fiscal 2012-2013 **Q1**

1st quarter ended June 30, 2012

KGH this quarter

Master Performance Report

Kingston General Hospital

Outstanding care, always

Table of Contents
KGH Master Performance Report
Q1 Fiscal 2012 - 2013

KGH 2015

Outstanding Care, Always

Strategic Direction 1

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

Table of Contents

- Diagnostic Imaging – MRI – 90th Percentile Wait Time (days)
- Percent of non-admitted low acuity patients (CTAS 4&5) treated within a wait time Target of <4hrs
- Percent of clinical services meeting or exceeding 90th percentile wait time targets (excluding cancer surgery)
- All Cancer Surgery Wait Time – 90th Percentile days
- Orthopedic Hip and Knee Replacement Surgery Wait Time 90th percentile days
- Patients admitted from the Emergency Department (ED) with complex conditions - 90th percentile wait time (hrs)
- All Paediatric Surgery Wait Time 90th Percentile Days
- Cardiac Bypass Surgery – 90th Percentile Wait Time (days)
- Coronary Angiography – 90th Percentile Wait Time (days)
- Coronary Angioplasty – 90th Percentile Wait Time (days)
- Diagnostic Imaging – CT – 90th Percentile Wait Time
- General Surgical Procedures (excluding confirmed and suspected cancer surgeries) – Wait Time 90th Percentile days
- Percent of wait time contracted volumes achieved
- Radiation Wait Time (Referral-Consult) Percent seen within 14 days

Milestone 10: Cancer Care Ontario access to care indicators are met **Page 63**

- Number of Cancer Care Ontario access to care contract indicators met (Radiation/Chemotherapy)
- Percent of Cancer Care Ontario access to surgical care contract indicators met
- All Cancer Surgery Wait Time – 90th percentile wait time (days)

Strategic Direction 2

Bring to life new models of interprofessional care and education

N/A

Milestone 11: Automation of interprofessional assessment-and-adverse-reaction documents is complete (e-doc project) **Page 67**

- Automation of interprofessional assessment & adverse reaction documents is Complete as part of the e-doc project

Milestone 12: Workplan to fulfill interprofessional education competencies completed **Page 71**

- Number of interprofessional organizational educational competencies are met

Table of Contents

Strategic Direction 3

Cultivate patient oriented research

N/A

Milestone 13: Clinical research space at KGH increases by 25% **Page 75**

- 8% percent increase of externally funded research dollars at KGH
- Square footage of clinical research space at KGH
- Active Clinical Trials
- New Clinical Trials
- Clinical Trials Generating Revenue

Strategic Direction 4

Increase our focus on complex-acute and specialty care

Milestone 14: Clinical Services Roadmap initiatives launched **Page 81**

- KGH participation in clinical services roadmap initiatives

Milestone 15: Target service volumes are met **Page 85**

- Percent of contracted volumes achieved
- Total inpatient admissions
- Total inpatient weighted cases
- OR cases (inpatient & outpatient)
- OR hours (inpatient & outpatient)
- Ambulatory care volumes
- Cardiac – angiography volumes
- Cardiac – angioplasty volumes
- Cardiac – bypass volumes
- Chronic kidney disease program – weighted units
- CT hours (Wait Time Strategy Allocation)
- MRI Hours (Wait Time Strategy Allocation)
- Emergency Department Admitted Patient Volumes All Levels of Acuity
- Emergency Department Non-Admitted Patient Visits High Acuity
- Emergency Department Non-Admitted Low Acuity (CTAS 4&5) volumes
- Primary Hip and Knee Replacement Volume (Quality Based Procedure (QBP))
- Kidney Transplants
- Stem Cell Transplants

Milestone 16: Evidence-based guidelines are adopted in 12 clinical areas **Page 97**

- Number of clinical areas that have implemented Open Source Order Sets (OSOS)

Table of Contents

Enabler 1

People

Enabler 2

Processes

Enabler 3

Facilities

Table of Contents

Enabler 4

Technology

Enabler 5

Finances

Enabler 6

Communication

Strategy milestone # 1

100% Accreditation Canada requirements are met with an unconditional three-year award

Strategic Direction	KGH 2015 outcome	Status
KGH 2015	Outstanding Care Always	Green

Indicator
100% Accreditation Canada Requirements Met

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Q1 has consisted of heightened preparation for the survey in latter part of Q2. Activities have consisted of mock accreditation surveys throughout Q1 with reports back to each team involved; walk-abouts to reinforce strengths and opportunities for improvement; communiques to teams and with KGH Today and This Week.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Performance supported by project lead C. Gosnell, Accreditation Steering Committee and full engagement of leadership group.

3. **Are we on track to meet the milestone by year end?**
   Final preparation activities are unfolding for the survey which begins September 9, 2012. Presurvey teleconference with surveyors conducted July 25.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Walk-abouts will continue until week preceding the survey. Document completion in compliance with request of surveyors is underway. Greatest risk identified with achieving 3 year unconditional award is whether the articulation and evidence of the Ethics and Safety frameworks are sufficient.

MS #01

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1
KGH 2015	100% Accreditation Canada Requirements are Met with an Unconditional Three-Year Award	100% Accreditation Canada Requirements Met	N/A	N/A	N/A	N/A	G

Indicates improving performance to target over the past 5 quarters

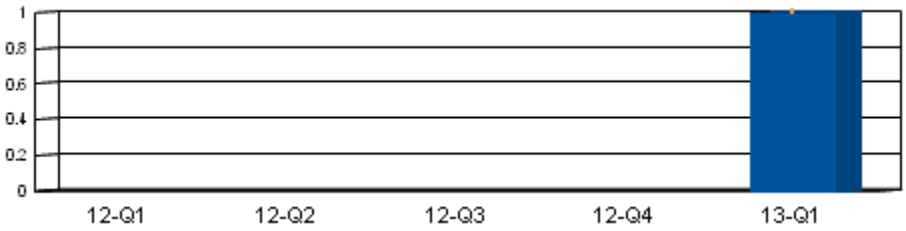
Indicates worsening performance to target over the past 5 quarters

MS #01

KGH 2015

100% Accreditation Canada Requirements are Met with an Unconditional Three-Year Award

Indicator: 100% Accreditation Canada Requirements Met



	Actual	Target
12-Q1		
12-Q2		
12-Q3		
12-Q4		
13-Q1	1	**1**

Interpretation - Patient And Business:

Accreditation preparation underway. Survey Not Until September (Accreditation Sept 9-13)

Definition: In September 2012 Kingston General Hospital will undergo an accreditation survey by Accreditation Canada. The Accreditation Canada survey process is one that enables health care organizations to assess their performance against national standards set by Accreditation Canada. Accreditation is essential to any hospital wishing to remain an academic centre. KGH voluntarily participates in this process, and was last surveyed in September 2009. At that time, KGH was assessed as meeting 94% of applicable national accreditation standards. To support the achievement of Outstanding Care Always, KGH is striving to achieve 100% performance against Accreditation Canada requirements to obtain a three year unconditional accreditation standing.

Target: Target 12/13: Q1 - Mock Surveys. Q2- Quality Road Map Submissions Completed. Q3-Accreditation Survey Occurs. Q4-Responding to results

Strategy milestone # 2

Quality Improvement Plan targets are met

Strategic Direction	KGH 2015 outcome	Status
KGH 2015	Outstanding Care Always	Yellow

Indicator
Number of Quality Improvement Plan Goals for Change Met

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

Of the 21 indicators in the QIP, 9 are green (43%), 5 yellow, 5 red and 2 NA. Performance values on 8 indicators are 1-4 quarters behind due to timing of surveys or Ministry reporting timelines. Four of the yellow/red indicators are improving over the previous quarter.

There are 9 of 14 indicators in the QIP goals for change section that are green or yellow. Of the 3 indicators, the Percent Discharge summary sent to primary care provider with 72 hrs remains red but improving. The others have no new data from the previous reporting period.

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

The tardiness of data availability challenges improvement initiative effectiveness. Nevertheless, corporately driven initiatives (Antibiotic Stewardship; Hand Hygiene compliance) and committee or program accountable performance targets (discharge summaries, infection rates, LOS) are showing positive trending.

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

Yes. The three red indicators are trending positively or have data collection issues that would support reaching the milestone.

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

Continued support of current initiatives and committees. Reassessment of current policies and peer hospitals in management of discharge summaries.

Kingston General Hospital

MS #02

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1
KGH 2015	Quality Improvement Plan Targets are Met	Number of Quality Improvement Plan Goals for Change Met	N/A	N/A	N/A	N/A	Y

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

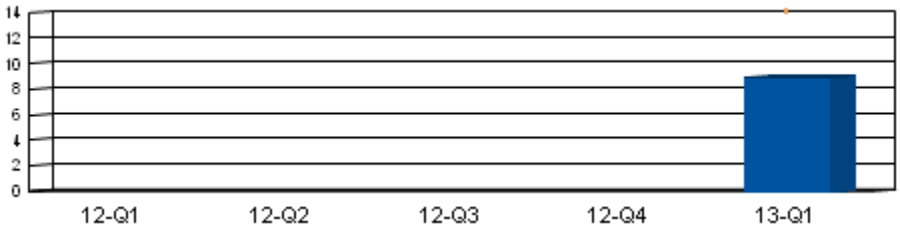
Kingston General Hospital

MS #02

KGH 2015

Quality Improvement Plan Targets are Met

Indicator: Number of Quality Improvement Plan Goals for Change Met



	Actual	Target
12-Q1		
12-Q2		
12-Q3		
12-Q4		
13-Q1	9	**14**

Interpretation - Patient And Business:

The 2012/13 QIP has a total 14 indicators. As of Q1, 4 are green, 3 are yellow, 5 are red and 2 are not yet reported.

Actions & Monitoring Underway to Improve Performance:

The Patient Safety and Quality Committee and the Joint Quality and Utilization Committee of MAC will need to provide effort and focus on the red indicators (Acute vs. Expected LOS; Mortality reviews by Departments; Patient satisfaction surveys on food and cleanliness; Discharge summaries sent within 72 hrs.)

Definition: The KGH is now in year 2 of the Province's Quality Improvement Plan (QIP). The QIP for fiscal 12/13 is made up of 22 indicators that were approved and submitted to the MOH in April 2012. In an effort to integrate the overall quarterly performance of the QIP into the Strategic Performance Report a roll-up indicator on overall QIP performance has been developed. This indicator reports on the percentage of the QIP indicators that are currently meeting target.

Target: Target 12/13: 14 of 14

Strategy milestone # 3

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

Strategic Direction	KGH 2015 outcome	Status
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**	**Green**

Indicator
Overall Acute Inpatient Satisfaction (%)

1. **What is our actual performance on each of the indicators for this milestone as listed above?** Based upon the recently received Fiscal 12 Q4 report (delay reporting is function of survey process) KGH is meeting the target of 75% overall acute care patient satisfaction. Further KGH exceeds the Ontario provincial teaching average and currently scores higher in 5 of the 8 dimensions of care. While improvement with food shows only marginal improvement relative to the last quarter, it is anticipated that with the fine-tuning of the Compass implementation in Q1 that results will improve and also impact on overall satisfaction. Note: the QIP milestone for rating of care received in hospital has decreased from 95% in Q3 to 92% in Q4 and thus now falls below the target of 94%.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The diimensions of physical care (85%) and access to care (84%) are the highest and are likely influenced by focus in all areas on quality/safety and on patient flow. Patient and family engagement on councils, committees and working groups continues to grow with 48 advisors involved in over 200 initiatives/groups thus ensuring a patient perspective in planning and decision making. Staff awareness of the focus on PFCC also increases and fosters staff engagement.

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?**
In support of the milestone and focus on patient and family centred care, all programs are involved in planning and education to support the launch of patient led feedback forums in Q3. The surgical program is leading by having piloted two sessions. Patient satisfaction results are also shared with each program, the PFAC and the Patient Safety and Quality Committee to create opportunity for review and suggestions.

Kingston General Hospital

MS #03

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
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	G	G	N/A	↑
		Overall Emergency Care Patient Satisfaction (%)	G	G	G	G	N/A	↑
		Overall, How Would You Rate the Care You Received at the Hospital?	G	G	G	Y	N/A	↓
		Patients Are Engaged in All Aspects of KGH Quality, Safety, and Service Improvement Initiatives	N/A	N/A	N/A	N/A	N/A	
		Percent of Clinical Programs that Have Conducted at Least One Patient and Family Feedback Forum *	N/A	N/A	N/A	N/A	G	
		Percent of Patients Who Respond "Satisfied" to the Food Patient Discharge Survey *	R	R	R	R	N/A	↓
		Percent of Patients Who Answer "Definitely Yes" to the NRC Picker Question " Would You Recommend this Hospital to Your Friends and Family?"	Y	G	G	Y	N/A	↓

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

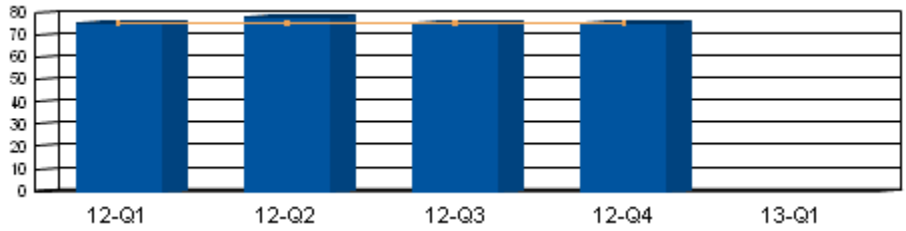
Kingston General Hospital

MS #03

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
12-Q1	75	**75**
12-Q2	78	**75**
12-Q3	75	**75**
12-Q4	75	**75**
13-Q1		

Interpretation - Patient And Business:

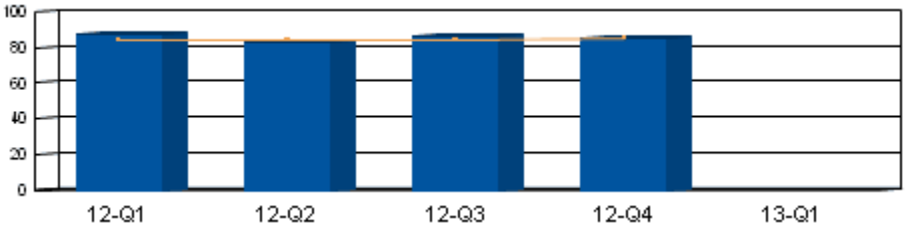
The current overall acute care satisfaction as with the previous quarter is on par with our target.

KGH currently scoring higher in 5 of the 8 dimensions of care than the ON teaching hospital average. Care dimensions of physical care (85%), and access to care (84%) scoring highest at KGH this quarter.

Definition: NRC Picker categorizes the majority of its acute care inpatient satisfaction survey questions under eight distinct dimensions of care: access to care, emotional support, information and education, involvement of family, respect for patient preferences, continuity and transition, physical comfort, and coordination of care. The resulting percent positive score represents an aggregate of these eight dimensions of care combined.

Target: Baseline 08/09: 93.3, Target 09/10: 93.8 or Greater, Target 10/11: Provincial Teaching Avg. or Better, Target 11/12: PTAOB, Target 12/13: PTAOB

Indicator: Overall Emergency Care Patient Satisfaction (%)

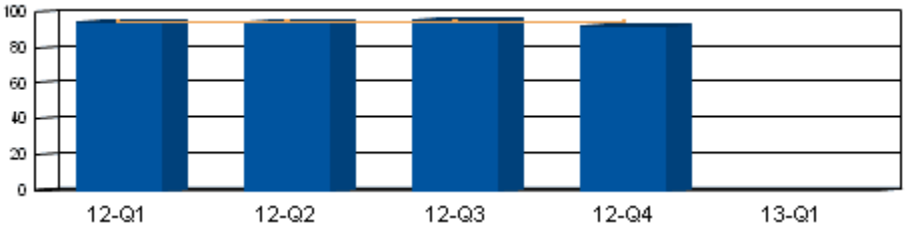


	Actual	Target
12-Q1	87	**84**
12-Q2	83	**84**
12-Q3	86	**84**
12-Q4	85	**85**
13-Q1		

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: PTAOB Target 12/13: PTAOB

Indicator: Overall, How Would You Rate the Care You Received at the Hospital?



	Actual	Target
12-Q1	94	**94**
12-Q2	94	**94**
12-Q3	95	**94**
12-Q4	92	**94**
13-Q1		

Interpretation - Patient And Business:

Overall for fiscal 2011-2012 overall care received is at 94%, on par with ON Teaching Hospital Avg.

Definition: The patient's perception of overall care received and is based on a single question (#44) on the NRC Picker patient satisfaction inpatient corporate survey. Possible responses to this question include poor, fair, good, very good and excellent. The percent positive score represents the combined responses of good, very good and excellent.

Target: Target: PTAOB

Kingston General Hospital

MS #03

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: Patients Are Engaged in All Aspects of KGH Quality, Safety, and Service Improvement Initiatives

	Actual	Target
13-Q1		

Definition: Our corporate initiative of having particular individuals involved all aspects of their care is taking the next step to formally receiving direct patient feedback on the care provided. This indicator monitors our progress with respect to this level of engagement.

Target: Target 2012/13: 100%

Indicator: Percent of Clinical Programs that Have Conducted at Least One Patient and Family Feedback Forum *

	Actual	Target
13-Q1		

Interpretation - Patient And Business:

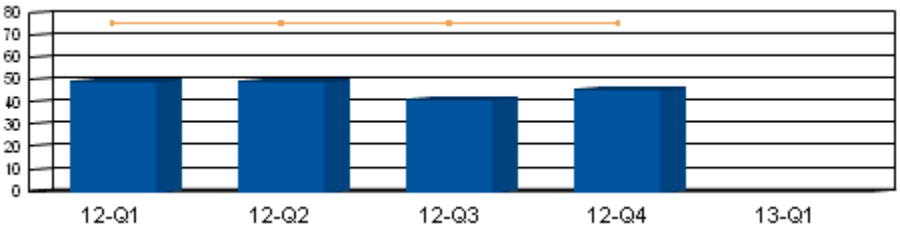
Plan has been developed and education is underway. Q1 meeting milestones in project plan.

Definition: "Patient Led Forums" will be a vehicle by which patients, families, staff and physicians will be supported in coming together to understand and respond to recent patient experiences at the Program level. The impetus behind this endeavor is to understand better the hospital experience from the patient and family perspective and to be responsive to that experience by rectifying areas of concern and/or supporting areas of strength.

0

Target: Target 12/13: 100% -- Q1 - Establishment of a Patient and Family Feedback Task Team, Q2 - Creation of a tool kit, Q3 - One Forum launched, Q4 - One Forum in all Programs

Indicator: Percent of Patients Who Respond "Satisfied" to the Food Patient Discharge Survey *



	Actual	Target
12-Q1	49	75
12-Q2	49	75
12-Q3	41	75
12-Q4	46	75
13-Q1		

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% -- Target 12/13: 75%

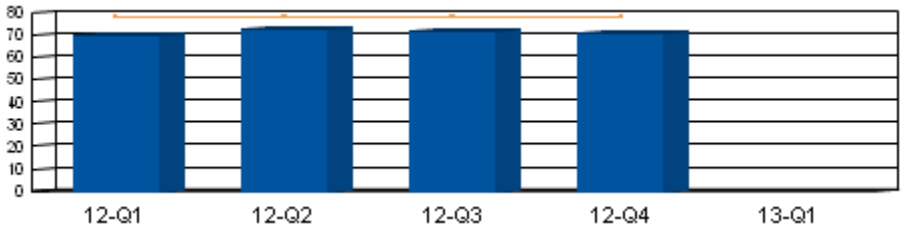
Kingston General Hospital

MS #03

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?"



	Actual	Target
12-Q1	70	**78**
12-Q2	73	**78**
12-Q3	72	**78**
12-Q4	71	**78**
13-Q1		

Interpretation - Patient And Business:

The question supports the overall acute care patient satisfaction and is a good indicator of the overall patient experience. The result has been relatively stable over the last the last fiscal year but remains below target of the ON Teaching Hospital Avg. Other patient satisfaction scores higher and on par or greater than target.

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: Target 11/12: PTAOB Target 12/13: PTAOB

Strategy milestone # 4

Patient safety culture ratings improve by 20%

Strategic Direction	KGH 2015 outcome	Status
Transform the patient experience through a relentless focus on quality, safety and service	**All preventable harm to patients is eliminated**	**Red**

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

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

The staff survey is an annual reporting in Q4, thus has no new information. Within the milestone are 8 other metrics with 4 green, 1 yellow, and 3 red. The yellow indicator (3 phases of surgical safety checklist) is trending positively and will be reflective of a new IT initiative in the OR with institution of PICS and more accurate, detailed reporting.

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

The red performance for mortality review is a function of compliance with timeliness of reporting and not completion.

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

Reaching a 70% rate of satisfaction will be a challenge, but improvement from the survey in Q4 is expected

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

Continued recruitment process for a Director of Patient Safety and Quality. The Patient Safety and Quality portfolio planning for Patient Safety Week. Current corporate preparation for Accreditation support staff awareness for patient safety as a prime initiative.

Kingston General Hospital

MS #04

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Transform the patient experience through a relentless focus on quality, safety and service	Patient safety culture ratings improve by 20%	Percent of Staff Surveyed Who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey	R	N/A	N/A	R	N/A	↓
		Number of Clinical Programs that Implement at Least One New Safety Checklist	N/A	N/A	N/A	N/A	G	
		Implementation of Surgical Safety Check List	G	G	G	G	G	↑
		Percent Mortality Reviews Completed with Review of Record Level HSMR Data *	G	N/A	N/A	N/A	N/A	
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) *	Y	Y	Y	Y	Y	↑
		Hospital Standardized Mortality Ratio (HSMR)	G	G	R	N/A	N/A	↓
		Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey *	G	G	G	G	N/A	↓
		Percent of Recommendations Considered and Acted Upon as per Critical Incident Investigations *	N/A	N/A	N/A	N/A	G	

↑ Indicates improving performance to target over the past 5 quarters

↓ Indicates worsening performance to target over the past 5 quarters

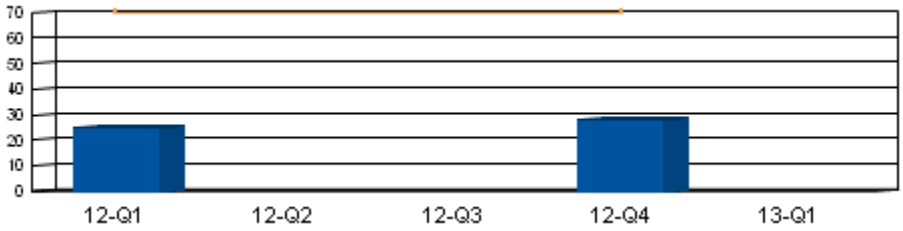
Kingston General Hospital

MS #04

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

Patient safety culture ratings improve by 20%

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



	Actual	Target
12-Q1	25	**70**
12-Q2		
12-Q3		
12-Q4	28	**70**
13-Q1		

Interpretation - Patient And Business:

Actions & Monitoring Underway to Improve Performance:

There was a 3.3 fold increase in respondents completing the survey. A 3% improved response will continue to focus efforts and actions to support these improvements: using the SAFE reporting e-learning module introducing safety concepts, the recruitment of the new position Director Quality & Patient Safety and work of the Patient Quality and Safety Committee.

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% Target 12/13: 48%

Indicator: Number of Clinical Programs that Implement at Least One New Safety Checklist

	Actual	Target
13-Q1		

Definition: A checklist is a list of action items arranged in a systematic manner that allows the user to record the completion of the individual items. The goals of checklists used in healthcare are primarily error reduction and adherence to best practices in clinical care. The aim of a checklist is to reinforce accepted safety practices and foster better communication and teamwork between clinical disciplines. Its use has been demonstrably associated with significant reductions in complication and death rates in hospitals and with improvements in compliance to basic standards of care. This indicator tracks the number of new safety checklists that have been implemented throughout the hospital.

Target: Target 12/13: 4

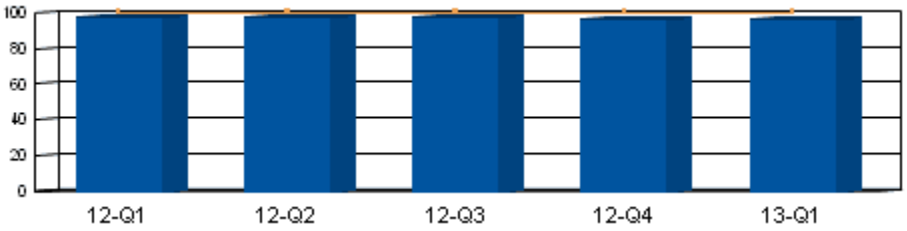
Kingston General Hospital

MS #04

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

Patient safety culture ratings improve by 20%

Indicator: Implementation of Surgical Safety Check List



	Actual	Target
12-Q1	97	**100**
12-Q2	97	**100**
12-Q3	97	**100**
12-Q4	96	**100**
13-Q1	96	**100**

Interpretation - Patient And Business:

1n 2009 the Ministry of Health announced the Surgical Safety Checklist (SSC) as part of its plans to improve patient safety in Ontario Hospitals. In July 2010 the SSC became a mandated indicator. The performance has been stable and unchanged over 5 quarters but remains below target of 100%.

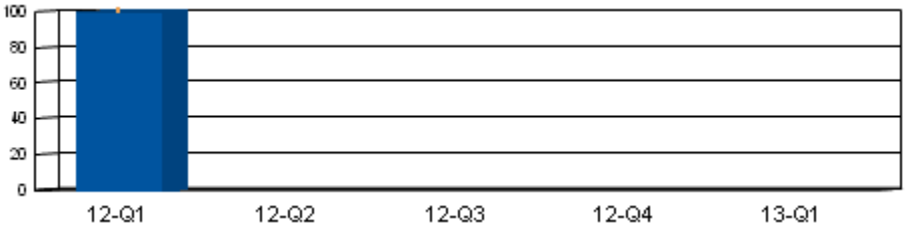
Actions & Monitoring Underway to Improve Performance:

The indicator has been recorded through the operating room computer software ORSOS. This software has allowed only the ability to track if all three phases of the SSC were completed or not completed. KGH's operating room has recently changed to PICS for its day to day operations. This new tool will allow leaders to track each of the individual phases to better develop strategies to reach the target of 100%. In addition, new models of leadership within the operating rooms will prompt accountability for the three phases.

