for each employee. This will increase the opportunities for following up and ensuring supports are put in place to permit employees to complete required training. Further training I enhancements will be put into place (e.g., on-line General Orientation, on-line On Boarding modules, tracking of refresher requirements) to ensure on-going mandatory training and re-training occurs at times convenient to the employee.

Target: Target 11/12: 100%

Strategy milestone # 18

100% of our KGH managers complete mandatory process improvement training

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Processes	**Continuous improvement environment created with consistent use of LEAN principles**	**Increase LEAN process adoption**

Indicator(s)	Status
Percent of Management Staff that Complete Mandatory Process Improvement Training	**N/A**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The Board agreed with the recommendation to move this milestone achievement to Fiscal 2013, due to a number of other priorities and capacity of the management. However, it is worth noting that a pilot project for process improvement training has been designed and will be implemented and evaluated in Q4 in anticipation of the planned wider rollout for fiscal 12/13.

Kingston General Hospital

Milestone #18

				11-Q1	11-Q2	11-Q3
E2 Processes	100% of KGH managers complete mandatory process		Percent of Management Staff Completing Mandatory Process Improvement Training	Y	R	N/A

Indicates worsening performance to target over the past 5 quarters

Indicates improving performance to target over the past 5 quarters

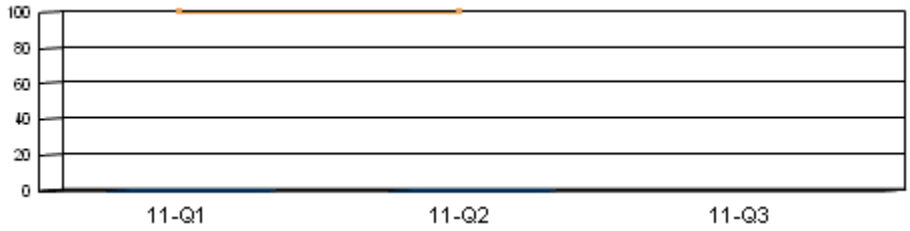
Kingston General Hospital

Milestone #18

E2 Processes

100% of KGH managers complete mandatory process improvment training

Indicator: Percent of Management Staff Completing Mandatory Process Improvement Training



	Actual	Target
11-Q1	0	**100**
11-Q2	0	**100**
11-Q3		

Definition: Introduction of lean principles to the KGH Leadership Group will enable a focus on long-term sustainability with a comprehensive approach to change. It will drive operational efficiency and cultural change at the same time. It provides tools for the managers to use and a consistent approach on how we expect the organization to be run. The measurement will be a percentage of our KGH Leadership Group (non-physician) who attends the training.

Target: Target 11/12: 100 %

Strategy milestone # 19

96% of our Phase 1 redevelopment is complete on time, on budget and new retail and nutrition facilities are in place

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Facilities	**Phase 1 redevelopment is complete, Phase 2 construction is underway and KGH has sufficient parking**	**Complete Phase 1 redevelopment and establish new retail and food service facilities**

Indicator(s)	Status
Redevelopment (Space for New Clinical, Retail, Nutrition Facilities)	**Green**
Phase 1 Redevelopment is Completed on Time and on Budget	**Green**
Phase 2 Redevelopment Planning Started	**Green**

1. What is our actual performance on each of the indicators for this milestone as listed above?

Redevelopment of facilities is on schedule and new retail, nutrition and lobby renovations will be completed in Q4. Phase 1 redevelopment is 99 percent complete as at December 31, 2011 and is ahead of schedule and on budget. Substantial Completion achieved December 22, 2011. Phase 2, Capital Branch and KGH agreed in Q3 to begin preparation of Step 1 Documentation for this project.

2. What are the contributing factors to the current performance of the indicators for this milestone?

Although Ministry approvals delayed the facility projects, staff and contractors efforts have been still able to meet our goal of completing these renovations prior to March 31, 2012. Phase 1 completion is on time and budget and this is the result of many staff, contractors, JPO, and consultant efforts. Over a thousand system shutdowns were managed by staff, many moves, and disruptions (floods etc.) were managed professionally and with ongoing cooperation by all engaged. In a few months the project will be completed and a final report produced. For Phase 2, Consultants to complete Step 1, were selected by RFP in Q3 and commenced work on planning in January 2012.

3. Are we on track to meet the milestone by year end?

Yes all three indicators are on track to support this milestone.

4. What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?

All projects will continue to be monitored by JPO, EMC, Resources Committee (Redevelopment Committee), and the Board.

Kingston General Hospital

Milestone #19

				10-Q4	11-Q1	11-Q2	11-Q3	
E3 Facilities	96% of our Phase 1 redevelopment is complete on time, on budget, and new retail and nutrition facilities are in place		Phase 1 Redevelopment is Completed on Time and On Budget	N/A	G	G	G	↑
			Phase 2 Redevelopment Planning Started	N/A	G	Y	G	↑
			Redevelopment (Space for new Clinical, Retail, Nutrition Facilities)	N/A	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

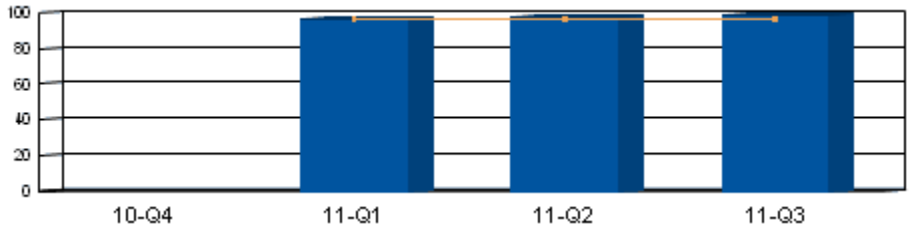
Kingston General Hospital

Milestone #19

E3 Facilities

96% of our Phase 1 redevelopment is complete on time, on budget, and new retail and nutrition facilities are in place

Indicator: Phase 1 Redevelopment is Completed on Time and On Budget



	Actual	Target
10-Q4		
11-Q1	96	96
11-Q2	97	96
11-Q3	99	96

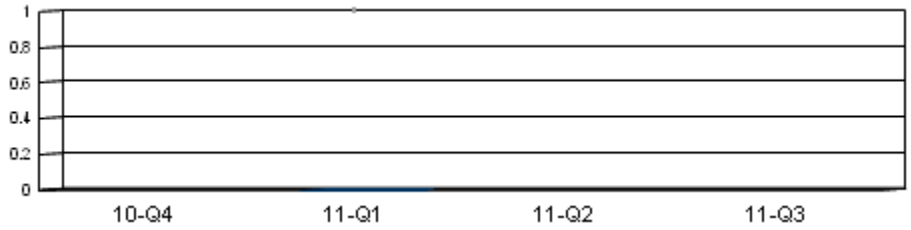
Interpretation - Patient And Business:

99.2% complete by dollar value. On time and on budget. Substantial Complete was achieved 2011 December 22.

