fiscal 2012-2013 **Q4**

4th quarter ended March 31, 2013

KGH this quarter

Master Performance Report

Kingston General Hospital

Outstanding care, always

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KGH Master Performance Report
Q4 Fiscal 2012 - 2013

KGH 2015

Outstanding Care, Always

Milestone 1: 100% Accreditation Canada requirements are met with an Unconditional three-year award — **Page 1**

- 100% Accreditation Canada requirements met

Milestone 2: Quality Improvement Plan targets are met — **Page 4**

- Number of Quality Improvement Plan goals for change met

Strategic Direction 1

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

Milestone 3: Overall patient satisfaction is at or better than the provincial teaching hospital average — **Page 7**

- Overall Acute Care Patient Satisfaction (%)
- Overall Emergency Care Patient Satisfaction (%)
- Overall, how would you rate the care you received at the hospital?
- Percent of clinical programs that have conducted at least one Patient and Family Feedback Forum
- Percent of patients who respond “satisfied” to the Food Patient Discharge survey
- Percent of patients who answer “definitely yes” to the NRC Picker question “Would you recommend this hospital to your friends and family?”

Milestone 4: Patient safety culture ratings improve by 20% — **Page 12**

- Percent of staff surveyed who rate KGH “very good” or “excellent” on the Patient Safety Culture survey
- Number of clinical programs that implement at least one new Safety Checklist
- Implementation of Surgical Safety Checklist
- Percent mortality reviews completed with quarterly review of record-level HSMR data
- All three phases of the Surgical Safety Checklist are performed (Briefing, Time Out, And Debriefing)
- Hospital Standardized Mortality Rate (HSMR)
- Percent of patients responding “satisfied” to the KGH Environmental Patient Discharge survey
- Percent of Recommendations considered and acted upon as per Critical Incident Investigations

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Milestone 5: Medication reconciliation is completed for every internal medicine program patient at admission **Page 18**

- Medication reconciliation is completed for every internal medicine program Inpatient at admission

Milestone 6: The number of new patients who acquire infections in our hospital is reduced by 10% **Page 21**

- Number of New Cases of Hospital Acquired Infection
- Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 patient days
- Percent of Sepsis Cases Reviewed by Department Head
- C-difficile (reported quarterly)
- C-difficile (reported monthly)
- Hand hygiene compliance
- Central Line Bloodstream Infections
- MRSA (Methicillin-Resistant Staphylococcus aureus)
- VRE (Vancomycin-Resistant Enterococcus)
- Ventilator Associated Pneumonia
- Surgical Site Infections (SSI) Prevention
- External environmental audits by Westech

Milestone 7: KGH overall length of stay is better than expected length of stay expected length of stay **Page 32**

- Average # ALC Patients Per Day
- Percent ALC Days
- Overall – Acute Average Length of Stay vs. ELOS Variance in Days (QIP)
- Percent of clinical services meeting ELOS target
- Overall – Acute Average Length of Stay days (based on HSAA)
- Improvement in KGH 30-day readmission rate as per SE LHIN CMG profile
- Readmission rate within 30 days for selected CMGs to any facility

Milestone 8: The Emergency Department wait time for admitted patients is improved by 20% **Page 38**

- 90th Percentile ED Wait Time - All Admitted Patients (Hrs) – QIP
- Percent of ED consults meeting target time (time between consult requested In ED and consultant arrival ED)
- Percent of non-admitted high acuity patients treated within a wait time target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)

Milestone 9: Clinical services meet the provincial wait time target **Page 42**

- Orthopedic Surgery (excluding total hip and knee replacements) Wait Time 90th Percentile days
- 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 59**

- 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 64**

- 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 67**

- Number of interprofessional organizational educational competencies are met

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Strategic Direction 3

Cultivate patient oriented research

Milestone 13: Clinical research space at KGH increases by 25% **Page 70**

- 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 75**

- KGH participation in clinical services roadmap initiatives

Milestone 15: Target service volumes are met **Page 78**

- 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 91**

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

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Enabler 1

People

Milestone 17: Overall staff satisfaction rating improves by 20% **Page 94**

- Staff satisfaction ratings will improve by 20% based on responses of agree and strongly agree to the statement “Overall I am satisfied with this organization”
- Average sick days per eligible employee per year
- Launch the staff scheduling project
- Percent of overtime hours
- Percent sick time hours

Milestone 18: Health and Safety Scorecard targets are met **Page 99**

- Number of Health & Safety Scorecard target indicators met

Milestone 19: Employee engagement action plans are in place at all team levels **Page 102**

- Employee engagement action plans at corporate and team level are complete
- Percent of staff that complete mandatory online training programs

Enabler 2

Processes

Milestone 20: 100% of KGH managers complete continuous improvement training **Page 105**

- Percent of management staff completing mandatory process improvement training

Enabler 3

Facilities

Milestone 21: Phase 2 redevelopment functional programming commences **Page 108**

- Phase 2 redevelopment project targets are met

Milestone 22: Carpets are removed from 75% of patient areas **Page 111**

- Quarterly carpet removal targets are met

Enabler 4

Technology

Milestone 23: Discharge summaries are sent to primary care providers within 72 hours of patient discharge **Page 114**

- Automated medication dispensing system in place throughout inpatient units within the hospital
- Implementation of an order management system for labs on all inpatient areas (% completion)
- Percent of discharge communication sent to continuing care provider with 72hrs of patient discharge

Enabler 5

Finances

Milestone 24: Investment in capital equipment, technology and infrastructure Reaches $15 million **Page 118**

- Hospital operations actual vs. plan variance ($000s)
- Total dollars for capital equipment, technology and infrastructure ($000s)
- Current ratio
- Total Margin
- Working Capital

Enabler 6

Communication

Milestone 25: Staff satisfaction with communication at KGH improves by 20% **Page 123**

- Implementation of improved website and social media tools

Strategy Scorecard (SSC) Summary **Page 126**

Quality Improvement Plan (QIP) Summary **Page 128**

Occupational Health & Safety (OHS) Scorecard **Page 130**

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?**
   The milestone was achieved with the conclusion of the September 2012 survey and the award of Accreditation with Exemplary Status. There was also subsequent Accreditation Canada assessment of the Stroke Program resulting in an award of distinction (the second hospital in Canada to receive such an award).

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The work associated with Accreditation Standards and Required Organization Practices is ideally embedded in the ongoing work of the organization. Activities continue with ROPs such as medication reconciliation, patient falls, etc. With the renewed approach to patient safety and quality, the focus on improvement activities and performance against measures that are aligned to the standards of Accreditation Canada, will be strengthened.

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

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   As above (2).

Kingston General Hospital

MS #01

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

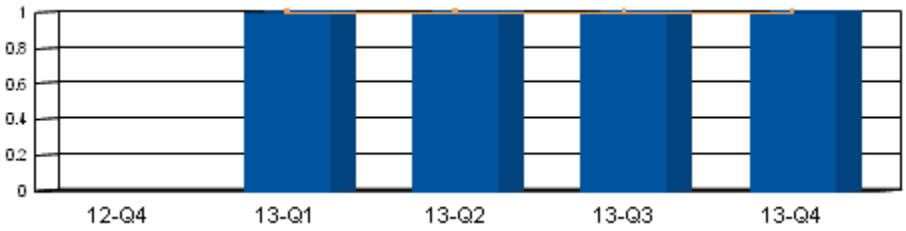
Kingston General Hospital

MS #01

KGH 2015

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

Indicator: 100% Accreditation Canada Requirements Met



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

Interpretation - Patient And Business:

The milestone was achieved with the conclusion of the Sept 2012 survey and the award of Accreditation with Exemplary Status.

Actions & Monitoring Underway to Improve Performance:

The work associated with Accreditation Canada Standards and Required Organizational Practices (ROP) are ideally embedded in the ongoing work of the organization. Activities continue with ROP's, such as medication reconciliation, patient falls. With the renewed approach to patient and safety, the alignment and focus on Accreditation standards/ROP will be strengthened.

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

Quality Improvement Plan targets are met

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

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?

NB: two Planned Improvement Initiatives for the 2012/13 QIP have been retired: Quarterly review of sepsis and ED consult times leaving 12 indicators being assessed.

Performance in Q4 has 8 indicators green or yellow. Hand hygiene has maintained a 94% compliance rate. An improvement in Antibiotics dispensed change yellow to green. Of the four red indicators, 3 are trending positively (food satisfaction, the three phases of the surgical check list and HSMR) with a negative trending seen in percent mortality reviews carried out. Although the Q4 HSMR is red (119), the indicator is reported as an annual rate and will therefore be reported as 106 (green).

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

Clinical department incorporation of hospital metrics into their QIPs has seen increased engagement on many indicators (e discharge, surgical checklists). The antibiotic stewardship initiation in late Q3 and front line education by the infection prevention and control team has aided the infection related indicators. Food surveys through NRC Picker are generally delayed by one quarter. More current and indepth survey by Compass have demonstrated food satisfaction > 85%.

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 mortality reviews are completed, timeliness within the assigned quarter is preventing the indicator from being green. The development of Departmental QIPs aligned to the hospital QIP will increase accountability and focus on this indicator. Current fiscal focus on Gridlock will begin a new approach to ED wait time problems. The redesign of accountability in the operating room in conjunction with implementation of the new OR software PICS will support surgical checklist improvements especially with the third phase (debriefing).

Kingston General Hospital

MS #02

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

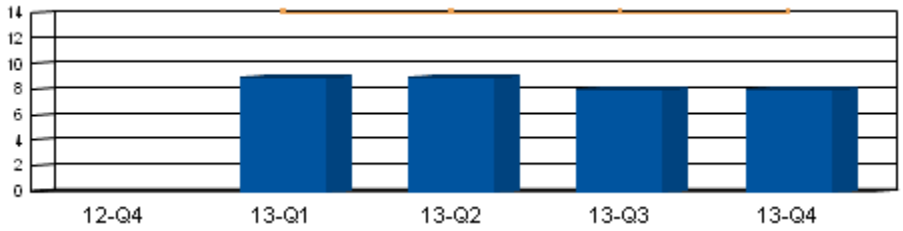
Kingston General Hospital

MS #02

KGH 2015

Quality Improvement Plan Targets are Met

Indicator: Number of Quality Improvement Plan Goals for Change Met



	Actual	Target
12-Q4		
13-Q1	9	**14**
13-Q2	9	**14**
13-Q3	8	**14**
13-Q4	8	**14**

Interpretation - Patient And Business:

Performance in Q4 has shown an improvement in 1 indicators going yellow to green (Anti-biotic Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days) and we continue to hold our gains in others that are either yellow or green. All four red indicators are trending for improvement (Food satisfaction; 3 phases of Surgical Safety Checklist; e-discharge in 72 hrs; mortality review by departments). Mortality reviews although completed have not met the timelines imposed upon the Departments. Antibiotics dispensed during the last quarter increased but coincides with the influenza outbreak.

NB: Two Planned Improvement Initiatives for the 2012/13 QIP have been retired: Quarterly review of sepsis and ED consult times leaving 12 indicators being assessed.

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

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?**
   The Q3 results, received April 2013, show that of 276 patients surveyed, the overall patient satisfaction at KGH is 76.5% (77 %) which is improved from Q2 (76%) and exceeds the Ontario Teaching Hospital Average (OTHA) of 75.3%. For overall care received, KGH achieved 94.6% which compares unfavourably to 96.3% in Q2 and favourably to the OTHA of 94.2%. Supporting indicators, including satisfaction with food and recommendation of the hospital to friends/family, all trend positively. The high performance in the Emergency survey is particularly impressive given the increase in ED volumes and the challenges with patient flow.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   KGH leadership is resolved to improve processes and is proactive in engaging patient and staff perspectives with the design of change. The infrastructure and rigor with Continuous Improvement is driving change and producing results that are shared within the KGH community. This coupled with KGH's status as a leader in Patient and Family Centred Care and patient engagement supports staff awareness, engagement and pride.

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

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The work in the next year will focus on ensuring that standards for patient and family centred care are defined, embedded in practice and consistently demonstrated. Ensuring the "Always" with "Outstanding Care". Patient led feedback forums will continue with expectation of at least 2 per year per program with 4 continuous improvement cycles emanating from each program. The new infrastructure with Patient Experience Specialists aligned to each program/service will ensure that data is reviewed and used to make improvements within the Continuous Improvement framework. The survey process will also be expanded to include Critical Care.

Kingston General Hospital

MS #03

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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?	Y	G	G	G	N/A	↑
		Percent of Clinical Programs that Have Conducted at Least One Patient and Family Feedback Forum *	N/A	G	G	G	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	G	N/A	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

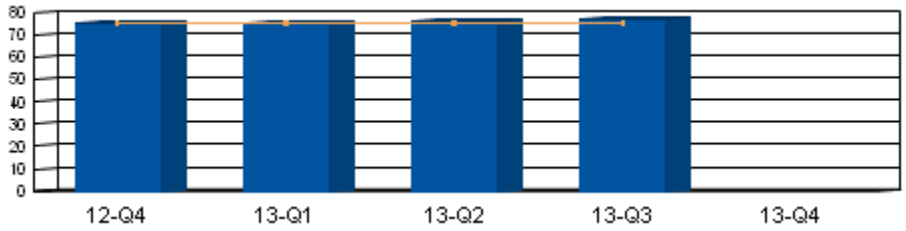
Kingston General Hospital

MS #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-Q4	75	**75**
13-Q1	75	**75**
13-Q2	76	**75**
13-Q3	77	**75**
13-Q4		

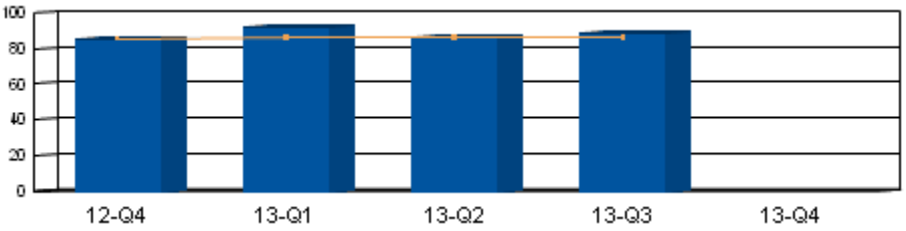
Interpretation - Patient And Business:

The current overall acute care satisfaction as with the previous quarter is on target.
KGH currently scoring above the ON Teaching Av on 5 of the 8 dimensions of care. Involvement of Family, Continuity & Transition, and Coordination of Care are within 1-2 percentage points.

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-Q4	85	**85**
13-Q1	92	**86**
13-Q2	86	**86**
13-Q3	89	**86**
13-Q4		

Interpretation - Patient And Business:

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

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

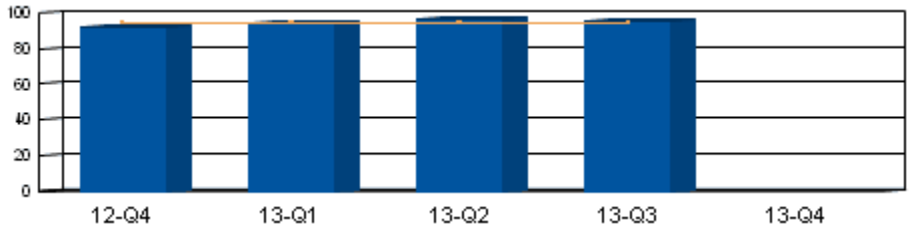
Kingston General Hospital

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, How Would You Rate the Care You Received at the Hospital?



	Actual	Target
12-Q4	92	**94**
13-Q1	94	**94**
13-Q2	96	**94**
13-Q3	95	**94**
13-Q4		

Interpretation - Patient And Business:

Based upon the Q3 results, received April 2013, the positive percent score including good, very good and excellent, for KGH is 94.6% compared to 96.3% in the last reported quarter, and to the Ontario teaching av in Q3 of 94.2%. Remaining above the Ontario and Ontario Teaching Hospital average is attributed to the focus on the part of programs and services in aligning activities to the strategy and transforming the patient experience, and to the active engagement of patients/families in the design of improvements.

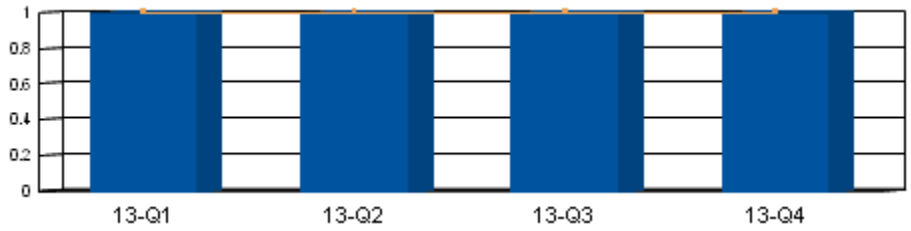
Actions & Monitoring Underway to Improve Performance:

As the work on the strategy and annual corporate plans unfold, there will continue to be focus on transforming the patient experience. The teams are supported in making improvements with the training about LEAN methodology, and with resources such as the newly created Patient Experience Consultant roles within the safety/quality infrastructure. Patient led feedback sessions also enable teams to learn of specific opportunities through the experience of specific patient populations (ie one forum per program minimum 2x per year). The Patient Experience conference (May 2013) will be event to further increase understanding of the link of PFCC, ICPM and IPE and build capacity within KGH to make improvements.

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

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



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

Interpretation - Patient And Business:

Each of the 9 programs has completed formal patient led feedback sessions. Lessons learned from the forums have been raised with staff and action plans are developed to sustain or remedy processes and behaviors which impact the patient experience. These are being approached using the process excellence education (LEAN methodology and PlanDoStudyAct - PDSA cycles). Feedback thus far has been universally positive from both patient and staff perspectives.