Definition: This Surgical Safety Checklist (SSC) compliance indicator is a process measure that is part of the hospital's QIP. It measures overall compliance of the initial phase (the "Briefing") of the surgical safety checklist for each surgical patient. All surgeries carried out in a fully equipped operating room are eligible to report the use the SSC. The SSC is considered performed when the designated checklist coordinator confirms that surgical team members have implemented and/or addressed all of the necessary tasks and items in each of the three phases-'Briefing', 'Time Out' and 'Debriefing'-of the checklist, based upon the Canadian Patient Safety Institute (CPSI)'s Surgical Safety Checklist.

Target: Target 12/13: 100%

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



	Actual	Target
12-Q1	100	**100**
12-Q2		
12-Q3		
12-Q4		
13-Q1		

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

Target: QIP Target 11/12: 75% Target 2012/13: 100%

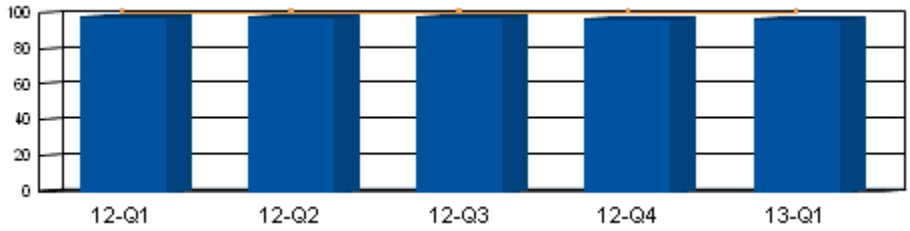
Kingston General Hospital

MS #04

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

Patient safety culture ratings improve by 20%

Indicator: All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) *



	Actual	Target
12-Q1	97	**100**
12-Q2	97	**100**
12-Q3	97	**100**
12-Q4	96	**100**
13-Q1	96	**100**

Interpretation - Patient And Business:

1n 2009 the Ministry of Health announced the Surgical Safety Checklist (SSC) as part of its plans to improve patient safety in Ontario Hospitals. In July 2010 the SSC became a mandated indicator. The performance has been stable and unchanged over 5 quarters but remains below target of 100%.

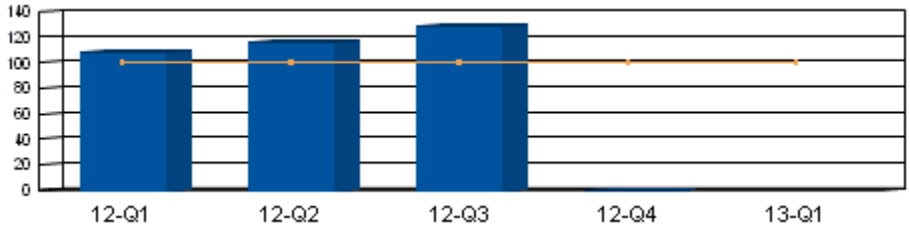
Actions & Monitoring Underway to Improve Performance:

The indicator has been recorded through the operating room computer software ORSOS. This software has allowed only the ability to track if all three phases of the SSC were completed or not completed. KGH's operating room has recently changed to PICS for its day to day operations. This new tool will allow leaders to track each of the individual phases to better develop strategies to reach the target of 100%. In addition, new models of leadership within the operating rooms will prompt accountability for the three phases.

Definition: The Surgical Safety Checklist (SSC) compliance indicator is a process measure that is part of the hospital's QIP. It refers to the percentage of surgeries in which a three-phase surgical safety checklist was performed correctly and appropriately for each surgical patient. All surgeries carried out in a fully equipped operating room are eligible to report the use the SSC. The SSC is considered performed when the designated checklist coordinator confirms that surgical team members have implemented and/or addressed all of the necessary tasks and items in each of the three phases-'Briefing', 'Time Out' and 'Debriefing'-of the checklist, based upon the Canadian Patient Safety Institute (CPSI)'s Surgical Safety Checklist.

Target: Target 2012/13: 100%

Indicator: Hospital Standardized Mortality Ratio (HSMR)



	Actual	Target
12-Q1	108	**100**
12-Q2	116	**100**
12-Q3	128	**100**
12-Q4		**100**
13-Q1		**100**

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. Target 12/13: 100

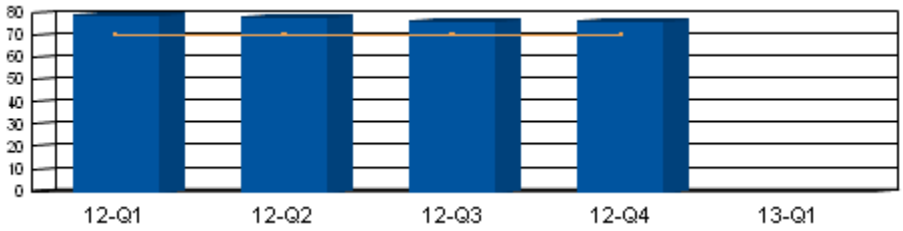
Kingston General Hospital

MS #04

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

Patient safety culture ratings improve by 20%

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



	Actual	Target
12-Q1	79	**70**
12-Q2	78	**70**
12-Q3	76	**70**
12-Q4	76	**70**
13-Q1		

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

Target: Target 2012/13: 85%

Indicator: Percent of Recommendations Considered and Acted Upon as per Critical Incident Investigations *

	Actual	Target
13-Q1	100	**100**

Interpretation - Patient And Business:

Of the 10 recommendations resulting from 2 critical incident reviews held Apr-Jun, 3 are completed and 7 are in planning/in progress.

Actions & Monitoring Underway to Improve Performance:

In keeping with the Excellent Care for All Act, Critical Incident Reviews generate recommendation(s) to mitigate reoccurrence. The Patient Safety and Quality of Care Committee and the Joint Quality and Utilization Committees review incidents/follow up on a monthly basis to ensure completeness.

Definition: The purpose of the Critical Incident review process is to assess and evaluate provision of health care resulting from a patient safety related incident with a view to improving or maintaining the quality of healthcare. The review team makes recommendations to prevent recurrence and assigns responsibility for implementation consideration of each recommendation. In addition, that there are fully implemented processes and reporting through MAC and Patient Safety and Quality Committee to the Quality of patient care Committee of the Board.

Target: Target 2012/13: 100%

Strategy milestone # 5

Medication reconciliation is completed for every internal medicine program inpatient at admission

Strategic Direction	KGH 2015 outcome	Status
Transform the patient experience through a relentless focus on quality, safety and service	**All preventable harm to patients is eliminated**	**Green**

Indicator
Medication Reconciliation is Completed for Every Internal Medicine Program Inpatient at Admission

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   A focus on this milestone within the Internal Medicine program has allowed a 93% of inpatients receiving a medication reconciliation.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Devoted pharmacy and pharmacy technicians to the medicine program have enabled the performance of 93%. Access to Order Sets (paper forms) for medication reconciliation has been identified as a concern and links to similar issues recognized in Milestone # 16.

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, devoted support by Pharmacy to the program will ensure continued progress to the target of 100%.

Kingston General Hospital

MS #05

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Transform the patient experience through a relentless focus on quality, safety and service	Medication reconciliation is completed for every internal medicine program inpatient at admission	Medication Reconciliation is Completed for Every Internal Medicine Program Inpatient at Admission	R	G	G	G	N/A	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

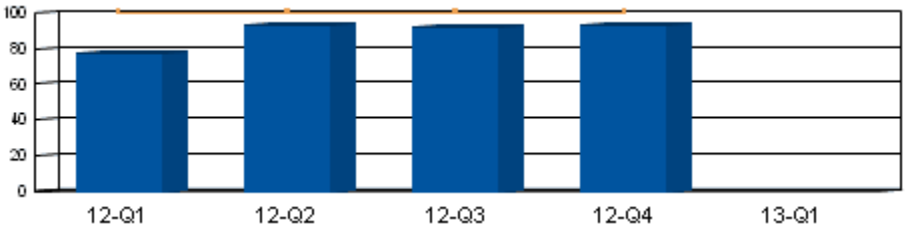
Kingston General Hospital

MS #05

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

Medication reconciliation is completed for every internal medicine program inpatient at admission

Indicator: Medication Reconciliation is Completed for Every Internal Medicine Program Inpatient at Admission



	Actual	Target
12-Q1	77	**100**
12-Q2	93	**100**
12-Q3	92	**100**
12-Q4	93	**100**
13-Q1		

Interpretation - Patient And Business:

Difficulty for providers with accessing paper admission order sets in ER and patient care units may be a barrier to addressing 100% target. Otherwise, Medication Reconciliation Program is on track in Internal Medicine with favorable results of 93%.

Definition: Medication reconciliation (med rec) on admission is a process in which healthcare professionals work with patients and families to document an accurate and complete list of the patient's medication information at the time of admission to the hospital It is well demonstrated in the patient safety literature that completing the medication reconciliation process will significantly reduce the chance of a medication discrepancy during the hospital stay.

Target: Target 2012/13: 100%

Strategy milestone # 6

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

Strategic Direction	KGH 2015 outcome	Status
Transform the patient experience through a relentless focus on quality, safety and service	**All preventable harm to patients is eliminated**	**Green**

Indicator
Number of New Cases of Hospital Acquired Infection

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   There are 14 indicators within this milestone: 3 green, 4 yellow, 4 red and 1 N/A. There was reduction in the number of new infections by more than 50% over the last quarter (54 to 21 cases). This was attributable to a decrease in the C. Diff rates. There was a rise in the MRSA, VRE and VAP rates in this last quarter. This was due to only 1 or 2 cases of each infection. External audits on environmental cleaning falls below target as well.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The VAP target change made this indicator red for this quarter. Hand hygiene compliance was unchanged but now yellow due to a target change. *It is being recommended that the indicator "Percent of sepsis cases reviewed by Department Heads" be put on hold due to concerns of over taxing the clinical departments at this time.*

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?**

   Antibiotic stewardship has just been initiated August 9. Increase focus of the Infection Prevention and Control Service on education and presence on wards will support hand hygiene and contact precaution measures.

Kingston General Hospital

MS #06

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Transform the patient experience through a relentless focus on quality, safety and service	The number of new patients who acquire infections in our hospital is reduced by 10%	Number of New Cases of Hospital Acquired Infection	G	Y	Y	R	G	↑
		Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days *	R	Y	R	Y	Y	↑
		Percent of Sepsis Cases Reviewed by Department Head *	N/A	N/A	N/A	N/A	N/A	
		C-Difficile (Reported Quarterly)	G	R	R	R	Y	↑
		C-Difficile (Reported Monthly)	R	R	R	R	R	↑
		Hand Hygiene Compliance *	Y	Y	G	G	Y	↑
		Central Line Bloodstream Infections	G	R	G	G	G	↑
		MRSA (Methicillin-resistant Staphylococcus Aureus)	Y	Y	G	G	Y	↓
		VRE (Vancomycin-resistant Enterococcus)	Y	Y	G	G	R	↓
		Ventilator Associated Pneumonia	G	G	G	R	R	↓
		Surgical Site Infection (SSI) Prevention	Y	Y	Y	Y	G	↑
		External Environmental Audits by Westech	N/A	N/A	N/A	N/A	Y	

Indicates improving performance to target over the past 5 quarters ↑ Indicates worsening performance to target over the past 5 quarters ↓

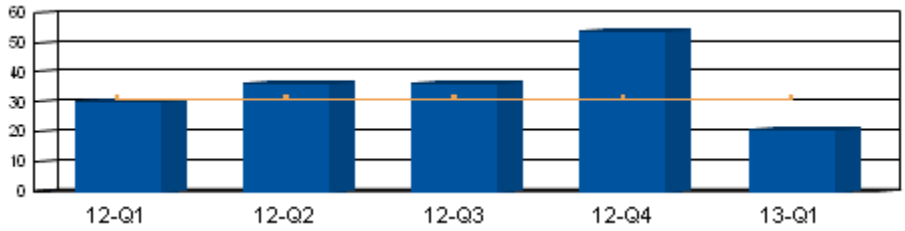
Kingston General Hospital

MS #06

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

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

Indicator: Number of New Cases of Hospital Acquired Infection



	Actual	Target
12-Q1	30	**31**
12-Q2	36	**31**
12-Q3	36	**31**
12-Q4	54	**31**
13-Q1	21	**31**

Interpretation - Patient And Business:

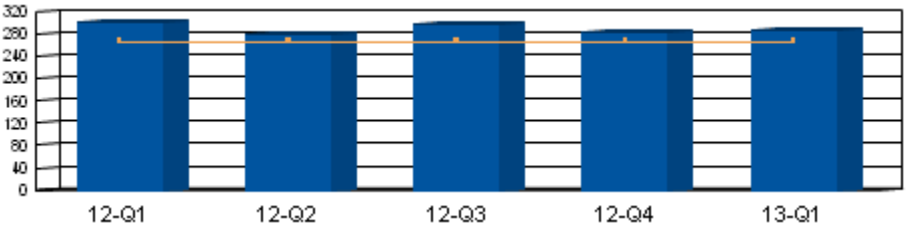
Patient Perspective: High levels of hand hygiene have also helped to reduce transmission of HAI across the institution.

Business Perspective: The target has been achieved principally due to a decrease in seasonal rates of CDI in the last quarter. There was a decrease in our CDI rates of 68% from the fourth quarter of 2011-2012 during the first quarter 2012-2013. We did have one case of an MRSA bacteremia and two cases of VRE bacteremias.

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 Target 12/13: 31

Indicator: Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days *



	Actual	Target
12-Q1	303	**267**
12-Q2	278	**267**
12-Q3	299	**267**
12-Q4	285	**267**
13-Q1	287	**267**

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. Fiscal 2012/13: 267

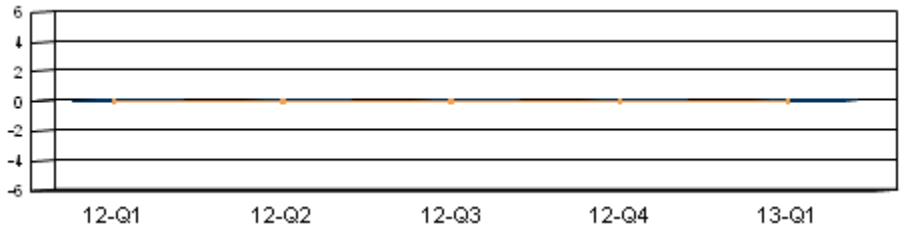
Kingston General Hospital

MS #06

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

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

Indicator: Percent of Sepsis Cases Reviewed by Department Head *

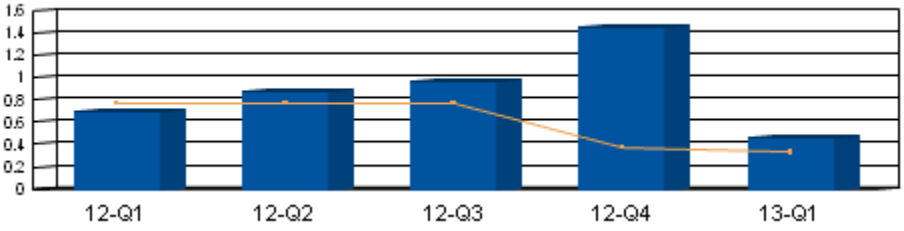


	Actual	Target
12-Q1		
12-Q2		
12-Q3		
12-Q4		
13-Q1		

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

Target: Target 11/12: 75% Target 2012/13: 100%

Indicator: C-Difficile (Reported Quarterly)



	Actual	Target
12-Q1	0.7	**0.8**
12-Q2	0.9	**0.8**
12-Q3	1.0	**0.8**
12-Q4	1.5	**0.4**
13-Q1	0.5	**0.3**

Interpretation - Patient And Business:

Patient Perspective: The KGH rate for this quarter was 0.46 cases per 1000 patient days; a 68% drop in rate compared with the previous quarter. IPAC continued with the measures initiated last quarter during the CDI outbreak from January to April 2012. CDI cases during this current quarter were not clustered to any specific geographical area of the hospital.

Business Perspective: Measures implemented include: Emphasis on the implementation of and adherence to Contact Precautions including the appropriate use of PPE (gowns and gloves) and strict hand hygiene. Other measures were rapid identification and isolation of cases of queried CDI and emphasis on thorough environmental cleaning of direct patient care areas with sporicidal cleaners. The pending introduction of an Antimicrobial Stewardship Program (ASP) to proactively improve appropriate antibiotic use in the hospital will be the final component needed to maintain the reduced incidence of CDI in the hospital.

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.

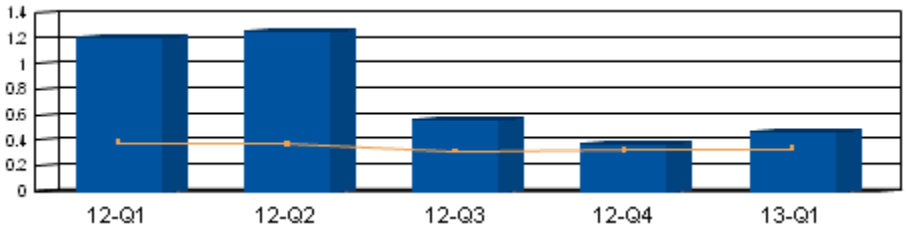
Target: Fiscal 2011/12 - QIP Goal = 0.30, QIP Target For Compensation = 0.77 Fiscal 2012/13: 0.3

MS #06

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

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

Indicator: C-Difficile (Reported Monthly)



	Actual	Target
12-Q1	1.2	**0.4**
12-Q2	1.3	**0.4**
12-Q3	0.6	**0.3**
12-Q4	0.4	**0.3**
13-Q1	0.5	**0.3**

Interpretation - Patient And Business:

Please note the last 5 quarters are monthly values (Feb 2012 - June 2012)

Patient Perspective: The KGH rate for this quarter was 0.46 cases per 1000 patient days; a 68% drop in rate compared with the previous quarter. IPAC continued with the measures initiated last quarter during the CDI outbreak from January to April 2012. CDI cases during this current quarter were not clustered to any specific geographical area of the hospital.

Business Perspective: Measures implemented include: Emphasis on the implementation of and adherence to Contact Precautions including the appropriate use of PPE (gowns and gloves) and strict hand hygiene. Other measures were rapid identification and isolation of cases of queried CDI and emphasis on thorough environmental cleaning of direct patient care areas with sporicidal cleaners. The pending introduction of an Antimicrobial Stewardship Program (ASP) to proactively improve appropriate antibiotic use in the hospital will be the final component needed to maintain the reduced incidence of CDI in the hospital.

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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 Target 12/13: PAOB

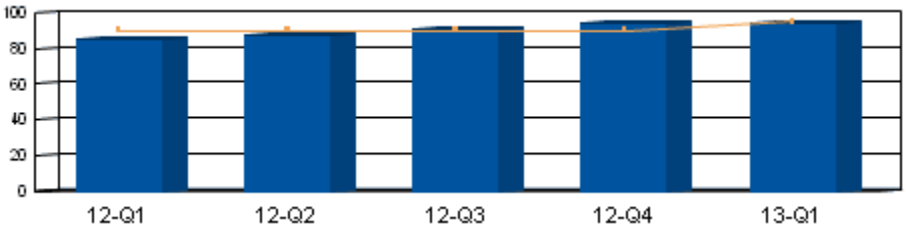
Kingston General Hospital

MS #06

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

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

Indicator: Hand Hygiene Compliance *



	Actual	Target
12-Q1	85	**90**
12-Q2	87	**90**
12-Q3	91	**90**
12-Q4	94	**90**
13-Q1	94	**95**

Interpretation - Patient And Business:

Patient Perspective: In June patients who were on Contact Precautions related to being colonized for VRE received hand hygiene education as part of the information about KGH's changes in our practice and management of VRE. Staff education for this change also included a reminder of the importance of strict hand hygiene. Continued attention to HH across the institution will be important to reducing the incidence of nosocomial infections overall.

Business Perspective: Continued messaging about hand hygiene and the use of the HandyAudit tool supports the organizations emphasize on the importance of strict hand hygiene practices for all staff. We are currently in the process of updating the current device PDA model for the newer iPod model. This new device will assist us in improving the gathering of hand hygiene data due to improved functionality that will assist us in meeting our target.

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: Target 11/12: 90% Target 12/13: 95%

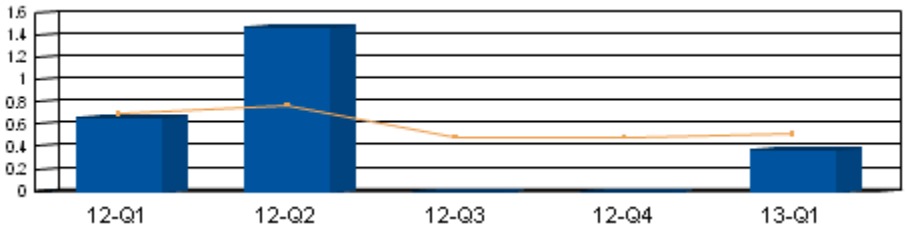
Kingston General Hospital

MS #06

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

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

Indicator: Central Line Bloodstream Infections



	Actual	Target
12-Q1	0.7	**0.7**
12-Q2	1.5	**0.8**
12-Q3	0.0	**0.5**
12-Q4	0.0	**0.5**
13-Q1	0.4	**0.5**

Interpretation - Patient And Business:

Actions & Monitoring Underway to Improve Performance:

Continue close monitoring for use and compliance with CLI bundle strategies

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.

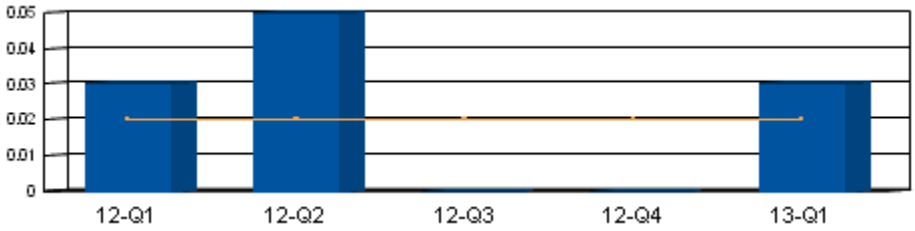
Target: Target 09/10: 1.2 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: PAOB Target 2012/13: PAOB

MS #06

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

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

Indicator: MRSA (Methicillin-resistant Staphylococcus Aureus)



	Actual	Target
12-Q1	0.0	**0.0**
12-Q2	0.1	**0.0**
12-Q3	0.0	**0.0**
12-Q4	0.0	**0.0**
13-Q1	0.0	**0.0**

Interpretation - Patient And Business:

Patient Perspective: The rate of MRSA bacteremias for this quarter was 0.03 which represents only one case.

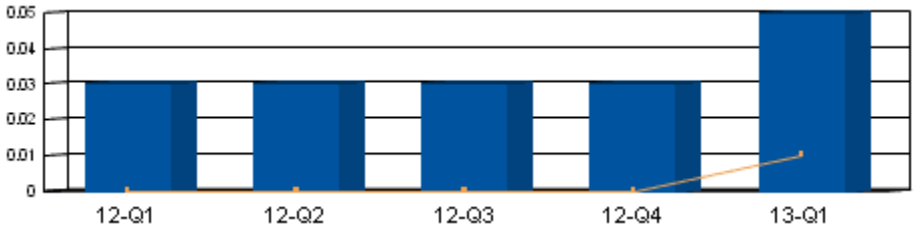
Business Perspective: Continued surveillance and isolation of MRSA cases, education and improvements in hand hygiene all contribute to efforts to achieve our target.

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: PAOB, Target 2012/13: PAOB

Indicator: VRE (Vancomycin-resistant Enterococcus)



	Actual	Target
12-Q1	0.0	**0.0**
12-Q2	0.0	**0.0**
12-Q3	0.0	**0.0**
12-Q4	0.0	**0.0**
13-Q1	0.1	**0.0**

Interpretation - Patient And Business:

Patient Perspective: The rate of VRE bacteremias for this quarter was 0.05 which represents only two cases.

Business Perspective: The hospital has reconsidered its in-house admission screening and implementation of Contact Precautions for known VRE patients. As of June 25th, 2012, KGH discontinued these practices. KGH IPAC continues to perform surveillance of VRE bacteremias and other infection and bacteremias will continue to be reported as required by the province.

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: PAOB, Target 2012/13: PAOB

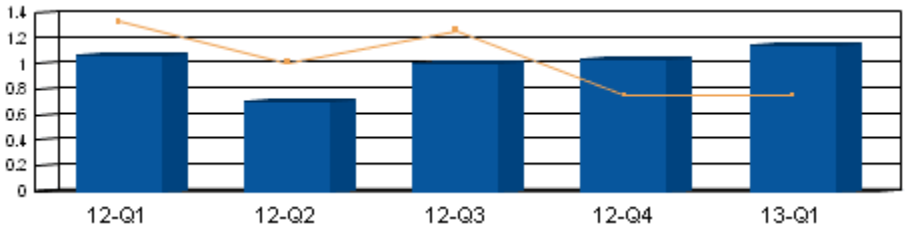
Kingston General Hospital

MS #06

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

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

Indicator: Ventilator Associated Pneumonia



	Actual	Target
12-Q1	1.1	**1.3**
12-Q2	0.7	**1.0**
12-Q3	1.0	**1.3**
12-Q4	1.0	**0.8**
13-Q1	1.1	**0.8**

Interpretation - Patient And Business:

Patient perspective: VAP poses a significant risk and increased critical are and hospital length of stay.
The use of a VAP 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 in the past.....coordinator monitoring this closely.

Business perspective: small numbers have significant impact to the rates. Total number of ventilator days decreased this quarter making denominator smaller and hence impact of 2 cases on the q1 rate was significant.

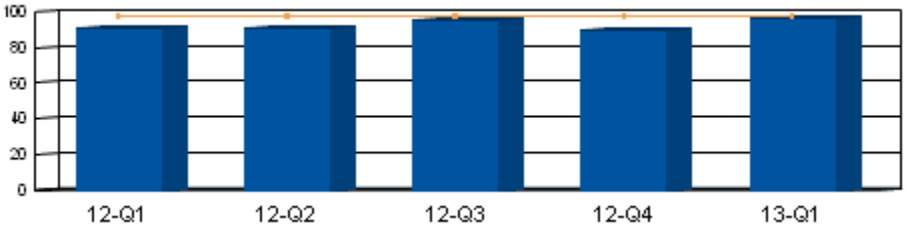
Actions & Monitoring Underway to Improve Performance:

VAP bundle has been implemented and reviewed on case by case basis on bedside rounds and through safety/best practices check list. Safety Coordinator will be monitoring closely. Stretch target also reduced (below provincial target) to encourage further improvement.