Definition: Project completed by 2012 March within the budget of $196M.

Target: Target 11/12: 96%

Indicator: Phase 2 Redevelopment Planning Started



	Actual	Target
10-Q4		
11-Q1	0	1
11-Q2		
11-Q3		

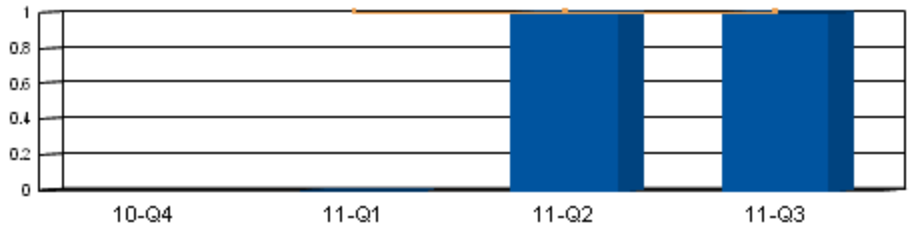
Interpretation - Patient And Business:

Programming Consultants have been hired. Stakeholder consultations for stage 1 submission is underway.

Definition: MOHLTC responded to precapital submission for Phase 2 Redevelopment and granted approval for preparation of Stage 1 proposal.

Target: Target 11/12: Yes

Indicator: Redevelopment (Space for new Clinical, Retail, Nutrition Facilities)



	Actual	Target
10-Q4		
11-Q1	0	1
11-Q2	1	1
11-Q3	1	1

Interpretation - Patient And Business:

Nutrition Services Pantries and Lobby Renovations are 80% complete; on time and on budget.

Definition: Phase I Redevelopment remains on schedule with substantial completion was achieved on 2011 December 22. Retail project has received approval from MoHLTC and construction has begun.

Target: Target 11/12: Yes

Strategy milestone # 20

Our new solar farm is established and 50% of carpets are removed from inpatient areas

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Facilities	**KGH is clean, green and carpet-free**	**'Green' KGH by conserving energy and removing carpets from inpatient areas**

Indicator(s)	Status
Percent of Square Footage of Carpet Removal Complete	**Green**
Solar Farm Established	**N/A**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The carpet project schedule was refined at Q2 to reflect the contracted time lines and plans completed for the project. 40% of the project to be completed by March 31, 2012. We are on target for this goal.
   The Solar project remains on hold and we are still awaiting the approval for our application to Ontario Power Authority. In late October a review of rates of solar energy reimbursement was announced by the Province and this information is still outstanding.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The carpet project is moving on schedule. Project management is key and clinical and Planning department leadership have been supportive as well as ongoing assistance from support areas to meet deadlines. Solar on hold as noted above.

3. **Are we on track to meet the milestone by year end?.**
   Yes the Carpet Project is on Schedule.
   Solar Project status for Year end is still unknown.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Both projects are continuing to be monitored by Facilities and JPO as well as the Operations Committee.

Kingston General Hospital

Milestone #20

				10-Q4	11-Q1	11-Q2	11-Q3	
E3 Facilities	Our new solar farm is established and 50% of carpets are removed from inpatient areas		Percent of Square Footage of Carpet Removal Complete	N/A	G	G	G	↑
			Solar Farm Established		Y	R	R	

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

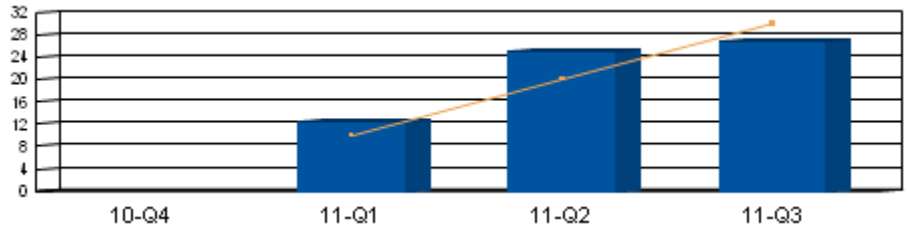
Kingston General Hospital

Milestone #20

E3 Facilities

Our new solar farm is established and 50% of carpets are removed from inpatient areas

Indicator: Percent of Square Footage of Carpet Removal Complete



	Actual	Target
10-Q4		
11-Q1	12.6	**10**
11-Q2	25	**20**
11-Q3	27	**30**

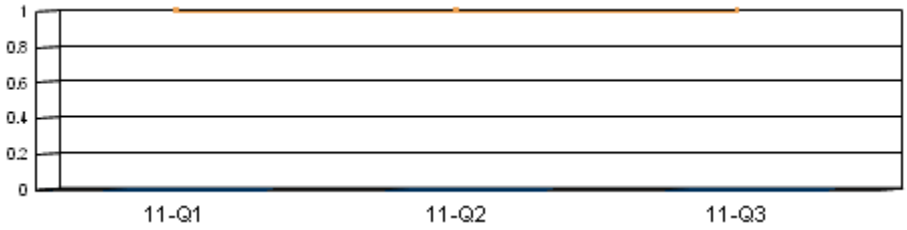
Interpretation - Patient And Business:

Entire project 27% complete at end of Q3. Phase 1A is complete; Phase 1B progressing well (Kidd 7 now complete) C3 and D4 have been added to this phase. Entire project will be 40% complete in Q4 and is scheduled for completion in Q3 2014.