Actions & Monitoring Underway to Improve Performance:

Each program has committed to conducting a minimum of 2 patient feedback forums in the next year with a minimum of 4 PDSA's for each program resulting from the forums.

The proposed redesign of the supports for quality and safety, with alignment of patient experience consultants to use and enable use of information, and design of improvement processes will support this commitment.

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.

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

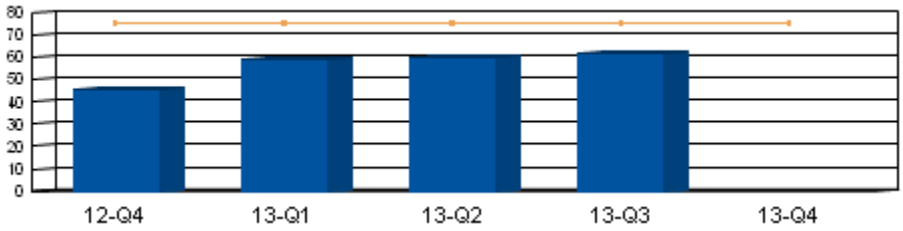
Kingston General Hospital

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 Respond "Satisfied" to the Food Patient Discharge Survey *



	Actual	Target
12-Q4	46	**75**
13-Q1	59	**75**
13-Q2	60	**75**
13-Q3	62	**75**
13-Q4		**75**

Interpretation - Patient And Business:

KGH results for Q3 showed a 3% increase in satisfaction, and continues to rise, nearing our target of 75%.
Our result of 62% is on par with the ON Teaching Hosp Av.

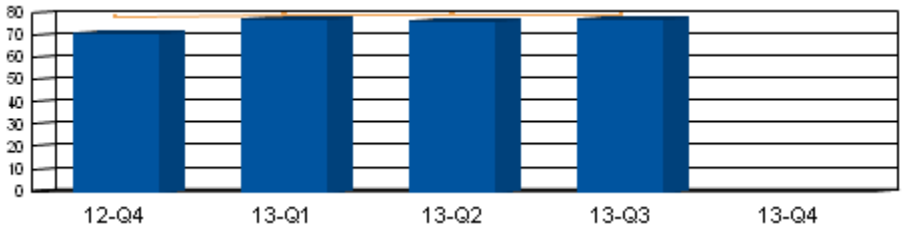
Actions & Monitoring Underway to Improve Performance:

We continue to improve the Steamplicity program, listening to & making changes based on, feedback from patients & families.

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%

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-Q4	71	**78**
13-Q1	77	**79**
13-Q2	76	**79**
13-Q3	77	**79**
13-Q4		

Interpretation - Patient And Business:

The question supports the overall acute care patient experience. KGH result this quarter continues to be within striking distance of meeting the ON Teaching Hosp Av.

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

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	Yellow

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 milestone is comprised of 8 indicators. The key indicator was initially to be an annual measure of the Patient Safety Culture Survey but has been delayed until Q2 of the next fiscal year and thus remains red. Of the remaining 7 indicators, 4 are green or yellow. The 3 red indicators are part of the QIP and improving in 2 and negatively trending in one. A more in depth review of the individual red metrics shows that HSMR reported in its usual annualized format would give a value of 106 (green). Surgical safety checklist is 91% complete with only the debrief phase lagging behind the other two phases. Interpretation of the milestones seven other would therefore be better represented as yellow rather than red.

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

   Reporting of these indicators through the Patient Safety and Quality Committee has generated focus on the organizational groups and initiatives managing the indicators. Environmental services, SPA program and Process Excellence have all been key drivers on these indicators.

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

   Yes

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

   The decision to delay the repeat Patient Safety Culture Survey until the fall has been strategically made to allow implementation of changes in the Patient Safety, Quality and Risk portfolio to better support the organizational preparedness for the survey. Integration of Patient Advisor Specialists into the programs, Accreditation preparedness, and a rigorous critical incident review process will help prepare the organization for the fall survey with an expectation to see improvement in the key indicator.

Kingston General Hospital

MS #04

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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	N/A	N/A	
		Number of Clinical Programs that Implement at Least One New Safety Checklist	N/A	G	G	G	G	↑
		Implementation of Surgical Safety Check List	G	G	G	G	G	↑
		Percent Mortality Reviews Completed with Review of Record Level HSMR Data *	R	R	R	N/A	N/A	↓
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) *	Y	R	R	R	R	↑
		Hospital Standardized Mortality Ratio (HSMR)	G	G	G	R	N/A	↓
		Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey *	G	Y	Y	Y	N/A	↑
		Percent of Recommendations Considered and Acted Upon as per Critical Incident Investigations *	N/A	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

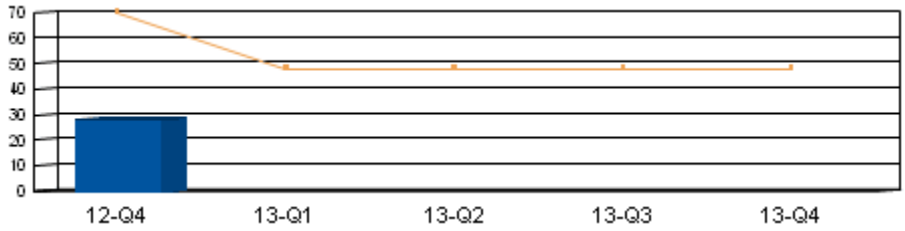
Kingston General Hospital

MS #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-Q4	28	**70**
13-Q1		**48**
13-Q2		**48**
13-Q3		**48**
13-Q4		**48**

Interpretation - Patient And Business:

No update. Patient Safety Culture survey will be administered again Fall 2013.

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.

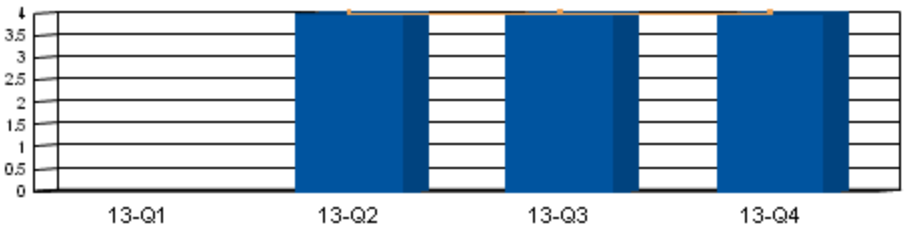
The Patient Safety Culture Tool includes 40 items (plus demographic items). Two items assign an overall patient safety grade of the unit and the organization. The remaining 38 items measure the following dimensions:
- Senior leadership support for safety
- Supervisory leadership support for safety
- 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		
13-Q2	4	**4**
13-Q3	4	**4**
13-Q4	4	**4**

Interpretation - Patient And Business:

Quarterly targets quickly met by programs to implement checklists as part of their safety and quality initiatives.

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

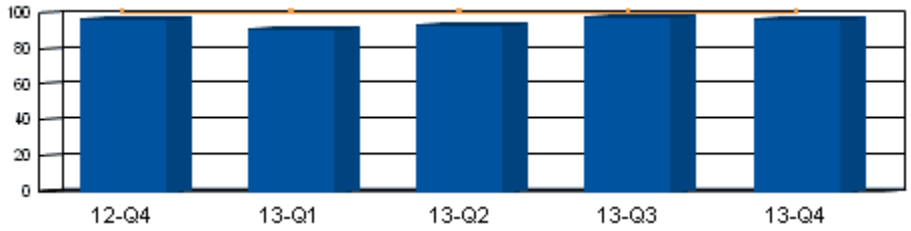
Kingston General Hospital

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-Q4	96	**100**
13-Q1	91	**100**
13-Q2	93	**100**
13-Q3	98	**100**
13-Q4	96	**100**

Interpretation - Patient And Business:

Previously this indicator has been recorded through the operating room computer software ORSOS. This earlier software only tracked if all three phases of the SSC were completed or not completed. The implementation of the new PICIS system provides a more accurate monitoring of each separate phase permitting the program an opportunity to identify where the focus is needed to improve.
This slight decrease from the previous quarter is related to the inconsistency of SSCL documentation for emergency A (0-2 hours)cases where the teams focus is on stabilizing the patient.

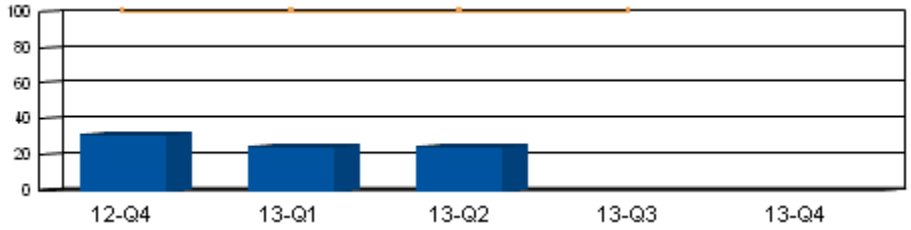
Actions & Monitoring Underway to Improve Performance:

SPA program leadership will continue to monitor results and work with individual surgical service teams on targeting specific areas need for improvement.

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-Q4	31	**100**
13-Q1	24	**100**
13-Q2	24	**100**
13-Q3		**100**
13-Q4		

Interpretation - Patient And Business:

Mortality review is an integral part of most clinical departments. The mortality reviews assigned to the departments through the HSMR data set if provided on a quarterly basis. Although reviews are virtually all completed, they have not been completed within the time frame commitment.

Actions & Monitoring Underway to Improve Performance:

Departments have aligned their quality committees and structures to the MAC Quality Committee (Joint Quality and Utilization Committee). Mortality review value and process will be supported by this accountability structure aimed at improving the timeliness of reviews and reports.

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%

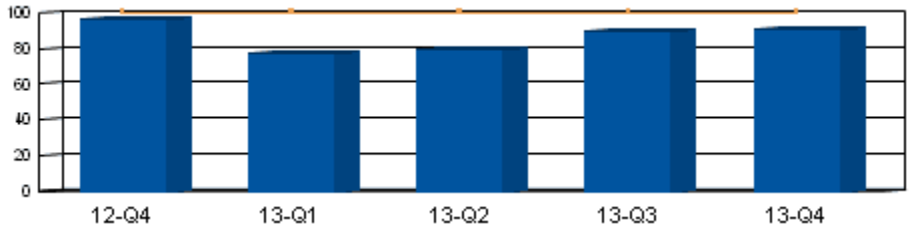
Kingston General Hospital

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-Q4	96	**100**
13-Q1	77	**100**
13-Q2	80	**100**
13-Q3	90	**100**
13-Q4	91	**100**

Interpretation - Patient And Business:

The indicator continues to trend positively as staff continue to transition from the ORSOS electronic system to the new PICIS system for the monitoring of the surgical safety checklists (SSCL) in the Operating Room. Overall the compliance for all services to complete the 3 phases of the surgical safety checklist for all operative activity (urgent, elective) for this quarter (2,208 cases) is the following: Briefing - 96%, Timeout- 97% and the final Debrief - 93%. Focus on urgent/emergent activity SSCL reporting is required to meet the overall average target of 100%.

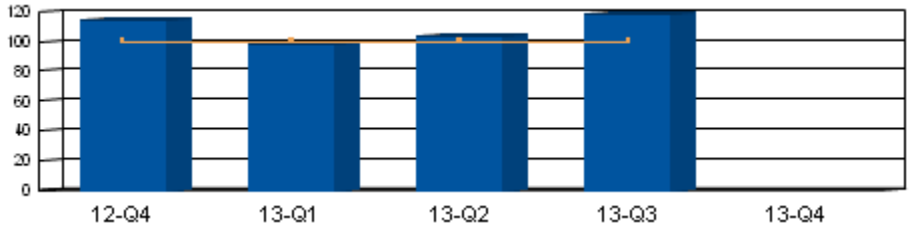
Actions & Monitoring Underway to Improve Performance:

Ongoing education and continuous monitoring is being supported by the program to assist the following services in improving their compliance in completing the 3 phases of SSCL reporting for urgent activity in the operating room.

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-Q4	114	**100**
13-Q1	98	**100**
13-Q2	103	**100**
13-Q3	119	**100**
13-Q4		

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

The most recent data available data from CIHI is Q1 and Q2 of fiscal 12/13. The HSMR has been decreasing steadily since Q3 fiscal 11/12. Both the Q1 and Q2 values are deemed statistically not significant which means our HSMR is where it should be. The Canadian Institute for Health Information (CIHI) provides the HSMR calculations to all hospitals in Ontario. Quarterly morality reviews are on-going by the clinical departments. Any concerns or trends are reported to the MAC's Joint Quality and Utilization Committee. Of note is a continued drop on the 5 year ANNUAL mortality rate.

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

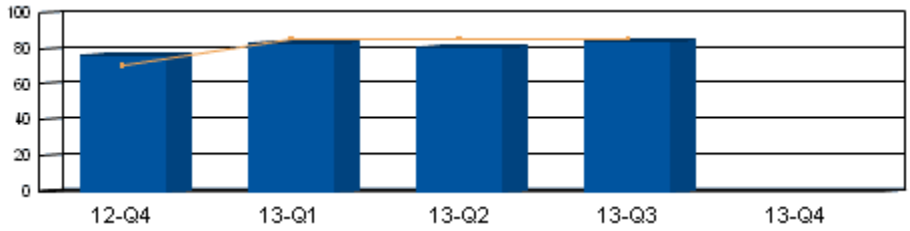
Kingston General Hospital

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-Q4	76	**70**
13-Q1	83	**85**
13-Q2	81	**85**
13-Q3	84	**85**
13-Q4		

Interpretation - Patient And Business:

The 84% represents the feedback which is received through the NRC + Picker Patient Satisfaction Survey which is conducted on discharge. This current result demonstrates improvement and the leadership team will continue to work with our staff to meet target.

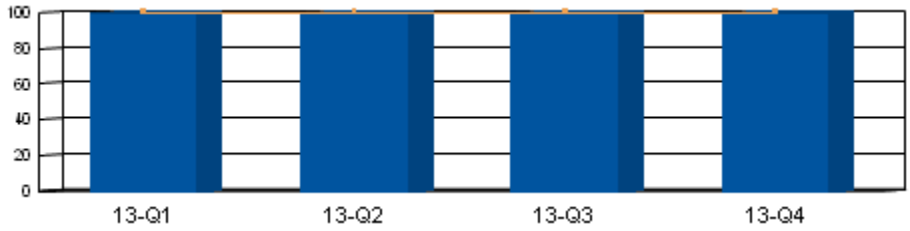
Actions & Monitoring Underway to Improve Performance:

Results of survey continue to be shared with our team with an emphasis on the importance of first impression and daily room cleaning.

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**
13-Q2	100	**100**
13-Q3	100	**100**
13-Q4	100	**100**

Interpretation - Patient And Business:

All resulting review recommendations have been considered. Two (2) Critical Incident Reviews were held under the Quality of Care Information Act (QCIPA) from
2013 Jan-Mar. There were a total of 14 resulting recommendations. Four (4) of these are complete, one (1) is ongoing and the outstanding nine (9) are in progress, many currently part of ongoing improvement cycles.

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 CEO, Medical Advisory Committee 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 97% of inpatients receiving a medication reconciliation on admission.

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.

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.

Kingston General Hospital

MS #05

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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	G	G	Y	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

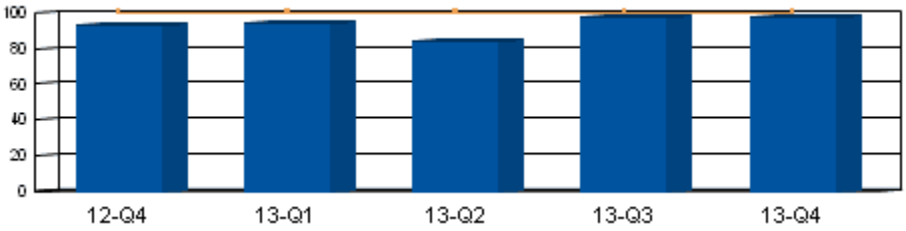
Kingston General Hospital

MS #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-Q4	93	**100**
13-Q1	94	**100**
13-Q2	84	**100**
13-Q3	98	**100**
13-Q4	97	**100**

Interpretation - Patient And Business:

The medication reconciliation on admission in internal medicine indicator result of 97% demonstrates the commitment of the Medicine Program and the Queen's Medicine Department to establish medication reconciliation as an essential quality component of safe patient care.

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?**
   In the last 3 quarters, this milestone has progressed red to yellow to green! The number of new infections has decreased almost 50% from Q4 F11-12. Seven of the 10 supporting indicators have shown significant change (R to Y or G; Y to G) or continuing Green and trending positively. Only MRSA infections remains red due to three infections in Q4.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Infection Prevention and Control redesign to focus on education has been a key factor in decreased infection rates. A C difficile has not had an outbreak declared for 1 year. Implementation of an antibiotic stewardship program has also been instrumental.

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?**

   Infection Prevention and Control working with programs will continue supporting education on hospital acquired infections especially regarding compliance with MRSA screening. Antibiotic Stewardship will continue refocus in the ICU as part of the CAHO ARTIC project and then look to a broader implementation as resources support it.