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, Target 2012/13: PAOB

Indicator: Surgical Site Infection (SSI) Prevention



	Actual	Target
12-Q1	91	**97**
12-Q2	91	**97**
12-Q3	95	**97**
12-Q4	90	**97**
13-Q1	96	**97**

Interpretation - Patient And Business:

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

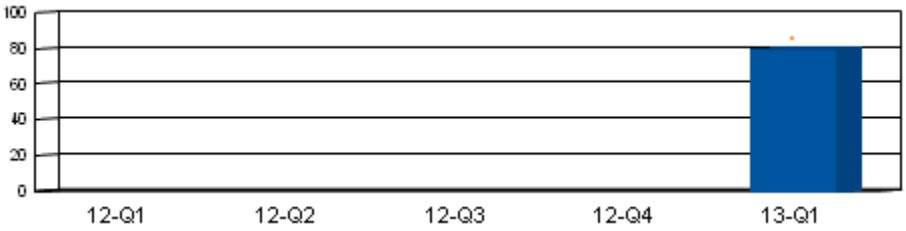
Kingston General Hospital

MS #06

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

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

Indicator: External Environmental Audits by Westech



	Actual	Target
12-Q1		
12-Q2		
12-Q3		
12-Q4		
13-Q1	80	**85**

Interpretation - Patient And Business:

Since the last Westech audit we have identified areas that require improvements, particularly the OR, Imaging, and clinical labs. Managers continue to work with our staff on the Westech standards.

Actions & Monitoring Underway to Improve Performance:

We have been involved with Westech since March 2011. The Westech cleaning standard is a very detailed cleaning audit that has required very extensive training of both staff and managers. Although improvement has been demonstrated work continues to achieve the 85% target.

Definition: Westech System Inc. is an external company that performs cleaning audits throughout the Hospital. The audit categorizes the many areas of the hospital into four (4) risk categories. Patient rooms are considered Risk 2 (High risk). The audit provides detailed areas for improvement to focus education and training required for staff and management.

Target: Target 2012/13: 85%

Strategy milestone # 7

KGH overall average length of stay is better than expected length of stay

Strategic Direction	KGH 2015 outcome	Status
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**	**Yellow**

Indicator
Overall – Acute Average Length of Stay vs. ELOS – Variance in Days

1. **What is our actual performance on each of the indicators for this milestone as listed above?** Based upon the Q4 data, the overall indicator for ALOS relative to ELOS is better than the target, and continues to hold at approximately a half day better than target. It is important to note that this is calculated on an overall basis and 5 of the 18 services (Hematology, Neurology, Obs/Gyn, Orthopedics and Otolaryngology) exceed expected length of stay.

   The most worrisome indicator with preventable delays is the increase in the number of ALC patients per day (from av of 23 in Q4 to 36 in Q1)as this has domino effect of impeding access, throughput and efficiencies in resource (bed and human resource alignment).

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The gains made with overall length of stay are attributed to oversight by the Patient Flow Task Force and with program operational and medical leads. In addition, the Concurrent Review team provides “real time” utilization information on the patient care continuum. Concurrent reviews are conducted systematically across all inpatient care programs throughout the year.

3. **Are we on track to meet the milestone by year end?** Overall yes with further opportunities for improvement with specific services. ALC challenges must be resolved to mitigate potential implications with predictable increase in late Q3 and Q4.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** Continue PFTF oversight with additional regular meetings with services/programs that exceed targets. Review and refresh of ALC and Home First processes. Program continuous improvement and tactical plan work include initiatives, such as supports for earliest and best alignment of patients to service areas; discharge prediction and planning, patient checkout and communication to environmental services that will further reduce lengths of stay and enable access.

Kingston General Hospital

MS #07

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Transform the patient experience through a relentless focus on quality, safety and service	KGH overall average length of stay is better than expected length of stay	Average # ALC Patients per Day	R	R	G	G	R	↓
		Percent ALC Days	Y	Y	G	G	N/A	↑
		Overall - Acute Average Length of Stay vs. ELOS Variance in Days - QIP *	G	G	G	G	Y	↑
		Percent of Clinical Services Meeting or Exceeding ELOS Target	R	R	R	R	R	↑
		Overall - Acute Average Length of Stay Days (Based on HSAA)	Y	G	Y	Y	N/A	↑
		Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile *	Y	Y	G	G	R	↓
		Readmission Rate Within 30 Days for Selected CMG's to Any Facility *	R	R	N/A	N/A	N/A	

↑ Indicates improving performance to target over the past 5 quarters

↓ Indicates worsening performance to target over the past 5 quarters

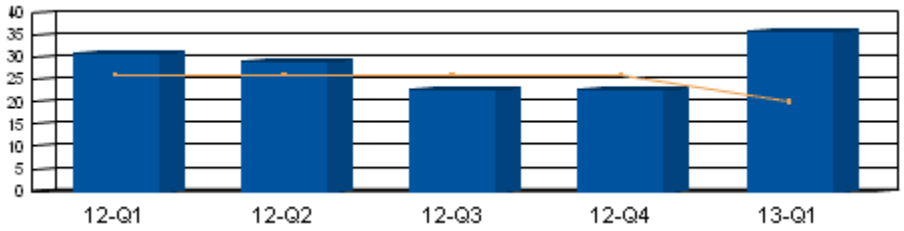
Kingston General Hospital

MS #07

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

KGH overall average length of stay is better than expected length of stay

Indicator: Average # ALC Patients per Day



	Actual	Target
12-Q1	31	**26**
12-Q2	29	**26**
12-Q3	23	**26**
12-Q4	23	**26**
13-Q1	36	**20**

Interpretation - Patient And Business:

Result of 36 for this quarter is preliminary pending final results from WTIS.

The number of patients designated as ALC for Long Term Care account for the greatest increase in the total (and average) numbers. Contributing factors include reduced admissions to Home First due to complexity of clinical cases; staff turnover in the KGH and CCAC teams impacting continuity in application of procedures; increased number of complex cases with limited destination choices leading to long lengths of stay. External factors include an increase in crisis placements from the community into long term care facilities reducing access to these beds by KGH patients.

Actions & Monitoring Underway to Improve Performance:

Weekly meetings take place with CCAC to discuss ALC and Home First patients for the purpose of discussion barriers to discharge. Refresher sessions and orientations are ongoing with the clinical team to present monthly results and seek input on barriers to success of Home First. Orientations provided to new residents. Meetings to occur with Providence Care to promote timely transfer of ALC patients.

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. Target 12/13: 20

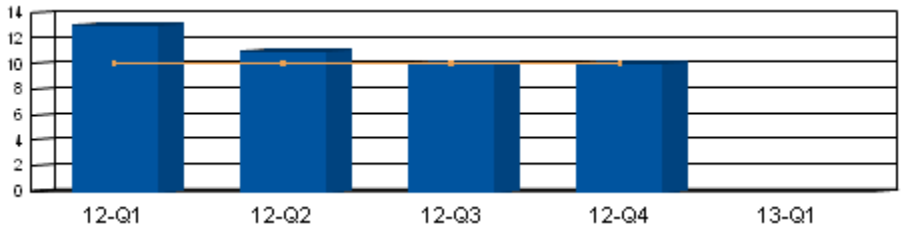
Kingston General Hospital

MS #07

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

KGH overall average length of stay is better than expected length of stay

Indicator: Percent ALC Days



	Actual	Target
12-Q1	13	**10**
12-Q2	11	**10**
12-Q3	10	**10**
12-Q4	10	**10**
13-Q1		

Interpretation - Patient And Business:

Although data are not available at this time, the result indicator will be 'red' for the first quarter based on the increased number of ALC patients since Q4.

Q1 results are concerning given the impact on patients waiting for admission to LTC, and patients in ER waiting for admission to an acute care bed.

The Patient Flow Task Force will continue with oversight of the indicator. ALC rates, conversion rates and Home First trends are reviewed monthly with consideration of opportunities for improvement. Given the majority (>65%) of the ALC patients are awaiting discharge to long term care facilities, the focus is on this category of ALC.

Actions & Monitoring Underway to Improve Performance:

Ongoing education and presentation of results with staff and physicians. Focus is on barriers to discharge.

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% 12/13 Target: 10%

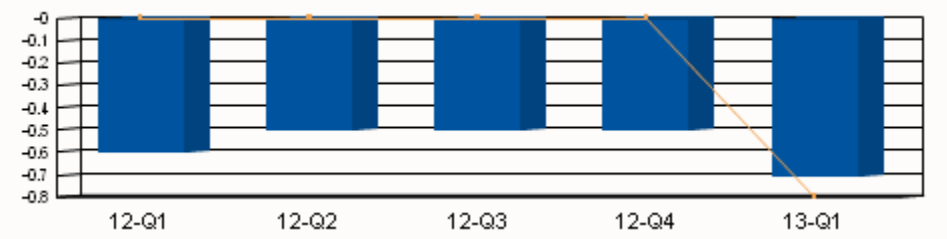
Kingston General Hospital

MS #07

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

KGH overall average length of stay is better than expected length of stay

Indicator: Overall - Acute Average Length of Stay vs. ELOS Variance in Days - QIP *



	Actual	Target
12-Q1	-0.6	-0.0
12-Q2	-0.5	-0.0
12-Q3	-0.5	-0.0
12-Q4	-0.5	-0.0
13-Q1	-0.7	**-0.8**

Interpretation - Patient And Business:

A positive trend in overall performance continued in Q1. The -0.7 day variance for Q1 (fiscal 12/13) indicates that our overall actual length of stay remains below (or better) than our expected length of by 0.7 of a day, almost achieving our target of -0.8 days. However, it is important to note that this is calculated on an overall basis. There remains opportunity in 4 of 18 services to achieve expected length of stay. They are the services of Nephrology, Neurology, Neurosurgery, and Otolaryngology.

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: Target 12/13: -0.8 Days

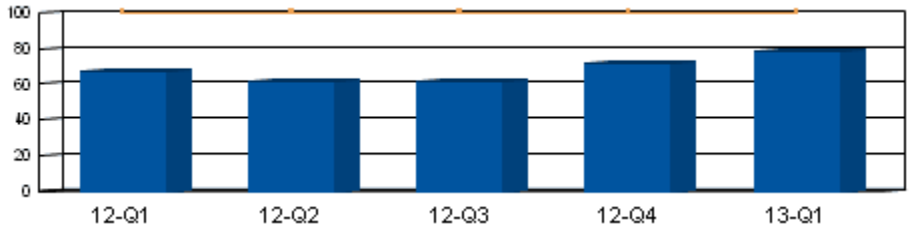
Kingston General Hospital

MS #07

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

KGH overall average length of stay is better than expected length of stay

Indicator: Percent of Clinical Services Meeting or Exceeding ELOS Target



	Actual	Target
12-Q1	67	**100**
12-Q2	61	**100**
12-Q3	61	**100**
12-Q4	72	**100**
13-Q1	78	**100**

Interpretation - Patient And Business:

As of Q1 (fiscal 12/13), 78 percent of services (14 of 18) are achieving (or outperforming) their expected length of stay. The services that are not currently at their expected length of stay are Nephrology, Neurology, Neurosurgery, and Otolaryngology.

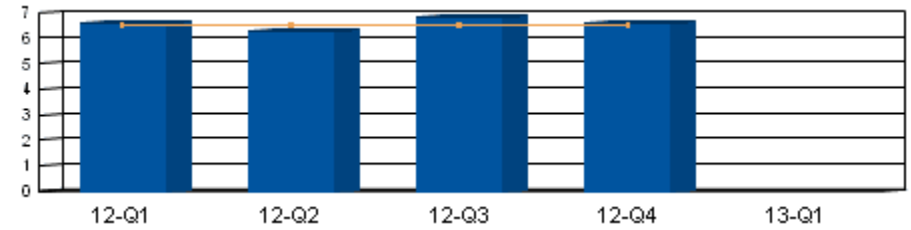
Actions & Monitoring Underway to Improve Performance:

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: Target 12/13: 100%

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



	Actual	Target
12-Q1	7	**7**
12-Q2	6	**7**
12-Q3	7	**7**
12-Q4	7	**7**
13-Q1		

Interpretation - Patient And Business:

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).

Actions & Monitoring Underway to Improve Performance:

The average length of stay for Q4 has dropped back down to 6.6 days putting us .1 days above the target of 6.5 days. It is worth noting that at the same time are average length of stay compared is .5 days below our expected. So although our ALOS remains slightly above target, we are remaining well below where we are expected to perform. There continues to be tremendous efforts placed on this achieving this target though the implementation of a variety of initiatives lead by a variety of disciplines.

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. Target 12/13: 6.5 Days

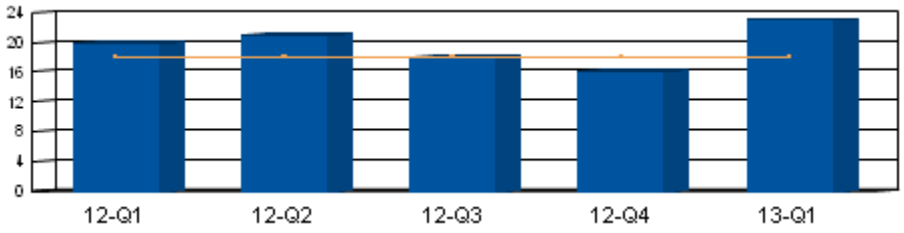
Kingston General Hospital

MS #07

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

KGH overall average length of stay is better than expected length of stay

Indicator: Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile *

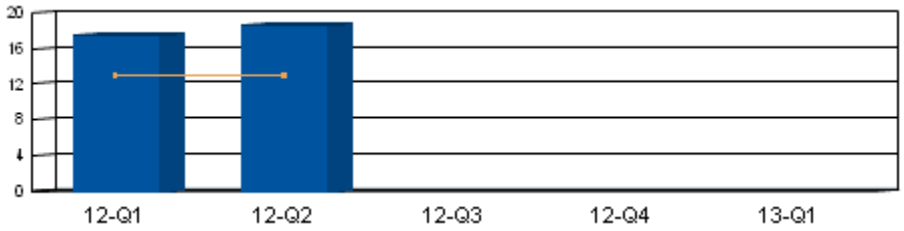


	Actual	Target
12-Q1	20	**18**
12-Q2	21	**18**
12-Q3	18	**18**
12-Q4	16	**18**
13-Q1	23	**18**

Definition: This indicator focuses on just on the readmission rate to KGH within 30 days of admission. It is defined as the number of patients readmitted to KGH for non-elective inpatient care divided by the total number of admissions. It will be calculated on a CMG basis using the SE LHIN CMG profile from their MLPA agreement – a performance agreement that focuses on system performance and financial accountabilities.

Target: Target 12/13: 18%

Indicator: Readmission Rate Within 30 Days for Selected CMG's to Any Facility *



	Actual	Target
12-Q1	17	**13**
12-Q2	19	**13**
12-Q3		
12-Q4		
13-Q1		

Actions & Monitoring Underway to Improve Performance:

An analysis of the SE LHIN data to review specific CMGs is challenging given the inclusion of readmissions to ANY facility in the LHIN. Individual readmissions to KGH will allow assessment of opportunities to further improve the readmission rates.

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: Target 11/12: 12.9%, Target 12/13: 12.9%

Strategy milestone # 8

The Emergency Department wait time for admitted patients is improved by 20%

Strategic Direction	KGH 2015 outcome	Status
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**	**Yellow**

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

1. **What is our actual performance on each of the indicators for this milestone as listed above?** The milestone involves 3 measures. While the goal of 9 of 10 patients spending less that 22 hours in the ED waiting for an inpatient bed has not been met as yet, the downward trend in wait time continues and remains below the previous years target of 31 hours. The percent of ED consults meeting target time does not yet have reported results. The target for percent of non admitted high acuity patients treated in <8 hours was met and shows marginal improvement relative to the previous quarter.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** While the 90th percentile wait time of 27 hours shows a further reduction and sustained improvement relative to the previous year's target of 31 hours, the target, in negotiation with the LHIN, was significantly reduced this year to 22 hours. The evidence that gains have been made is evidenced by a 2 hour reduction relative to the same quarter last year in spite of an increase in total ED admissions by 51 and inpatient units running overcapacity by as much as 10%.

3. **Are we on track to meet the milestone by year end?** Overall the reported results show favourable trends with targets being met or approached with anticipation that targets will be met by year end.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** As with the ELOS milestone, continue PFTF oversight and support for the program continuous improvement and tactical plan work that enable mining of data from EDIS for service planning (focus on consult times and direct admissions); ED avoidance (CSR roadmap work); supports for earliest and best alignment of patients to service areas; inpatient discharge prediction and planning.

Kingston General Hospital

MS #08

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Transform the patient experience through a relentless focus on quality, safety and service	The emergency department wait time for admitted patients is improved by 20%	90th Percentile ED Wait Time - All Admitted Patients (Hrs) - QIP	G	G	G	G	Y	↓
		Percent of ED Consults Meeting Target Time (Time Between Consult Requested in ED and Consultant Arrival ED) *	N/A	N/A	N/A	N/A	N/A	
		Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)	G	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

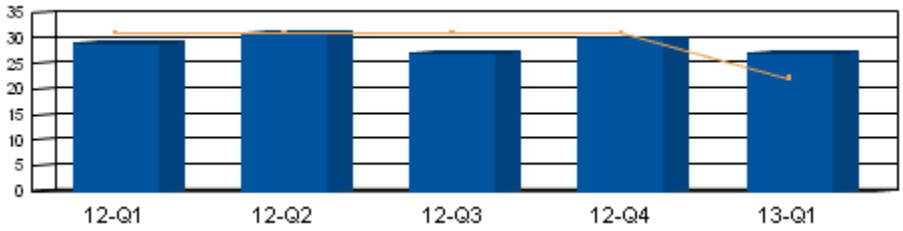
Kingston General Hospital

MS #08

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

The emergency department wait time for admitted patients is improved by 20%

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



	Actual	Target
12-Q1	29	**31**
12-Q2	31	**31**
12-Q3	27	**31**
12-Q4	30	**31**
13-Q1	27	**22**

Interpretation - Patient And Business:

The target of 9/10 patients spending less than 22 hours in the Emergency Department waiting for an inpatient bed has not been met in Q1. Although sustaining improvements made last fiscal, the reduction in the target by 9 hours (30%) has moved this indicator from green to yellow. Last year's target of 31 hours was sustained for the whole year.

Total admissions from the ED for Q1 this fiscal are 54 more than Q1 last fiscal with an improvement of 2 hours in the same time period. Inpatient units have admissions from other sources as well as ED and have been consistently running over capacity by as much as 10%.

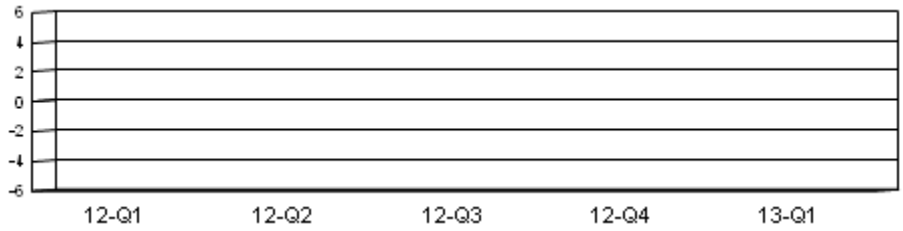
Actions & Monitoring Underway to Improve Performance:

LOS in the ED is continuously monitored in real time with EDIS, and supports timely and factual communication with inpatient units to support planning.
LOS is being monitored at a corporate level and discussed at Patient Flow Task Force.
Consultant arrival times are also being monitored from time of consult request to arrival in the ED and time of consult request to disposition decision.
A medicine nurse remains in a patient flow coordinator position for the medicine units.
Changes with bed assignment process, i.e. Bed Allocator role and reporting/communication tools, continue to be monitored and improved.
Overcapacity beds, flex beds and short stay beds are utilized as appropriate.

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: Target 11/12: 31 Hours Target 12/13: 22 Hours

Indicator: Percent of ED Consults Meeting Target Time (Time Between Consult Requested in ED and Consultant Arrival ED) *



	Actual	Target
12-Q1		
12-Q2		
12-Q3		
12-Q4		
13-Q1		

Definition: This indicator is part of the Ministry of Health's (MOH0 Most Responsible Physician (MRP) initiative aimed at meeting the corporate target(s) associated with achieving our ED wait time targets. Within ED wait times, there are many important sub-processes that contribute to the overall wait time. This one focuses the involvement of outside consultants who when asked down to the ED, see the patient, assess the patient, and make a decision as to whether or not to admit the patient.

Target: Target 12/13: 10% Improvement

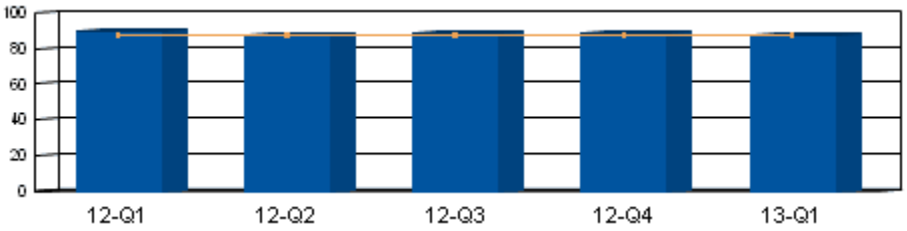
Kingston General Hospital

MS #08

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

The emergency department wait time for admitted patients is improved by 20%

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



	Actual	Target
12-Q1	90	**87**
12-Q2	87	**87**
12-Q3	88	**87**
12-Q4	88	**87**
13-Q1	87	**87**

Interpretation - Patient And Business:

Patient Perspective: Based on the Q1 results, the ED has sustained the improvement in the ED wait time meeting the 87% target for non-admitted, high acuity patients for the past 5 quarters.
The target was sustained with a significant increase in visits in this category. Volumes for this category of patient acuity increased by 479 visits over last quarter and 913 visits compared to the same quarter last year.

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. We have not been informed yet about targets for 2013 or what the funding will be for this fiscal.

Actions & Monitoring Underway to Improve Performance:

Initiatives are in progress to sustain gains made with respect to this target e.g. improved lab result notification, improvement of 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. Averages off-load time this quarter is 8 minutes.

Color coding on EDIS alerts staff if patients are approaching target time.

We have been green in the past 5 quarters.

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% Target 12/13: 87%

Strategy milestone # 9

Clinical services meet the provincial wait time target

Strategic Direction	KGH 2015 outcome	Status
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**	**Red**

Indicator
Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (excluding Cancer Surgery)

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   65% of clinical services are meeting the 90th percentile wait time (34 of 52). Of the 17 red indicators, 14 are KGH activity. The majority are very low volume activity and have a primary focus on oncologic surgery.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Low volume activity and competing for resources against oncologic surgery challenges the 90th percentile. Average and median wait times better reflect the realities of the practices.

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

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

   Spa leadership has engaged support staff to help with office level coding of wait times (ensure patients on wait list are ready for surgery). Additional OR emergency time and 2 rooms running of weekends is expected to positively influence the wait times.

Kingston General Hospital

MS #09

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
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	Orthopedic Surgery (Excluding Total Hip and Knee Replacements) - 90th Percentile Wait Time (Days)	R	R	R	R	R	↑
		Diagnostic Imaging- MRI – 90th Percentile Wait Time (Days)	R	R	R	R	R	↓
	Clinical services meet the provincial wait time target	Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs	R	R	R	R	Y	↑
		Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (Excluding Cancer Surgery)	Y	R	R	R	R	↓
		Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↓
		Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)	R	R	R	R	R	↑
		Percent of Patients Admitted (from the Emergency Department) Within a Wait Time Target of < 8 hrs	G	Y	G	Y	G	↑
		Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th Percentile Wait Time (Hrs)	R	R	R	R	R	↑
		All Paediatric Surgery - 90th Percentile Wait Time (Days)	R	R	R	R	G	↑
		Cardiac Bypass Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
		Coronary Angiography - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
		Coronary Angioplasty - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
		Diagnostic Imaging - CT – 90th Percentile Wait Time (Days)	G	G	G	G	G	↓
		General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)	G	G	R	R	R	↓
		Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	R	R	R	R	R	↓

	12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Percent of Wait Time Contracted Volumes Achieved	R	Y	Y	Y	R	↓
Radiation Wait time (Referral-Consult) Percent Seen Within 14 Days	G	R	R	R	R	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

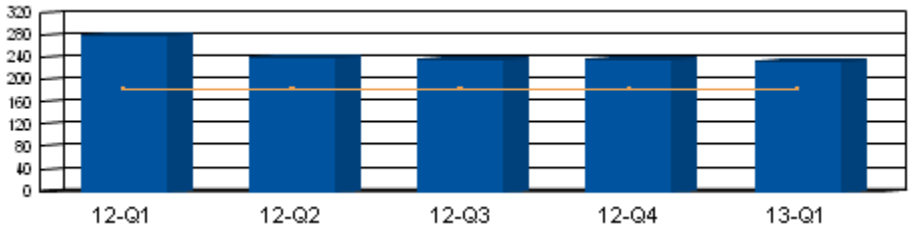
Kingston General Hospital

MS #09

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 Surgery (Excluding Total Hip and Knee Replacements) - 90th Percentile Wait Time (Days)



	Actual	Target
12-Q1	281	**182**
12-Q2	240	**182**
12-Q3	235	**182**
12-Q4	237	**182**
13-Q1	232	**182**

Interpretation - Patient And Business:

This KPI for the first quarter reflects an ongoing positive trend with decreasing days to meet the target. There were 395 cases completed in this quarter with 5 cases having accumulated wait times between 332 to 738 days. The 90 % wait time in days was 208 for the month of June which was an improvement of 50 days from the beginning of this quarter.

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 on weekends to KGH it is anticipated that the wait times will continue to improve SPA Program leadership concluded a review of wait time list coding as well as offered education to office support staff to assist in closer monitoring of patient lists in an effort to reduce substantial wait times due to inaccurate coding and patient unavailability which strongly influence the wait times.

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.