Definition: Phase 1 A equals 14% Phase 1 B equals 37% and Phase 2 equals 49% of total $7M project.

Target: Target 11/12: 40%

Indicator: Solar Farm Established



	Actual	Target
11-Q1	0	**1**
11-Q2	0	**1**
11-Q3	0	**1**

Definition: A 110 kW solar farm is proposed for the roof of Burr Wing. 468 solar panels will be connected to the City of Kingston utility grid and will generate guaranteed revenue of $86,841 for 20 years through a contract with the Ontario Power Authority. Before installing the solar panels, the application must be approved by the Ontario Power Authority. Current processing times are estimated at 7 months. The KGH application is not expected to be approved until fall 2011 following which detailed engineering and installation to be complete by the end of 2012. Measurement of completion of this outcome will be based on the % completion of the project.

Target: Target 11/12: Yes

Strategy milestone # 21

50% of our automated medication dispensing system is in place

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Technology	**Rapid transmission of information improves care and operational efficiency**	**Enable automated medication dispensing**

Indicator(s)	Status
Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital	**N/A**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   As reported in Quarter 2 our original goal was to have 50% of the medication carts in operation by March 31, 2012. This plan timeline is no longer reasonable and will be adjusted given longer procurement timelines. Product selection is expected in Q4 and implementation will now begin in fiscal 2012/13 and is expected to take us into 2013/14. Actual delivery and live dates will be confirmed in the contract negotiations.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The major contributor to this result has been our under estimation of the time required for the new procurement guidelines to be followed; the capacity of 3SO to manage the remaining on boarding hospitals; as well as our increased demand from hospitals for procurement services to support new initiatives.

3. **Are we on track to meet the milestone by year end?**
   No (see above)

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Given the above realities the KGH Selection Committee for the Medication Carts is working with 3SO to advance the procurement process and senior leadership of both organizations have been engaged to support. We remain committed to meeting this milestone over the next two years.

Kingston General Hospital

Milestone #21

				11-Q1	11-Q2	11-Q3
E4 Technology	50% of our automated medication		Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital	G	R	N/A

Indicates worsening performance to target over the past 5 quarters

Indicates improving performance to target over the past 5 quarters

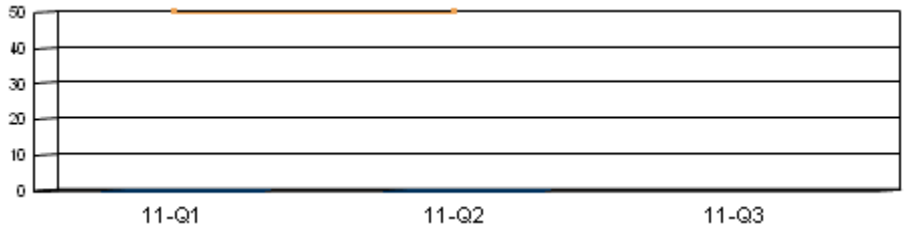
Kingston General Hospital

Milestone #21

E4 Technology

50% of our automated medication dispensing system is in place

Indicator: Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital



	Actual	Target
11-Q1	0	**50**
11-Q2	0	**50**
11-Q3		

Interpretation - Patient And Business:

Preferred vendor has been selected. Contract negotiations to commence with this vendor coordinated by 3SO involving Finance, IM and Pharmacy

Definition: Automated dispensing cabinets improve patient safety, workflow efficiency, cost analysis and offer secure storage of medications. Indicator is % of locations stocked with medications with cabinets installed.

Target: Target 11/12: 50%

Strategy milestone # 22

Our lab order and DI management system is in place

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Technology	**Rapid transmission of information improves care and operational efficiency**	**Introduce lab and diagnostic imaging order management systems**
Indicator(s)		**Status**
Implementation of an Order Management System for Labs on All Inpatient Areas		**Red**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   In Q3 a project manager was put in place and the finalized project plan was reviewed in early January 2012. Implementation is expected to be completed by June 30, 2012.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The largest challenge was finding a project manager. This factor and the competing demands on clinical leadership with other projects and facility renewal have contributed to the three month extended time line.

3. **Are we on track to meet the milestone by year end?**
   No, and we have now agreed to the revised time line as at the end of June. EMC has accepted the limitations that resources and capacity provide in making the original date unattainable.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Detailed plans are being reviewed to ensure resources required and impacted clinical staff are engaged early in the process. Regular follow up and monitoring is in place to warn of any barriers or delays in completing the project.

Kingston General Hospital

Milestone #22

				11-Q1	11-Q2	11-Q3
E4 Technology	Our lab and diagnostic imaging order management		Implementation of an Order Management System for Labs on All Inpatient Areas (% completion).	G	R	R

Indicates worsening performance to target over the past 5 quarters

Indicates improving performance to target over the past 5 quarters

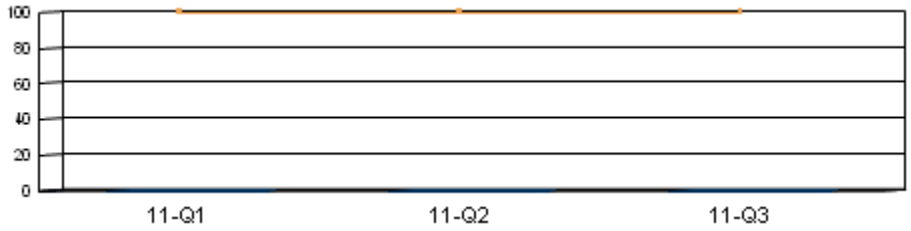
Kingston General Hospital

Milestone #22

E4 Technology

Our lab and diagnostic imaging order managment systems are in place

Indicator: Implementation of an Order Management System for Labs on All Inpatient Areas (% completion).



	Actual	Target
11-Q1	0	**100**
11-Q2	0	**100**
11-Q3	0	**100**

Definition: The goal of the electronic order entry project is to reduce patient risk involved with specimen collection and assist us in meeting Ontario Lab Accreditation standards. The project will introduce efficiencies in clerical time by reducing data entry in the diagnostic areas, while improving our capacity to deliver result more quickly to clinical staff. Existing technologies are being leveraged in order to achieve our goal.