Kingston General Hospital

MS #06

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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	R	G	R	R	G	↑
		Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days *	Y	Y	G	Y	G	↑
		Percent of Sepsis Cases Reviewed by Department Head *	N/A	N/A	N/A	N/A	N/A	
		C-Difficile (Reported Quarterly)	R	Y	R	R	Y	↑
		C-Difficile (Reported Monthly)	R	R	R	R	Y	↑
		Hand Hygiene Compliance *	G	Y	Y	G	Y	↑
		Central Line Bloodstream Infections	G	G	Y	G	G	↑
		MRSA (Methicillin-resistant Staphylococcus Aureus)	G	Y	Y	R	R	↓
		VRE (Vancomycin-resistant Enterococcus)	G	R	Y	R	G	↑
		Ventilator Associated Pneumonia	R	R	G	G	G	↓
		Surgical Site Infection (SSI) Prevention	Y	G	G	Y	Y	↑
		External Environmental Audits by Westech	N/A	Y	Y	N/A	Y	

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

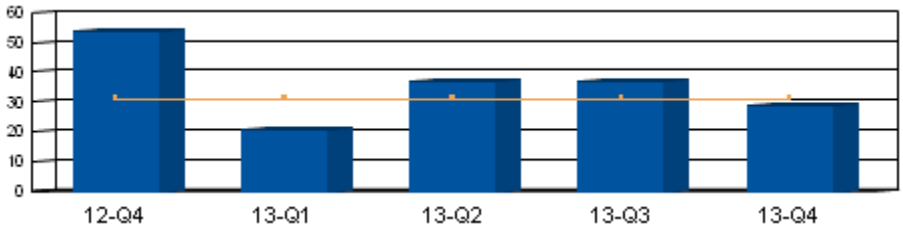
Kingston General Hospital

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-Q4	54	**31**
13-Q1	21	**31**
13-Q2	37	**31**
13-Q3	37	**31**
13-Q4	29	**31**

Interpretation - Patient And Business:

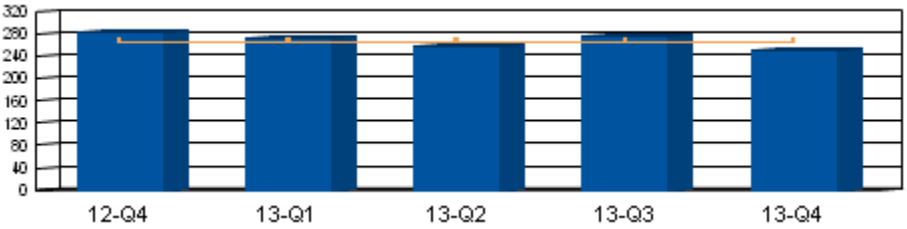
Patient Perspective: Reduction in total HAIs has an important impact on patient safety and improves the patient's expectation of harm reduction during their hospital journey.

Business Perspective: High levels of hand hygiene, appropriate staffing of IPAC and the institution of an Antibiotic Stewardship program have all helped to reduce transmission of HAIs across the institution. The target reduction has been achieved principally due to a decrease in CDI infections over the last 12 months coupled with stable rates of MRSA and 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-Q4	285	**267**
13-Q1	271	**267**
13-Q2	257	**267**
13-Q3	275	**267**
13-Q4	252	**267**

Interpretation - Patient And Business:

Reduced targeted antibiotic use has achieved the QIP target. This has happened despite staffing and IT resources in ASP being suboptimal. The launch of the CAHO ARTIC ICU-ASP project will temporarily remove ASP resources from non-ICU areas of the hospital until its completion in Dec. 2013. This may have a detrimental effect on this QIP indicator going forward.

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

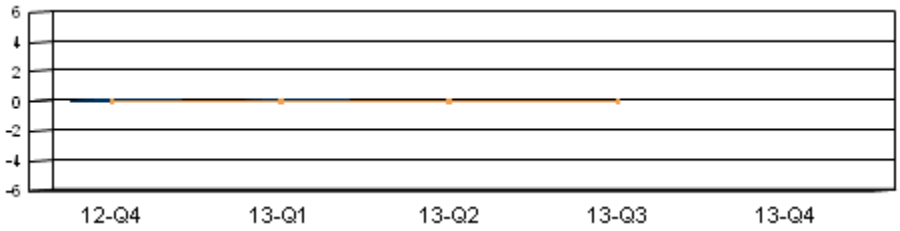
Kingston General Hospital

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-Q4	0	**0**
13-Q1	0	**0**
13-Q2		**0**
13-Q3		**0**
13-Q4		

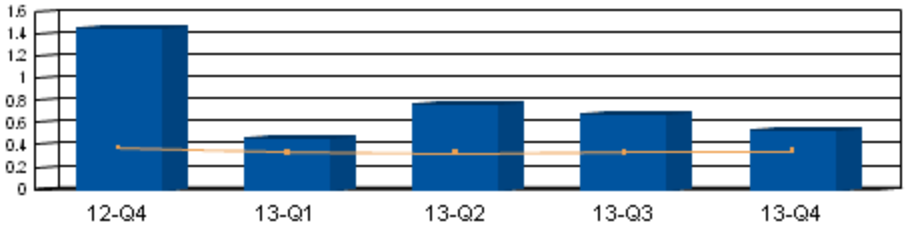
Interpretation - Patient And Business:

This indicator has been folded into the mortality review process.

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-Q4	1.5	**0.37**
13-Q1	0.5	**0.33**
13-Q2	0.8	**0.32**
13-Q3	0.7	**0.33**
13-Q4	0.5	**0.34**

Interpretation - Patient And Business:

Patient Perspective: The KGH rate for this quarter was 0.54 cases per 1000 patient days; a decrease from the previous quarter. In January there were 6 cases of CDI. In February, there were 9 cases of CDI and in March there were 5 cases giving us a total of 20 cases for the quarter. In comparison to quarter 3, where we had 25 cases and 28 cases in quarter 2 of 2011/2012. Overall our CDI rates are trending downwards.

Actions & Monitoring Underway to Improve Performance:

KGH has not had a CDI outbreak declared since Q4 F 11/12, the longest duration in last 5 years. IPAC redesign and leadership has been a key component in this success along with the new ASP.

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

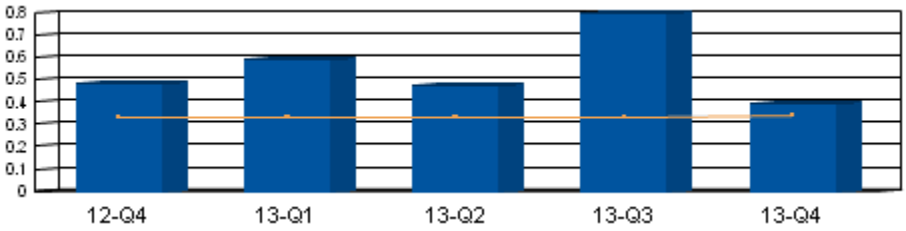
Kingston General Hospital

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: C-Difficile (Reported Monthly)



	Actual	Target
12-Q4	0.48	**0.33**
13-Q1	0.59	**0.33**
13-Q2	0.47	**0.33**
13-Q3	0.80	**0.33**
13-Q4	0.39	**0.34**

Interpretation - Patient And Business:

Please note the last 5 quarters are monthly values (Nov 12 - Mar 13).

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

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

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

Target: Target 09/10: 0.26 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better Target 12/13: PAOB

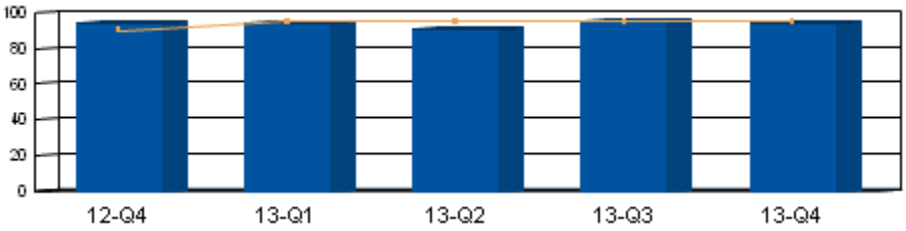
Kingston General Hospital

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-Q4	94	**90**
13-Q1	94	**95**
13-Q2	91	**95**
13-Q3	95	**95**
13-Q4	94	**95**

Interpretation - Patient And Business:

Patient Perspective: In January, February and March patients continue to receive hand hygiene education from nursing and IPAC Service. During fiscal 12/13 all staff education sessions relating to IPAC and HH were updated and the LMS module on Hand Hygiene was finished in collaboration with People Services. Front-line hand hygiene auditors attended a full day education session in March. KGH as an organization continues to maintain its focus on HH understanding the importance this action plays in reducing the incidence of nosocomial infections overall.

Actions & Monitoring Underway to Improve Performance:

Target has been reached! A 10% improvement in compliance over the last 7 quarters (F11/12 Q1). A multidisciplinary, multifaceted approach to a complex change in culture.

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%

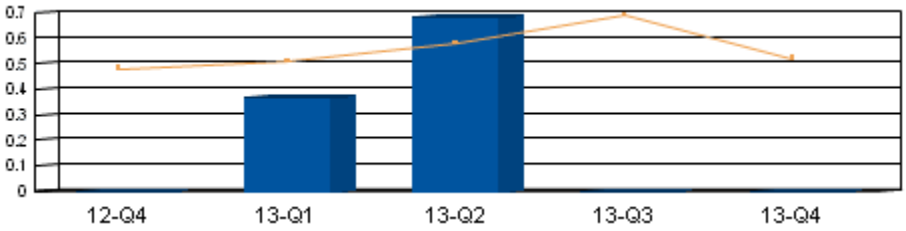
Kingston General Hospital

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-Q4	0.00	**0.48**
13-Q1	0.37	**0.51**
13-Q2	0.68	**0.58**
13-Q3	0.00	**0.69**
13-Q4	0.00	**0.52**

Interpretation - Patient And Business:

Continued and sustained improvement in this area. To ensure this is indeed occurring, random auditing has been stepped up.

Actions & Monitoring Underway to Improve Performance:

Continue to closely monitor. Application of CLI bundle and CLI checklists attributes to this success.

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

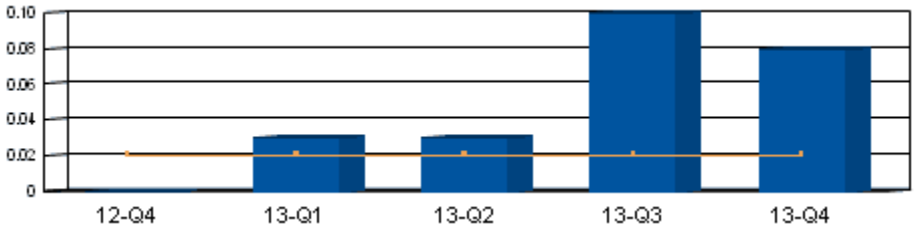
Kingston General Hospital

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: MRSA (Methicillin-resistant Staphylococcus Aureus)



	Actual	Target
12-Q4	0.00	**0.02**
13-Q1	0.03	**0.02**
13-Q2	0.03	**0.02**
13-Q3	0.10	**0.02**
13-Q4	0.08	**0.02**

Interpretation - Patient And Business:

Patient Perspective: The rate of MRSA bacteremias for this quarter was 0.08 per 1000 patient days which represents three cases. One case occurred in a patient who was known to be colonized for MRSA prior however the other two were new.

Business Perspective: Additional attention to admission screening compliance will need to be a focus in the coming months to ensure we are identifying patients with MRSA on admission. Admission screening is very important as those patients not screened within 72 hours will then be counted as nosocomial, potentially increasing our hospital rates.

Actions & Monitoring Underway to Improve Performance:

Further reinforcement of Admission Screening protocol in concert with hand hygiene and IPAC standards will be paramount to ensure MRSA is being identified on admission and patients are placed on appropriate precautions.

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

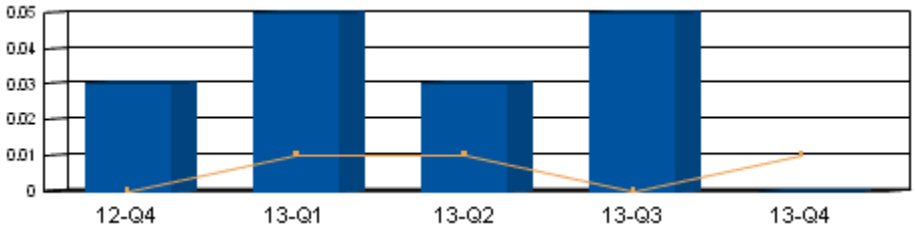
Kingston General Hospital

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: VRE (Vancomycin-resistant Enterococcus)



	Actual	Target
12-Q4	0.03	**0.00**
13-Q1	0.05	**0.01**
13-Q2	0.03	**0.01**
13-Q3	0.05	**0.00**
13-Q4	0.00	**0.01**

Interpretation - Patient And Business:

Patient Perspective: The rate of VRE bacteremias for this quarter was 0 which reflects no cases in January, February and March. VRE Bacteremia rates remain low despite the discontinuation of VRE precautions (surveillance and isolation) in July 2012.

Business Perspective: KGH IPAC continues to survey and collect data on VRE infections but not colonization. All clinical isolates are reviewed to determine clinical relevance. Bacteremias are reported as required to the province.

Actions & Monitoring Underway to Improve Performance:

Executive focus on this indicator awaits assessment and analysis of data in light of a practice change in management of colonized VRE patients since July 2012 concurrently with TOH, UHN and LHSC.

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

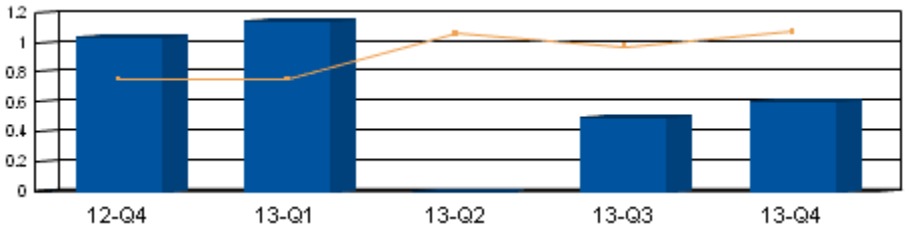
Kingston General Hospital

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-Q4	1.03	**0.75**
13-Q1	1.14	**0.75**
13-Q2	0.00	**1.06**
13-Q3	0.50	**0.97**
13-Q4	0.60	**1.07**

Interpretation - Patient And Business:

Steady and sustained improvement over past 3 quarters. To ensure accuracy, random auditting has been stepped up. Indicative of the VAP bundle that has been implemented. Overall our rates well below provincial average of peer hospitals

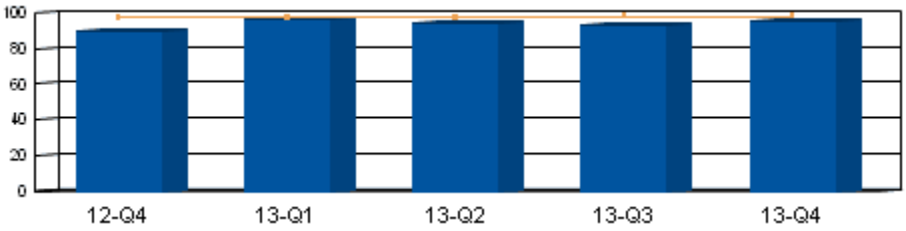
Actions & Monitoring Underway to Improve Performance:

Continued monitoring and auditing

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-Q4	90	**97**
13-Q1	96	**97**
13-Q2	94	**97**
13-Q3	93	**98**
13-Q4	95	**98**

Interpretation - Patient And Business:

Patient Perspective: The rate of appropriate timing of prophylactic antibiotic administration for patients undergoing orthopedic procedures this quarter was 95%, which is an improvement from Q3, 93% but still below the target of 98%.

Business Perspective: Collaborative efforts between IPAC and the SPA Program continue. Their focus is on accurate documentation of the prophylactic antibiotic administration with the goal of steadily improving to ensure we achieve our target.

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

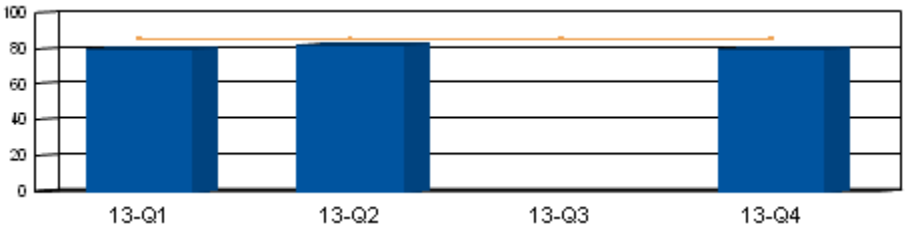
Kingston General Hospital

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
13-Q1	80	**85**
13-Q2	82	**85**
13-Q3		**85**
13-Q4	79	**85**

Interpretation - Patient And Business:

We continue to identified areas that require improvements, particularly the OR, Imaging, and clinical labs. Managers continue to work with our staff on the Westech standards. The most recent audit demonstrated improvement in our Critical Care areas.

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%

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?**
   There is a slight increase in the Acute Average Length of Stay; however the overall positive trend in 2013 performance continues. There are fewer services (3 of 18 versus 5 in the last quarter) yet to achieve ELOS (Hematology, Nephrology, and Neurology). The Average number of ALC patients per day and percent ALC days are supporting milestones that are not meeting targets. In Q4 there was modest reversal of the negative trend with ALC numbers.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   In many respects in spite of not meeting the target , performance on some measures is the best in many quarters and relative to previous years (low of 3 services not achieving ELOS; ALOS). This is attributed to the focus of work within programs and departments and oversight by the Patient Flow Task Force and MAC. Continuous Improvement initiatives with PDSA's are driving incremental gains. ALC numbers are most influenced by waits for Long Term Care Home (LTCH) placement. Delays for placement at Providence Care (PC), & particularly palliative care, have been reduced through collaborative efforts and process improvements, and launch of Home First at PC.