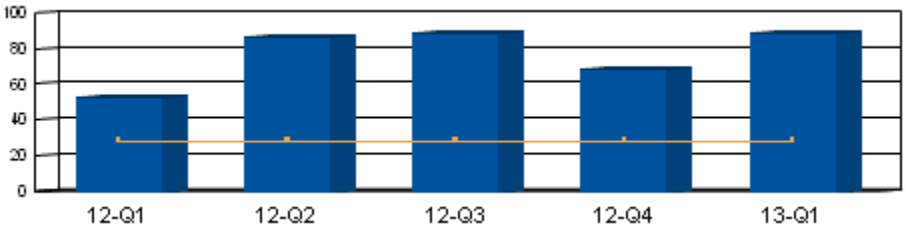
Target: Baseline 08/09: 183 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

MS #09

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
12-Q1	53	**28**
12-Q2	86	**28**
12-Q3	88	**28**
12-Q4	68	**28**
13-Q1	88	**28**

Interpretation - Patient And Business:

The wait time for MRI continues to be a challenge. The demand for service far exceeds the capability of a single magnet. A 5th FT MRI technologist has been hired. Her orientation will be complete by September. This will allow us to maintain expanded hours.

These lengthy wait times are an issue in that they contribute to delayed diagnosis or delay in medical management decisions. This is stressful for the patients and frustrating for the healthcare providers.

Actions & Monitoring Underway to Improve Performance:

Expanded hours will be protected as of September.
The purchase of the MRI software upgrades that should occur in September/October will decrease the length of time it takes to perform many of the procedures allowing us to perform more cases within a day.
Priority 1 and 2 cases along with most Cancer Center cases are performed at KGH. Al specialized cases are performed at KGH, pediatric sedation cases, general anesthetic cases, cardiac MRI, OBSP breast screening, breast biopsy are performed at KGH. Where possible Priority 3 and 4 cases predominantly non-contrast cases are forwarded to the KMRI private clinic when possible. Patients from the Belleville area are forwarded to the Belleville hospital if possible. However, even with this organization KGH cannot address all the MRI needs in a timely fashion with a single magnet. This will continue to be an issue until a second hospital based MRI magnet is available at KGH.
We will continue to discuss with the SELHIN the need for a second MRI at KGH.

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 Target 12/13: 28 Days

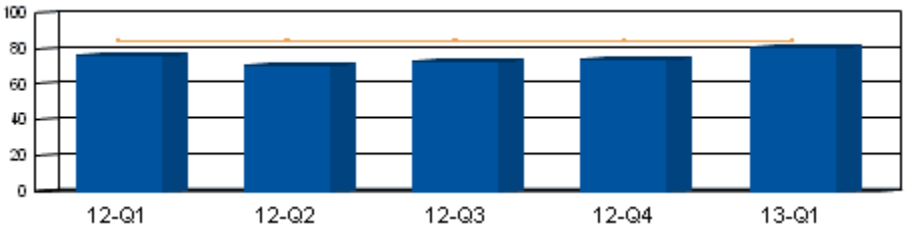
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q1	76	**84**
12-Q2	71	**84**
12-Q3	73	**84**
12-Q4	74	**84**
13-Q1	81	**84**

Interpretation - Patient And Business:

Patient Perspective: Based on Q1 results the ED is slightly below the new ED target wait time for the CTAS 4 and 5 patients. While this indicator has improved by7percent over last quarter. 19% of non-admitted low acuity patients are waiting in the ED longer than the 4 hour target.
Patients in this category will wait longer in the waiting room when the department is above capacity to allow more urgent patients to be seen and assessed. This may be appropriate in some cases.

Business Perspective:
High volumes of patients with higher acuity means that patients in this category wait longer for physician assessment, diagnosis and treatment.

Actions & Monitoring Underway to Improve Performance:

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.
Section B is being utilized as a fast track area but sometime these beds are not readily available as they are used for procedures, mental health assessments and overflow when the department is busy.
The Emergency Program Council continues to look for ways to redesign flow within the department to continue to move toward target.

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%. Target 12/13: 84%

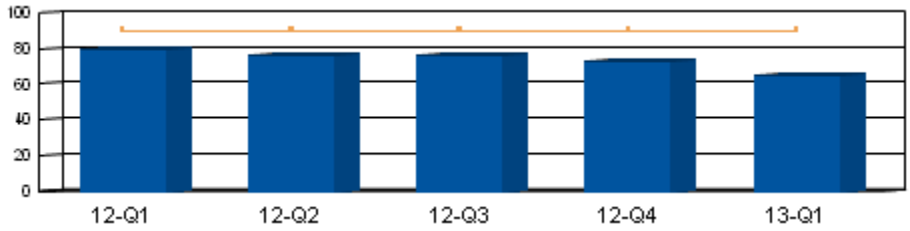
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

Indicator: Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (Excluding Cancer Surgery)



	Actual	Target
12-Q1	80	**90**
12-Q2	76	**90**
12-Q3	76	**90**
12-Q4	73	**90**
13-Q1	65	**90**

Interpretation - Patient And Business:

Achieving wait time targets is a quality of care measure that is publically reported on the Ministry's Wait Time website. In total 52 indicators are rolled up to provide an overview of the wait time initiative. At Q1 there are 18 red indicators: 17 surgical and MRI.

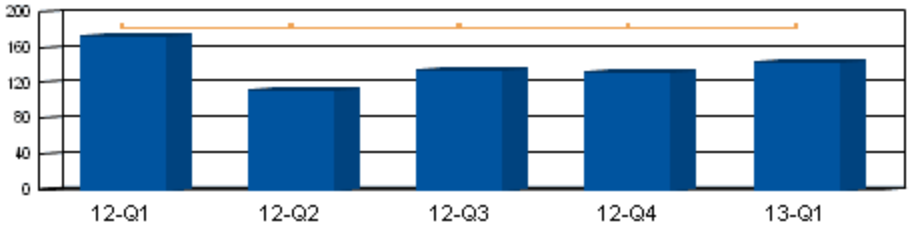
Actions & Monitoring Underway to Improve Performance:

The Wait Time Strategy Committee reviews wait time and volume indicators with the SPA leadership. Recommendations are initiated to address red indicators. A coordinator is working with the surgical offices to review waiting lists to help manage outstanding long duration waiting times.

Definition: FY2013 includes all surgical wait time categories reportable to the Wait Times Information System. This excludes Ophthalmic, Otolaryngic and Cancer surgery. Diagnostic Imaging: MRI and CT are also included.

Target: Target 12/13: 90%

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



	Actual	Target
12-Q1	173	**182**
12-Q2	111	**182**
12-Q3	135	**182**
12-Q4	132	**182**
13-Q1	144	**182**

Interpretation - Patient And Business:

This KPI indicator continues to maintain its green target status. The median days waiting were relatively stable at 72 days across the quarter. The 90% percentile wait time in April was 261 days decreasing to 189 days in June. Access to additional operating room time in the evenings (Mon, Wed, Thurs, Fri) as well as weekends (2 additional OR's resourced) continues to assist in keeping this indicator within the target range.

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. Target 12/13: 182 Days

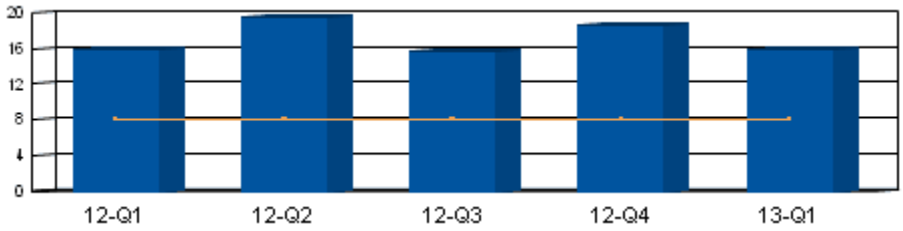
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q1	15.8	**8**
12-Q2	19.6	**8**
12-Q3	15.7	**8**
12-Q4	18.7	**8**
13-Q1	15.9	**8**

Interpretation - Patient And Business:

Patient Perspective: Based on the Q1 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 patient's inpatient beds are not available once the decision to admit has been made. Nine of 10 patients were admitted to an inpatient bed within 15.9 hours, 3 hours better than last quarter with a decrease in the number of patients admitted. Delays in moving patients include a high demand for critical care beds, particularly level 2 beds, mental health beds and 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 and treat patients within target times. Volumes of admitted patients were 323 higher this quarter than expected and 55 visits higher than same quarter last year. 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).

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,

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 (or from when a patient arrives as direct to service) to the arrival of consultant service is the first time stamp and time from consult request to disposition decision is the second.
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. We have not been informed about funding for Pay for Results for this fiscal. The express beds and numerous positions supporting patient flow are at risk without funding which would have a negative impact on patient flow.

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. Target 12/13: 8hrs

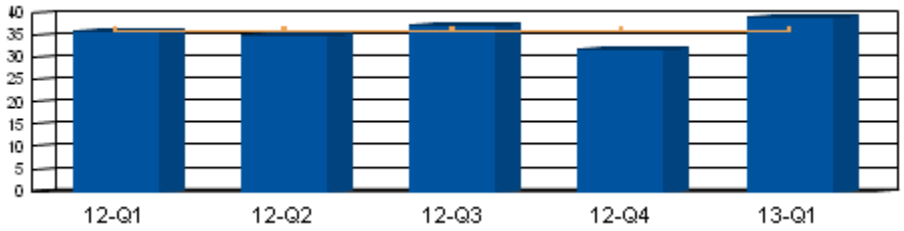
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

Indicator: Percent of Patients Admitted (from the Emergency Department) Within a Wait Time Target of < 8 hrs



	Actual	Target
12-Q1	36	**36**
12-Q2	35	**36**
12-Q3	37	**36**
12-Q4	32	**36**
13-Q1	39	**36**

Interpretation - Patient And Business:

Patient Perspective: Based on Q1 results, improvements to patient flow have been made over this past year and this target has been met in Q1. While many patients are waiting longer than 8 hours before reaching their inpatient bed, 39% 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 843 days which is 241 days more than the previous quarter and 124 days more than Q1 last fiscal.

Business Perspective: When the ED is backed up with patients waiting for an inpatient bed 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 and funding for this fiscal are unknown at this time.

Actions & Monitoring Underway to Improve Performance:

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 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%. Target 12/13: 36%

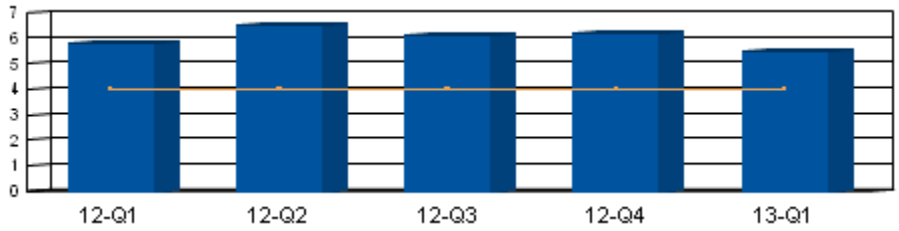
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

Indicator: Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th Percentile Wait Time (Hrs)



	Actual	Target
12-Q1	5.8	**4**
12-Q2	6.5	**4**
12-Q3	6.1	**4**
12-Q4	6.2	**4**
13-Q1	5.5	**4**

Interpretation - Patient And Business:

Patient Perspective: Based on the Q1 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 5.5 hours. The ability to see patients in this category is dependent on available assessment space. With the increase in admitted patients and a significant increase in higher acuity patients, these patients tend to wait longer. While this indicator remains red, there is a positive trend toward target.

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 claw back if targets are not met.

Actions & Monitoring Underway to Improve Performance:

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. Target 12/13: 4hrs

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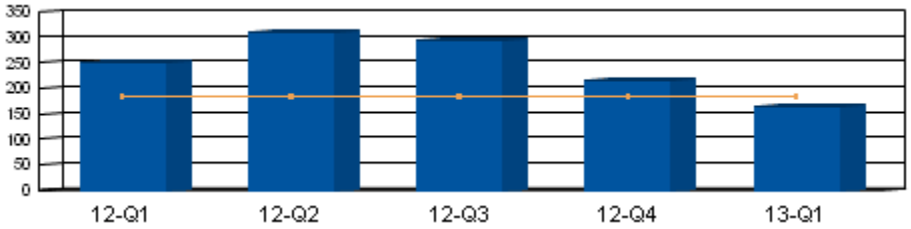
Indicator: All Paediatric Surgery - 90th Percentile Wait Time (Days)



	Actual	Target
12-Q1	250	**182**
12-Q2	310	**182**
12-Q3	293	**182**
12-Q4	217	**182**
13-Q1	164	**182**

Interpretation - Patient And Business:

The 90% for ENT in this first quarter had the highest wait time in April of 300 days which then decreased to115 days in June. The ENT service average median is 53 days in Q1 which is a significant improvement of 13 days from the last quarter. Improvements to physician resources for this service have positively improved long surgery waiting lists.

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:

SPA Program leadership has concluded a review of wait time list coding along with education to office support staff to assist in closer monitoring of patient lists across the services.

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. Target 12/13: 182 days

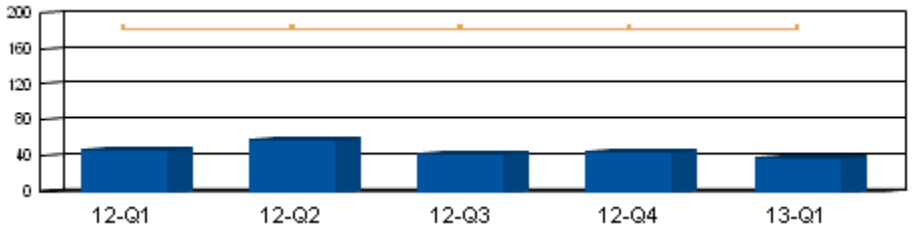
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q1	46	**182**
12-Q2	57	**182**
12-Q3	43	**182**
12-Q4	45	**182**
13-Q1	37	**182**

Interpretation - Patient And Business:

Patient Perspective: Based on Q1 activity, KGH is meeting the performance target for elective cardiac bypass surgery wait times. Wait time at the 90th percentile is 37 days which is 145 days below the provincial target. 100% of all cases were completed within the recommended maximum wait time of 182 days. The median wait time was 17 days. Patients are not waiting beyond the RMWT for cardiac surgery at KGH.

Business Perspective: A more coordinated approach to monitoring and scheduling cardiac bypass surgery has been beneficial with respect to increasing access to care and maintaining wait times. Streamlining the work of the Regional Cardiac Care Coordinators so that one coordinator has assumed primary responsibility for surgery will enhance the service at KGH.

Actions & Monitoring Underway to Improve Performance:

A Regional Cardiac Care Coordinator (RCCC) dedicated to cardiac surgery monitors wait lists daily and books patients according to a pre-defined urgency rating scale. Patients are given the option of being referred to another center outside of the LHIN if KGH cannot complete their surgery within the target wait time. If a delay is identified, it is followed-up by the RCCC.

There are no concerns at the time with wait times for any urgency.

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 Target 12/13: 182 Days

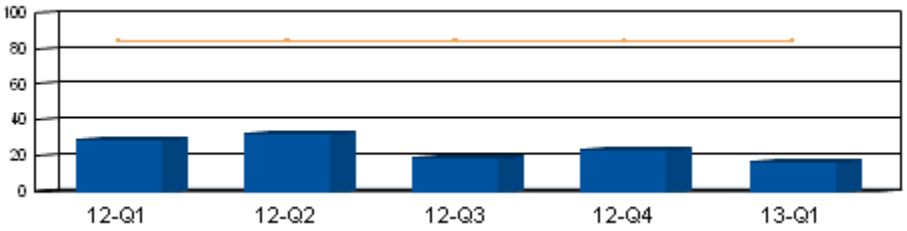
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q1	29	**84**
12-Q2	32	**84**
12-Q3	19	**84**
12-Q4	23	**84**
13-Q1	17	**84**

Interpretation - Patient And Business:

Patient Perspective: Based on Q1 activity, KGH is meeting wait time target for cardiac angiography. Wait time for elective angiography is 17 days at the 90th percentile. This is 67 days below the provincial target. 100% of patients had their elective angiogram within the recommended wait time. The median wait time for elective angiography was 8.6 days.

Business Perspective: Completing procedures within the target wait time helps KGH stay on target for completing funded volumes and helps to avoid the cost inefficiencies associated with longer wait times including inpatient LOS.

Actions & Monitoring Underway to Improve Performance:

A Regional Cardiac Care Coordinator (RCCC) dedicated to cardiac cath monitors wait lists daily and books patients according to urgency rating. All patients in the region are booked for procedures based on this urgency rating.
Close attention is paid to ensuring we are serving the regional hospitals and patients across the LHIN in an equitable manner. This is achieved in part through the same day program and the STEMI By-pass protocol.

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. Target 12/13: 84 Days

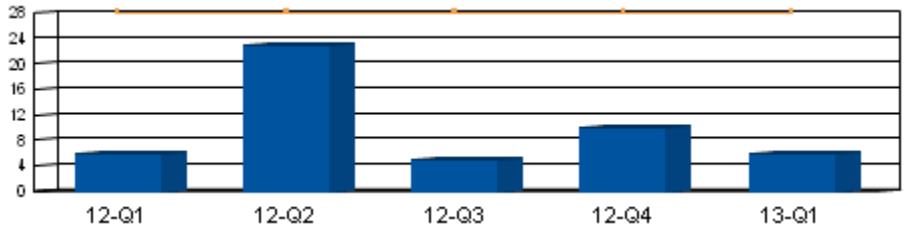
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q1	6	**28**
12-Q2	23	**28**
12-Q3	5	**28**
12-Q4	10	**28**
13-Q1	6	**28**

Interpretation - Patient And Business:

Patient Perspective: Based on Q1 activity, KGH is meeting the wait time target for coronary angioplasty. The wait time at the 90th percentile is 6 days which is 22 days below the provincial target. The median for elective PCI in Q1 averages 2 days. 100% of all patients are completed with the recommended wait time for elective and semi-urgent. Urgent volumes are very low since many urgent patients are done at the same time as their angiography.

Business Perspective: Completing all procedures within the target wait time helps KGH stay on target for completing additional funded volumes and helps to avoid the cost inefficiencies associated with longer wait times.

Actions & Monitoring Underway to Improve Performance:

A Regional Cardiac Care Coordinator (RCCC) dedicated to cardiac cath monitors wait lists daily and books patients according to urgency rating. Many angioplasties occur as same sitting PCI which means diagnostic angiograms are followed by angioplasty in one procedure. The number of same sitting PCIs done at KGH is just at the provincial average. This results in one lab time for the patient rather than 2 separate procedures booked at 2 different times.

No concerns as wait times are well under target.

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. Target 12/13: 28 Days

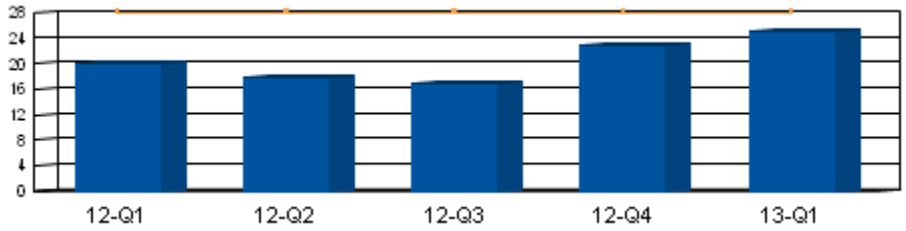
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q1	20	**28**
12-Q2	18	**28**
12-Q3	17	**28**
12-Q4	23	**28**
13-Q1	25	**28**

Interpretation - Patient And Business:

KGH consistently is below the provincial target of 28 days. The LHIN target for KGH is 15 days. We will strive to achieve this over the next 2 quarters. The patient population of KGH is primarily priority 1, 2 and "timed" studies. Achieving a wait time of 15 days or less should be achievable.
A low wait time supports earlier medical management and patient discharge as well as decreases ER length of stay.

Actions & Monitoring Underway to Improve Performance:

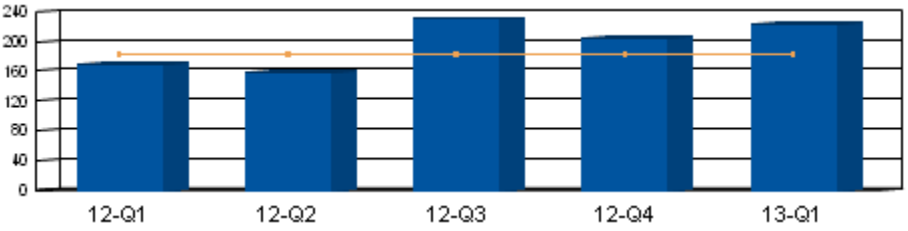
Striving for an aggressively low wait time target benefits the patient population in that the care providers receive the necessary diagnostic results in a time frame that allows for quick decision making and medical management there by supporting earlier discharges or decreased ER wait times.

We will continue to monitor booking practices and access to ensure that wait times remain low.

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. Target 12/13: 28 Days

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



	Actual	Target
12-Q1	169	**182**
12-Q2	159	**182**
12-Q3	230	**182**
12-Q4	204	**182**
13-Q1	223	**182**

Interpretation - Patient And Business:

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 to assist with reducing long wait time cases. There is also opportunity to extend operating room time during the week for longer cases (10 hour days) when necessary. For this first quarter the 90% wait times have moved from 219 days in April to 241 days in June which can be directed related to completed surgical cases that ranged from 276 days to 1488 days in time waiting.

Actions & Monitoring Underway to Improve Performance:

SPA Program leadership concluded a review of wait time list coding as well as offered education to office support staff to assist in closer monitoring of patient lists in an effort to reduce substantial wait times due to inaccurate coding and patient unavailability which strongly influence the 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. Target 12/13: 182 Days

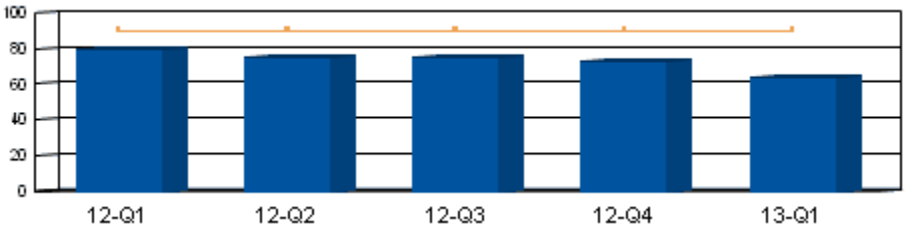
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q1	80	**90**
12-Q2	75	**90**
12-Q3	75	**90**
12-Q4	73	**90**
13-Q1	64	**90**

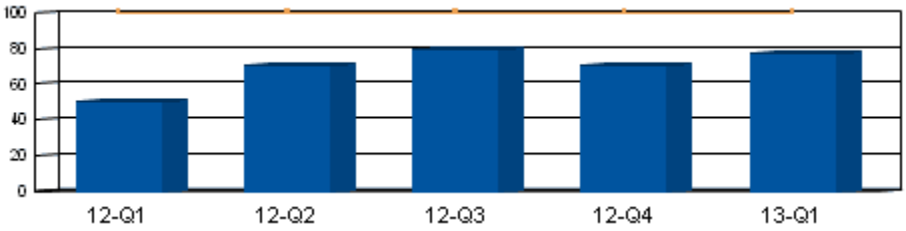
Actions & Monitoring Underway to Improve Performance:

The Wait Time Strategy Committee reviews wait time and volume indicators with the SPA leadership. Recommendations are initiated to address red indicators. A coordinator is working with the surgical offices to review waiting lists to help manage outstanding long duration waiting 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% Target 12/13: 90%

Indicator: Percent of Wait Time Contracted Volumes Achieved



	Actual	Target
12-Q1	50	**100**
12-Q2	70	**100**
12-Q3	80	**100**
12-Q4	70	**100**
13-Q1	77	**100**

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 F2013: Anorectal,Gall Bladder, Intestinal IP, Groin Hernia, Ventral Hernia,Paediatric Oral Maxiofascial (Dental) OP, Paediatric Scoliosis,, Paediatric Cleft Lip, Paediatric ACL, MRI, CT,Cancer Surgery, Cardiac (includes Angioplasty, Angiography,Bipass Surgery).

Target: Target 11/12: 100% Target 12/13: 100%

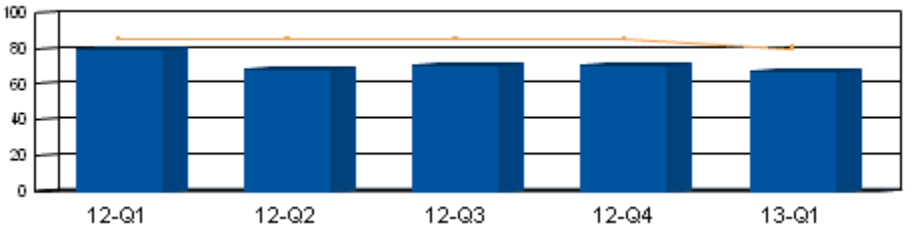
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

Indicator: Radiation Wait time (Referral-Consult) Percent Seen Within 14 Days



	Actual	Target
12-Q1	80	**85**
12-Q2	68	**85**
12-Q3	71	**85**
12-Q4	70	**85**
13-Q1	67	**80**

Interpretation - Patient And Business:

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%. Target 12/13: 80%

Strategy milestone # 10

Cancer Care Ontario access to care indicators are met

Strategic Direction	KGH 2015 outcome	Status
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**	**Red**

Indicator
Number of Cancer Care Ontario Access to Care Contract Indicators Met (Radiation/Chemotherapy)

1. **What is our actual performance on each of the indicators for this milestone as listed above?** The CCO indicators, for chemotherapy/radiation and surgical care which show failure to meet the CCO contract indicators do not as yet include Q1 results. The first indicator is also a composite of chemotherapy which shows variable performance and radiation oncology which shows downward trend with widened gap between target and actual. The ministry cancer surgical wait time results for Q1 demonstrate that KGH continues to exceed the target and show reduction

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The program has been challenged over the past year with a number of issues associated with interim program leadership and redevelopment that have complicated efforts to address access indicators. The improvement with the ministry wait time indicator demonstrates the ability of the program to collaborate with the SPA program leadership to support focused management of oncology OR scheduling.

3. **Are we on track to meet the milestone by year end?** Not as yet; however with the appointment of the new Oncology Department Head/Cancer Program PMD, there is confidence that the now full and permanent program leadership team will address perceptions and issues with CCO data integrity and making process improvements.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** In addition to the oversight by the Cancer Care Program Council, there is review of performance on a monthly basis with the Wait Time Committee and on a quarterly basis with CCO for the purpose of improvement planning. The program is planning and implementing tactics that support the expectations for access as detailed in the recently approved Cancer Program Strategic Plan. An improvement team established between Cancer and SPA programs to study issues and introduce process improvements.