The indicator we will be calculating to measure our success in transitioning to the new system is the percentage of tests that are ordered electronically on the unit over the total number of tests ordered.

Target: Target 11/12: 100%

Strategy milestone # 23

Timely e-discharge summaries are completed for every patient

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Technology	**Rapid transmission of information improves care and operational efficiency**	**Implement electronic discharge for every patient**

Indicator(s)	Status
Percent of Discharge Communication Sent to Continuing Care Provider Within 72hrs of Patient Discharge	**Red**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Results at the end of Q3 indicate we have improved only slightly from Q2. We are now at 36% compared to our target for March 31, 2012 of 80%.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The performance on this indicator is aligned with our chart deficiencies experience and adoption of e-discharge tools. More deficiencies the less likelihood of improving our performance on this indicator and without the e-discharge tool use it is difficult for discharge communications to be completed in 72 hours.

3. **Are we on track to meet the milestone by year end?**
   Efforts continue to improve these results and we hope to see significant improvement before year end, but we expect to still need to focus on this initiative into 2012/13 to meet our 80 percent goal.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   We continue to increase efforts to encourage adoption and use of the e-discharge tools (education and training). In addition, we continue to enforce chart completion to reduce the number of deficiencies. Improvement is being seen as deficiencies have dropped significantly, but this improvement still leaves the bulk of the discharge communications slightly longer than our 72 hour goal. 46% of discharge communications are happening between 72 and 120 hours.

Kingston General Hospital

Milestone #23

				10-Q4	11-Q1	11-Q2	11-Q3	
E4 Technology	Timely E-Discharge summaries are completed for every		Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge	N/A	R	R	R	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

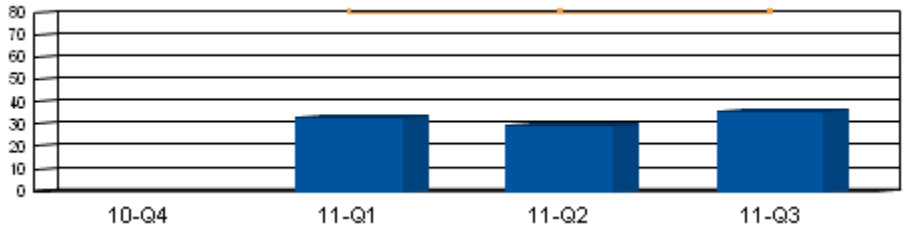
Kingston General Hospital

Milestone #23

E4 Technology

Timely E-Discharge summaries are completed for every patient

Indicator: Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge



	Actual	Target
10-Q4		
11-Q1	33	**80**
11-Q2	29	**80**
11-Q3	36	**80**

Interpretation - Patient And Business:

While there has been significant improvement in the overall number of chart deficiencies, only 36% were completed and signed within the 72 hour target. This does not represent a material change from the previous quarter. Health Information Services continues monitoring of compliance along Medical Administration to apply sanctions to those physicians who are not compliant with hospital policy.

Actions & Monitoring Underway to Improve Performance:

A detailed analysis of our Q3 performance indicates that 90% of all discharge summaries were complete at discharge, but only 36% were signed and therefore available for distribution to primary care.

Health Information Services working with the Patient Records Committee is reviewing practice at other academic hospitals to consider amending our policy requiring signature for distribution.

Definition: The percentage is based on the total number of discharges for the quarter versus the number of discharge summaries available for distribution to the Family Physicians within 72 hours from discharge. NB. Normal newborn and deliveries do not require discharge summaries so these numbers have been excluded from the calculation.

Target: QIP Target 11/12: 80%

Strategy milestone # 24

Our operating deficit is eliminated and our capital spend reaches $12 million

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Finances	**Our operating budget is balanced and we are able to allocate $20 million a year to capital expenditures**	**Eliminate our operating deficit and build our capital investment capacity**

Indicator(s)	Status
Total Dollars for Capital Equipment	**Yellow**
Total Margin	**Green**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**

   As at December 31, 2011 we have allocated $11.4 million towards capital equipment from the hospitals internal budgets. Additional funds have also been secured from Foundations and the Ministry of Health and Long Term Care. Total margin at December 31, 2011 is 6% positive and reflects the impact of: operational improvements, one time revenues for prior year taxes and capital planning costs recovered, as well as new program funding allocations. Reports on these results can be found in the financial statements of the hospital.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**

   Capital allocations are overseen by the Hospital's Capital Committee and improvements in the allocation have been the result of ongoing efforts by leadership and staff to meet benchmarks (efficiencies) and to move savings from operating to capital allocations. Ongoing management of resources similarly has supported the operational results. Efforts of leadership specifically assisted in recovery of $4.9 million for past planning costs from the Ministry of Health and Long Term Care, Post Construction Operating Planning Funding, and $2 million as rebates in sales taxes.

3. **Are we on track to meet the milestone by year end?**

   It is unknown at this time as to whether the Capital Allocation will grow any further before March 31, 2012. It is being monitored. Yes – we expect our margin to remain positive for fiscal 2012.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   Ongoing review and oversight by leadership at all levels in respect of capital and operating budgets is expected to support the continuation of the current results for the year.