3. **Are we on track to meet the milestone by year end?**
   Where we had met the target in Q3, the slight reduction in ALOS relative to ELOS, compounded by ALC, resulting in being just below target.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The priority improvements for 2013/2014 have an emphasis on patient flow. A value stream mapping process for Gridlock, with internal and key external partners, is expected to produce 4 tactics , as a start, to enable appropriate access to and movement of patients through and from KGH. ALOS/ELOS will continue as measure of performance and are expected to be improved. Review of long stay (100day) ALC patients occurs with KGH/CCAC team to identify options/alternative patient choice.

Kingston General Hospital

MS #07

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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	G	R	R	R	R	↓
		Percent ALC Days	G	G	R	R	R	↓
		Overall - Acute Average Length of Stay vs ELOS Variance in Days - QIP *	G	Y	Y	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	G	Y	G	↑
		Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile *	G	R	Y	G	G	↑
		Readmission Rate Within 30 Days for Selected CMG's to Any Facility *	Y	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 ↓

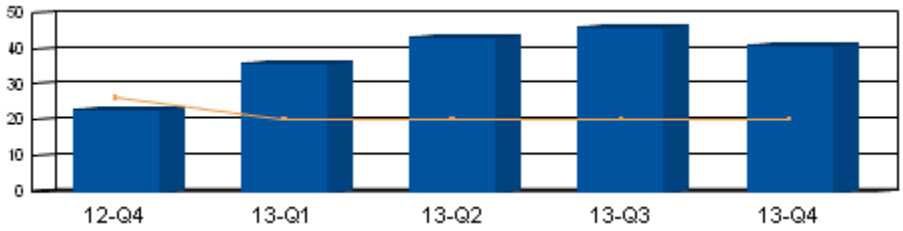
Kingston General Hospital

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-Q4	23	**26**
13-Q1	36	**20**
13-Q2	43	**20**
13-Q3	46	**20**
13-Q4	41	**20**

Interpretation - Patient And Business:

The average number of ALC patients for Q4 was 41. The average for the entire fiscal year was 41. The designation of ALC to Long Term Care (LTC) continues to provide the major challenge. Patients waiting for bed availability in LTC homes usually account for 65% of the total ALC population. InQ4, this patient population accounted for >80% of the total.

Although the median length of stay for ALC-LTC patients dropped by 20 days, the average length of stay has increased by virtue of increasing numbers of patients staying for extended periods of time. During Q4 there were periods of time where there were 11 patients who had been ALC-LTC for longer than 100 days.

Actions & Monitoring Underway to Improve Performance:

A case by case review of ALC-LTC patients waiting > 100 days for a bed in the LTC home of their choice did not result in any changes to the list.

Changes to the WTIS - ALC reporting requires documentation of barriers to discharge to most appropriate destination. Mobility and behaviors are ongoing issues for this patient population, and lead to increases in both numbers of patients and lengths of stay. Unfortunately reporting out from WTIS(access to the database) is not expected for a number of months.

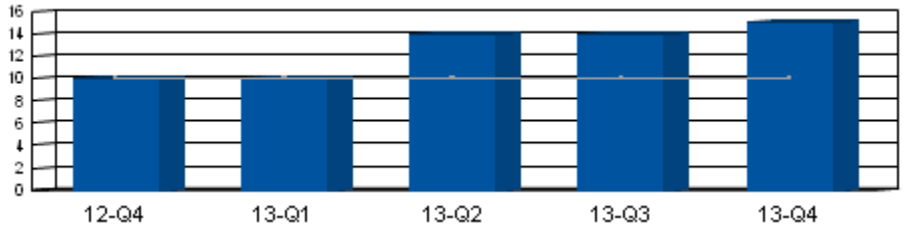
Meetings are ongoing with CCAC and the LHIN to address capacity issues in the community. In addition, work is underway to reduce revisits to the emergency department and/or readmissions from the LTC homes.

An inventory (case by case review) of all ALC patients > 30 days will be undertaken in the next quarter (designed by the LHIN).

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

Indicator: Percent ALC Days



	Actual	Target
12-Q4	10	**10**
13-Q1	10	**10**
13-Q2	14	**10**
13-Q3	14	**10**
13-Q4	15	**10**

Interpretation - Patient And Business:

This figure continues to rise given the increase in the number of ALC patients, and in the number of ALC patients in the organization for > 100 days. With the average number of ALC patients at 41 (target of 20), and on average > 8 patients waiting >100 days for their bed at the LTC home, the % ALC days is above the target of 10%.

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%

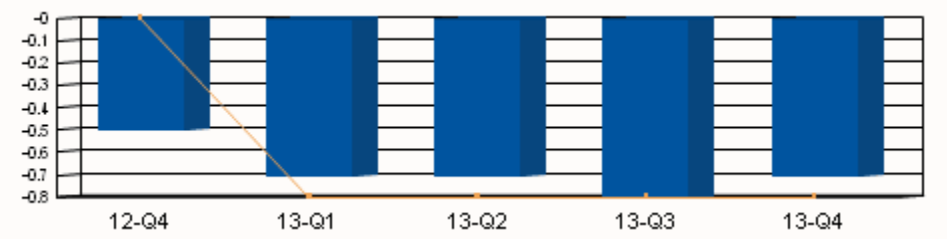
Kingston General Hospital

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-Q4	-0.5	**0.0**
13-Q1	-0.7	**-0.8**
13-Q2	-0.7	**-0.8**
13-Q3	-0.8	**-0.8**
13-Q4	-0.7	**-0.8**

Interpretation - Patient And Business:

A positive trend in overall performance continued in Q4. The -0.7 day variance for Q4 (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, 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 3of 18 services to achieve expected length of stay. They are the services of Haematology, Nephrology,and Neurology.

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

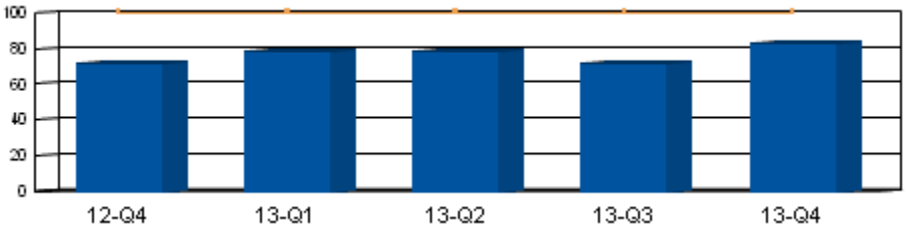
Kingston General Hospital

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-Q4	72	**100**
13-Q1	78	**100**
13-Q2	78	**100**
13-Q3	72	**100**
13-Q4	83	**100**

Interpretation - Patient And Business:

As of Q4 (fiscal 12/13), 83 percent of services (15 of 18) are achieving (or outperforming) their expected length of stay. Despite a status of Red, It is of note that this is the best performance of this indicator in the last 3 years. The services that are not currently at their expected length of stay are Haematology,Nephrology, and Neurology. The three services that were over in Q4 totaled a mere 212 days collectively. This should be viewed as insignificant.

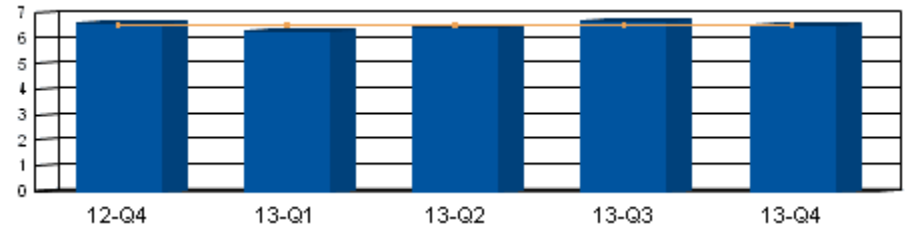
Actions & Monitoring Underway to Improve Performance:

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-Q4	6.6	**6.5**
13-Q1	6.3	**6.5**
13-Q2	6.4	**6.5**
13-Q3	6.7	**6.5**
13-Q4	6.5	**6.5**

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 at 6.5 days is right on the target of 6.5 days. It is worth noting that at the same time our average length of stay compared to expected length of stay is .7 days below our expected. There continues to be tremendous efforts placed on this achieving this target though the implementation of a variety of tactics 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 from 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

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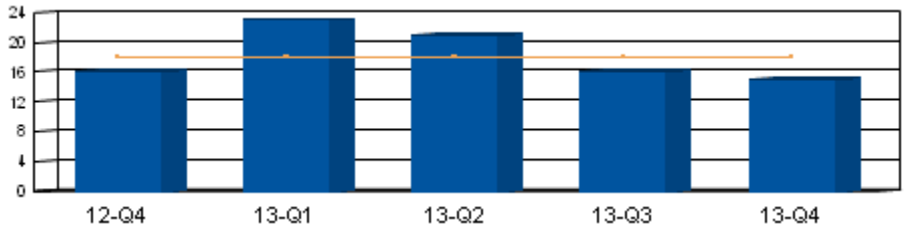
Kingston General Hospital

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-Q4	16	**18**
13-Q1	23	**18**
13-Q2	21	**18**
13-Q3	16	**18**
13-Q4	15	**18**

Interpretation - Patient And Business:

The SE LHIN readmission metric is for a selection of CMGs primarily focused in cardiology, respirology, gastroenterolgy and neurology. Unplanned hospital admissions exact a toll on patients, families and the health care system. Avoidable readmissions is a system level issue that is linked to the integration of care along the continuum of care. Providing the right care in the right place at the right time can reduce hospital readmissions.

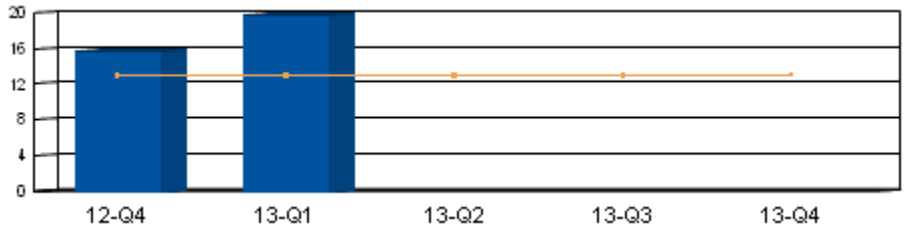
Actions & Monitoring Underway to Improve Performance:

The 30 day readmission rate for Q4 is performing better than target and continues on a positive trend. In fact, Q4 is showing the best performance over the last 8 quarters. Further analysis of these data at the Program/Department level using CMG performance is ongoing and will continue to support identification of opportunities to further improve the readmission rates.

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-Q4	15.6	**13**
13-Q1	19.8	**13**
13-Q2		**13**
13-Q3		**13**
13-Q4		**13**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

The latest data received form the SE LHIN is for Q1 of fiscal 12/13. It shows that we are readmission rate for select CMGs are above the target rate of 12.9. It is important to note that this readmission calculation takes into account admission to ANY facility before the readmission is calculated. Individual readmissions to KGH are tracked to our other readmission indicator and shows good performance. This suggests that there remains an issue with patients being admitted/readmitted across other institutions.

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%

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	Red

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 ED wait times continue to trend negatively with the Q4 result of 40 hours being the longest wait measure in F2013 and 18 hours longer than the 22 hour target. This performance is consistent with the fact of Gridlocks being called on a more frequent basis (n-15 in Fiscal 2013; 1, 2, 5 & 7 in Q1-4 respectively) with longer durations (7 days in April 2013). As of March 2012 (Apr to Mar fiscal12/13), 20% or 10,692 of all ED visits (53,479 visits) were admitted. This is slightly higher than our peers. Of those 10,692 people, 7,847 (73%) were admitted within the 22hr target. Of the 2,845 patients that exceeded the 22 hrs target, 2,322 (82%) were admitted by 48 hrs. Of the remaining 523 patients, 375 were admitted by 72 hrs. Only 148 patients waited beyond 72 hrs.
2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Factors influencing performance activity relate to intake (approx. 10% increase visits to ED and increase in Medicine Program admissions) and delayed discharge (ALC numbers, LTCH closure, Psych bed reduction), repatriation challenges). Initiatives with improvement initiatives have mitigated the extent of impact on throughput and have assured minimal impact to measures such as surgical/procedural activity. Regional partners report similar increases.
3. **Are we on track to meet the milestone by year end?**
   We did not meet the milestone.
4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The priority improvements for 2013/2014 have an emphasis on patient flow, and one specifically on Gridlock which is largely influenced by ED activity. A value stream mapping process for Gridlock, with internal and key external partners, is expected to produce 4 tactics , as a start, to enable appropriate access to and movement of patients through and from KGH. The ED wait times will continue as measures of performance and are expected to be improved. As well, support will continue with regional strategies (Home First, Health Links) and CAHO initiatives (MOVE On) that are designed to support avoidance of hospitalizations, reduced lengths of stay and support with transitions from hospital to home. We will strive to get regional profile of activity and utilization to enable best use of resources at a system level.

Kingston General Hospital

MS #08

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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	Y	R	R	R	↓
		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	Y	G	G	↑

↑ Indicates improving performance to target over the past 5 quarters

↓ Indicates worsening performance to target over the past 5 quarters

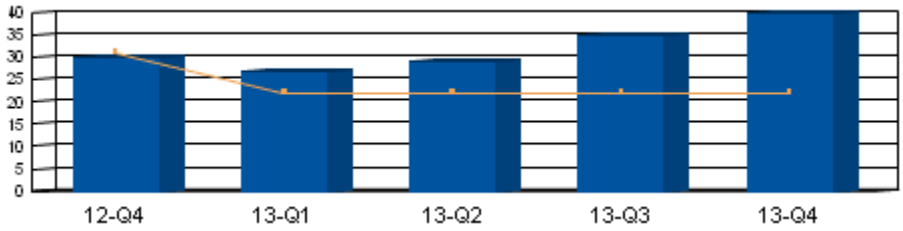
Kingston General Hospital

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-Q4	30	**31**
13-Q1	27	**22**
13-Q2	29	**22**
13-Q3	35	**22**
13-Q4	40	**22**

Interpretation - Patient And Business:

ED wait times at the 90th percentile for all admitted patients have been trending negatively since Q1. The Q4 result of 40 hours is 38 hours longer than the 22 hour target. Ninety percent of all patients admitted through the ED wait up to 40 hours to be moved to an inpatient bed. Ten percent wait longer than this.

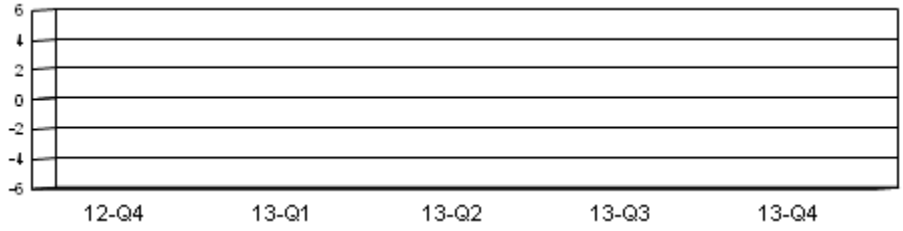
Actions & Monitoring Underway to Improve Performance:

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 the Patient Flow Task Force meetings.
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.
Working with the expectation that managers are coming to ED with summary of expected discharges and plans for flow.
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. Additional bed capacity has been created in OPPU during periods of high pressure in order to decant admitted patients out of the ED.
Strategy for next year includes identifying top sources of gridlock with recommendations on how to address opportunities identified.

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-Q4		
13-Q1		
13-Q2		
13-Q3		
13-Q4		

Interpretation - Patient And Business:

Time required for calculation not currently available.

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

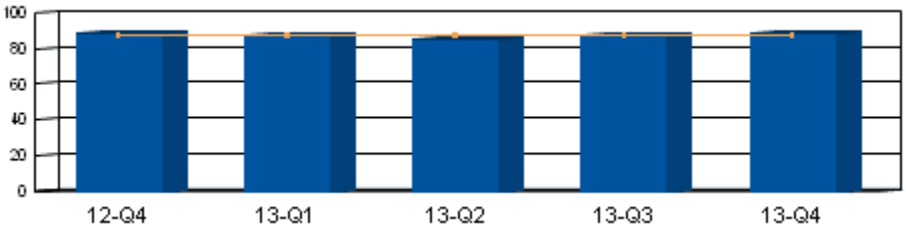
Kingston General Hospital

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-Q4	88	**87**
13-Q1	87	**87**
13-Q2	85	**87**
13-Q3	87	**87**
13-Q4	89	**87**

Interpretation - Patient And Business:

Based on the Q4 results, the ED has sustained the improvement in the ED wait time surpassing the 87% target for non-admitted, high acuity patients in Q4. The target was met in Q1 and Q3.
This target has been sustained even with a significant increase in visits in this category. Volumes for this category of patient acuity have increased by 3010 visits this year compared to last year.

Actions & Monitoring Underway to Improve Performance:

Work continues to identify and eliminate all delays in the ED visit. Using LEAN principles, we are working to optimize the use of stretchers and chairs to increase capacity resulting in improved time to care. 90 percent of all patients presenting to the ED are seen by a physician within 2.5 hours. Reducing the time to initial contact with the emergency attending physician and early initiation of tests has been the focus of our Rapid Assessment Zone (RAZ) pilots.