Kingston General Hospital

MS #10

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Transform the patient experience through a relentless focus on quality, safety and service	Cancer Care Ontario access to care indicators are met	Number of Cancer Care Ontario Access to Care Contract Indicators Met (Radiation/Chemotherapy)	R	R	R	R	R	↓
		Percent of Cancer Care Ontario Access to Surgical Care Contract Indicators Met	R	R	R	R	R	↓
		All Cancer Surgery Wait Time - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

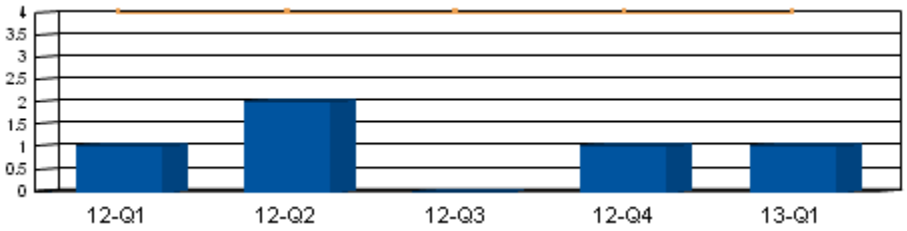
Kingston General Hospital

MS #10

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

Cancer Care Ontario access to care indicators are met

Indicator: Number of Cancer Care Ontario Access to Care Contract Indicators Met (Radiation/Chemotherapy)



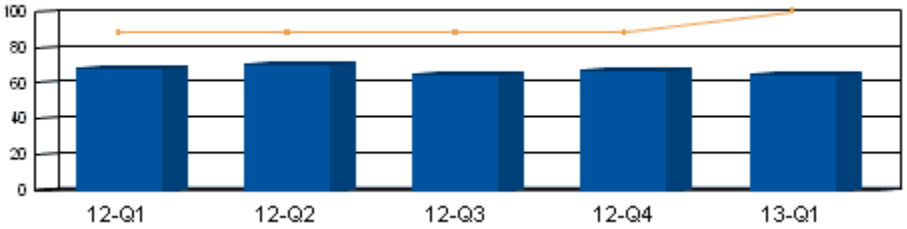
	Actual	Target
12-Q1	1	**4**
12-Q2	2	**4**
12-Q3	0	**4**
12-Q4	1	**4**
13-Q1	1	**4**

Interpretation - Patient And Business:

Definition: Cancer Care Ontario reports on wait times for access to both systemic (IV chemotherapy) and radiation therapy. Systemic access is measured according to the interval referral to consult (14-day target), and consult to treatment (28-day target). Radiation access is measured according to the interval from referral to consult (14-day target), and the time between being ready for treatment and receiving treatment (1, 7, or 14 day target for priorities 1, 2, and 3, respectively). CCO measures the percent of patients who were treated within their respective access targets. This indicator is a roll-up of the four access to care contract indicators met.

Target: 12/13 Target 4

Indicator: Percent of Cancer Care Ontario Access to Surgical Care Contract Indicators Met



	Actual	Target
12-Q1	68	**88**
12-Q2	70	**88**
12-Q3	65	**88**
12-Q4	67	**88**
13-Q1	65	**100**

Interpretation - Patient And Business:

Based on Q1 results, KGH is not meeting the established Cancer Care Ontario (CCO) target for access to cancer surgery.

Actions & Monitoring Underway to Improve Performance:

Given that KGH has not been meeting the CCO target for the past number of quarters, an improvement project has been launched to drive changes that move KGH to achieving the established target and reducing the overall wait time for cancer surgery.

Part of the improvement strategy includes a weekly review of:

1. Number of patients who have exceeded the wait time associated with the priority assigned to their case;
2. Length of time they have been waiting beyond the assigned target; and
3. Type of cases waiting by disease site and surgeon.

Using this information, close interaction occurs with surgeon's offices to determine what action is required to enable the patient access to treatment as quickly as possible.

Other aspects of the improvement project include addressing data quality issues and assessing overall resources utilization dedicated to cancer surgery.

Definition: Surgical wait times are measured by tracking the time between when a surgeon decides to operate and when the surgery takes place. The priority of the case, determined by the surgeon, depends on many factors such as the type of cancer, patient complexity and progression of the disease. This access indicator measures the percent of patients who meet their priority access targets (2, 3, or 4), from the date of decision to treat until surgery date, for those aged 18 and older, undergoing treatment-intent oncology surgery for all disease sites except for skin and lymphoma.

Target: 12/13 Target 100%

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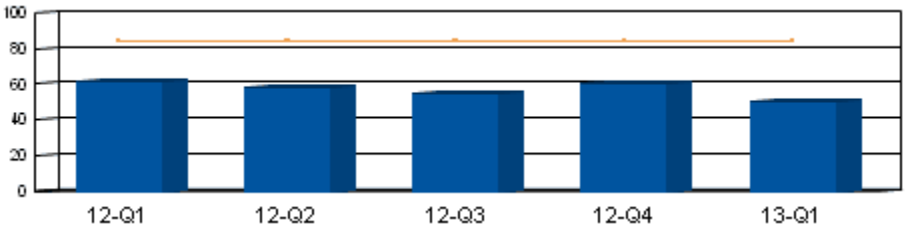
Cancer Care Ontario access to care indicators are met

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



	Actual	Target
12-Q1	61	**84**
12-Q2	58	**84**
12-Q3	55	**84**
12-Q4	60	**84**
13-Q1	50	**84**

Interpretation - Patient And Business:

The KGH 90th percentile wait continues to better than the provincial target in days waiting. With an established provincial target of 90% patient care access KGH continues to trend positively in meeting this new target with this quarter reporting at 64.3%.

The following are updates of key procedures:

Urology: 90th percentile wait has decreased by 30 days. The median wait in June of 30 days was down from 53 days in April.. Overall the trending is still positive and efforts for further improvement are being monitored.

Gynecology - 90th percentile wait in June is 33 days down from 66 days in April. The median wait was increased slightly by 16 days for June.

Actions & Monitoring Underway to Improve Performance:

The SPA program leadership will continue to support central management of Oncology time. To assist with cancer surgery wait lists available operative time is provided to Oncology with the inclusion of extended operating days and extra booked cases. This appears to be effective in managing the wait list and providing patients with more timely service.

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.

Strategy milestone # 11

Automation of interprofessional assessment-and-adverse-reaction documents is complete (e-doc project)

Strategic Direction	KGH 2015 outcome	Status
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**	**N/A**

Indicator
Automation of Interprofessional Assessment & Adverse Reaction Documents is Complete as Part of the E-Doc Project

1. **What is our actual performance on each of the indicators for this milestone as listed above?** While work continues in support of interprofessional practice and with bedside documentation as part of the system support to the model of care, the automation of the documents is currently on hold as a result of capital funding and project management resource limitations.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Following deliberation by EMC, limited capital dollars and limited project support resources have been aligned and allocated to other projects deemed to be higher priority, and with greater and earlier return on investment (scheduling project).

3. **Are we on track to meet the milestone by year end?** No. The decision to put this initiative on hold can be revisited during the year if circumstances change.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** Work will continue on the design and content of the interprofessional assessment and adverse reaction documents with the goal of content readiness for automation when capital and project management resources available.

Kingston General Hospital

MS #11

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1
Bring to life new models of interprofessional care and education	Automation of interprofessional assessment-and-adverse-reaction documents is complete (e-doc project)	Automation of Interprofessional Assessment & Adverse Reaction Documents is Complete as Part of the E-Doc Project	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

Kingston General Hospital

MS #11

Bring to life new models of interprofessional care and education

Automation of interprofessional assessment-and-adverse-reaction documents is complete (e-doc project)

Indicator: Automation of Interprofessional Assessment & Adverse Reaction Documents is Complete as Part of the E-Doc Project

	Actual	Target
13-Q1		

Interpretation - Patient And Business:

Project is on hold and will be proceeding to board for decision regarding timelines.

Definition: As part of transitioning to a fully automated patient record, and in support of interprofessional document as an underpinning of communication amongst providers, the electronic documentation (e-doc) project is being extended to include automation of interprofessional assessment and adverse reaction documents. This component of the project necessitates development of content for the documents and translation of that content into an electronic format, as well as change in practice of providers with documentation practices.

Target: Target 100%

Strategy milestone # 12

Workplan to fulfill interprofessional education competencies completed

Strategic Direction	KGH 2015 outcome	Status
Bring to life new models of interprofessional care and education	**KGH is recognized as a centre of excellence in interprofessional education**	**Red**

Indicator
Number of Interprofessional Organizational Educational Competencies Are Met

1. **What is our actual performance on each of the indicators for this milestone as listed above?** The IPE charter had included a Q1 deliverable of having a detailed action plan developed to enable and provide evidence of organizational competencies related to educating professional staff and learners. This detailed action plan has not been finalized as yet.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** An IPE planning session was held in Q1 facilitated by Eric Lockhart, Queen's University and actions were proposed; however securing full engagement of the Steering Committee for review and final endorsement has proven to be a challenge. As well, profile of the relevance and value of the initiative within the organization has been limited by supports given vacancies in communication resources, and also by competing priorities.

3. **Are we on track to meet the milestone by year end?** Not as yet but expect that recent assignment of a communication expert to support communication and marketing of the IPE initiative will give momentum. As well there is work underway to recruit at least 2 IPE champions for each program.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** The oversight structure for this initiatve is being reconsidered with possible shift from current Steering Committee to smaller more nimble IP project team. An IPE communication strategy will give assurance that there is much in place and underway in support of IPE – it will not all be new or incremental work. Clear alignment of the IPE work to PFCC and Interprofessional Practice Model as foundational to the patient experience could also support relevance and value to providers, and promote engagement.

Kingston General Hospital

MS #12

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1
Bring to life new models of interprofessional care and education	Workplan to fulfill interprofessional-education competencies is completed	Number of Interprofessional Organizational Educational Competencies Are Met	N/A	N/A	N/A	N/A	R

Indicates improving performance to target over the past 5 quarters

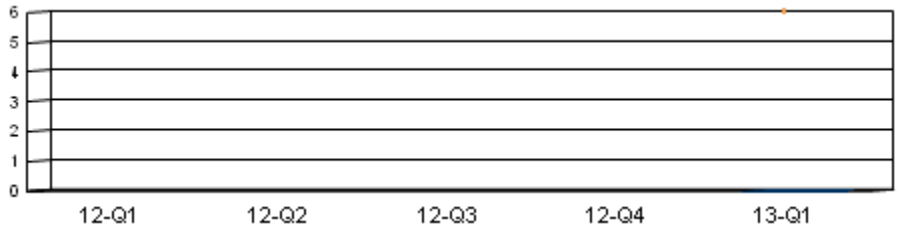
Indicates worsening performance to target over the past 5 quarters

MS #12

Bring to life new models of interprofessional care and education

Workplan to fulfill interprofessional-education competencies is completed

Indicator: Number of Interprofessional Organizational Educational Competencies Are Met



	Actual	Target
12-Q1		
12-Q2		
12-Q3		
12-Q4		
13-Q1	0	**6**

Interpretation - Patient And Business:

Accountability themes include supporting ongoing learning; ensuring practitioners receive support and supervision when acquiring new knowledge and skills and in becoming reflective practitioners; ensuring learning activities help enhance practice; creating an environment that supports quality care, practice and research; and ensuring the environment enhances practice & enables development of expertise.

Professional Practice Council, Nursing Practice Council, interprofessional education (IPE) support teams, IPE Evaluation Committee & IPE Steering Committee as well as external stakeholders have provided feedback regarding the 'wish list' related to the organizational accountabilities. The action plan for the organizational accountabilities will be presented to IPE Steering Committee for approval.

Actions & Monitoring Underway to Improve Performance:

As an Academic Health Science Centre, learning is a mandate we are required to fulfill.

The action plan will be developed with clear timelines and most responsible persons.

The IPE Steering Committee reports to the Operations Committee and provides regular updates to the Research and Education Committee of the Board.

Definition: There are 10 organizational accountabilities related to educating professional staff. The accountabilities are viewed through the lens of staff continuing education & professional development, as well as the student learning experience.

Performance will be measured by degree of completion of the work plan, which includes activities, timelines and deliverables that addresses the 10 interprofessional education accountabilities.

Target: 2012/2013 Target: 6

Strategy milestone # 13

Clinical research space at KGH increases by 25%.

Strategic Direction	KGH 2015 outcome	Status
Cultivate patient oriented research	**Externally funded research at KGH has increased by 50%**	**N/A**

Indicator(s)
Square Footage of Clinical Research Space at KGH
8% Increase of Externally Funded Research Dollars at KGH

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 continues with the planning of a Clinical Investigation Unit. A Needs Assessment for the KGHRI has been completed and disseminated to EMC. It includes a draft floor plan for the Unit, a marketing/communication strategy, and the identified need to expand the provision of services offered to researchers. A draft research strategic plan has been created and will be disseminated to EMC by the end of Q3 of F13.

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

   Accessing the space on Connell 4 for the Clinical Investigation Unit; the space is currently occupied by Medical Genetics and others. Converting Connell 4 into the Clinical Investigation Unit is dependent 100% on the funds raised through UHKF.

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

   Yes. Connell 4 is expected be turned over to KGHRI in early 2013. UHKF has started to create a fundraising strategy for the Clinical Investigation Unit.

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.

Kingston General Hospital

MS #13

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Cultivate patient oriented research	Clinical research space at KGH increases by 25%	8% Increase of Externally Funded Research Dollars at KGH	N/A	G	G	G	N/A	↑
		Square Footage of Clinical Research Space at KGH	N/A	N/A	N/A	N/A	N/A	
		Active Clinical Trials	G	G	G	G	G	↑
		New Clinical Trials	G	R	R	G	R	↓
		Clinical Trials Generating Revenue	G	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

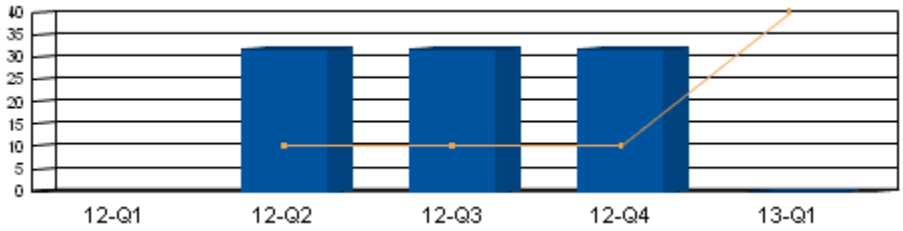
Kingston General Hospital

MS #13

Cultivate patient oriented research

Clinical research space at KGH increases by 25%

Indicator: 8% Increase of Externally Funded Research Dollars at KGH



	Actual	Target
12-Q1		
12-Q2	32	**10**
12-Q3	32	**10**
12-Q4	32	**10**
13-Q1		**40**

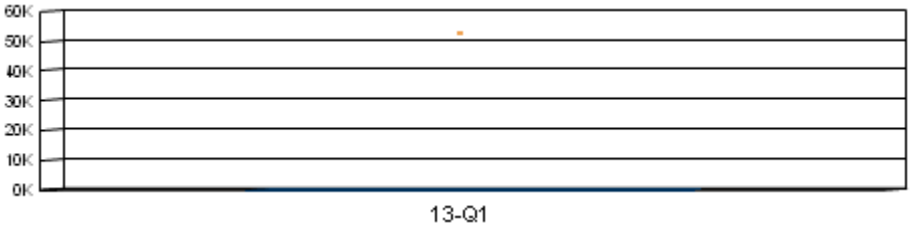
Interpretation - Patient And Business:

KGH Research Annual Report will be released in fall 2012 and the data for percent increase in research funds will be recorded in Q2/Q3. Real F2012 data will be used for reporting of F2013 data for this performance indicator since real figures for F2013 will not be available until September 2013. 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 M, $16.3 M, and $21.6 M in external funding from government sources, foundations, societies and agencies, industry, and other sources in F2009 (baseline), F2010, and F2011 respectively. Our 2015 Target is $23.5 M. Real F2012 data will be used for reporting of F2013 data for this performance indicator since real figures for F2013 will not be available until September 2013. 95% of the data is obtained from external sources and is not available on a quarterly basis for reporting.

Target: 2012/2013 Target: 40%

Indicator: Square Footage of Clinical Research Space at KGH



	Actual	Target
13-Q1		**52500**

Interpretation - Patient And Business:

Complete turnover of Connell 4 to KGHRI expected to occur in early 2013. Currently only three offices are occupied by KGHRI within the wing.

Definition: Current square footage for research space at KGH is ~42,000 sq/ft. Ongoing plans to increase research space during F2013 by 25 percent are under development. Potential space on Connell 4 has been identified that will provide the majority of space (~8,500 sq/ft). Additional space (~3,000 sq/ft) has been identified on Angada 0. Occupancy of both areas will help us meet this performance indicator however they are dependent on the current occupants vacating the area in the coming fiscal year to remain on target.

Target: 2012/2013 Target 52,500 sq/ft

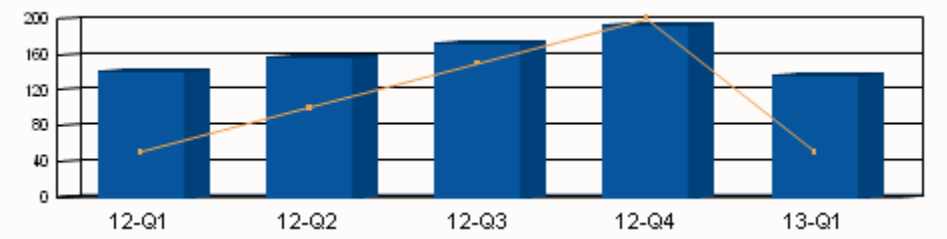
Kingston General Hospital

MS #13

Cultivate patient oriented research

Clinical research space at KGH increases by 25%

Indicator: Active Clinical Trials



	Actual	Target
12-Q1	140	**50**
12-Q2	157	**100**
12-Q3	172	**150**
12-Q4	192	**200**
13-Q1	136	**50**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q1.

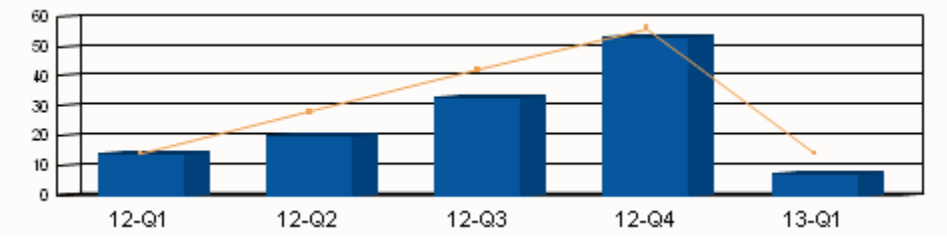
Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the first quarter (Q1).

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. Target 12/13: 200 Trials.

Indicator: New Clinical Trials



	Actual	Target
12-Q1	14	**14**
12-Q2	20	**28**
12-Q3	33	**42**
12-Q4	53	**56**
13-Q1	7	**14**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to new clinical trials at KGH during Q1.

Business Perspective: Based on the fiscal year to date, KGH is behind target by the end of the first quarter (Q1). As per our Agreement Affiliation with Queen's University, clinical trial contracts, agreements and grants are administered by the Office of Research Services' Contracts Office. In general, the summer is typically slow for the initiation of new clinical trials.

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. Target 12/13: 56 Trials.

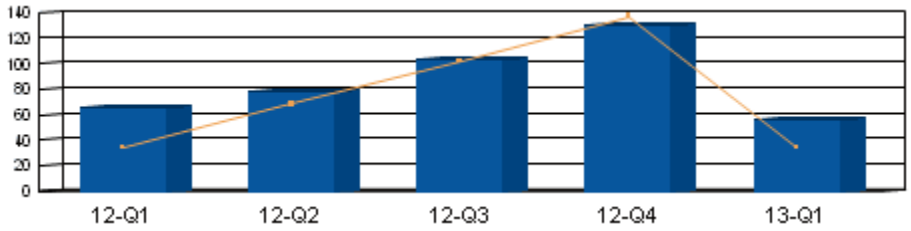
Kingston General Hospital

MS #13

Cultivate patient oriented research

Clinical research space at KGH increases by 25%

Indicator: Clinical Trials Generating Revenue



	Actual	Target
12-Q1	66	**34**
12-Q2	79	**68**
12-Q3	103	**102**
12-Q4	131	**137**
13-Q1	56	**34**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q1.

Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the first quarter (Q1).

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. Target 12/13: 137 Trials.

Strategy milestone # 14

Clinical Services Roadmap initiatives launched

Strategic Direction	KGH 2015 outcome	Status
Increase our focus on complex-acute and specialty care	**KGH services are well aligned and integrated with the broader health care system**	**Green**

Indicator
KGH Participation in a Clinical Services Road Map

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   KGH continues to provide key leadership positions at most SE LHIN CSR tables and discussions. In addition, DTZ is the Clinical Executive Lead on the CSR Program Management Team.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Active participation at SECHEF, weekly meetings with the LHIN PMO.

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?**
   Ongoing support

Kingston General Hospital

MS #14

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Increase our focus on complex-acute and specialty care	Clinical Services Roadmap initiatives launched	KGH Participation in Clinical Services Roadmap Initiatives	G	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

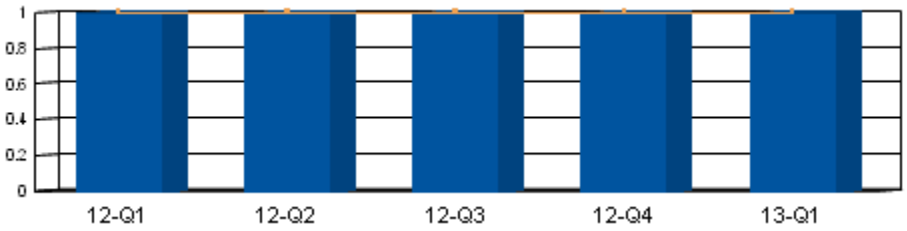
Kingston General Hospital

MS #14

Increase our focus on complex-acute and specialty care

Clinical Services Roadmap initiatives launched

Indicator: KGH Participation in Clinical Services Roadmap Initiatives



	Actual	Target
12-Q1	1	**1**
12-Q2	1	**1**
12-Q3	1	**1**
12-Q4	1	**1**
13-Q1	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:

Wave 1 initiatives have been identified and leadership from each of the partner hospitals is being sought. KGH continues to participate and provide leadership.

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. Target 12/13: Yes (Interim Targets - Q1 - Review of Surgical Charter. Q2 - Final Draft Surgical Charter for PMO Group with Working Team. Q3 - SECHEF Review of Final Draft. Q4. SECHEF Approval of Surgical Charter)

Strategy milestone # 15

Target service volumes are met

Strategic Direction	KGH 2015 outcome	Status
Increase our focus on complex-acute and specialty care	**KGH services are well aligned and integrated with the broader health care system**	**Green**

Indicator
Percent of Contracted Volumes Achieved

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Last full data is for Q4 and has 96% of services meeting target (22 green, 1 yellow, 1 red).

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   SPA leadership oversight; added OR emergency time and extra room on weekends have allowed the clinical services to maintain scheduled surgeries without substitution of urgent/emergency cases.

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?**

   SPA program has added support to clinical offices to help with OR bookings to manage wait times and volumes.

Kingston General Hospital

MS #15

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Increase our focus on complex-acute and specialty care	Target service volumes are met	Percent of Contracted Volumes Achieved	G	Y	G	G	G	↑
		Total Inpatient Admissions	G	G	G	G	G	↑
		Total Inpatient Weighted Cases	G	G	G	G	N/A	↑
		OR Cases (Inpatient and Outpatient)	G	G	G	G	G	↑
		OR Hours (Inpatient & Outpatient)	G	G	G	G	G	↑
		Ambulatory Care Volumes	G	G	G	G	G	↑
		Cardiac - Angiography Volumes	G	G	G	G	Y	↑
		Cardiac - Angioplasty Volumes	G	G	G	G	G	↑
		Cardiac - Bypass Volumes	G	G	G	G	G	↑
		Chronic Kidney Disease Program - (Weighted Units)	G	G	Y	G	G	↑
		CT Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑
		MRI Hours (Wait Time Strategy Allocation)	G	Y	G	G	G	↑
		Emergency Department Admitted Patient Volumes – All Levels of Acuity	G	G	G	G	G	↑
		Emergency Department Non-Admitted Patient Visits – High Acuity	G	G	G	G	Y	↑
		Emergency Department Non-Admitted Low Acuity (CTAS 4&5) volumes	G	G	G	G	G	↑

	12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Primary Hip & Knee Replacement Volume (Quality Based Procedure (QBP))	N/A	N/A	N/A	N/A	Y	
Kidney Transplants	G	R	R	G	G	↑
Stem Cell Transplants	G	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

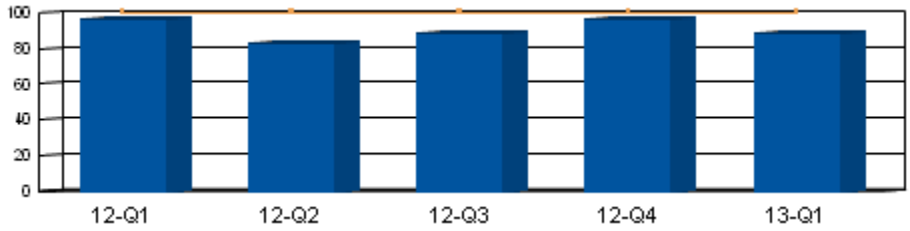
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Percent of Contracted Volumes Achieved

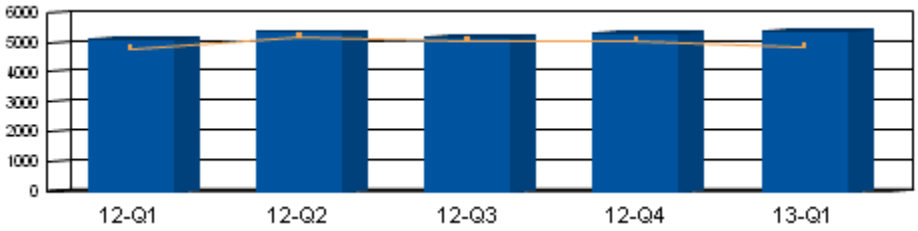


	Actual	Target
12-Q1	96	**100**
12-Q2	83	**100**
12-Q3	88	**100**
12-Q4	96	**100**
13-Q1	89	**100**

Definition: Service Volumes include: Stem Cell Transplants, Ambulatory Care Volumes, Cardiac (Angiography, Angioplasty, Bypass) Volumes, Chronic Kidney Disease Program-Weighted Units, CT Hours, Emergency Department Admitted Patient Volumes - All Levels of Acuity, Emergency Department Non-Admitted Low Acuity (CTAS 4&5) Volumes, Emergency Department Non-Admitted Patient Visits - High Acuity, Primary Hip and Knee Volumes, Kidney Transplants, MRI Hours, OR Cases(Inpatient and Outpatient),OR Hours (Inpatient & Outpatient), Total Inpatient Admissions, Total Inpatient Weighted Cases, Anorectal Surgery , Gall Bladder Surgery Intestinal Surgery, Groin Hernia, Ventral Hernia Surgery, Paediatric Dental Surgery , Paediatric Cleft Lip Surgery, Paediatric Scoliosis Surgery, Paediatric ACL Repair Surgery , Cancer Surgery Agreement Volumes.