Kingston General Hospital

Milestone #24

			10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
E5 Finances	Our operating deficit is eliminated and our capital spend reaches $12 million	Current Ratio	G	G	G	G	G	↑
		Hospital Operations Actual vs Plan Variance ($000's)	G	G	G	G	G	↑
		Total Dollars for Capital Equipment ($000's)		Y	Y	Y	Y	↑
		Total Margin	G	G	G	G	G	↑
		Working Capital ($000's)	G	G	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

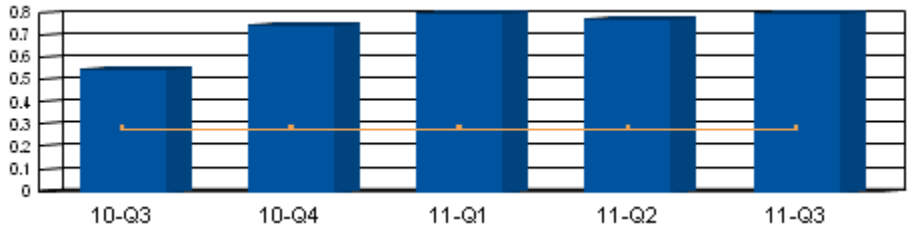
Kingston General Hospital

Milestone #24

E5 Finances

Our operating deficit is eliminated and our capital spend reaches $12 million

Indicator: Current Ratio



	Actual	Target
10-Q3	0.55	**0.28**
10-Q4	0.74	**0.28**
11-Q1	0.80	**0.28**
11-Q2	0.77	**0.28**
11-Q3	0.80	**0.28**

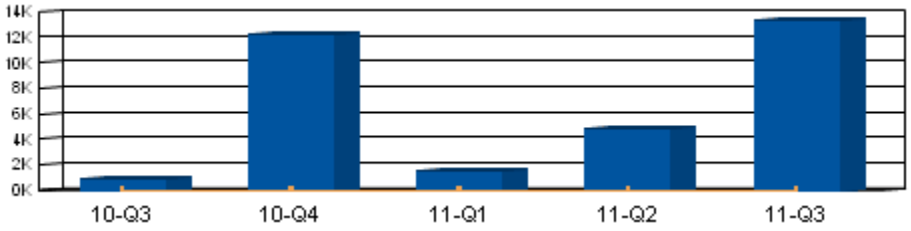
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: This is a measure of liquidity indicating the facility's ability to meet short-term obligations. It is calculated by dividing Current Assets by Current Liabilities and comparing to 1. A measure of less than 1.0 means that the hospital is at risk of not being able to meet its current commitments and has limited opportunity to invest in the future (for further information see Working Capital Template).

Target: Baseline 08/09: 0.54, Target 09/10: 0.46, Target 10/11: 0.28, Target 11/12 0.28

Indicator: Hospital Operations Actual vs Plan Variance ($000's)



	Actual	Target
10-Q3	868	**0**
10-Q4	12265	**0**
11-Q1	1528	**0**
11-Q2	4875	**0**
11-Q3	13359	**0**

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: The Hospital operations variance is a comparison of the operating fund surplus or deficit versus planned. It is calculated by subtracting net actual operating expenses [excludes net facility capital] compared to plan. It measures the degree to which the hospital is able to plan, monitor, and live within its financial resources.

Target: Baseline 08/09: 9892, Target 09/10: 0, Target 10/11: 0, Target 11/12: 0

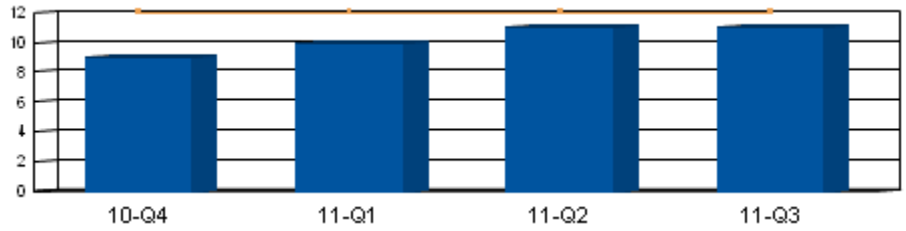
Kingston General Hospital

Milestone #24

E5 Finances

Our operating deficit is eliminated and our capital spend reaches $12 million

Indicator: Total Dollars for Capital Equipment ($000's)



	Actual	Target
10-Q4	9	12
11-Q1	10	12
11-Q2	11	12
11-Q3	11	12

Interpretation - Patient And Business:

The total dollars available for capital investment will support the replacement of clinical, non-clinical and information management technology.

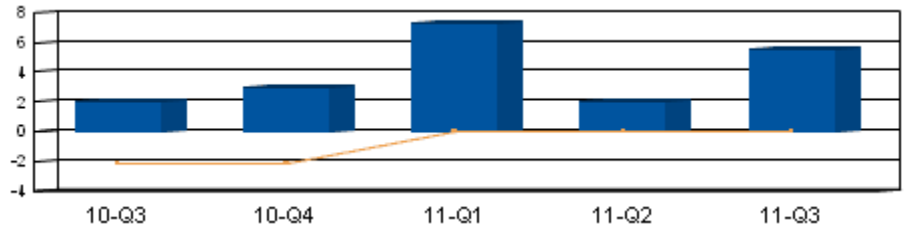
Actions & Monitoring Underway to Improve Performance:

The hospital currently has the capacity to provide $11.4M in capital investment in fiscal 2012. The organization is continuing to implement the identified operational efficiency initiatives. Additional savings resulting from these activities will be directed towards reaching the $12M target.

Definition: Total amount available for capital investment. Calculated as net equipment amortization less long-term loan payments.

Target: Target 11/12: 12M

Indicator: Total Margin



	Actual	Target
10-Q3	2.08	-2.17
10-Q4	2.95	-2.17
11-Q1	7.32	0.00
11-Q2	2.01	0.00
11-Q3	5.59	0.00

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Operating margin "measures total operating revenues in excess of total expenses". It is a measurement of management's efficiency and the hospital's ability to live within available financial resources. Calculated as: Operating Surplus/(Deficit) divided by Operating Revenue. To ensure consistency in calculation between hospitals, the Province has provided a specific definition based on the Hospitals MIS Chart of Accounts. It is inclusive of all fund types (fund 1, 2, and 3), but excludes facility amortization).