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%

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**	**Yellow**

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?**
   83% (43 of 52) of the clinical services are meeting the 90th percentile wait times minimally changed from 85% in Q3. Of the 17 indicators in this milestone, 6 are green and 4 are yellow. All yellow indicators are trending favourably.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Focus on waitlist management in the physician offices and Waitlist Committee tracking of all waitlist cases with programs.

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

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

   SPA leadership and the Wait Times Committee continue their focus on monitoring activity. Daily patient flow initiatives via the Patient Flow Committee and Discharge project hope to improve access.

Kingston General Hospital

MS #09

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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	Y	Y	Y	↑
		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	Y	R	R	R	↑
		Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (Excluding Cancer Surgery)	R	R	Y	Y	Y	↑
		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	Y	G	Y	Y	Y	↑
		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	G	Y	G	G	↑
		Cardiac - Bypass Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
		Cardiac - Coronary Angiography - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
		Cardiac - 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)	R	R	Y	Y	R	↓
		Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	R	R	Y	Y	Y	↑

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

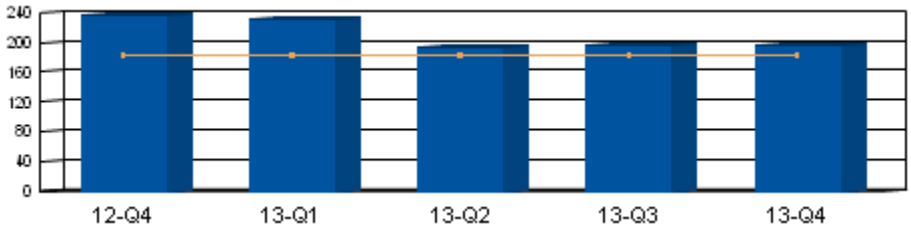
Kingston General Hospital

MS #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-Q4	237	**182**
13-Q1	232	**182**
13-Q2	193	**182**
13-Q3	197	**182**
13-Q4	196	**182**

Interpretation - Patient And Business:

There were 332 cases completed in this quarter with 6 cases having accumulated wait times between 211 to 602 days. The overall 90 % wait time for this indicator was 142 days in January slightly increasing to 176 days in March. The median wait time also slightly increased from 54 days to 74 days for this quarter which is 11days more from the previous quarter. Factors influencing wait times for this service in this quarter included: a 12% cancellation rate due to increased organizational activity for other programs requiring a slowdown in operating room activity to enable resources to be redirected to support patient care, as well as 529 cases on the current wait list with 29% of these cases ranging from 207 to 1,635 days waiting for their procedures.

Actions & Monitoring Underway to Improve Performance:

Wait times are monitored at the joint KGH/HDH Wait list committee meetings. Additional ortho trauma operative time allocated on weekends to KGH wait times should permit the opportunity to complete elective case volumes. In addition SPA Program leadership will continue to support office staff with the monitoring of their wait time lists.

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

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

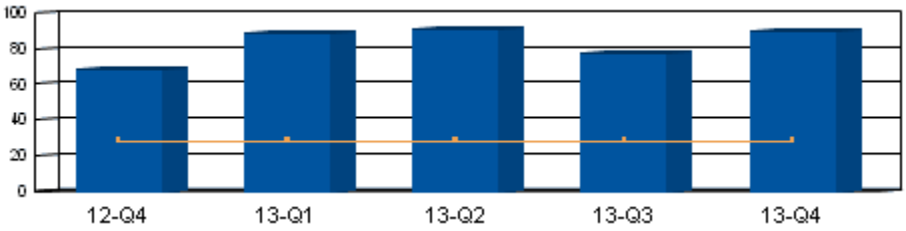
Kingston General Hospital

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-Q4	68	**28**
13-Q1	88	**28**
13-Q2	91	**28**
13-Q3	77	**28**
13-Q4	90	**28**

Interpretation - Patient And Business:

The demand for MRI services is far greater than the ability of a single magnet to image. This has a negative effect on many patient populations as they must wait for service. Physicians are delayed in their ability to make decisions when waiting for MRI results.

Prov average wait time: 70 days

UHN: 82 days
Sudbury 42 days
Ottawa: 123 days
Hamilton 51 days
London: 77 days

All of the above sites have multiple magnets.

Actions & Monitoring Underway to Improve Performance:

Submitting a proposal to the LHIN for a send hospital based magnet in the tertiary care setting.

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

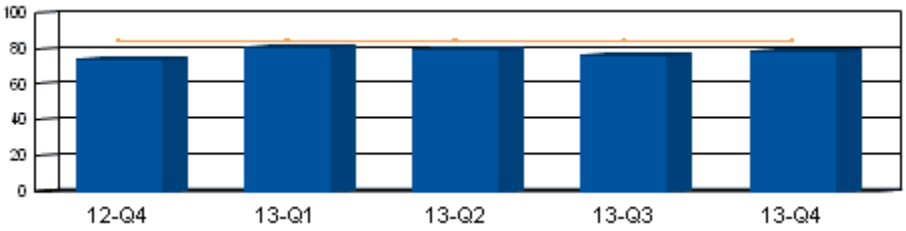
Kingston General Hospital

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-Q4	74	**84**
13-Q1	81	**84**
13-Q2	79	**84**
13-Q3	76	**84**
13-Q4	78	**84**

Interpretation - Patient And Business:

Based on Q4 results, the ED is not meeting the target wait time for the percent of patients - CTAS 4 and 5 - discharged within 4 hours. This patient population makes up 25% of all ED visits. Inpatient days in ED were up this year at 4326 days, an increase of 1462 days over last year. Admitted patients in ED beds for this length of time combined with a higher proportion of high acuity patients negatively impacts our capacity to see less acute patients.

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 sometimes 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 identify and trial ways to redesign flow within the department to continue to move toward target with a focus on optimizing stretcher use and reducing time to initiation of investigations. Principles of a rapid assessment zone (RAZ) were trialed in December, February and March with some encouraging preliminary results, particularly in the reduction of ED total length of stay.
The Emergency Department Information System (EDIS) is a valuable tool that allows for continuous monitoring of ED wait times and patient flow 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%

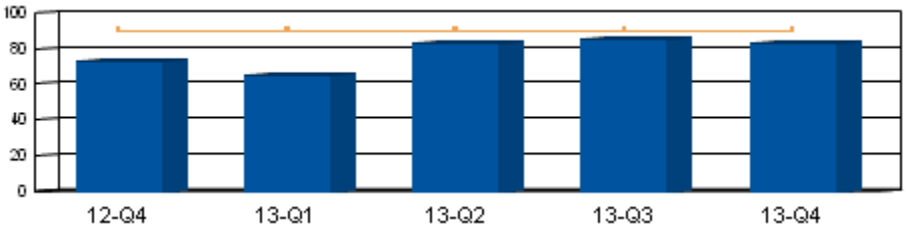
Kingston General Hospital

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-Q4	73	**90**
13-Q1	65	**90**
13-Q2	83	**90**
13-Q3	85	**90**
13-Q4	83	**90**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

The Q4 results indicate that the target of 90% has still not been reached. Q4 results show that 43 of 52 (83%) of publically reported wait times meet the 90th percentile wait time target. As of Q4, There were 9 Red wait time categories: MRI, General Surgery Anorectal Procedures, General Surgery Gastroesophagael Reflux Disease Surgery, Gynaecology Hysterectomy Surgery, Gynaecology Hysteroscopic Endometrial Albation, Gynaecology Surgery for Urinary Incontinence, Other Oral and Maxillofacial Surgery and Dentistry, Other Orthopaedic Surgery, Other Urologic Surgery. The program leadership closely monitors wait times in conjunction with the Wait Times Committee. Departments and Divisions are informed of their rates and encouraged to look at means to improve wait times

Definition: 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%

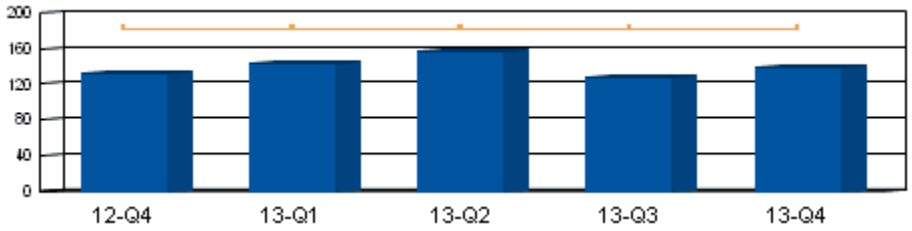
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q4	132	**182**
13-Q1	144	**182**
13-Q2	156	**182**
13-Q3	127	**182**
13-Q4	139	**182**

Interpretation - Patient And Business:

This indicator continues to trend positively well below target although there was a slight increase in wait times of 12 days from the previous quarter.

There were 93 cases completed in this quarter with median days waiting starting at 64 days in January increasing to 104 days in March. Contributing to this slight increase is a cancellation rate for this service of 35% as a result of increased organizational activity causing "gridlock" and a slowdown in operating room activity as well as the monitoring of Quality Based Procedures (QBP) As the volumes for the primary hip QBP's appeared to be over exceeding the target, future hip procedures were put on hold towards the end of the quarter to address the primary knee volumes which were reported to be falling severely short of reaching their targeted volume.

It should be noted that additional PACU (recovery room) resources were introduced in the 3rd quarter to minimize any cancellations for the total joint QBP program.

There are currently 223 cases on the current service wait list with wait times that range from 528- 2404 days suggesting that additional education and support is required for office staff in managing the lists.

Actions & Monitoring Underway to Improve Performance:

Future monitoring and the creation of a steering committee to oversee this QBP will assist in ensuring that the balance in achieving targets without negatively impacting wait times for this population. Education and support to office staff will continue to assist in the monitoring of wait time lists.

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

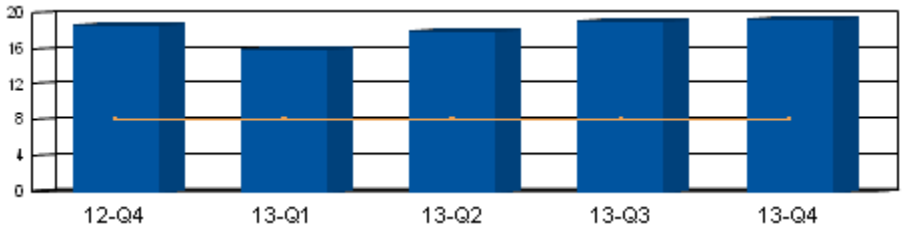
Kingston General Hospital

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-Q4	18.7	**8**
13-Q1	15.9	**8**
13-Q2	17.9	**8**
13-Q3	19.0	**8**
13-Q4	19.3	**8**

Interpretation - Patient And Business:

ED wait times at the 90th percentile for patients admitted with complex conditions is 19.3 hours. Nine of ten patients are moved to an inpatient bed within 19.3 hours of arrival to the department while 10 percent wait longer than 19.3 hours. This has been trending negatively since Q1. The Q4 result of 19.3 hours is 11.3 hours longer than the 8 hour target.

Actions & Monitoring Underway to Improve Performance:

Ongoing collaboration with program leadership to ensure timely transfer of admitted patients with complex conditions (particularly to critical care beds). 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 utilization of critical care beds, reduce bed empty time (notification of bed ready at start of clean), continuous improvement projects to improve LOS and gain efficiencies through eliminating non-value added activity.
Strategy for next year includes identifying top sources of gridlock with recommendations on how to address opportunities identified.

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 than 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

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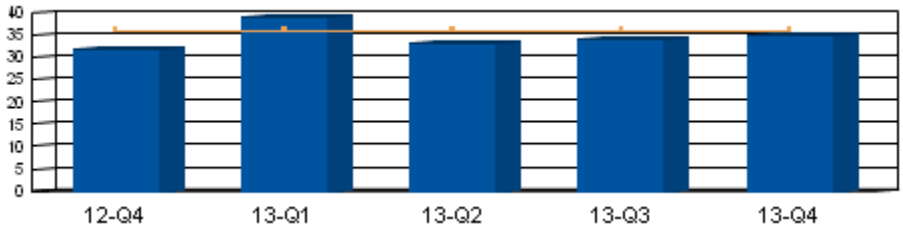
Transform the patient experience through a relentless focus on quality, safety and service

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-Q4	32	**36**
13-Q1	39	**36**
13-Q2	33	**36**
13-Q3	34	**36**
13-Q4	35	**36**

Interpretation - Patient And Business:

In Q4 35 percent of patients admitted from the ED were transferred to an inpatient bed within the 8 hour target. As the patient visit volumes increase, the number of admissions also increases.
Emergency Department admitted patient volumes are above target by 150 admissions this quarter and 1038 admissions above target YTD. Admitted patient volumes from the ED are up 350 admissions over last year.
Increasing LOS of admitted patients in the ED negatively impacts our capacity to see non-admitted patients in a timely fashion. On average, 19% of all visits to the ED result in admission.

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 the earliest point in the day with a 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. ED physicians are working toward shortening the time to consult.

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%

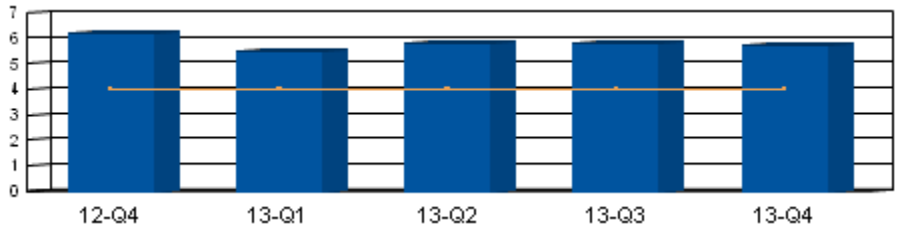
Kingston General Hospital

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-Q4	6	**4**
13-Q1	6	**4**
13-Q2	6	**4**
13-Q3	6	**4**
13-Q4	6	**4**

Interpretation - Patient And Business:

Based on the Q4 results, KGH is failing to meet the ED 90th percentile wait time target of 4 hours for patients presenting with minor or uncomplicated conditions. Ten percent of patients in this category had a total length of stay longer than 5.7 hours. The ability to see patients in this category is dependent on available assessment space. With the increase in overall volumes, admitted patients, increased inpatient bed days and a significant increase in higher acuity patients, these patients tend to wait longer for assessment after triage. 90 percent of all patients presenting to the ED are seen by a physician within 2.5 hours of arrival to the department.

Actions & Monitoring Underway to Improve Performance:

A team of ED staff, physicians and Patient Experience Advisors have been working with LEAN principles to eliminate delays in patient flow through the ED. We piloted a Rapid Assessment Zone (RAZ) for 2 days in December, again in February and March. Each of these short pilots demonstrated encouraging results in reduced wait times and overall ED length of stay for all patients. The team is also looking at ways to optimize stretcher and chair utilization to increase capacity within the department.

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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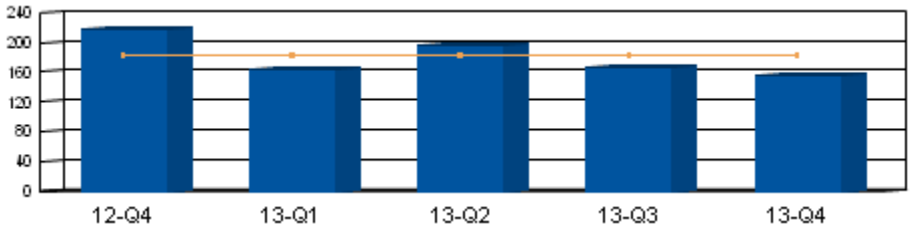
MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q4	217	**182**
13-Q1	164	**182**
13-Q2	195	**182**
13-Q3	167	**182**
13-Q4	157	**182**

Interpretation - Patient And Business:

Improved monitoring of office wait times along with access to general emergency OR time continues to contribute to the positive trending of this indicator. For this quarter the pediatric service summary breakdown is outlined below:

General Surgery (209 cases):
90% percentile has slightly increased from 180 days in January to 187 days in March with an average median of 41days which is an overall improvement of 3 days from last quarter. There were 7 completed cases with wait times from 252-439 days which contributed to the increase for this service in this quarter.

Orthopedics (1 cases)
One case with an average wait time of 10 days. Due to the small volumes for this quarter it has small impact on this indicator.

Urology (9 cases)
90% percentile was 170 days in January trending more positively to 111days in March. In this quarter there was an average median wait of 106 days. Influencing this services wait times are 4 outstanding cases ranging from wait times of 327 to 465 days.

ENT (26 cases)
90% percentile for this quarter decreased from 75 days in January to 62 days with an average median wait time of 22 days. This is an improvement from last quarter of 50 days.

Actions & Monitoring Underway to Improve Performance:

Access to extra available general emergency time to assist with addressing wait times has been encouraged by the program to the service. Future monitoring of this indicator continues to be provided by the Wait Time Committee and SPA program council.

The recruitment for an 0.5FTE pediatric general surgery is underway.