Target: 2012/2013 Target: 100%

Indicator: Total Inpatient Admissions



	Actual	Target
12-Q1	5,082	**4782**
12-Q2	5,345	**5195**
12-Q3	5,204	**5055**
12-Q4	5,332	**5058**
13-Q1	5,383	**4850**

Interpretation - Patient And Business:

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, Target 12/13: 20,500

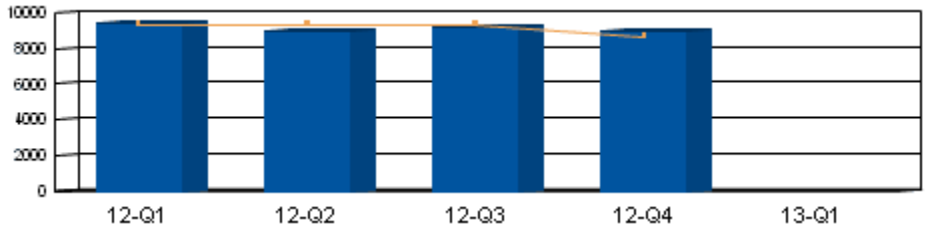
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Total Inpatient Weighted Cases



	Actual	Target
12-Q1	9,363	**9326**
12-Q2	9,014	**9326**
12-Q3	9,207	**9326**
12-Q4	8,959	**8654**
13-Q1		

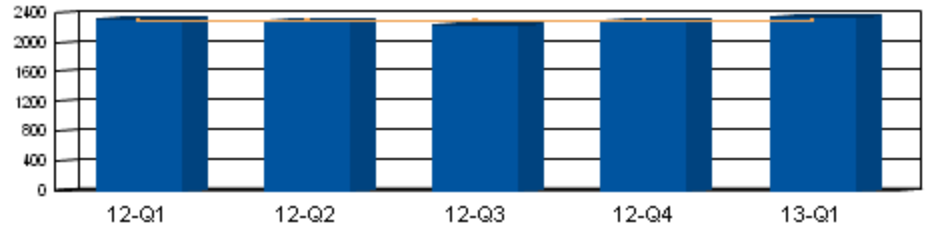
Interpretation - Patient And Business:

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, Target 12/13: 34616

Indicator: OR Cases (Inpatient and Outpatient)



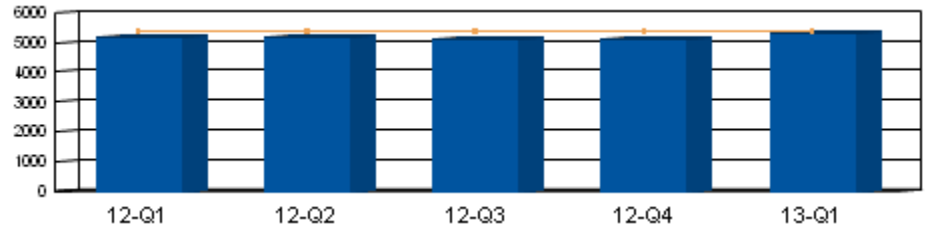
	Actual	Target
12-Q1	2,318	**2286**
12-Q2	2,274	**2286**
12-Q3	2,234	**2286**
12-Q4	2,290	**2286**
13-Q1	2,331	**2286**

Interpretation - Patient And Business:

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, Target 12/13: 9145

Indicator: OR Hours (Inpatient & Outpatient)



	Actual	Target
12-Q1	5,146	**5345**
12-Q2	5,145	**5345**
12-Q3	5,104	**5345**
12-Q4	5,088	**5345**
13-Q1	5,294	**5345**

Interpretation - Patient And Business:

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

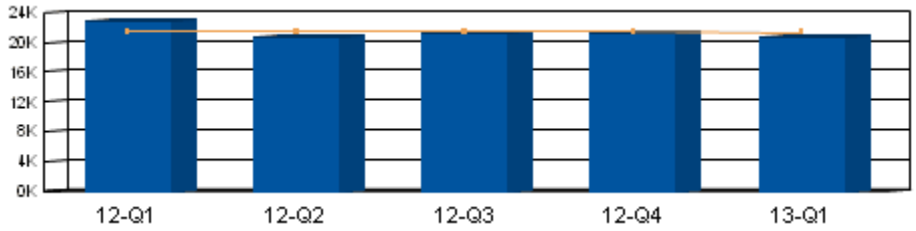
Target: Baseline 08/09: 21143, Target 09/10: 18148, Target 10/11: 18148, Target 11/12: 21378, Target 12/13: 21378

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Ambulatory Care Volumes



	Actual	Target
12-Q1	22,878	**21400**
12-Q2	20,797	**21400**
12-Q3	21,184	**21400**
12-Q4	21,194	**21400**
13-Q1	20,796	**21323**

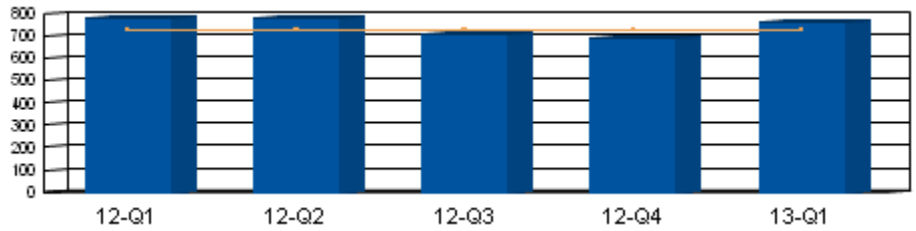
Interpretation - Patient And Business:

Ambulatory target volumes will be reflective of the current transition of clinics/patient activity transferring to the Hotel Dieu starting in September 2012.

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, Target 12/13: 85292

Indicator: Cardiac - Angiography Volumes



	Actual	Target
12-Q1	779	**725**
12-Q2	777	**725**
12-Q3	705	**725**
12-Q4	686	**725**
13-Q1	759	**725**

Interpretation - Patient And Business:

Patient Perspective: The are no concerns as volumes are over target at the end of Q1. This volume meets the patient demand within the region and procedures are being done well within the recommended wait times for all angiography.

Business Perspective: KGH slightly exceeded target at the end of Q1 Funding will be earned to support completed cases and KGH will have achieved the volumes that address demand in the community.

Actions & Monitoring Underway to Improve Performance:

Volumes are monitored monthly and quarterly internally by the Cardiac Program and the Wait Time Committee as well as externally by the Cardiac Care Network of Ontario. The data gathered and reported by the CCN allows us to benchmark against peer hospitals within the province and monitor trends across the province.

Please note that volumes are based on last year's funded volumes as funded volumes for 2013 have not been received yet.

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, Target 12/13: 2900

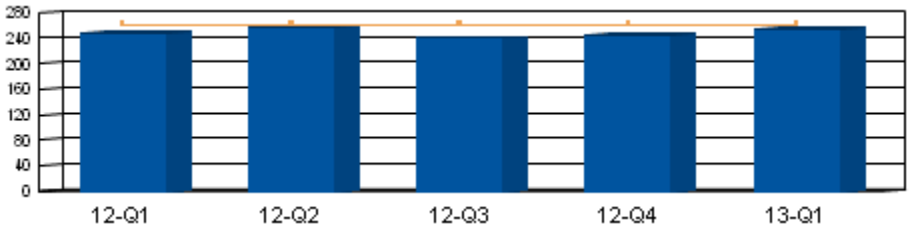
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Cardiac - Angioplasty Volumes



	Actual	Target
12-Q1	249	**262**
12-Q2	256	**262**
12-Q3	240	**262**
12-Q4	245	**262**
13-Q1	254	**262**

Interpretation - Patient And Business:

Patient Perspective: There are no concerns as volumes are close to target. This volume meets the patient demand within the region and procedures are being done well within the recommended wait times for all angioplasties with virtually no wait list. Most of the angioplasties are completed as part of the diagnostic catheterization procedure. This is referred to as same sitting PCI (percutaneous intervention) or ad hoc. This means that the patient has only one procedure for diagnostic and intervention when appropriate.

Business Perspective: KHG is on target at the end of Q1 Volumes having remained steady and are consistent with last year's volumes. This appears to be the trend across the province. Approximately 33% of angiographies lead to angioplasty which is in line with the provincial average. Funding will be earned to support completed cases and KGH will have achieved the volumes that address demand in the community.

Actions & Monitoring Underway to Improve Performance:

Volumes are monitored monthly and quarterly by the Cardiac Program and Waitlist Committee, as well as monthly by the Cardiac Care Network of Ontario. The information gathered and reported by the CCN allows us to benchmark against peer hospitals within the province and monitor trends across the province.

We still do not know what our funded volumes are for F13 and are assuming the same targets as last fiscal until we hear otherwise. Receiving funded volume targets so late into the fiscal year makes planning for any increase in activity very difficult.

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, Target 12/13: 1050

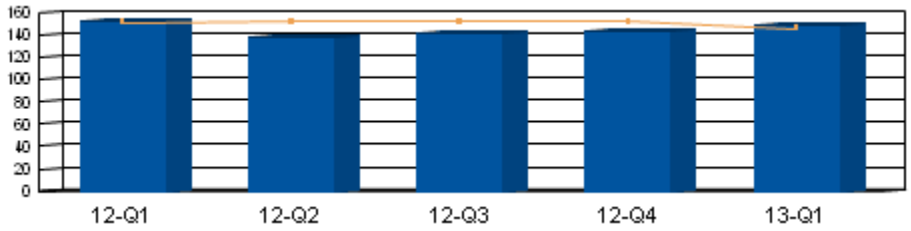
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Cardiac - Bypass Volumes



	Actual	Target
12-Q1	153	**151**
12-Q2	138	**152**
12-Q3	141	**152**
12-Q4	143	**152**
13-Q1	148	**146**

Interpretation - Patient And Business:

Patient Perspective: Cardiac Surgery volumes were met in Q1.Maximum recommended wait times for all bypass surgeries are being met within the volume we have achieved to date and patient needs are being met.
Volumes have remained constant over the past 3 years.

Business Perspective: The targeted volumes funded volumes are on track at the end of Q1.

Actions & Monitoring Underway to Improve Performance:

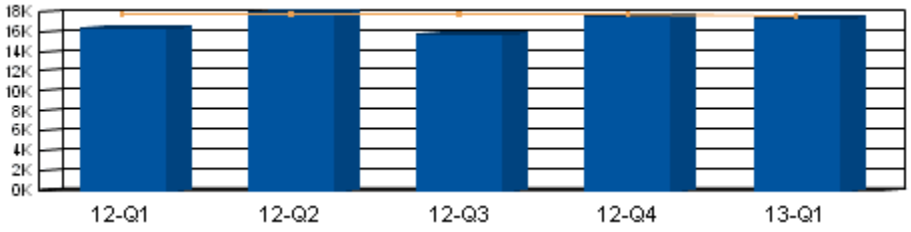
Cardiac surgical volumes are monitored weekly and monthly by the Cardiac and SPA Program in order to achieve target volumes and wait times and to mitigate cancellations. Surgical volumes and wait times are monitored by the Cardiac Care Network (CCN) of Ontario. The monthly reports generated by the CCN allow us to benchmark against peer hospitals and monitor trends across the province.

Recruitment for a 4th cardiac surgeon is underway.

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, Target 12/13: 582

Indicator: Chronic Kidney Disease Program - (Weighted Units)



	Actual	Target
12-Q1	16,265	**17707**
12-Q2	17,888	**17707**
12-Q3	15,792	**17707**
12-Q4	17,638	**17707**
13-Q1	17,336	**17498**

Interpretation - Patient And Business:

Overall weighted units (WU) are on track across the Program (medicine) and within the Renal Service.
The WUs cover all aspects of the care continuum, at a high level, and do not allow care elements to be highlighted.

Actions & Monitoring Underway to Improve Performance:

A new funding model is being developed and implemented within the fiscal year.
Whilst overall activity measured by WUs is within target, in the future, elements of care will be able to be articulated more specifically.
Operationally, higher acuity activity has increased within the quarter, specifically in the main Renal Unit. Activity in our satellite units remains flat/as planned. The higher acuity activity in the main renal unit has led to short term increase in Overtime.

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, Target 12/13: 69992

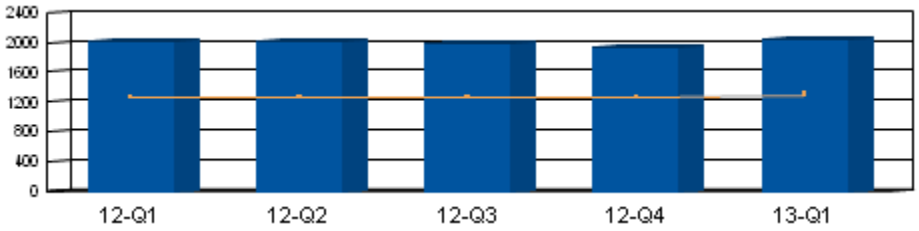
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: CT Hours (Wait Time Strategy Allocation)



	Actual	Target
12-Q1	2,012	**1263**
12-Q2	2,015	**1263**
12-Q3	1,979	**1263**
12-Q4	1,929	**1263**
13-Q1	2,032	**1297**

Interpretation - Patient And Business:

We continue to exceed target operational hours due to the fact that the 2 CT's are operated daily. This level of operational hours allows us to meet the needs of the patient population of KGH and the Kingston area.

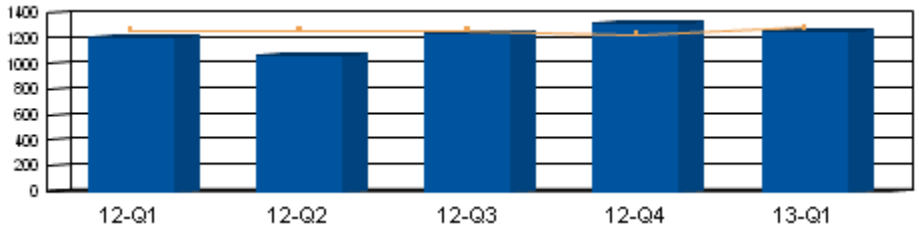
Actions & Monitoring Underway to Improve Performance:

We will continue to monitor and maintain this level of service.

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, Target 12/13: 5050 hrs.

Indicator: MRI Hours (Wait Time Strategy Allocation)



	Actual	Target
12-Q1	1,212	**1259**
12-Q2	1,071	**1259**
12-Q3	1,239	**1259**
12-Q4	1,322	**1228**
13-Q1	1,262	**1283**

Interpretation - Patient And Business:

Extensive effort has gone into recruiting staff and maintaining our expanded hours on a weekly basis.

Expanded hours allow for more cases to be completed and ultimately a reduction in wait time. Quicker access to MRI results in earlier diagnosis and medical management decisions.

A minimum of 5 FTE plus 1 PT staff member is required to maintain an adequate number of operational hours. We will do everything we can to maintain this minimum staffing level.

Adequate staffing also results in staff satisfaction and a safer work environment.

Actions & Monitoring Underway to Improve Performance:

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, Target 12/13: 5134 hrs.

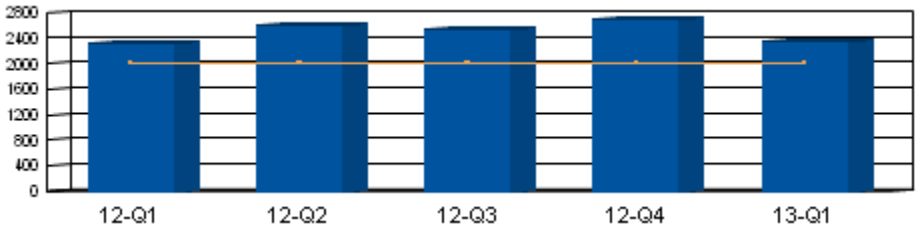
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

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



	Actual	Target
12-Q1	2,309	**2002**
12-Q2	2,591	**2002**
12-Q3	2,555	**2002**
12-Q4	2,713	**2002**
13-Q1	2,364	**2002**

Interpretation - Patient And Business:

The volume of admitted patients from the emergency department exceeds the target by 16%. Overall emergency visits exceed the target by 1942 visits. Admission rate from the ED is 18% of all visits so the increase in admissions is a reflection of the increased visits. This is a comparable admission rate to peer hospitals that have admissions rates between 10 and 22% in Q1 of this year.

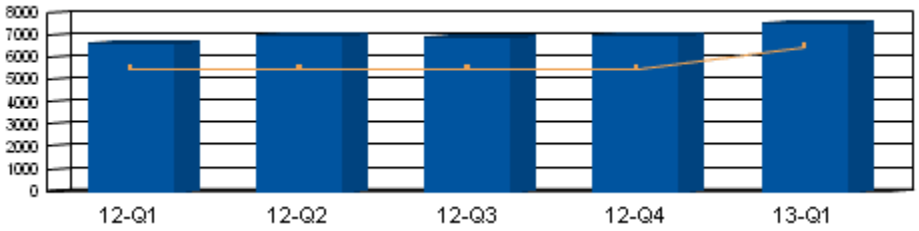
Actions & Monitoring Underway to Improve Performance:

Admission volumes continue to be higher than target and higher than same time last fiscal. The move of the Mental Health inpatient unit at the end of Q1 last year accounts for some of this increase but new beds opened to align with that activity.
Admission rate is as expected relative to volumes.

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, Target 12/13: 8163

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



	Actual	Target
12-Q1	6,599	**5481**
12-Q2	6,953	**5481**
12-Q3	6,867	**5481**
12-Q4	7,033	**5481**
13-Q1	7,512	**6481**

Interpretation - Patient And Business:

The visits in this category of non-admitted, high acuity make up the greatest proportion of all ED visits. The target was exceeded in Q1 by 031 visits which is the highest volume we have seen in the past 4 years.

Actions & Monitoring Underway to Improve Performance:

Target has been adjusted by 1000 visits per quarter to reflect trend seen over past several quarters.

Higher volumes and/ or a higher proportion of high acuity, non-admitted patients may increase overall emergency length of stay as patients of higher acuity often require more tests, more complex interventions and a longer monitoring period before being discharged.

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, Target 12/13: 25924

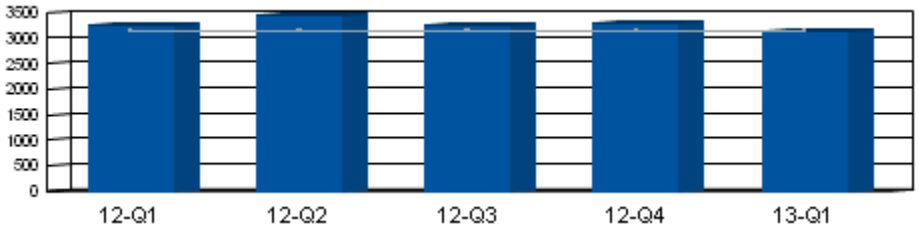
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

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



	Actual	Target
12-Q1	3,257	**3138**
12-Q2	3,441	**3138**
12-Q3	3,250	**3138**
12-Q4	3,284	**3138**
13-Q1	3,136	**3138**

Interpretation - Patient And Business:

Target volumes for non-admitted low acuity patients are on target for Q1 of this year.

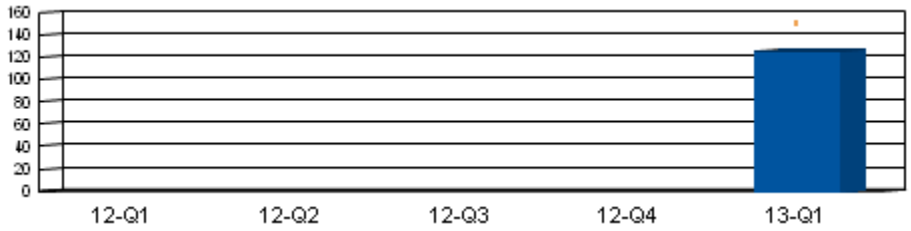
Actions & Monitoring Underway to Improve Performance:

Overall patients in the ED have increased. This category of non-admitted, low acuity patients is expected to make up a smaller proportion of all visits as we educate the public to use the Urgent Care Centre at HDH for lower acuity complaints.

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, Target 12/13: 12552

Indicator: Primary Hip & Knee Replacement Volume (Quality Based Procedure (QBP))



	Actual	Target
12-Q1		
12-Q2		
12-Q3		
12-Q4		
13-Q1	126	**150**

Definition: As of Fiscal 12/13, primary hip and knee replacement volume has been removed from the Wait Time Strategy (WTS) Allocation contract. It is now covered off under year 1 Quality Based Procedure (QBP) funding methodology. As a result, there is no longer a base and incremental component to the volume. Both procedures have now been assigned a total volume for the year as per negotiation with the SE LHIN. The KGH is obligated to deliver on 100% of the volume. Both primary hip and primary knee cases have been assigned a cost that is earned back by the hospital as the agreed volumes are achieved.

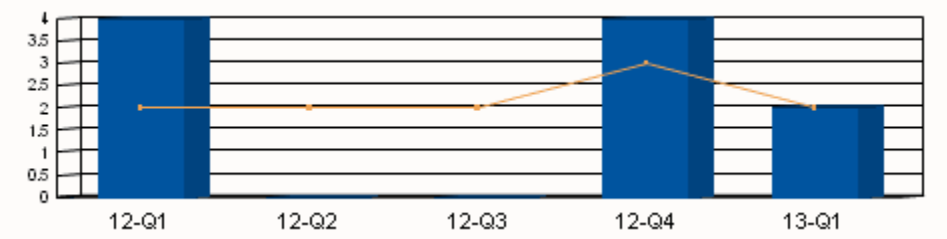
Target: Baseline 08/09: 878, Target 09/10: 876, Target 10/11: 876, Target 11/12: 819, Target 12/13: 599

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Kidney Transplants



	Actual	Target
12-Q1	4	**2**
12-Q2	0	**2**
12-Q3	0	**2**
12-Q4	4	**3**
13-Q1	2	**2**

Interpretation - Patient And Business:

Kidney Transplant activity is low volume and driven by available organs (deceased donors). Activity is therefore unpredictable in time.

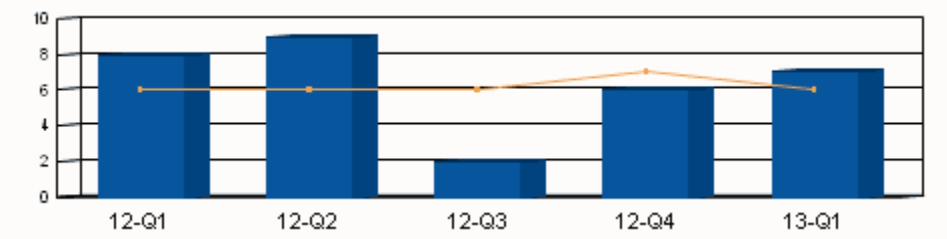
Actions & Monitoring Underway to Improve Performance:

Kidney Transplantation is a significant life-changing opportunity for recipients. At the present time, organ availability drives the clinical activity, support and promotion of a 'donor-culture' is important for the organization to recognize.

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, Target 12/13: 9

Indicator: Stem Cell Transplants



	Actual	Target
12-Q1	8	**6**
12-Q2	9	**6**
12-Q3	2	**6**
12-Q4	6	**7**
13-Q1	7	**6**

Interpretation - Patient And Business:

At the end of Q1 F13, KGH is on track for its stem cell transplant volumes

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, Target 12/13: 25

Strategy milestone # 16

Evidence-based guidelines are adopted in 12 clinical areas

Strategic Direction	KGH 2015 outcome	Status
Increase our focus on complex-acute and specialty care	**Best evidence used to guide practice**	**Green**

Indicator
Number of Clinical Areas That Have Implemented Open Source Order Sets(OSOS)

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The indicator is above target and seeing many services and programs adopting the OS.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Steering committee supporting the initiative. Link to Patient Safety and Quality agenda.

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?**

   Although development is progressing well, there are concerns regarding utilization of the OS once developed. Cataloging, maintaining the OS and clinical uptake will not occur without IT support. "Set Point" has been recommended and is under review.

Kingston General Hospital

MS #16

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Increase our focus on complex-acute and specialty care	Evidence-based guidelines are adopted in 12 clinical areas	Number of Clinical Areas that have Implemented Open Source (OS)	G	R	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

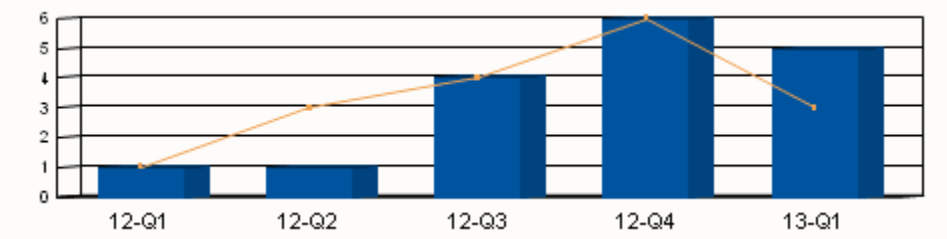
Kingston General Hospital

MS #16

Increase our focus on complex-acute and specialty care

Evidence-based guidelines are adopted in 12 clinical areas

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



	Actual	Target
12-Q1	1	**1**
12-Q2	1	**3**
12-Q3	4	**4**
12-Q4	6	**6**
13-Q1	5	**3**

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 Q1, 5 clinical areas had achieved Implementation, 2 greater than target.