Target: Baseline 08/09: (3.9%), Target 09/10: (4.0), Target 10/11: (2.17), Target 11/12: 0

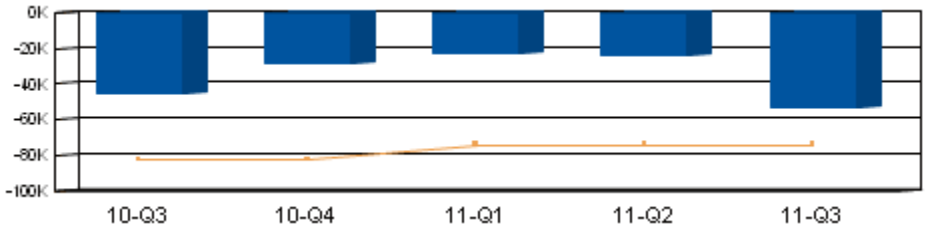
Kingston General Hospital

Milestone #24

E5 Finances

Our operating deficit is eliminated and our capital spend reaches $12 million

Indicator: Working Capital ($000's)



	Actual	Target
10-Q3	-45150	**-82352**
10-Q4	-28451	**-82352**
11-Q1	-22214	**-74000**
11-Q2	-23560	**-74000**
11-Q3	-53191	**-74000**

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Working Capital (WC) is the net result of Current Assets (CA) less Current Liabilities (CL). A positive position (CA>CL) indicates funds exist in excess of current obligations, and a negative position (CL<CA) indicates an inability to meet current obligations with current resources. KGH is currently in a negative working capital position and reliant on support from the SE LHIN to ensure ample cash flow to meet current obligations.

Target: Baseline 08/09: (50413), Target 09/10: (76369), Target 10/11: (82000), Target 11/12: (74000)

Strategy milestone # 25

Patient, staff and stakeholder engagement takes place through improved website and social media tools

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Communication	**We continue to engage and report openly and regularly on our progress**	**Improve engagement using modern communication and collaboration tools**

Indicator(s)	Status
Implementation of Improved Website and Social Media Tools	**Green**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   - KGHConnect.ca, was launched in November, 2011. More than 1,500 people on our stakeholder mailing list received an eBlast to introduce our new social media website and to encourage them to sign up.
   - The first KGH Connect community event hosted by the PFAC was held at St. Lawrence College on November 10.
   - Communications strategy and website development for proactive disclosure of executive compensation and FOI legislation compliance was successfully implemented.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   We are working collaboratively with IM to ensure new social media platforms are supported as we continue to broaden our public outreach.

3. **Are we on track to meet the milestone by year end?**
   Yes. Our goal is find ing ways in which social media platforms can be used for on-going engagement and interaction with all KGH stakeholders.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   By year-end we will have completed a user needs assessment study of internet/intranet use. This will help IM (technology) and Public Affairs (communications, branding) to develop a joint three-year web strategy to ensure web-based communication meet organizational and stakeholder needs. We are finding ways to engage our internal and external stakeholders through modern communication and collaboration tools.

Kingston General Hospital

Milestone #25

				11-Q1	11-Q2	11-Q3	
E6 Communication	Patient, staff, and stakeholder engagement takes		Implementation of Improved Website and Social Media Tools	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

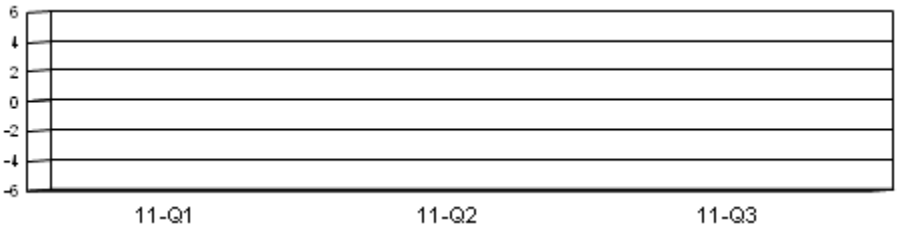
Kingston General Hospital

Milestone #25

E6 Communication

Patient, staff, and stakeholder engagement takes place through improved website and social media tools

Indicator: Implementation of Improved Website and Social Media Tools



	Actual	Target
11-Q1		
11-Q2		
11-Q3		

Interpretation - Patient And Business:

KGH Connect, a new social media-based website designed to enhance community engagement, was launched in November. The first live community event under the KGH Connect brand, called, Patients Know Best, hosted by the PFAC took place in November 2011.

Actions & Monitoring Underway to Improve Performance:

A plan to develop a web strategy to improve the Internet and Intranet in partnership with IM was finalized. Web user focus groups to provide input have been selected and sessions have been scheduled to take place in Q4.

Definition: Purpose:
KGH will continue to engage and report openly and regularly on our progress: KGH is dedicated to building on the momentum of stakeholder engagement that helped shape KGH 2015. We are committed to communicating with internal and external stakeholders on our progress in ways that exemplify our guiding principles of respect, transparency, engagement, accountability and value for money.

Importance:
We will continue to engage our stakeholders through enhanced communication tools and techniques that will strengthen the KGH brand, instill public confidence in the organization, and help to achieve its aim, outstanding care, always.

Calculation:

- Staff and public engagement metrics
- Brand awareness metrics

Target: Target 11/12: Yes

Kingston General Hospital

Performance Report (KPI)
Q3 F2011 - 2012

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	Overall patient satisfaction is at or better than the provincial teaching hospital average		Overall Acute Care Patient Satisfaction (%)	G	G	N/A	N/A	N/A	
			Overall Emergency Care Patient Satisfaction (%)	G	G	N/A	N/A	N/A	
			Percent of Patients who Answer "Definitely Yes" to the NRC Picker Question " Would you recommend this Hospital to Your Friends and	Y	R	N/A	N/A	N/A	
	70% of our people who are surveyed rate us as excellent		Hospital Standardized Mortality Ratio (HSMR)	G	G	N/A	N/A	N/A	
	The number of new cases who acquire infections in our hospital is reduced by 10%		C-difficile	R	R	R	R	R	↓
			Central Line Bloodstream Infections	G	G	G	R	G	↑
			MRSA (Methicillin-resistant Staphylococcus aureus)	R	Y	Y	Y	G	↑
			Number of New Cases of Hospital Acquired Infection	R	R	G	Y	Y	↑
			Surgical Site Infection (SSI) Prevention	Y	Y	Y	Y	Y	↑
			Ventilator Associated Pneumonia	G	G	G	G	G	↓
			VRE (Vancomycin-resistant Enterococcus)	Y	G	Y	Y	G	↓
	We achieve 100% hand hygiene compliance across all units and staff		Hand Hygiene Compliance	Y	G	Y	Y	G	↑
	100% of our clinical services discharge patients at their expected LOS		Average # ALC Patients per Day	G	G	R	R	G	↑
			Overall - Acute Average Length of Stay Days (Based on HSAA)	Y	Y	Y	G	N/A	↑