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

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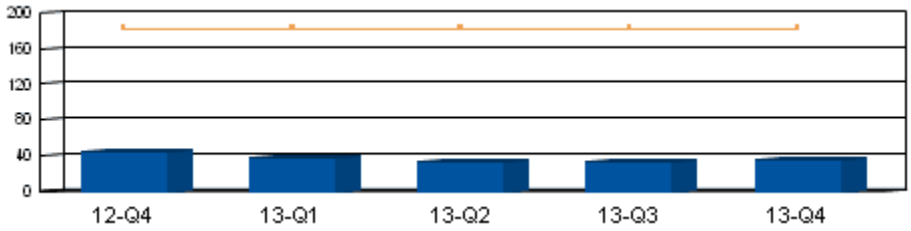
Transform the patient experience through a relentless focus on quality, safety and service

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q4	45	**182**
13-Q1	37	**182**
13-Q2	33	**182**
13-Q3	33	**182**
13-Q4	35	**182**

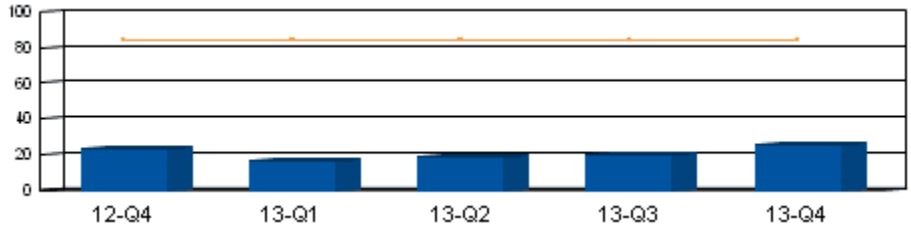
Interpretation - Patient And Business:

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

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

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



	Actual	Target
12-Q4	23	**84**
13-Q1	17	**84**
13-Q2	19	**84**
13-Q3	20	**84**
13-Q4	26	**84**

Interpretation - Patient And Business:

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

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

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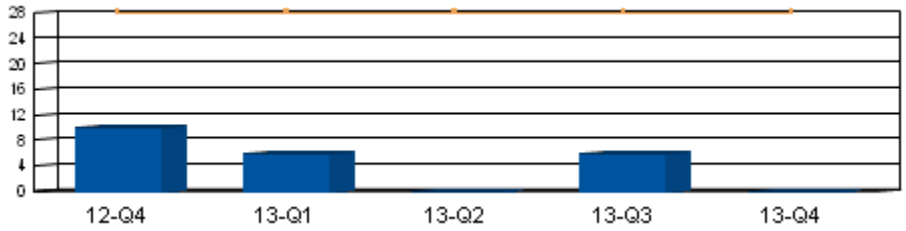
Transform the patient experience through a relentless focus on quality, safety and service

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q4	10	**28**
13-Q1	6	**28**
13-Q2	0	**28**
13-Q3	6	**28**
13-Q4	0	**28**

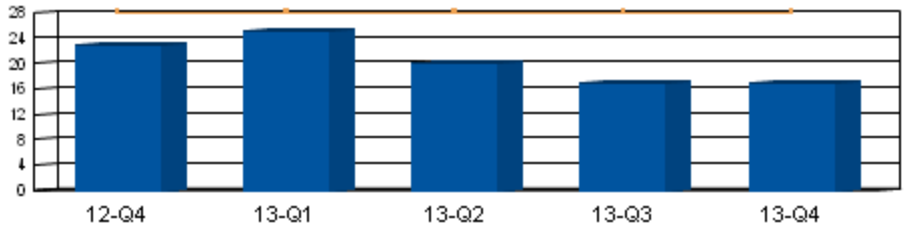
Interpretation - Patient And Business:

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

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

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



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

Interpretation - Patient And Business:

KGH has been exceptionally successful in achieving a very low wait time target. Careful attention to bookings and maximizing efficiency has led to this success. This low wait time ensures that the needs of the emergent and IP population are met as well as the needs of the highly specialized time sensitive cancer care population.

Provincial average wait time: 36 days
UHN wait time 50 days
London: 32 days
Hamilton: 44 days
Ottawa: 89 days
Sudbury: 54 days

We are awesome!

Actions & Monitoring Underway to Improve Performance:

Continue present practices to maintain a wait time between 15 and 18 days on average.

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

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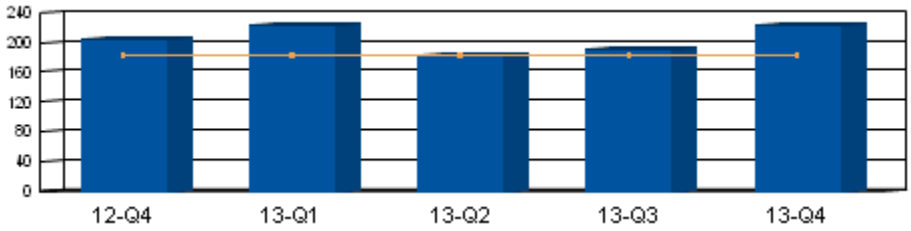
Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q4	204	**182**
13-Q1	223	**182**
13-Q2	183	**182**
13-Q3	192	**182**
13-Q4	224	**182**

Interpretation - Patient And Business:

For this quarter, the overall cancellation rate for the Operating room was 12% due to increased organizational activity causing gridlock and the slowdown of operating room activity to address limited available resources (bed space, critical care resources) for patient care. The increase in trauma cases during this quarter has also had an impact on the elective wait times for this service. This service has also been impacted by the loss of one general surgeon who in February has taken a leave of absence.

There were 201 completed cases with 90% wait times for this quarter decreasing slightly from 223 days in January to 216 days in March with an average median time of 68 days. Contributing to the overall quarter's increase in the 90% wait time of 224 days is the completion of 6 cases averaging from 258 to 439 days waiting in this quarter.

Currently there are 324 general surgery (non-cancer) cases on the waiting list with 27 cases averaging a wait time of 205-1348 days.

Actions & Monitoring Underway to Improve Performance:

Continued program support with monitoring office wait lists and continued access to additional OR time during the evening and on weekends should positively contribute to achieving the provincial target of 182 days. Additional support and education will be provided to the service's administrative staff for the purpose of monitoring cases that currently exceed the provincial target on the waiting list.

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

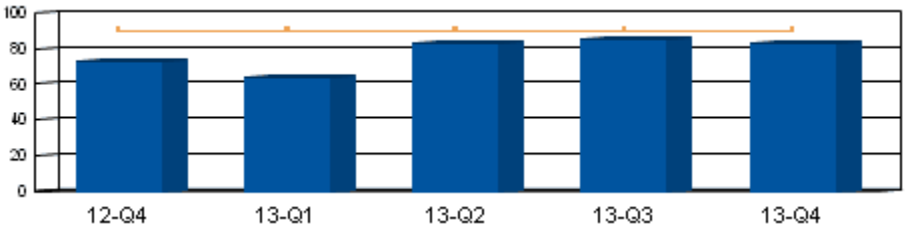
Kingston General Hospital

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-Q4	73	**90**
13-Q1	64	**90**
13-Q2	83	**90**
13-Q3	85	**90**
13-Q4	83	**90**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

The Q4 results indicate that the target of 90% has still not been reached. Q3 results show that 39 of 47 (83%) of publically reported surgical wait times meet the 90th percentile wait time target. As of Q4, there were 8 red: General Surgery Anorectal Procedures, Gastroesophagael Reflux Disease Surgery, Gynaecology Hysterectomy Surgery, Hysteroscopic Endometrial Albation, Gynaecology Surgery for Urinary Incontinence, Other Oral and Maxillofacial Surgery and Dentistry, Other Orthopaedic Surgery, Other Urologic Surgery The surgical program leadership closely monitors wait times in conjunction with the Wait Times Committee. Departments and Divisions are informed of their rates and encouraged to look at means to improve wait times. Also it is assumed that specific initiatives within the SPA program targeted at closely monitoring individual wait lists is having a positive impact as well.

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%

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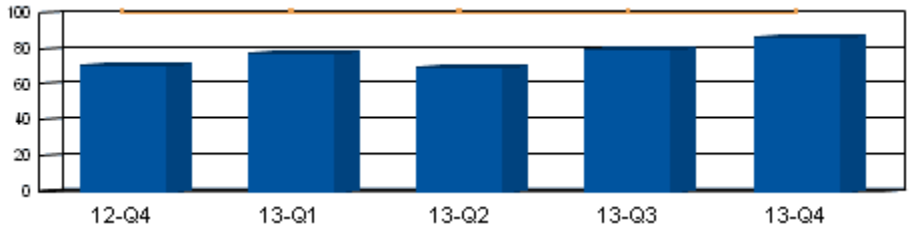
Clinical services meet the provincial wait time target

Indicator: Percent of Wait Time Contracted Volumes Achieved



	Actual	Target
12-Q4	70	**100**
13-Q1	77	**100**
13-Q2	69	**100**
13-Q3	79	**100**
13-Q4	86	**100**

Interpretation - Patient And Business:

As of Q4 there were 2 incremental volume contracts that were not on target (gallbladders, ped ACL repair). It is of note that incremental volumes in both of these were returned to the SE LHIN late in the year. Also most of these cases occur at the HDH.

Actions & Monitoring Underway to Improve Performance:

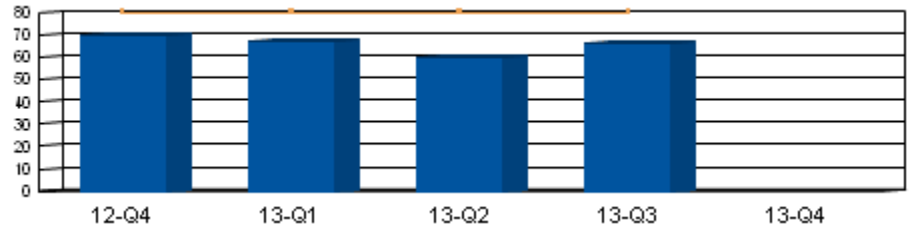
The Wait List Management Committee and the Surgical Program closely monitoring these issues.

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), Total Joint Revisions.

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

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



	Actual	Target
12-Q4	70.0	**80**
13-Q1	67.0	**80**
13-Q2	59.6	**80**
13-Q3	66.0	**80**
13-Q4		

Interpretation - Patient And Business:

Q4 data not yet available

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

Target: Target 09/10: 80%, Target 10/11: 80%, Target 11/12: 80%. Target 12/13: 80%

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?**
   Based upon the Q3 data (Q4 not available), the milestone is not met. As in previous quarters, only 1 of the 4 CCO indicators (radiation ready to treat to start of radiation treatment) aligned to this milestone has been met. New case consultations, systemic treatment wait times and cancer surgery wait times are below target. While there has been tremendous engagement and effort in designing improvements, the impact of these efforts takes time to be reflected in the indicators. Trends in January – March, not yet formally reported, suggest improvement.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Surgical Oncology wait times in Q4 have improved due to efforts with review and accuracy of priority assignment and through collaborative efforts with the SPA program to optimize emergency OR time. While new med onc. consults are being seen in slightly shorter times, a specialist vacancy has limited access. Similarly vacancies (1.6 FTE) of radiation oncologists is impacting access. The resolve of the program leaders, including new Department Head/PMD, to improve standing within the province is ensuring focus and accountability.

3. **Are we on track to meet the milestone by year end?** The target has not been met.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Appreciating the complexity of the continuum for patients with cancer, energy will continue to be directed to achieving this milestone and supporting indicators in 2013/14 by:
   - Review of OR allocation to achieve target surgery wait time
   - Recruitment of a radiation oncologist in July 2013 and medical oncologist in Fall 2013 to stabilize and sustain access at or better than provincial target
   - A CI project launched in Q4 looking at rad & med onc. consults for patients with breast cancer (largest overall population and poorest 14 day access performance) , with PDSA's occurring into Q1 of F13.

Kingston General Hospital

MS #10

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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 ↓

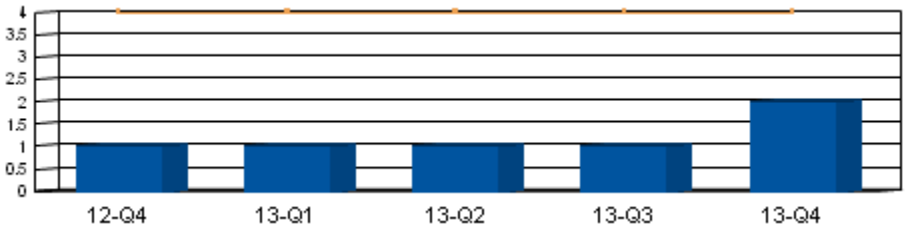
Kingston General Hospital

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-Q4	1	**4**
13-Q1	1	**4**
13-Q2	1	**4**
13-Q3	1	**4**
13-Q4	2	**4**

Interpretation - Patient And Business:

At the end of Q4, KGH is not meeting this indicator. 2 of the 4 indicators met the CCO contracted access to care indicator target.

Specifically, the indicators included in this group are wait time from:

- radiation referral to a radiation oncologist to consultation (target is 80% of all referrals to a radiation oncologist are seen within 14 days)
- radiation ready-to-treat date to start of radiation treatment (target is 87% of all patients who will receive radiation treatment start their treatment within target for all priority categories (1, 7, or 14 days)
- systemic referral to a medical oncologist to consultation (target is 67% of all referrals to a medical oncologist are seen within 14 days)
- systemic consultation to start of chemotherapy treatment (target is 85% of all patients who will receive radiation treatment start their treatment in 14 days)

KGH continues to meet the radiation consultation to start of radiation treatment indicator and in Q4, Systemic referral to consult is meeting the provincial access target noted above.

Actions & Monitoring Underway to Improve Performance:

Access to care indicators are closely monitored as part of the KGH and Cancer Care Ontario performance scorecards and quarterly review processes. MRPs within the cancer program have been assigned responsibility to monitor and review this data with their respective committees on a monthly basis.

Formal improvement initiatives were launched in Q4 F13 to address data quality, capacity, process or accountability issues impacting on KGH's ability to meet these access targets. Oncologist vacancies in both Radiation and Medical Oncology are contributing to the challenge in meeting these wait time targets.

Cancer Program clinical and operational leaders are overseeing these initiatives and will be reporting on progress through KGH's and CCO's Quarterly Review mechanism. A new 0.6 radiation oncologist will join the team in July 2013 and a new 1.0 medical oncologist will join the team in mid-September 2013. This should help move KGH closer to meeting the access targets in F14.

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: Target 4

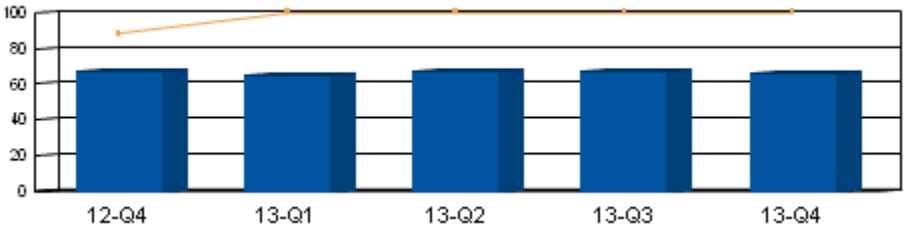
Kingston General Hospital

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



	Actual	Target
12-Q4	67	**88**
13-Q1	65	**100**
13-Q2	67	**100**
13-Q3	67	**100**
13-Q4	66	**100**

Interpretation - Patient And Business:

KGH is a Cancer Surgery Agreement Hospital with CCO and is accountable for achieving provincially established wait time target by priority category for all cancer surgery it performs. CCO flows incremental cancer surgery funding to KGH annually to support cancer surgery volumes.

As of the end of Q4 F13, KGH is not meeting this target. From a patient perspective patients are waiting longer than the assigned priority wait time target to have their surgery performed at KGH.

From a business perspective, CCO currently does not tie incremental funding to wait time target achievement so the incremental funding is not yet at risk because KGH isn't meeting its wait time target for cancer surgery. CCO has discussed the possibility of linking funding to wait time achievement. From an internal and external performance reporting perspective, the "red" trend on this indicator may suggest KGH has operational or capacity issues acting as barriers to wait time target achievement.

Actions & Monitoring Underway to Improve Performance:

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: Target 100%

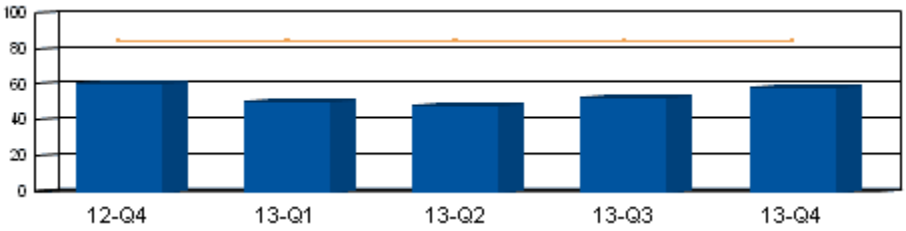
Kingston General Hospital

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



	Actual	Target
12-Q4	60	**84**
13-Q1	50	**84**
13-Q2	48	**84**
13-Q3	52	**84**
13-Q4	58	**84**

Interpretation - Patient And Business:

The KGH 90th percentile wait time continues to better than the provincial target in days waiting although there was a slight increase of 6 days for this quarter. Although there was a 12% operating room cancellation rate due to increased unpredictable patient activity, protocol was strictly adhered to ensuring that cancer cases were given top priority along with trauma cases for completion.

Of the 932 cancer cases completed this year the average 90% percentile wait time was 52 days for the 11 disease sites. The only disease sites not currently achieving this target are a) Endocrine- 122 days, b) GU-76 days, c) Prostate- 70 days and Lung-66 days

Actions & Monitoring Underway to Improve Performance:

The SPA and Oncology program leadership continue to monitor wait times. Services are supported with the continuation of extended operating days and extra booked cases on the general emergency board to manage wait times.

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.

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

	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?**
   This milestone remains on hold pending decision regarding change in the IT platform at KGH, and then assignment/alignment of resources to support the project.