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, Target 12/13: 12

Strategy milestone # 17

Overall staff satisfaction rating improve by 20%

Enabler	KGH 2015 outcome	Status
People	**KGH is designated as one of the best places to work**	**Red**

Indicator(s)
Staff Satisfaction Ratings Will Improve by 20% based on Responses of Agree and Strongly Agree to the Statement "I am Satisfied with this Organization"

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Worklife Pulse Survey results was received in Q1 and there has been significant improvement overall . The results will be communicated in Q2 and action plan developed. Other initiatives to improve this rating is the Scheduling Project, Attendance Promotion and reduction of overtime. Results in Q1 was that the scheduling initiative was trending red as the project manager returned to previous role , average sick days /% sick days and overtime were yellow in a positive trend.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The challenge with the Scheduling project continues to be the lack of in-house skilled resources to assign to the project. Updated sick time poster and sick time blitz with leaders in the Spring and refreshed awareness of leaders and staff that this continues to be an important goal even though PIP completed. Highest variances in overtime were in critical care due to staffing challenges and pediatric programs due to increased activity and volumes in pediatrics .

3. **Are we on track to meet the milestone by year end?**
   This is a stretch target, and we will be unable to assess until year end; however, we are trending to reach targets in the specific initiatives.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   A project manager for scheduling has been hired. New project sponsor visited Vancouver to visit sites of best practice in Canada in July. Continued focus on attendance and disability management to reduce sick time. Recruitment and orientation of critical care nurses to be in place by the end of August. Plan will be developed to respond to the Worklife Pulse Survey results.

Kingston General Hospital

MS #17

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
People	Overall staff satisfaction ratings improve by 20%	Staff Satisfaction Ratings Will Improve By 20% based on Responses of Agree and Strongly Agree to the Question "Overall I am Satisfied with This Organization"	R	N/A	N/A	N/A	N/A	
		Average Sick Days per Eligible Employee per Year	Y	Y	Y	Y	Y	↓
		Launch the Staff Scheduling Project	G	R	N/A	G	N/A	↑
		Percent of Overtime Hours	Y	Y	Y	Y	Y	↓
		Percent Sick Time Hours	Y	Y	Y	Y	Y	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

Kingston General Hospital

MS #17

People

Overall staff satisfaction ratings improve by 20%

Indicator: Staff Satisfaction Ratings Will Improve By 20% based on Responses of Agree and Strongly Agree to the Question "Overall I am Satisfied With This Organization"

	Actual	Target
13-Q1		

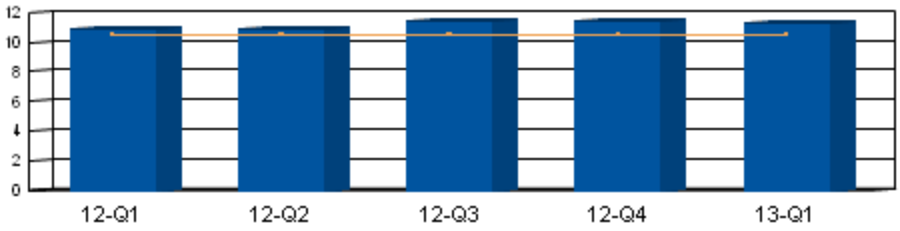
Actions & Monitoring Underway to Improve Performance:

Activity to commence in Q2

Definition: The Pulse Survey conducted in March of each year currently has a 36% positive response rate to the comment "overall I am satisfied with this organization". Through the development of various initiatives at all levels of the organization it is anticipated that the hospital will realize a score in the area of 56% to this comment in March 2013.

Target: 12/13 Target: 56%

Indicator: Average Sick Days per Eligible Employee Per Year



	Actual	Target
12-Q1	10.9	**10.5**
12-Q2	10.9	**10.5**
12-Q3	11.4	**10.5**
12-Q4	11.4	**10.5**
13-Q1	11.3	**10.5**

Interpretation - Patient And Business:

The rolling average has started to decline. We continue to have some success with active disability management. The average number of incidents remains close to the lowest number for KGH at 2.50.

The monthly statistics were encouraging for the quarter. Despite the rolling average not yet meeting our goal, we were green within the quarter based on the monthly numbers. The quarter average is 2.59 and if absenteeism levels remained at similar levels for the next 3 quarters, we would expect to reach the target. Most significant is that CUPE dropped from 1.29 in March to 0.92 in April. This is the lowest for CUPE since the winter of 2011.

Actions & Monitoring Underway to Improve Performance:

The sick time poster to raise awareness was disseminated across the organization and planning for other wellness activities will drive the future focus and communication. A 'Spring sick time target blitz' with leaders occurred and follow up tools will be forthcoming. The timing was key due to the introduction of all part time staff to the attendance reports and in advance of the summer vacation season which typically sees sick time also increase. Focused surveys of managers and staff that have been off ill was a project completed and results being reviewed for future changes. All part time staff are now automatically part of our regular attendance program monitoring.

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, Target 12/13: 10.5

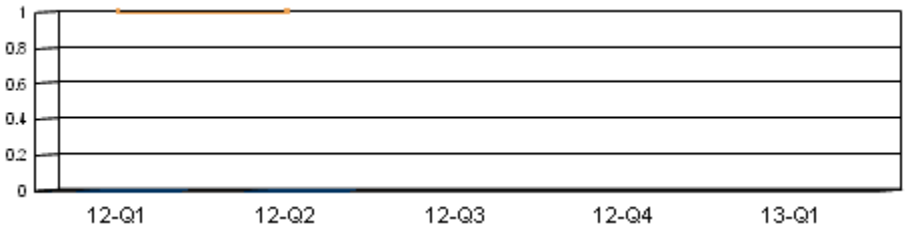
Kingston General Hospital

MS #17

People

Overall staff satisfaction ratings improve by 20%

Indicator: Launch the Staff Scheduling Project



	Actual	Target
12-Q1		1
12-Q2		1
12-Q3		
12-Q4		
13-Q1		

Interpretation - Patient And Business:

Delay in obtaining a Project Manager.

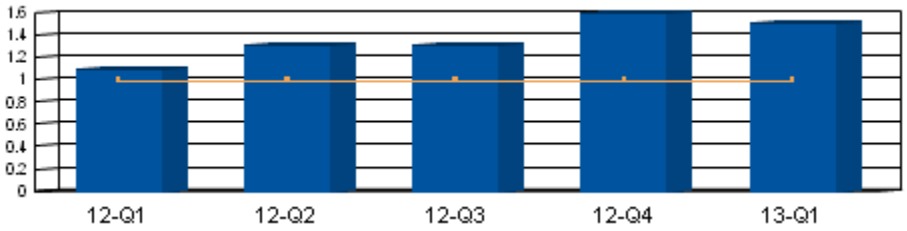
Actions & Monitoring Underway to Improve Performance:

Project Manager has been hired to commence before the end of August.

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, Target 12/13: Yes (Interim Targets - Q1 - Project Management In Place & Project Charter Developed. Q2 - Project Plan Finalized & Resources Secured. Q3 - Review & Standardize Where Applicable in Pt Care Areas. Q4 - Corporate Scheduling Office Established)

Indicator: Percent of Overtime Hours



	Actual	Target
12-Q1	1.1	1.0
12-Q2	1.3	1.0
12-Q3	1.3	1.0
12-Q4	1.6	1.0
13-Q1	1.5	1.0

Interpretation - Patient And Business:

There was a negative variance for overtime hours for the quarter. Overtime variances were highest in the Pediatrics and Critical Care programs; however, these were not the areas with the greatest sick time hours variances. Increased activity and volumes in the pediatric program at 117% occupancy and staffing challenges in Critical Care have been impacting directly on overtime.

Actions & Monitoring Underway to Improve Performance:

Efforts to recruit more registered nurses for critical care and emergency have been relatively successful, and the second quarter looks better as more of these staff begin their on unit orientations. Cross training for longer term benefits has impacted on the pediatric program and will continue into the next quarter.

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%, Target 12/13 0.99%

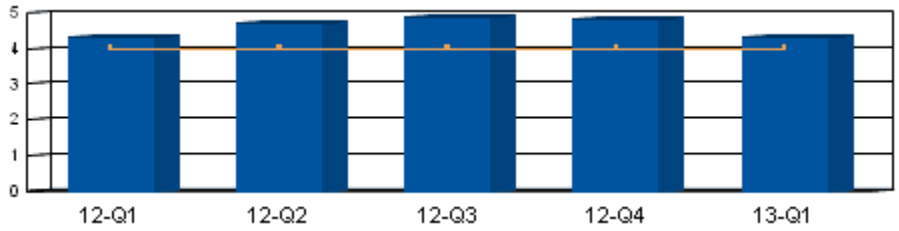
Kingston General Hospital

MS #17

People

Overall staff satisfaction ratings improve by 20%

Indicator: Percent Sick Time Hours



	Actual	Target
12-Q1	4.3	**4**
12-Q2	4.7	**4**
12-Q3	4.9	**4**
12-Q4	4.8	**4**
13-Q1	4.3	**4**

Interpretation - Patient And Business:

There was a negative variance for sick time hours and dollars for the quarter. Sick time hours variances were highest in pharmacy, emergency, surgery, ICCN and resource pool. Despite the rolling average also not yet meeting our goal, the quarter results were positive based on the monthly numbers. The quarter average is 2.59 and if the absenteeism levels remained at similar levels for the next 3 quarters, we would expect to reach the target.

Actions & Monitoring Underway to Improve Performance:

Planning for other wellness activities will drive future focus and communication. The number of notifications of illness at four or more days remains inconsistent and due to the variability and the continued challenge to complete this process, we will be looking at a potential process improvement activity to address this issue. Other planned activities include a review of the information on the intranet, methods of communication, scripting, and creating a follow up checklist or 'cheat sheet' for leaders stemming from their training/blitz.

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%, Target 12/13 4.0%

Strategy milestone # 18

Health and Safety Scorecard targets are met

Enabler	KGH 2015 outcome	Status
People	**All preventable harm to staff is eliminated**	**Green**

Indicator(s)
Number of Health & Safety Scorecard Target Indicators are Met

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Of the twenty-one (21) indicators, eighty percent are within target ranges with only four (4) indicators reflecting red.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   There was only one lost time injury this quarter which resulted in one day paid by WSIB. We are trending to receive a NEER rebate again this year. The red status areas are related to management's timely responses , respiratory fit testing and health care claims which were sixteen (16) as opposed to six (6)claims in the previous quarter. The latter was a result of a meningococcal exposure in the Emergency Room in May.

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

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   OHSW will continue to send reminders and investigation tools within Safe Reporting when investigations incomplete, and will schedule one-on-one training sessions with managers who have departments/units with regular employee incidents being reported. With regard to management response to JHSC inspections and completion of quarterly management inspections, these accountabilities will be reinforced in upcoming HR X-Change Sessions. OHSW will continue to work with management to facilitate improved compliance with respirator fit testing and training. Use of the Learning Management Systems (LMS) to deliver Respirator/Routine Practices Training is being explored.

Kingston General Hospital

MS #18

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1
People	Health and Safety Scorecard targets are met	Number of Health & Safety Scorecard Target Indicators Met	N/A	N/A	N/A	N/A	G

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

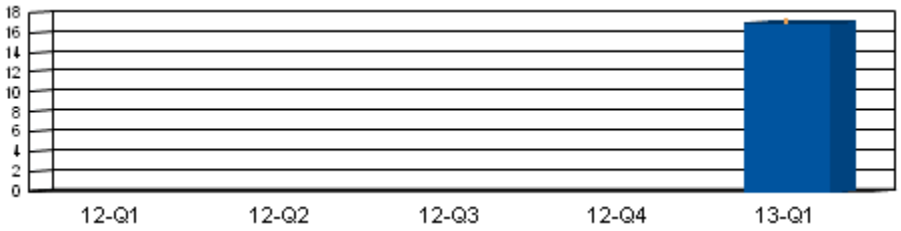
Kingston General Hospital

MS #18

People

Health and Safety Scorecard targets are met

Indicator: Number of Health & Safety Scorecard Target Indicators Met



	Actual	Target
12-Q1		
12-Q2		
12-Q3		
12-Q4		
13-Q1	17	**17**

Interpretation - Patient And Business:

17/21 of the Health & Safety indicators are met (11 green, 6 yellow). The 4 measures that are outside of target (red) are as follows: completion of incident investigations, management response to JHSC inspections/recommendations, completion of quarterly management inspections, and respirator fit testing compliance.

Actions & Monitoring Underway to Improve Performance:

To facilitate improvement in the measures not on target, the following actions are being undertaken: OHSW to continue to send reminders and investigation tools within Safe Reporting when investigations incomplete, but will also schedule 1:1 training sessions with managers who have dept/units with regular employee incidents being reported. With regard to management response to JHSC inspections and completion of quarterly management inspections, these accountabilities will be reinforced in upcoming Leadership Exchange Sessions. OHW will continue to work with management to facilitate improved compliance with respirator fit testing & training. OHSW is exploring the possibility of using the Learning Management Systems (LMS) to deliver Respirator/Routine Practices Training.

Definition: Occupational Health & Safety indicators demonstrate the hospital's progress in eliminating all preventable harm to staff. Through the measurement of leading health & safety indicators, we demonstrate our compliance with policy and legislation aimed at creating a safe work environment for staff. Lagging indicators are the injury/illness outcomes that help us to assess and improve our Health and Safety Management System.

Target: 12/13 Target: 17 of 21

Strategy milestone # 19

Employee engagement action plans are in place at all team levels

Enabler	KGH 2015 outcome	Status
People	**Staff are engaged in all aspects of our quality, safety and service improvement initiatives**	**Red**

Indicator(s)
Employee Action Plans at Corporate and Team Level are Complete

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

Work did not commence in Q1.

.

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

Monies or resources were not assigned to the initiative in Q1.

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

It could still be achieved by year end, should the organization have capacity to proceed and an engagement strategy has been completed and accepted by EMC in the fall.

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

Research into appropriate survey tool; note that there is a requirement under EFCAA to survey physicians, employees and volunteers related to engagement on a biannual basis. N.B. This year, the Workplace Pulse survey was conducted with employees, volunteers surveyed ; physicians haven not been surveyed related to engagement. Consideration to finalize the employee engagement and recognition strategy for fiscal 2013 with a survey in October 2013 and develop a separate physician engagement strategy and survey before end of this fiscal year.

Kingston General Hospital

MS #19

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
People	Employee engagement action plans are in place at all team levels	Employee Engagement Action Plans at Corporate and Team Level are Complete	R	N/A	N/A	N/A	N/A	
		Percent of Staff that Complete Mandatory Online Training Programs	R	Y	Y	Y	Y	↑

↑ Indicates improving performance to target over the past 5 quarters

↓ Indicates worsening performance to target over the past 5 quarters

Kingston General Hospital

MS #19

People

Employee engagement action plans are in place at all team levels

Indicator: Employee Engagement Action Plans at Corporate and Team Level are Complete

	Actual	Target
13-Q1		

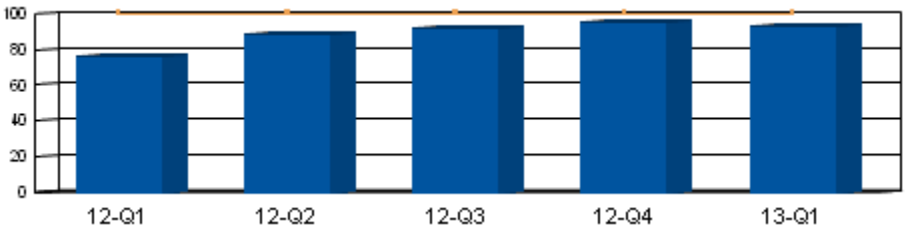
Interpretation - Patient And Business:

Activity to commence in Q2

Definition: On completion of the formal Staff Engagement Survey (scheduled for October 2012) responses will be analyzed to identify key opportunities for improvement at the departmental or program level. As a result leaders will be expected to develop plans that identify the improvement opportunities and what they will be doing to facilitate improvement.

Target: Target: 100% (Interim Targets - Q1 - Decision of Survey Tool. Q2 - Advisory Team & Project Plan Established. Q3 - Survey completed and Results Received by Managers. Q4 - Action Plans in Place)

Indicator: Percent of Staff that Complete Mandatory Online Training Programs



	Actual	Target
12-Q1	76	**100**
12-Q2	88	**100**
12-Q3	92	**100**
12-Q4	95	**100**
13-Q1	93	**100**

Interpretation - Patient And Business:

The slight reduction over last quarter is due to the 2 year remedial required for MSI and WHIMS training. Several departments have all come due in this quarter.

Actions & Monitoring Underway to Improve Performance:

MSI and WHIMS remedial are in process.

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%, Target 12/13: 100%

Strategy milestone # 20

100% of our KGH managers complete continuous improvement training

Enabler	KGH 2015 outcome	Status
Processes	**Continuous improvement environment created with consistent use of LEAN principles**	**Green**

Indicator(s)
Percent of Management Staff that Complete Mandatory Process Improvement Training

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Eighteen (18) were to be trained in Q1. This target was exceeded with twenty-eight being trained and four follow-up sessions to conduct a continuous improvement activity.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Strong leadership from the Process Excellence Team; excellent facilitation and planning to support the leaders through this activity.

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

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

   Leaders are being scheduled into upcoming workshops and support has been assigned to support them in their continuous improvement activity. A possible risk could be availability of experienced facilitators.

Kingston General Hospital

MS #20

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Processes	100% of KGH managers complete continuous improvement training	Percent of Management Staff Completing Mandatory Process Improvement Training	Y	R	R	R	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

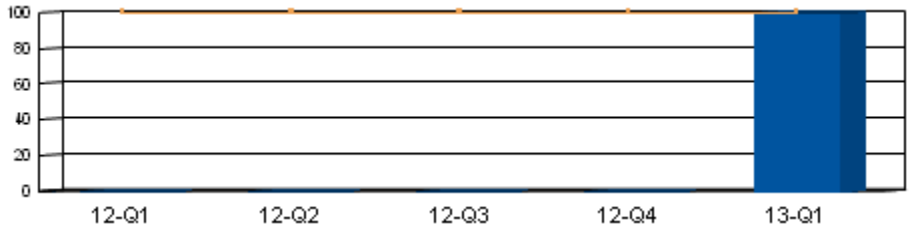
Kingston General Hospital

MS #20

Processes

100% of KGH managers complete continuous improvement training

Indicator: Percent of Management Staff Completing Mandatory Process Improvement Training



	Actual	Target
12-Q1		**100**
12-Q2		**100**
12-Q3		**100**
12-Q4		**100**
13-Q1	100	**100**

Interpretation - Patient And Business:

Q1 Target - Introduction of initiative to all leaders/development of module one training (introduction to CI) and commencement of training.

Actions & Monitoring Underway to Improve Performance:

18 members of the leadership group were targeted to be trained in Q1 and 28 were actually trained. Follow up meetings over the next 60 days are scheduled with each trained leaders to assess progress on one process improvement initiative.

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: 11/12 Target: 100% 12/13 Q1 Target: Intro and Development, 12/13 Q2 Additional 24 leaders CI; 36 leaders complete four follow-up, 12/13 Q3 Additional 24 leaders CI; 24 leaders complete four follow-up, 12/13 Q4 Additional 24 leaders CIT 30 leaders complete four follow-up.

Strategy milestone # 21

Phase 2 redevelopment functional programming commences

Enabler	KGH 2015 outcome	Status
Facilities	**Phase 1 redevelopment is complete, Phase 2 construction is underway and KGH has sufficient parking**	**Green**

Indicator
Phase 2 Redevelopment Project Targets are Met

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

   Work is progressing on Stage 1 submission and is currently on target for completing Master Program and Master Plan in Q2, and making to submit Stage 1 to MoHLTC in Q3.

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

   JPO is managing the project plan/and consultants to ensure completion of the Master Plan and master Program as required and this is being done under the oversight of the Steering Committee.

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

   We are at present still on target. The risk for time line is the impact of finalizing the following areas with our partners– fundraising plans are required in stage 1 and must be completed with HDH and PCC, agreements related with Queens University re – transfer of Etherington Building , and support of regional hospitals and LHIN for our Master Program. The LHIN also has to support our Master Plan and full Stage 1 Submission.

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

   Each of the activities required are part of the project plan and are being overseen by JPO and the Steering Committee. Presentations to the LHIN and Regional Hospitals are underway, and work with management of Queens, HDH, and PCC is progressing to finalize mutually acceptable plans before the end of Q2. Approvals to follow in Q3.

Kingston General Hospital

MS #21

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1
Facilities	Phase 2 redevelopment functional programming commences	Phase 2 Redevelopment Project Targets are Met	N/A	N/A	N/A	N/A	G

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

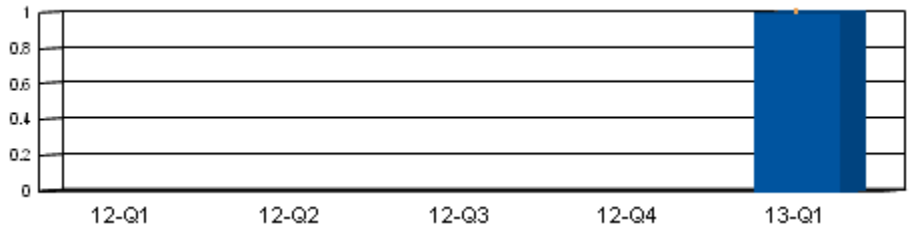
Kingston General Hospital

MS #21

Facilities

Phase 2 redevelopment functional programming commences

Indicator: Phase 2 Redevelopment Project Targets are Met



	Actual	Target
12-Q1		
12-Q2		
12-Q3		
12-Q4		
13-Q1	1	**1**

Interpretation - Patient And Business:

Stage One Proposal Submission (Master Program/Master Plan/Facility Development Plan i.e. Redevelopment Phase 2) is scheduled for Board approval in Q3. LHIN and MOHLTC submission will immediately follow. Functional Programming will commence following MOHLTC approval of the Stage One Proposal.

Actions & Monitoring Underway to Improve Performance:

The Planning Working Group and Steering Committee are continuing to meet and refine the Stage One Proposal documents in anticipation of the Board approval process this fall.

External consultation is proceeding with the LHIN and regional hospital partners.

Definition: The Phase 2 Redevelopment Project plans are being prepared in compliance with MOHLTC Capital Planning Toolkit. The Stage One: Proposal submission will be submitted to the MOHLTC in Fall 2012. Upon MOHLTC approval of the Stage One Proposal, the Stage Two: Functional Program process will commence. The planning schedule shows that Functional Programming will commence in Q4.

Target: 12/13 Q1 Target: Complete State 1 Submission. 12/13 Q2 Target: Steering Committee Completes & Approves Master Program/Plan & Creates Financial Plan. 12/13 Q3 Target: Submit Financial Plan to MOH. 12/13 Q4 Target: MOH Approval to go to Stage 2.

Strategy milestone # 22

Carpets are removed from 75% of patient areas

Enabler	KGH 2015 outcome	Status
Facilities	**KGH is clean, green and carpet-free**	**Yellow**

Indicator
Quarterly Carpet Removal Targets are Met

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The Q1 target for carpet removal was 48% completion by the end of Q1. We are at 41%. The target was based on the assumption that the Kidd 1 and Kidd 2 corridors would be completed in Q1.
2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The Kidd 1 and Kidd 2 corridors have not been completed due to phasing restrictions related to other projects (i.e. elevator upgrades and asbestos abatement on Kidd 2), and a desire to further evaluate porcelain tile, which is the preferred flooring for the Kidd 1 corridor.

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

   The delay has not had any financial impact nor does it pose a quality risk for the project. The schedule for removal on inpatient units has not been affected by the delays in the corridor removals.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The planning and construction teams do not anticipate any challenges in catching up and/or exceeding the targets in Q2 or Q3 once access to the Kidd 1 and Kidd 2 corridors is granted.

Kingston General Hospital

MS #22

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1
Facilities	Carpets are removed from 75% of patient areas	Quarterly Carpet Removal Targets are Met	G	G	G	G	Y

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

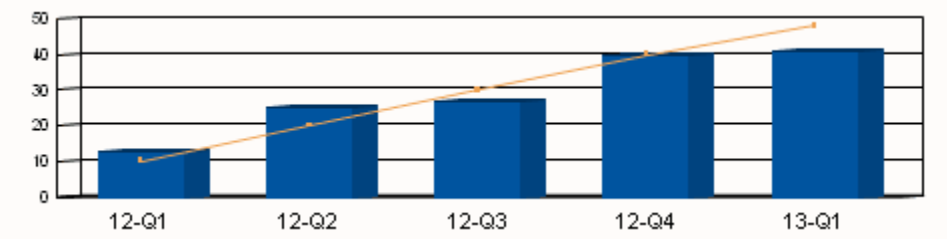
Kingston General Hospital

MS #22

Facilities

Carpets are removed from 75% of patient areas

Indicator: Quarterly Carpet Removal Targets are Met



	Actual	Target
12-Q1	13	**10**
12-Q2	25	**20**
12-Q3	27	**30**
12-Q4	40	**40**
13-Q1	41	**48**

Interpretation - Patient And Business:

The Q1 target for carpet removal was 48% completion. This was based on the assumption that the Kidd 1 and Kidd 2 corridors would be completed in Q1. Those areas have not been completed due to phasing restrictions related to other projects (i.e. elevator upgrades and asbestos abatement on Kidd 2), and a desire from the facility team to "live with" the porcelain tile in the Davies lobby for a while in order to evaluate the material and determine whether this is the preferred flooring for the Kidd 1 corridor.

The delay in achieving the Q1 target has not had any financial impact nor does it pose a quality risk for the project. The schedule for removal on inpatient units has not been affected by the delays in the corridor removals.

Actions & Monitoring Underway to Improve Performance:

The planning and construction teams do not anticipate any challenges in catching up and/or exceeding the targets in Q2 or Q3 once access to the Kidd 1 and Kidd 2 corridors is granted. In addition, some minor modifications in the future sequencing of the removal will result in targets being exceeded as some areas with a larger footprint are now proposed to be completed in advance of smaller areas (i.e. Kidd before Davies, etc.).

Definition: Phase 1B of the Carpet Removal Plan will be completed and Phase 2 will begin this year. Removal targets, based on % of square footage removed in patient care areas, are as follows: Q1 48%, Q2 52%, Q3 64%, Q4 75%.