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	100% of our clinical services discharge patients at their expected LOS		Overall - Acute Average Length of Stay vs. ELOS (Variance)	G	G	G	G	N/A	↑
			Percent ALC Days	R	R	Y	Y	N/A	↑
			Percent of Clinical Services Meeting ELOS Target	R	R	R	R	N/A	↑
			Readmission rate Within 30 Days for Selected CMG's	R	R	N/A	N/A	N/A	
	90% of patients receive their elective surgery within or faster than the provincially targeted wait time		All Cancer Surgery Wait time - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
			All Paediatric Surgery - 90th Percentile Wait Time (Days)	R	R	R	R	R	↓
			Cardiac Bypass Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
			Coronary Angiography - 90th Percentile Wait Time (Days)	G	G	G	G	N/A	↓
			Coronary Angioplasty - 90th Percentile Wait Time (hrs)	G	G	G	G	G	↑
			Diagnostic Imaging - CT – 90th Percentile Wait time (Days)	G	G	G	G	G	↑
			Diagnostic Imaging- MRI – 90th Percentile Wait time (Days)	R	R	R	R	R	↓
			General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)	G	G	G	G	R	↓
			Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)	R	G	G	G	G	↑
			Orthopedic Surgery (excluding total hip and knee replacements) - 90th Percentile Wait Time (Days)	R	R	R	R	R	↑
			Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	N/A	R	R	R	R	↑
			Radiation Wait time (Referral-Consult) Percent seen within 14 days	G	G	G	R	N/A	↓

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	The ED wait time for admitted patients is less than 8 hrs for 100% of patients		90th Percentile ED Wait Time (All Admitted Patients)	R	R	G	G	G	↑
			Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th percentile wait time (hrs)	R	R	R	R	R	↓
			Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)	R	R	R	R	R	↑
			Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)	Y	R	G	G	G	↑
			Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs	Y	R	R	R	R	↓
			Percent of Patients Admitted (from the Emergency Department) within a wait time target of <8 hrs	Y	Y	G	Y	G	↑
SD3 Cultivate patient oriented research	Externally funded research at KGH has increased by 10% and our clinician scientist program expands		Active Clinical Trials	G	G	G	G	G	↑
			Clinical Trials Generating Revenue	Y	G	G	G	G	↑
			New Clinical Trials	G	G	G	R	R	↑
			Percent Increase of Externally Funded Research Dollars at KGH	N/A	N/A	N/A	G	G	
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met		Stem Cell Transplants	Y	G	G	G	G	↑
			Ambulatory Care Volumes	G	G	G	G	G	↑
			Cardiac - Angiography Volumes	G	G	G	G	G	↑
			Cardiac - Angioplasty Volumes	G	G	G	G	G	↑
			Cardiac - Bypass Volumes	G	G	G	G	G	↓
			Chronic Kidney Disease Program- Weighted Units	G	G	G	G	Y	↓

			10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met	CT Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑
		Emergency Department Admitted Patient Volumes – All Levels of Acuity	G	G	G	G	G	↑
		Emergency Department Non-Admitted Low Acuity (CTAS 4&5) volumes	G	G	G	G	G	↑
		Emergency Department Non-Admitted Patient Visits – High Acuity	G	G	G	G	G	↑
		Hip and Knee Replacement Volume (Wait Time Strategy Allocation)	G	G	Y	Y	G	↑
		Kidney Transplants	Y	Y	G	R	R	↓
		MRI Hours (Wait Time Strategy Allocation)	G	R	G	Y	G	↑
		OR Cases (Inpatient and Outpatient))	G	G	G	G	G	↑
		OR Hours (Inpatient & Outpatient)	Y	Y	G	G	G	↑
		Percent of Wait Time Contracted Volumes Achieved	N/A	N/A	R	Y	Y	↑
		Total Inpatient Admissions	G	G	G	G	G	↑
		Total Inpatient Weighted Cases	G	G	G	G	N/A	↑
E1 People	Lost time injury claims are reduced by 10%	Lost Time Injury Claims	N/A	N/A	Y	Y	Y	↓
		Musculoskeletal Injuries (MSIs)	G	R	G	R	R	↓
		Percent Completion of Incident Investigations	R	R	R	R	Y	↑
		Reduction in Lost Time Injury Claims due to Musculoskeletal Injuries	N/A	N/A	R	R	Y	↑

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
E1 People	Lost time injury claims are reduced by 10%		Reduction in Needle Stick Injuries	N/A	N/A	R	Y	R	↓
	Average sick days per KGH employee are reduced to 10.5		Average Sick Days per Eligible Employee per Year	Y	Y	Y	Y	Y	↑
			Percent of Overtime Hours	Y	Y	Y	Y	Y	↓
			Percent Sick Time Hours	G	G	Y	Y	Y	↓
			Total Full Time Equivalents (FTE's)	Y	Y	G	G	G	↑
E4 Technology	Timely E-Discharge summaries are completed for every		Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge	N/A	N/A	R	R	R	↑
E5 Finances	Our operating deficit is eliminated and our capital spend reaches $12 million		Current Ratio	G	G	G	G	G	↑
			Hospital Operations Actual vs Plan Variance ($000's)	G	G	G	G	G	↑
			Total Dollars for Capital Equipment ($000's)	N/A	Y	Y	Y	Y	↑
			Total Margin	G	G	G	G	G	↑
			Working Capital ($000's)	G	G	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