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

3. **Are we on track to meet the milestone by year end?**
   No with awareness and acceptance of the rationale by the EMC/Board.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   It is expected that a corporate decision regarding the IT platform will be made by September 2013. In the interim, work continues with the promotion of interprofessional documentation with a view that documents and/or processes will be automated at a future date.

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		
13-Q2		
13-Q3		
13-Q4		

Interpretation - Patient And Business:

Project remains on hold pending decision regarding change in IT platform, and then alignment of resources to support the necessary work.

Actions & Monitoring Underway to Improve Performance:

Work continues with the promotion of interprofessional documentation, with a view that documents and/or processes will be automated in the future.

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%

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	Green

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?**
   Currently 7 of the 10 competencies outlined in the IPE workplan are met and work is nearing completion on the remaining 3. Outstanding workplan objectives include formal supports for reflective practice; strategy to document engagement in IPE activities; formalized education strategy for principle based decision making.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The IPE Steering Committee was redesigned and honed the focus and support for the workplan. All activities are essential first steps and foundational to an ongoing focus on IPE. The collaboration with Queen's has strengthened all efforts given that there is synergy in the strategies of the two organizations and opportunity to optimize resource sand talents.

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

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   IPE is an underpinning of and will be showcased at the May 2013 "Transforming the Patient Experience Knowledge Exchange". The report from Maria Tassone, from the Toronto Centre for IPE, and who conducted a KGH/Queen"s site visit in March, is pending and will inform next steps. In June 2013 KGH will be presenting its work with model of care and IPE at a conference in British Columbia. While there is not a tactic explicit to IPE in the 2014 Annual Corporate Plan, the approach to education at KGH will be designed with IPE as a principle and the accountabilities addressed in this past year will support that work.

Kingston General Hospital

MS #12

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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	R	Y	Y	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

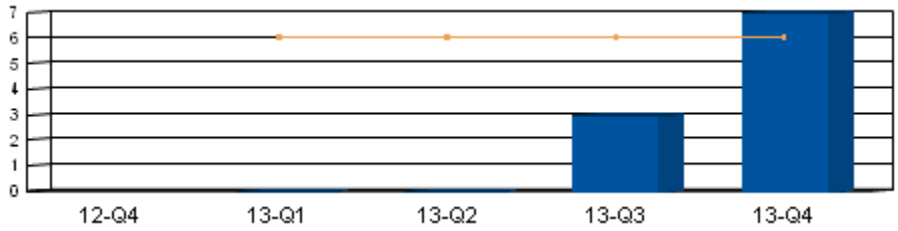
Kingston General Hospital

MS #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-Q4		
13-Q1	0	**6**
13-Q2	0	**6**
13-Q3	3	**6**
13-Q4	7	**6**

Interpretation - Patient And Business:

In Q4, there was focused effort on the organizational accountabilities related to educating professional staff. Four competencies have been completed or underway bringing the total for this fiscal year to seven.
Improvements have been made that influence a cultural and physical environment that supports and promotes IPE; there has been a review and redesign of educational processes for new and existing staff; leading practices that support safe, quality care have been implemented such as patient/family feedback forums; and communication strategies were introduced to increase opportunities for exchange of knowledge and continuous improvement.

Actions & Monitoring Underway to Improve Performance:

In Q4, there has been significant activity related to education that will support us achieving the 2015 outcome of KGH being recognized as a centre of excellence for interprofessional education. There are three outstanding accountabilities and work will continue into the next fiscal year.
Over the past year, a strong relationship has developed between the Queen's University Faculty of Health Sciences and KGH as both organizations work to achieve their strategic directions related to new models of education.

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

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%	Green

Indicator(s)
Square Footage of Clinical Research Space at KGH
Percent 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?**
   Planning of and fundraising for the Clinical Investigation Unit (CIU) continues. Approximately $150k has been identified to cover the costs of detailed drawings and minor modifications to enable use of existing space. UHKF has raised ~$150k towards renovations for CIU and successful GI and Neuroscience CFI Leading Edge Fund Applications include ~$1M for possible CIU renovations. Space up on Connell 4 has been made available for two KinArm robots which are now operational and three research offices. Fiscal 2012 funding increased by ~$500k marginally exceeding the cumulative target of a 40% increase over baseline.

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: complete turnover of Connell 4 is now slated for late 2013 due to the delays in clinic moves over to HDH. 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. The in-year increase in external funding was only 2.5%, attributable in part to an ~10% decrease in clinical trials revenue.

3. **Are we on track to meet the milestone by year end?**
   Slight delays in accessing full availability of Connell 4: occupancy of space now expected to occur in late 2013. Fundraising for the Clinical Investigation Unit is off to a promising start.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Ongoing discussion with Queen's for full capture of overhead from research projects. New overhead policy being drafted by Queen's is waiting sign off by Faculty and Hospitals once data from Queen's financial services is validate regarding overhead sharing.

Kingston General Hospital

MS #13

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

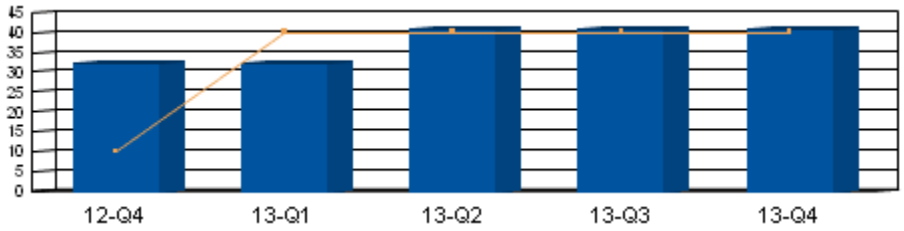
Kingston General Hospital

MS #13

Cultivate patient oriented research

Clinical research space at KGH increases by 25%

Indicator: Percent Increase of Externally Funded Research Dollars at KGH



	Actual	Target
12-Q4	32	**10**
13-Q1	32	**40**
13-Q2	41	**40**
13-Q3	41	**40**
13-Q4	41	**40**

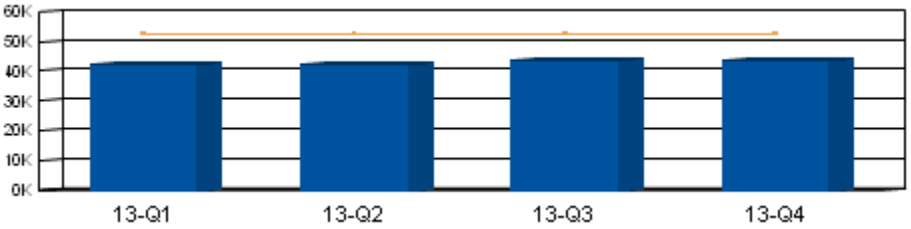
Interpretation - Patient And Business:

KGH Research Annual Report was released in fall 2012 and the data for percent increase in research funds was recorded in Q2. 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	42,000	**52500**
13-Q2	42,000	**52500**
13-Q3	43,451	**52500**
13-Q4	43,451	**52500**

Interpretation - Patient And Business:

Complete turnover of Connell 4 to KGHRI has been delayed as a result of the delay in the clinic moves over to HDH from FAPC. Occupancy now expected to occur in late 2013. Currently only four 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

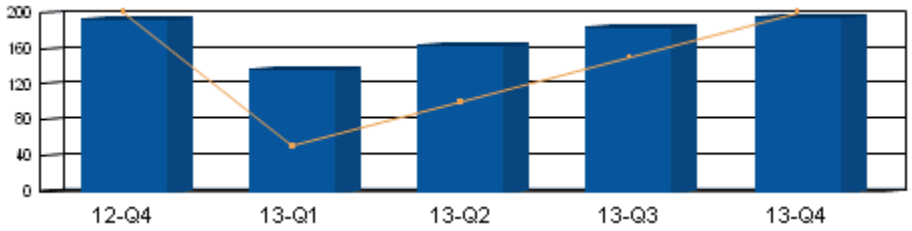
Kingston General Hospital

MS #13

Cultivate patient oriented research

Clinical research space at KGH increases by 25%

Indicator: Active Clinical Trials



	Actual	Target
12-Q4	192	**200**
13-Q1	136	**50**
13-Q2	163	**100**
13-Q3	184	**150**
13-Q4	195	**200**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q4.

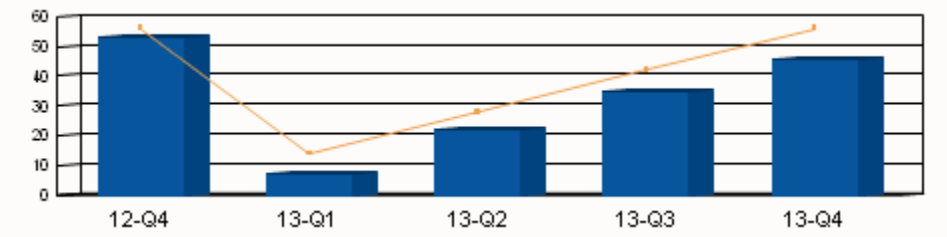
Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the fourth quarter (Q4).

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-Q4	53	**56**
13-Q1	7	**14**
13-Q2	22	**28**
13-Q3	35	**42**
13-Q4	46	**56**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to new clinical trials at KGH during Q4.

Business Perspective: Based on the fiscal year to date, KGH is slightly behind our target by the end of the fourth quarter (Q4). 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.

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.

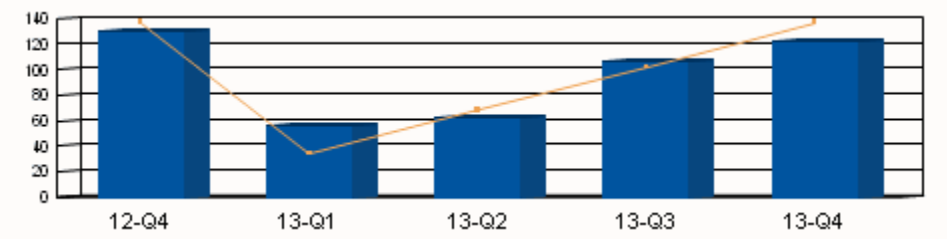
Kingston General Hospital

MS #13

Cultivate patient oriented research

Clinical research space at KGH increases by 25%

Indicator: Clinical Trials Generating Revenue



	Actual	Target
12-Q4	131	**137**
13-Q1	56	**34**
13-Q2	63	**68**
13-Q3	107	**102**
13-Q4	123	**137**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q4.

Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the fourth quarter (Q4).

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.

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?**
   The indicator/milestone is green.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Wave One tactics are being initiated throughout the SE LHIN partner hospitals. Programs and leadership in KGH is supporting initiation within KGH and supporting the CSR Leadership group.

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?**

   New engagement with the LHIN and regional partners focusing on capacity and roles in addition to patient flow discussions continue.

Kingston General Hospital

MS #14

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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 ↓

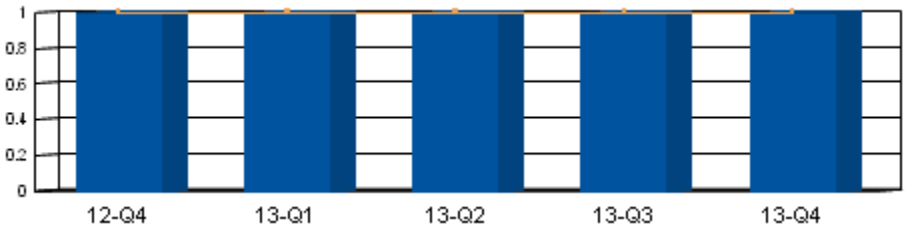
Kingston General Hospital

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-Q4	1	**1**
13-Q1	1	**1**
13-Q2	1	**1**
13-Q3	1	**1**
13-Q4	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)

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?**
   A wall of green!!! 17 of 18 indicators green. Only Kidney transplants showing yellow simply due to lack of grafts available for transplantation (i.e. not a hospital resource issue).

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Program leadership in SPA, Medicine and Diagnostic Imaging frequent review and reporting of volumes with programs and followed via the Waitlist Strategy Committee.

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?**

   Monthly reporting and review of all volumes (and wait times) at the Wait Times Strategy Committee.

Kingston General Hospital

MS #15

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

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

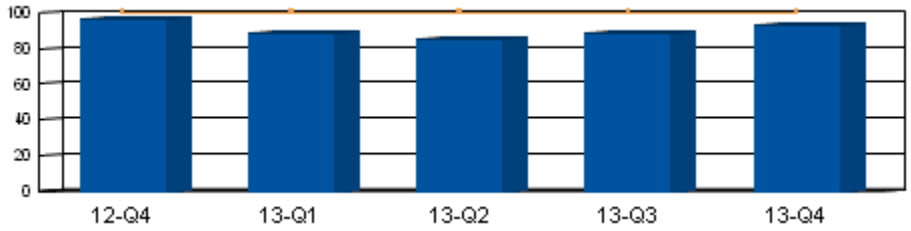
Kingston General Hospital

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-Q4	96	**100**
13-Q1	89	**100**
13-Q2	85	**100**
13-Q3	89	**100**
13-Q4	93	**100**

Interpretation - Patient And Business:

As of Q4, 26 of 28 (93%) contracted volumes were on target. The 2 that were not were general surgery (gallbladder surgery) and pediatric ACL repair. In both cases, incremental volume was returned to the SE LHIN late in the year. It is of note that most of surgeries occur at the HDH.

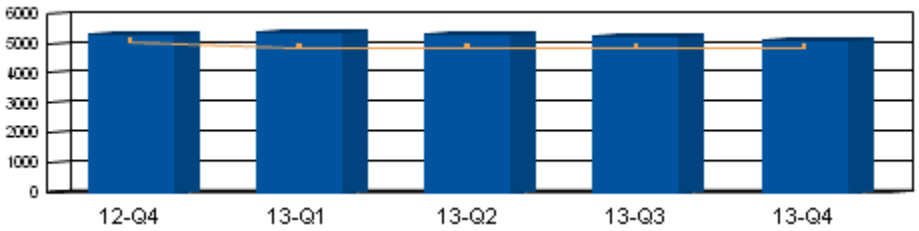
Actions & Monitoring Underway to Improve Performance:

Volumes to target are routinely monitored by appropriate committees of administration and MAC.

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 , Total Joint Revisions and Cancer Surgery Agreement Volumes.

Target: 2012/2013 Target: 100%

Indicator: Total Inpatient Admissions



	Actual	Target
12-Q4	5,332	**5058**
13-Q1	5,383	**4850**
13-Q2	5,284	**4850**
13-Q3	5,256	**4850**
13-Q4	5,130	**4850**

Interpretation - Patient And Business:

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

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

Target: Baseline 08/09: 19464, Target 09/10: 19400, Target 10/11: 19400, Target 11/12: 20,500, Target 12/13: 20,500

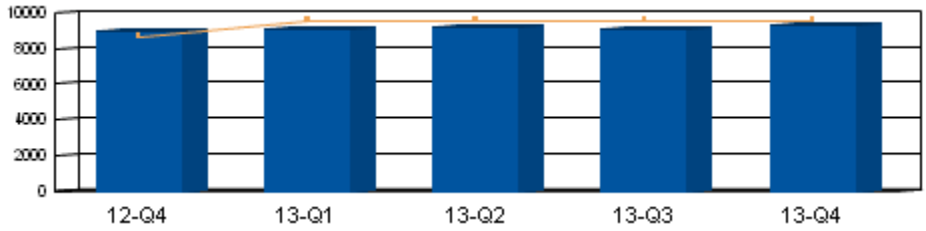
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Total Inpatient Weighted Cases



	Actual	Target
12-Q4	8,959	**8654**
13-Q1	9,060	**9556**
13-Q2	9,172	**9556**
13-Q3	9,080	**9556**
13-Q4	9,272	**9556**

Interpretation - Patient And Business:

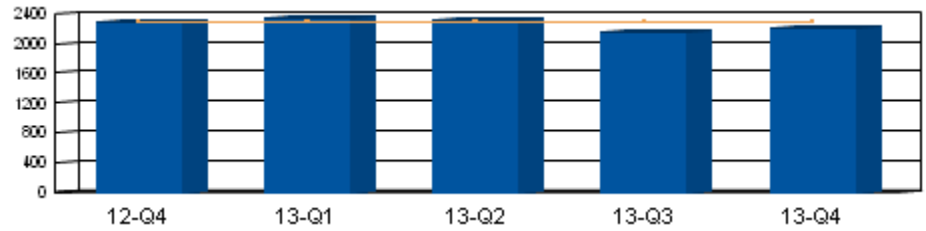
This indicator has been shaded "green" for the past 5 quarters and requires no progress comment.

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: 38224 (increase from prev. fiscal based the opening of 4 new critical care beds)

Indicator: OR Cases (Inpatient and Outpatient)



	Actual	Target
12-Q4	2,290	**2286**
13-Q1	2,331	**2286**
13-Q2	2,311	**2286**
13-Q3	2,159	**2286**
13-Q4	2,208	**2286**

Interpretation - Patient And Business:

The ability to meet case volumes continues to be a challenge as a result of the cancellations due to increased organizational patient activity and reduced access to inpatient resources (critical care program) for elective surgery activity. This challenge is also reflected in the OR cancellation rate which was 12% for this quarter, and a 12.2 % YTD rate.

Actions & Monitoring Underway to Improve Performance:

Inpatient and outpatient OR case volume activity is monitored by OR management and the Surgical Preoperative Anesthesia (SPA).