Target: 12/13 Target: 75% (Interim Targets - Q1 - 48%, Q2 - 52%, Q3 - 64, Q4 - 75%)

Strategy milestone # 23

Discharge summaries are sent to primary care providers within 72 hours of patient discharge

Enabler	KGH 2015 outcome	Status
Technology	**Rapid transmission of information improves care and operational efficiency**	**Red**

Indicator
Percent of Discharge Summaries Sent to Primary Care Provider within 72 hours of Patient Discharge

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The target for this indicator is 80% and as at Q1 we are at 42%, which remains consistent with the previous quarter. The number of charts completed before 120 hours continues to improve.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The major issue remains obtaining the sign off of the attending physician before 72 hours. Part of this issue is user friendly notifications about outstanding E-discharge forms waiting to be signed off that are not yet available. A system upgrade that was expected to provide the capacity for improved reporting has not been able to deliver the new reporting. Work with the vendor continues.

3. **Are we on track to meet the milestone by year end?**
   We will know better at the end of Q2 the potential to meet this milestone.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   As noted above, the enhancement of reporting by our vendor would assist Attending Physicians complete the task. This work continues and we hope for some resolution in the next quarter.

   Our practice and approach to E-discharge is also under review. Most of our peers at present distribute the draft unsigned E-discharge form, which ensures meeting the 72 hour requirement. This approach is being reviewed and if implemented would result in meeting the target. An update should be available at the end of Q2.

Kingston General Hospital

MS #23

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Technology	Discharge summaries are sent to primary care providers within 72 hours	Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital	G	R	N/A	G	G	↑
		Implementation of an Order Management System for Labs on All Inpatient Areas (% Completion).	G	R	R	G	G	↑
		Percent of Discharge Summaries Sent to Primary Care Provider within 72 hours of Patient Discharge - QIP *	R	R	R	R	R	↑

↑ Indicates improving performance to target over the past 5 quarters

↓ Indicates worsening performance to target over the past 5 quarters

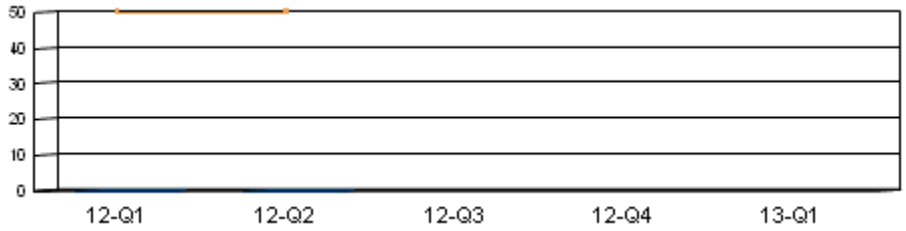
Kingston General Hospital

MS #23

Technology

Discharge summaries are sent to primary care providers within 72 hours

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



	Actual	Target
12-Q1		50
12-Q2		50
12-Q3		
12-Q4		
13-Q1		

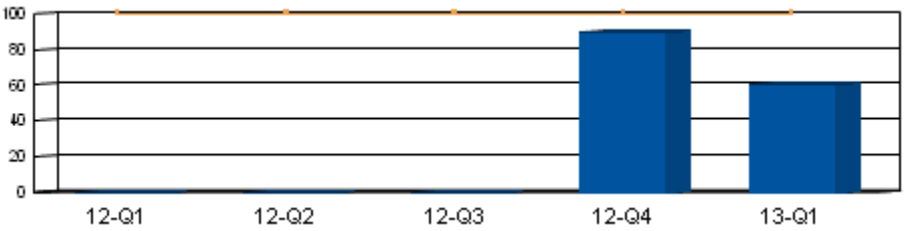
Interpretation - Patient And Business:

Contract signed between Hospital and Omnicell; project manager selected (Marian MacInnes)

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%. Updated Target 12/13: 25% (Interim Targets: Q1- Negotiate Contract. Q2 - Finalize Implementation Plans. Q3 - Complete 12.5. Q4 - 25)

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



	Actual	Target
12-Q1		100
12-Q2		100
12-Q3		100
12-Q4	90	100
13-Q1	60	100

Interpretation - Patient And Business:

All inpatient units have gone live with the lab order entry being done on the unit. As an overall project charter this accounts for 60% of the volume. The remaining areas (ER, Renal, FAPC, HDH and Outreach work) consist of 40% of the work volume and planning is underway in terms of getting the next group which is Renal to go live.

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% of inpatients. Updated Target 12/13: 100% (all remaining patient areas)

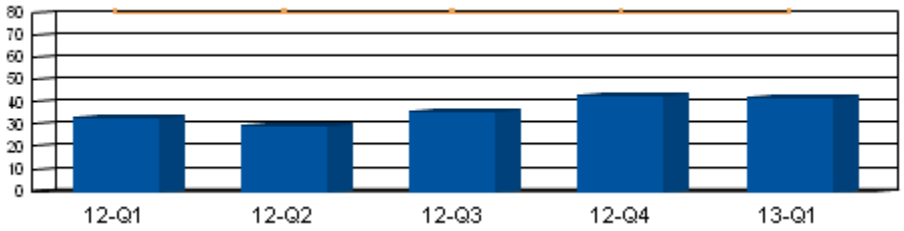
Kingston General Hospital

MS #23

Technology

Discharge summaries are sent to primary care providers within 72 hours

Indicator: Percent of Discharge Summaries Sent to Primary Care Provider within 72 hours of Patient Discharge - QIP *



	Actual	Target
12-Q1	33	**80**
12-Q2	29	**80**
12-Q3	36	**80**
12-Q4	43	**80**
13-Q1	42	**80**

Interpretation - Patient And Business:

First quarter results of 42% were consistent with the previous quarter. While performance was maintained, there was no improvement over the previous quarter. Despite this, the overall number of chart deficiencies remains within target and the number of discharge summaries completed beyond 120 hours continues to drop.

Actions & Monitoring Underway to Improve Performance:

Attending physician signature compliance continues to challenge performance. Health Information Services continues to work with Medical Administration to sanction as per policy. Discussions continue with our systems vendor to implement an electronic solution that will provide real-time chart deficiency status to physicians. The Patient Records Committee continues to review additional policy changes to ensure continued improvement to this indicator.

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%. QIP Target 12/13: 80%

Strategy milestone # 24

Investment in capital equipment, technology and infrastructure reaches $15 million

Enabler	KGH 2015 outcome	Status
Finances	**Our operating budget is balanced and we are able to allocate $20 million a year to capital expenditures**	**Green**

Indicator
Total Dollars for Capital Equipment, Technology and Infrastructure

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The Target is to achieve $15 million by March 31, 2013. We started the year with $10.5 million in the initial 12/13 budget. This capacity has been increased to $12.5 million at the end of Q1. As at July 31 it has been increased to approximately $13 million.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The organization continues to working towards identifying new operational efficiency initiatives. Savings resulting from these activities are directed towards reaching the $15M target. Supported by the Decision Support and Finance Teams all areas continue to work towards addressing this target.

3. **Are we on track to meet the milestone by year end?**
   Yes we are optimistic that this goal will be meet. We are currently ahead of where we expected to be at this early stage of the year. However, we must acknowledge the continuing inflationary and operational pressures all areas are facing as well as ongoing requests from LHIN and Provincial Projects that are also demands on operational efficiencies.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Decision Support has completed our annual benchmarking analysis comparison with peer hospitals based on data from 11/12 in July and continues to hold regular operational efficiency reviews with Program and Service Directors. This work will continue in Q2/Q3 and will support finding some operational efficiencies and help us plan for fiscal 13/14.
   This work is overseen by both Operations Committee and EMC, Quarterly.

Kingston General Hospital

MS #24

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Finances	Investment in capital equipment, technology and infrastructure reaches $15 million	Hospital Operations Actual vs Plan Variance ($000's)	G	G	G	G	G	↓
		Total Dollars for Capital Equipment, Technology and Infrastructure ($000's)	Y	Y	Y	G	G	↑
		Current Ratio	G	G	G	G	G	↑
		Total Margin	G	G	G	G	G	↑
		Working Capital ($000's)	G	G	G	G	G	↓

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

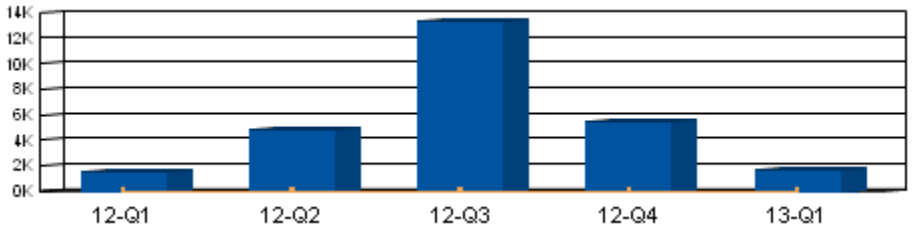
Kingston General Hospital

MS #24

Finances

Investment in capital equipment, technology and infrastructure reaches $15 million

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



	Actual	Target
12-Q1	1,528	**0**
12-Q2	4,875	**0**
12-Q3	13,359	**0**
12-Q4	5,532	**0**
13-Q1	1,651	**0**

Interpretation - Patient And Business:

The variance between the actual financial position and budgeted financial position measures the accuracy of the planning model and management's ability to live within the available financial resources.

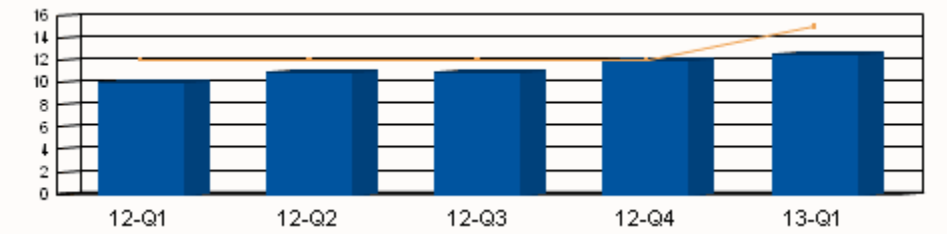
Actions & Monitoring Underway to Improve Performance:

This early in the fiscal year, the favourable position to budget should be considered as a timing difference. Lower than planned revenue for preferred accommodation is being addressed by a working group review; the results will come forward to the Operations Committee in August. The change in the OHIP schedule of benefits made by the Ministry effective April 1st is also having a negative impact on revenue results.

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, Target 12/13: 0

Indicator: Total Dollars for Capital Equipment, Technology and Infrastructure ($000's)



	Actual	Target
12-Q1	10.0	**12**
12-Q2	11.0	**12**
12-Q3	11.0	**12**
12-Q4	12.0	**12**
13-Q1	12.5	**15**

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 $12.5 million in capital investment in fiscal 2013. The organization is working towards identifying additional operational efficiency initiatives. Additional savings resulting from these activities will be directed towards reaching the $15M target.

Definition: Total amount available for capital investment. Calculated as net equipment amortization less long-term loan payments.

Target: Target 11/12: 12M, Target 12/13: 15M

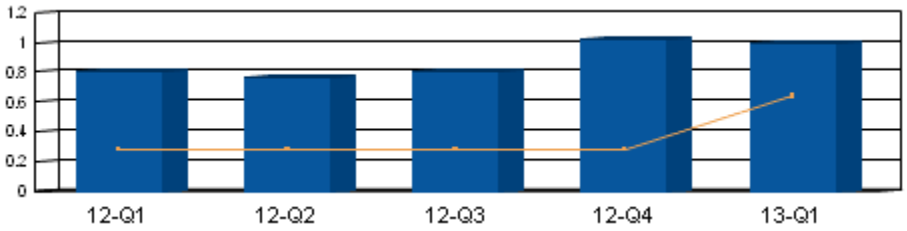
Kingston General Hospital

MS #24

Finances

Investment in capital equipment, technology and infrastructure reaches $15 million

Indicator: Current Ratio



	Actual	Target
12-Q1	0.8	**0.3**
12-Q2	0.8	**0.3**
12-Q3	0.8	**0.3**
12-Q4	1.0	**0.3**
13-Q1	1.0	**0.6**

Interpretation - Patient And Business:

A financially healthy hospital entity is able to provide and sustain services and the physical plant and equipment of the hospital. The current ratio is one of the measures that the public can consider in evaluating the hospital's performance in providing fiscal stewardship over the financial and physical resources entrusted to it by the public. A deteriorating current ratio signals issues, such as an inability to meet current obligations and/or ability to provide capital investment or meet emerging operational pressures. While these realities are true of hospitals like any business enterprise, it must also be acknowledged that hospitals in Ontario are part of a public system and therefore are supported with annual operating funds and cash flow from the Province, which provides a slightly different context.

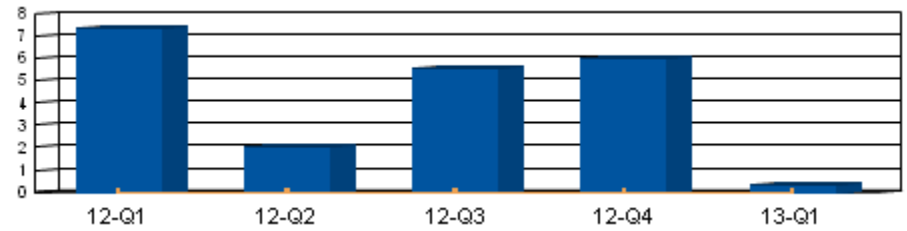
Actions & Monitoring Underway to Improve Performance:

The Q1 current ratio exceeds the fiscal 2011 target. This ratio is expected to decline as resources are expended for the purchase of capital investments in the remainder of the current fiscal year.

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, Target 12/13 0.64

Indicator: Total Margin



	Actual	Target
12-Q1	7.3	**0**
12-Q2	2.0	**0**
12-Q3	5.6	**0**
12-Q4	6.0	**0**
13-Q1	0.3	**0**

Interpretation - Patient And Business:

Note: Year-end target for Total Margin is 0. Q1 Target is -1.24 and has been shaded "green".

The variance between the actual financial position and budgeted financial position measures the accuracy of the planning model and management's ability to live within the available financial resources.

Actions & Monitoring Underway to Improve Performance:

The Q1 results indicate a total margin of $348 thousand; essentially a balanced operating budget.

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, Target 12/13: 0

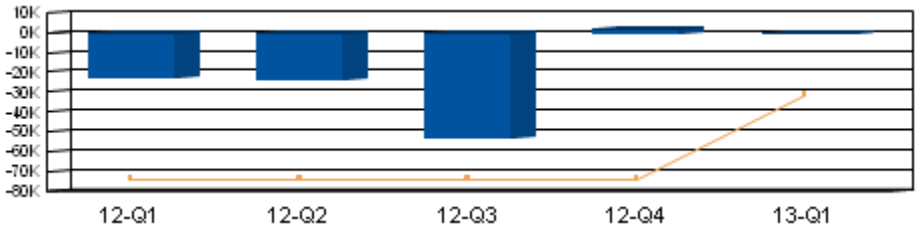
Kingston General Hospital

MS #24

Finances

Investment in capital equipment, technology and infrastructure reaches $15 million

Indicator: Working Capital ($000's)



	Actual	Target
12-Q1	-22,214	**-74000**
12-Q2	-23,560	**-74000**
12-Q3	-53,191	**-74000**
12-Q4	2,035	**-74000**
13-Q1	-601	**-31500**

Interpretation - Patient And Business:

A financially healthy hospital entity is able to provide and sustain services and the physical plant and equipment of the hospital. Working capital is one of the measures that the public can consider in evaluating the hospital's performance in providing fiscal stewardship over the financial and physical resources entrusted to it by the public. Deteriorating working capital signals issues, such as an inability to meet current obligations and/or ability to provide capital investment or meet emerging operational pressures. While these realities are true of hospitals like any business enterprise, it must also be acknowledged that hospitals in Ontario are part of a public system and therefore are supported with annual operating funds and cash flow from the Province, which provides a slightly different context.

Actions & Monitoring Underway to Improve Performance:

The -$601 thousand working capital deficit reflects the unadjusted position. As capital investment progresses during the fiscal year the working capital deficit will increase. The "adjusted" working capital deficit (excluding funds held for capital investment or other designated purposes) at Q1 is -$47.8 million.

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), Target 12/13: (31500)

Strategy milestone # 25

Staff satisfaction with communication at KGH improves by 20%

Strategic Direction	KGH 2015 outcome	Status
Communication	**We continue to engage and report openly and regularly on our progress**	**Yellow**

Indicator(s)
Staff Satisfaction with Communication at KGH will Improve by 20% based on responses to the statement "I am satisfied with communications in this organization"

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

Data for this indicator are not available as of this quarter. Communication plan in place with quarterly targets to influence the indicator.

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

Many factors contribute to the performance of the indicator for this milestone including communications at the corporate level and between management and front line staff. Research shows that effective, timely, accessible communications with staff contributes to employee engagement. A 20% improvement in satisfaction with Communications at KGH would indicate staff is better informed of specific programs and initiatives; adoption of new practices and behaviours, and a better understanding of new policies, as well as corporate strategic goals.

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?

To support the organization in achieving this milestone by year end, the communication and public affairs department has established five focused tactics for this year. They include:

- Build the structure and processes to deliver excellent strategic corporate communications in a timely and effective manner;
- Create a web strategy to facilitate effective communications at KGH
- Design and implement a new corporate website and intranet
- Contribute to the development and implementation of a KGH branded, patient-centred environment
- Communicate openly and regularly on our progress

Kingston General Hospital

MS #25

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Communication	Staff satisfaction with communication at KGH improves by 20%	Staff Satisfaction with Communication at KGH Will Improve by 20% Based on Responses to the Statement I am Satisfied with Communications in this Organization	N/A	N/A	N/A	N/A	Y	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

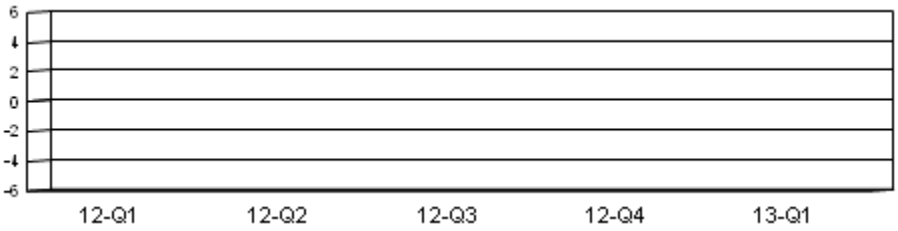
Kingston General Hospital

MS #25

Communication

Staff satisfaction with communication at KGH improves by 20%

Indicator: Staff Satisfaction with Communication at KGH Will Improve by 20% Based on Responses to the Statement I am Satisfied with Communications in this Organization



	Actual	Target
12-Q1		
12-Q2		
12-Q3		
12-Q4		
13-Q1		

Interpretation - Patient And Business:

Definition: Staff satisfaction with communications will be measured through the Worklife Pulse Survey and the engagement survey. Worklife Pulse survey assesses work environment, which is evaluated on a number of aspects including communication, supervision, and learning, involvement in decision making, safety, and worklife balance. Research shows that effective communications with staff, which includes the methods used to facilitate communications between management and frontline staff in a timely fashion and through channels that are accessible by staff, contributes to employee engagement. A 20% improvement in satisfaction with Communications at KGH would indicate staff is better informed of specific programs and initiatives; adoption of new practices and behaviours, and a better understanding of new policies, as well as corporate strategic goals.

Target: 12/13 Target: 47%

Kingston General Hospital

QIP - Fiscal 2012/13 Q1

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
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, How Would You Rate the Care You Received at the Hospital?	G	G	G	Y	N/A	↓
		Patients Are Engaged in All Aspects of KGH Quality, Safety, and Service Improvement Initiatives	N/A	N/A	N/A	N/A	N/A	
		Percent of Clinical Programs that Have Conducted at Least One Patient and Family Feedback Forum *	N/A	N/A	N/A	N/A	G	
		Percent of Patients Who Respond "Satisfied" to the Food Patient Discharge Survey *	R	R	R	R	N/A	↓
	Patient safety culture ratings improve by 20%	Number of Clinical Programs that Implement at Least One New Safety Checklist	N/A	N/A	N/A	N/A	G	
		Implementation of Surgical Safety Check List	G	G	G	G	G	↑
		Percent Mortality Reviews Completed with Review of Record Level HSMR Data *	G	N/A	N/A	N/A	N/A	
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) *	Y	Y	Y	Y	Y	↑
		Hospital Standardized Mortality Ratio (HSMR)	G	G	R	N/A	N/A	↓
		Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey *	G	G	G	G	N/A	↓
		Percent of Recommendations Considered and Acted Upon as per Critical Incident Investigations *	N/A	N/A	N/A	N/A	G	
	The number of new patients who acquire infections in our hospital is reduced by 10%	Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days *	R	Y	R	Y	Y	↑
		Percent of Sepsis Cases Reviewed by Department Head *	N/A	N/A	N/A	N/A	N/A	
		C-Difficile (Reported Quarterly)	G	R	R	R	Y	↑
		Hand Hygiene Compliance *	Y	Y	G	G	Y	↑

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
	KGH overall average length of stay is better than expected length of stay	Overall - Acute Average Length of Stay vs ELOS Variance in Days - QIP *	G	G	G	G	Y	↑
		Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile *	Y	Y	G	G	R	↓
		Readmission Rate Within 30 Days for Selected CMG's to Any Facility *	R	R	N/A	N/A	N/A	
	The emergency department wait time for admitted patients is improved by 20%	90th Percentile ED Wait Time - All Admitted Patients (Hrs) - QIP	G	G	G	G	Y	↓
		Percent of ED Consults Meeting Target Time (Time Between Consult Requested in ED and Consultant Arrival ED) *	N/A	N/A	N/A	N/A	N/A	
Technology	Discharge summaries are sent to primary care providers within 72 hours	Percent of Discharge Summaries Sent to Primary Care Provider within 72 hours of Patient Discharge - QIP *	R	R	R	R	R	↑

Indicates improving performance to target over the past 5 quarters ↑ Indicates worsening performance to target over the past 5 quarters ↓

Kingston General Hospital

Strategy Performance Report - Fiscal 2012/13 Q1

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
KGH 2015	100% Accreditation Canada Requirements are Met with an Unconditional Three-Year Award	100% Accreditation Canada Requirements Met	N/A	N/A	N/A	N/A	G	
	Quality Improvement Plan Targets are Met	Number of Quality Improvement Plan Goals for Change Met	N/A	N/A	N/A	N/A	Y	
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	G	G	N/A	↑
		Overall Emergency Care Patient Satisfaction (%)	G	G	G	G	N/A	↑
	Patient safety culture ratings improve by 20%	Percent of Staff Surveyed Who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey	R	N/A	N/A	R	N/A	↓
	Medication reconciliation is completed for every internal medicine program inpatient at admission	Medication Reconciliation is Completed for Every Internal Medicine Program Inpatient at Admission	R	G	G	G	N/A	↑
	The number of new patients who acquire infections in our hospital is reduced by 10%	Number of New Cases of Hospital Acquired Infection	G	Y	Y	R	G	↑
	KGH overall average length of stay is better than expected length of stay	Average # ALC Patients per Day	R	R	G	G	R	↓
		Overall - Acute Average Length of Stay vs ELOS Variance in Days - QIP *	G	G	G	G	Y	↑
	The emergency department wait time for admitted patients is improved by 20%	90th Percentile ED Wait Time - All Admitted Patients (Hrs) - QIP	G	G	G	G	Y	↓
	Clinical services meet the provincial wait time target	Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (Excluding Cancer Surgery)	Y	R	R	R	R	↓
	Cancer Care Ontario access to care indicators are met	Number of Cancer Care Ontario Access to Care Contract Indicators Met (Radiation/Chemotherapy)	R	R	R	R	R	↓
		Percent of Cancer Care Ontario Access to Surgical Care Contract Indicators Met	R	R	R	R	R	↓
Bring to life new models of interprofessional care and education	Automation of interprofessional assessment-and-adverse-reaction documents is complete (e-doc project)	Automation of Interprofessional Assessment & Adverse Reaction Documents is Complete as Part of the E-Doc Project	N/A	N/A	N/A	N/A	N/A	
	Workplan to fulfill interprofessional-education competencies is completed	Number of Interprofessional Organizational Educational Competencies Are Met	N/A	N/A	N/A	N/A	R	

			12-Q1	12-Q2	12-Q3	12-Q4	13-Q1	
Cultivate patient oriented research	Clinical research space at KGH increases by 25%	8% Increase of Externally Funded Research Dollars at KGH	N/A	G	G	G	N/A	↑
		Square Footage of Clinical Research Space at KGH	N/A	N/A	N/A	N/A	N/A	
Increase our focus on complex-acute and specialty care	Clinical Services Roadmap initiatives launched	KGH Participation in Clinical Services Roadmap Initiatives	G	G	G	G	G	↑
	Target service volumes are met	Percent of Contracted Volumes Achieved	G	Y	G	G	G	↑
	Evidence-based guidelines are adopted in 12 clinical areas	Number of Clinical Areas that have Implemented Open Source (OS)	G	R	G	G	G	↑
People	Overall staff satisfaction ratings improve by 20%	Staff Satisfaction Ratings Will Improve By 20% based on Responses of Agree and Strongly Agree to the Question "Overall I am Satisfied With This Organization"	N/A	N/A	N/A	R	R	
	Health and Safety Scorecard targets are met	Number of Health & Safety Scorecard Target Indicators Met	N/A	N/A	N/A	N/A	G	
	Employee engagement action plans are in place at all team levels	Employee Engagement Action Plans at Corporate and Team Level are Complete	N/A	N/A	N/A	N/A	R	
Processes	100% of KGH managers complete continuous improvement training	Percent of Management Staff Completing Mandatory Process Improvement Training	Y	R	R	R	G	↑
Facilities	Phase 2 redevelopment functional programming commences	Phase 2 Redevelopment Project Targets are Met	N/A	N/A	N/A	N/A	G	
	Carpets are removed from 75% of patient areas	Quarterly Carpet Removal Targets are Met	G	G	G	G	Y	↓
Technology	Discharge summaries are sent to primary care providers within 72 hours	Percent of Discharge Summaries Sent to Primary Care Provider within 72 hours of Patient Discharge - QIP *	R	R	R	R	R	↑
Finances	Investment in capital equipment, technology and infrastructure reaches $15 million	Hospital Operations Actual vs Plan Variance ($000's)	G	G	G	G	G	↓
		Total Dollars for Capital Equipment, Technology and Infrastructure ($000's)	Y	Y	Y	G	G	↑
Communication	Staff satisfaction with communication at KGH improves by 20%	Staff Satisfaction with Communication at KGH Will Improve by 20% Based on Responses to the Statement I am Satisfied with Communications in this Organization	N/A	N/A	N/A	N/A	Y	↑

↑ Indicates improving performance to target over the past 5 quarters

↓ Indicates worsening performance to target over the past 5 quarters