Kingston General Hospital

Quality Improvement Plan (QIP)
Q3 F2011-2012

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	15 Patient experience advisors are integrated into		Number of Patient Experience Advisors on Key Planning/Decision Making Forums	Y	Y	G	G	G	↑
	Overall patient satisfaction is at or better than the provincial teaching hospital average		Percent of Patients Responding "Satisfied" to the Food Patient Discharge Survey	R	R	N/A	N/A	N/A	
			Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey (QIP)	Y	Y	N/A	N/A	N/A	
			Percent of Patients who Answer "Definitely Yes" to the NRC Picker question "Would you Recommend this Hospital to your Friends and	G	Y	N/A	N/A	N/A	
	70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture		Hospital Standardized Mortality Ratio (HSMR)	G	G	N/A	N/A	N/A	
			Percent Mortality Reviews Completed with Quarterly Review of Record Level HSMR Data	R	G	N/A	N/A	N/A	
	The number of new cases who acquire infections in our hospital is reduced by 10%		Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 patient days	Y	R	R	Y	R	↑
			C-difficile (QIP)	R	R	G	R	R	↓
			Environmental Audits	G	G	Y	G	G	↑
			Percent of Sepsis Cases Reviewed by Department Head		N/A	N/A	N/A	N/A	
			Ventilator Associated Pneumonia (QIP)	G	G	G	G	G	↓
	We achieve 100% hand hygiene compliance across		Hand Hygiene Compliance (QIP)			Y	Y	G	↑
	100% of our clinical services discharge patients at their expected LOS		Average # ALC Patients per Day	G	G	R	R	G	↑
			Percent ALC Days	R	R	Y	Y	N/A	↑

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	100% of our clinical services discharge patients at their expected LOS		Percent of Clinical Services Meeting ELOS Target	R	R	R	R	N/A	↑
			Readmission rate Within 30 Days for Selected CMG's	R	R	N/A	N/A	N/A	
	The ED wait time for admitted patients is less than 8 hrs for		90th Percentile ED Wait Time (All Admitted Patients)	R	R	G	G	G	↑
SD2 Bring to life new models of interprofessional	100% of our clinical areas have implemented ICPM		Implementation of ICPM in All Inpatient Units and Extended to Ambulatory Setting by March 2012		N/A	G	G	G	↑
E1 People	Average sick days per KGH employee are reduced to 10.5		Average Sick Days per Eligible Employee Per Year	Y	Y	Y	Y	Y	↑
E4 Technology	Timely E-Discharge summaries are completed for every		Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge		N/A	R	R	R	↑
E5 Finances	Our operating deficit is eliminated and our capital spend		Total Margin	G	G	G	G	G	↑

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Kingston General Hospital

Strategy Scorecard (SSC) Summary Q3 F2011 - 2012

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	15 Patient experience advisors are integrated into KGH committees		Number of Patient Experience Advisors on Key Planning/Decision Making Forums	Y	Y	G	G	G	↑
	Overall patient satisfaction is at or better than the provincial average		Overall Acute Care Patient Satisfaction (%)	G	G	N/A	N/A	N/A	
	70% of our people who are surveyed rate us as excellent		Percent of Staff surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey	N/A	R	R	N/A	N/A	
	The number of new cases who acquire infections in our hospital are reduced		Number of New Cases of Hospital Acquired Infection	R	R	G	Y	Y	↑
	We achieve 100% hand hygiene compliance across all units and staff		Hand Hygiene Compliance (SSC)	N/A	N/A	Y	Y	Y	↑
	100% of our clinical services discharge patients at their expected LOS		Percent of Clinical Services Meeting ELOS Target	R	R	R	R	N/A	↑
	90% of patients receive their elective surgery within or better than prov. avg.		Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	N/A	R	R	R	R	↑
	The ED wait time for admitted patients is less than 8 hrs for every patient		Percent of Patients Admitted (from the Emergency Department) within a Wait Time Target of <8Hrs (SSC)	R	R	R	R	R	↑
SD2 Bring to life new models of interprofessional care and education	100% of our clinical areas have implemented ICPM		Implementation of ICPM in All Inpatient Units and Extended to Ambulatory Setting by March 2012	N/A	N/A	G	G	G	↑
	The KGH Interprofessional education council		IPE Work Plan Launched	N/A	G	G	G	G	↑
SD3 Cultivate patient oriented research	Externally funded research at KGH has increased by 10%		Percent Increase of Externally Funded Research Dollars at KGH	N/A	N/A	N/A	G	G	
SD4 Increase our focus on complex-acute and specialty care	KGH clinical staff adopt evidence-based guidelines		Number of Clinical Areas that have Implemented Open Source (OS)	N/A	N/A	G	R	G	↑
	KGH services align with our role as the region's complex acute and specialty care		KGH Cancer Care Plan	N/A	N/A	G	G	G	↑
	100% of Target service volumes are met		Percent of Wait Time Contracted Volumes Achieved	N/A	N/A	R	Y	Y	↑

				10-Q3	10-Q4	11-Q1	11-Q2	11-Q3	
E1 People	Lost time injury claims are reduced by 10%		Lost Time Injury Claims	N/A	N/A	Y	Y	Y	↓
	Average sick days per KGH employee are reduced to 10.5		Average Sick Days per Eligible Employee Per Year	Y	Y	Y	Y	Y	↑
	100% of our staff complete mandatory online training		Percent of Staff that Complete Mandatory Online Training Programs	N/A	N/A	R	Y	Y	↑
E2 Processes	100% of KGH managers complete mandatory process		Percent of Management Staff Completing Mandatory Process Improvement Training	N/A	N/A	Y	R	N/A	
E3 Facilities	Our new solar farm is established and 50% of carpets are removed		Percent of Square Footage of Carpet Removal Complete	N/A	N/A	G	G	G	↑
	96% of our Phase 1 redevelopment is complete on time,		Phase 1 Redevelopment is Completed on Time and On Budget	N/A	N/A	G	G	G	↑
E4 Technology	50% of our automated medication dispensing system in place		Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital	N/A	N/A	G	R	N/A	
	Our lab and diagnostic imaging order management		Implementation of an Order Management System for Labs on All Inpatient Areas (% completion).	N/A	N/A	G	R	R	
	Timely E-Discharge summaries are completed for every patient		Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge	N/A	N/A	R	R	R	↑
E5 Finances	Our operating deficit is eliminated and our capital spend		Total Dollars for Capital Equipment ($000's)	N/A	Y	Y	Y	Y	↑
E6 Communication	Patient, staff, and stakeholder engagement takes place		Implementation of Improved Website and Social Media Tools	N/A	N/A	G	G	G	↑

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