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

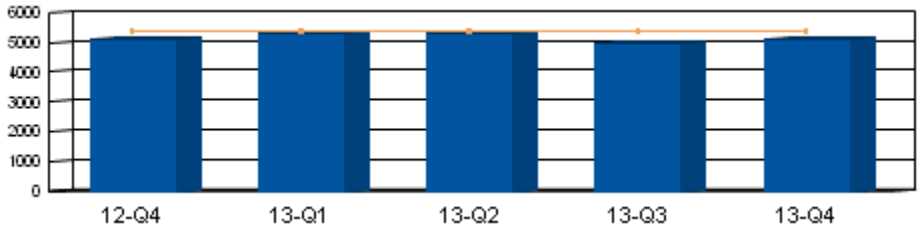
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: OR Hours (Inpatient & Outpatient)



	Actual	Target
12-Q4	5,088	**5345**
13-Q1	5,294	**5345**
13-Q2	5,332	**5345**
13-Q3	5,004	**5345**
13-Q4	5,114	**5345**

Interpretation - Patient And Business:

The number of gridlock days called this quarter in response to increased organizational patient activity and reduced access to inpatient resources for elective surgery activity is reflected in this quarter's ability to meet the top end of this targeted volume.

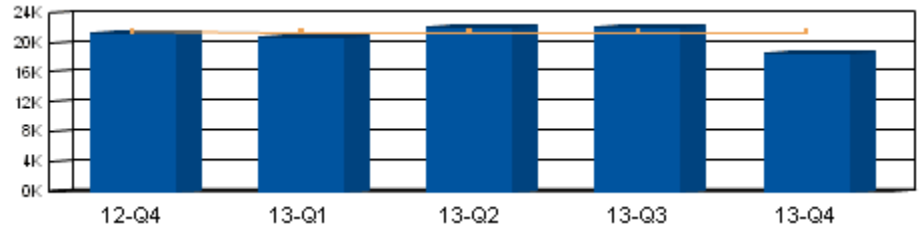
Actions & Monitoring Underway to Improve Performance:

Program leadership continues to monitor patient flow and utilize any additional strategies such as temporary Recovery Room overnight stays to ensure that OR cancellations are minimized.

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

Indicator: Ambulatory Care Volumes



	Actual	Target
12-Q4	21,194	**21400**
13-Q1	20,796	**21323**
13-Q2	22,085	**21323**
13-Q3	22,068	**21323**
13-Q4	18,613	**21323**

Interpretation - Patient And Business:

The changes to the ambulatory volumes is a direct result of the clinic moves to the Hotel Dieu Hospital.

Actions & Monitoring Underway to Improve Performance:

New target volumes to be created to better reflect remaining KGH ambulatory for next fiscal year.

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

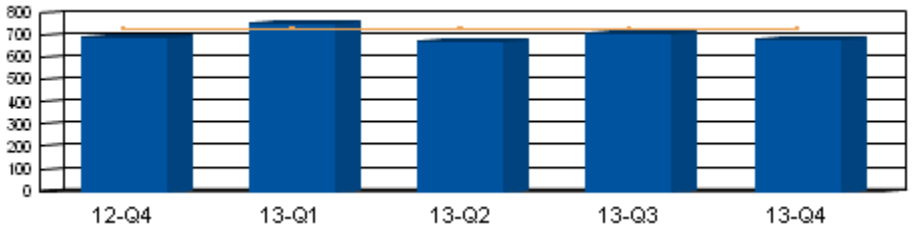
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Cardiac - Angiography Volumes



	Actual	Target
12-Q4	686	**725**
13-Q1	755	**725**
13-Q2	674	**725**
13-Q3	711	**725**
13-Q4	678	**725**

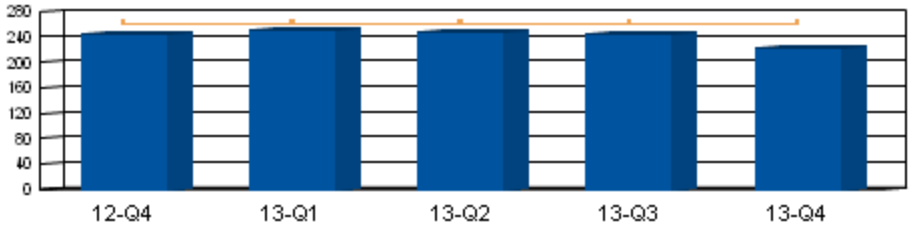
Interpretation - Patient And Business:

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

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

Target: Baseline 08/09: 1709, Target 09/10: 3100 , Target 10/11: 3100, Target 11/12: 2900, Target 12/13: 2900

Indicator: Cardiac - Angioplasty Volumes



	Actual	Target
12-Q4	245	**262**
13-Q1	252	**262**
13-Q2	248	**262**
13-Q3	244	**262**
13-Q4	222	**262**

Interpretation - Patient And Business:

Cardiac Angioplasty volumes are below target in Q4. No concerns as funded base volumes are more than adequate to meet the needs of patients in the region. Procedures are being done well within the recommended wait times for all angioplasties with virtually no wait list. Most angioplasties are completed as part of the diagnostic catheterization (angiography) procedure resulting in 0 days wait time. This is referred to as same sitting PCI (percutaneous intervention) or ad hoc. This means that the patient has only one procedure for both the diagnostic and intervention components when appropriate.

Actions & Monitoring Underway to Improve Performance:

Demand has remained steady and is consistent with last year's volumes. This trend in volumes is consistent across the province. Approximately 33% of angiographies lead to angioplasty which is in line with the provincial average. Funded base volume is 1050. This year an additional 18 procedures were added to base and another 6 procedures added as a one-time increase. This year's total funded activity is 1074 angioplasties which is more volume than is required to meet the needs of patients in this region and more volume than requested. This may result in a recovery of funding related to this line although projected targets were met.

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.
These numbers are Ontario Funded Volumes only.

Target: Baseline 08/09: 1084, Target 09/10: 1150 , Target 10/11: 1150, Target 11/12: 1050, Target 12/13: 1050

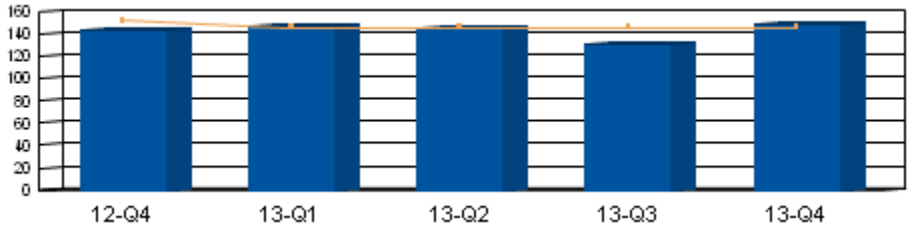
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Cardiac - Bypass Volumes



	Actual	Target
12-Q4	143	**152**
13-Q1	147	**146**
13-Q2	145	**146**
13-Q3	131	**146**
13-Q4	148	**146**

Interpretation - Patient And Business:

Cardiac surgery volumes were slightly behind target volumes at the end of Q3 due to a short waiting list, patients delaying surgery by choice, or they required additional testing and then repeat clinic appointments prior to surgery. Target volumes were met in Q4. Maximum recommended wait times for elective bypass surgeries are being met 100% of the time. Volumes have remained constant over the past 3 years.

Actions & Monitoring Underway to Improve Performance:

MoH approved a request in Q4 to reallocate unused cardiac surgery funding to complex ablations. This addressed our complex ablation waiting list and reduced the amount of funding that would be payable back to the MoH at year end.
Cardiac surgical volumes are monitored weekly and monthly by the Cardiac and SPA Programs and the Wait Times Committee 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 complete with an anticipated start date of July 2013.

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.
These numbers are Ontario Funded Volumes only.

Target: Target 10/11: 580, Target 11/12: 606, Target 12/13: 582

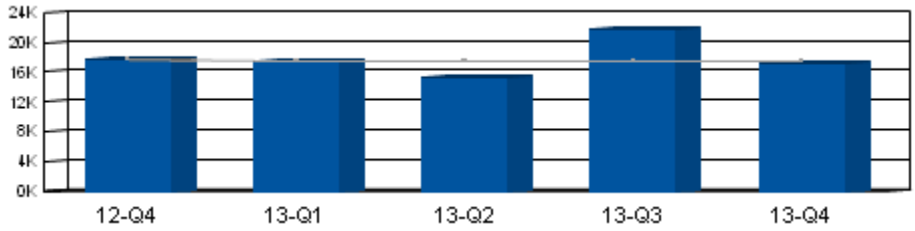
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Chronic Kidney Disease Program - (Weighted Units)



	Actual	Target
12-Q4	17,638	**17707**
13-Q1	17,336	**17498**
13-Q2	15,171	**17498**
13-Q3	21,763	**17498**
13-Q4	17,123	**17498**

Interpretation - Patient And Business:

This activity area covers a range of clinical activities with the renal service.
This is activity is driven by clinical need of the patient population. Whilst the overall population with CKD remains relatively stable the clinical acuity of patients has seen greater activity in the Q4 period.

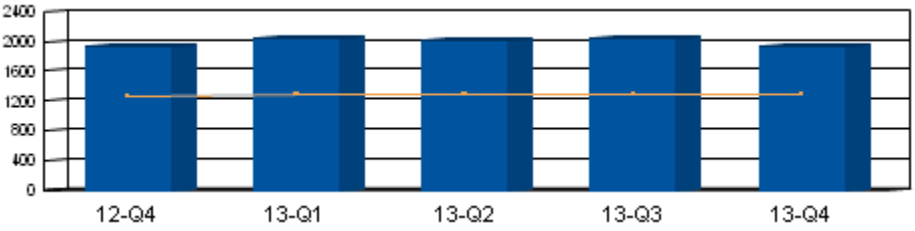
Actions & Monitoring Underway to Improve Performance:

Most of the increasing activity is seen in the main Renal Unit (burr 3). Patients with greater clinical instabilities having treatment throughout the programs seven locations will 'fall-back' to the KGH site when clinically necessary.
The main concern with this pattern is the continuing capacity (human and physical) to support patient's clinical needs.

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

Indicator: CT Hours (Wait Time Strategy Allocation)



	Actual	Target
12-Q4	1,929	**1263**
13-Q1	2,032	**1286**
13-Q2	2,026	**1286**
13-Q3	2,033	**1286**
13-Q4	1,945	**1286**

Interpretation - Patient And Business:

KGH's wait time hours allotment is based on a single scanner. KGH always far surpasses the LHIN designated operating hours because 2 CT scanners are operated daily. This is required in order to meet the needs of the ER, IP and specialized Cancer Center patient population.

Actions & Monitoring Underway to Improve Performance:

Maintain the same operating hours. This number of hours has been found to be ideal for workflow and meets the patient population needs.

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.

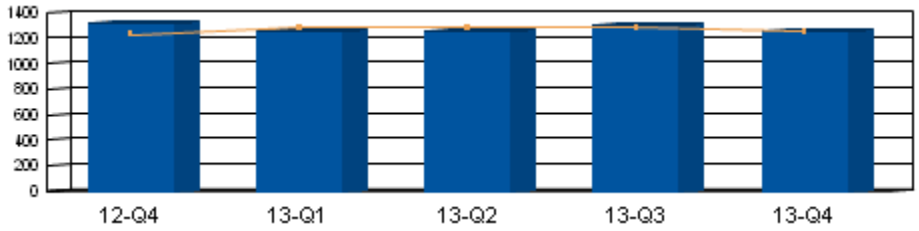
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: MRI Hours (Wait Time Strategy Allocation)



	Actual	Target
12-Q4	1,322	**1228**
13-Q1	1,262	**1283**
13-Q2	1,250	**1283**
13-Q3	1,298	**1283**
13-Q4	1,257	**1250**

Interpretation - Patient And Business:

KGH was successful in meeting its MRI wait time hours target. This was through tremendous effort on the technologist's part. The schedule does have many hours where only one technologist is working at a time. KGH continues to pursue an optimal staffing level in MRI.

Achieving the hours is paramount to meeting the needs of the patients. Decreased hours result is increased wait time.

Actions & Monitoring Underway to Improve Performance:

An employee is presently completing his MRI training. He will be done in May 2014. He will be a huge asset to the MRI team and available for PT coverage.

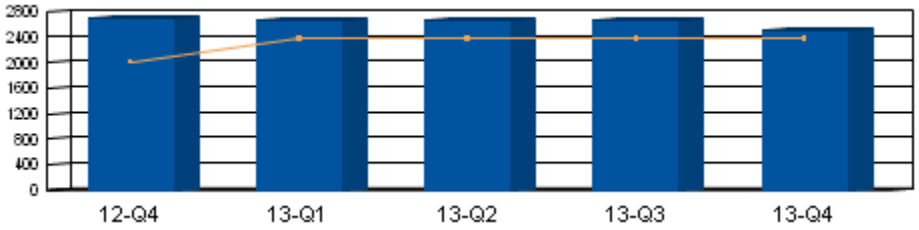
If we manage to install a second magnet within 2 years it will allow us to increase our number of wait time hours.

This will allow patients to access the service they need in a timeline that positively supports their journey of care from diagnosis to treatment.

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. As of Q4 12/13 Target changed to 5000 hrs.

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



	Actual	Target
12-Q4	2,713	**2002**
13-Q1	2,658	**2370**
13-Q2	2,683	**2370**
13-Q3	2,657	**2370**
13-Q4	2,520	**2370**

Interpretation - Patient And Business:

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

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

Target: Baseline 08/09: 8163 , Target 09/10: 8163, Target 10/11: 8163, Target 11/12: 8008, Target 12/13: 8163

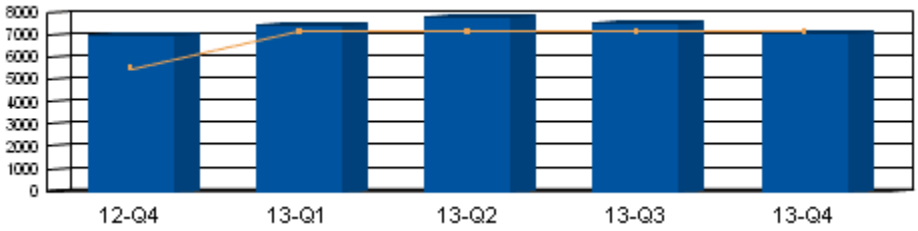
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

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



	Actual	Target
12-Q4	7,033	**5481**
13-Q1	7,423	**7149**
13-Q2	7,766	**7149**
13-Q3	7,575	**7149**
13-Q4	7,045	**7149**

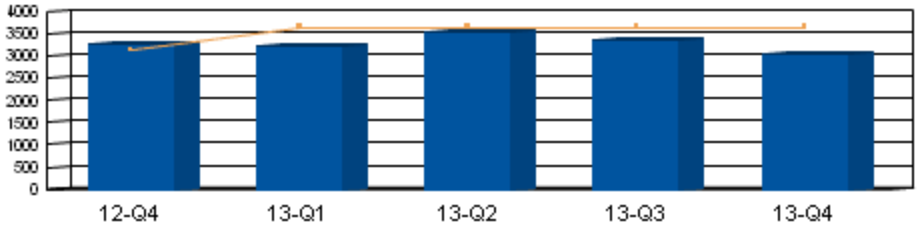
Interpretation - Patient And Business:

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

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

Target: Baseline 08/09: 22823, Target 09/10: 22823, Target 10/11: 22823, Target 11/12: 21924, Target 12/13: 25924

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



	Actual	Target
12-Q4	3,284	**3138**
13-Q1	3,242	**3647**
13-Q2	3,547	**3647**
13-Q3	3,349	**3647**
13-Q4	3,028	**3647**

Interpretation - Patient And Business:

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

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

Target: Baseline 08/09: 14270, Target 09/10: 14270, Target 10/11: 14270, Target 11/12: 12552, Target 12/13: 12552

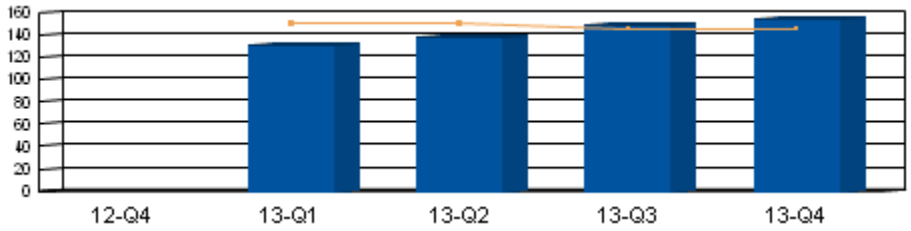
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

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



	Actual	Target
12-Q4		
13-Q1	131	**150**
13-Q2	138	**150**
13-Q3	148	**145**
13-Q4	154	**145**

Interpretation - Patient And Business:

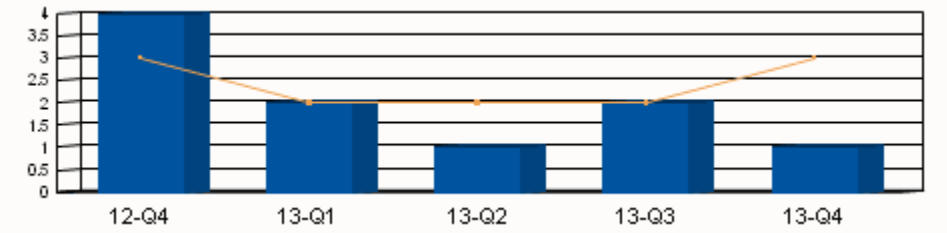
From the operational perspective KGH exceeded the initial targets assigned by the SELHIN. The completed YTD volumes for primary unilateral hips were 236/230, for primary unilateral knees 355/351 and 122/108 revisions. Additional funding was offered to KGH by the SELHIN to assist in over achieving the reported volumes.

As the first QBP implementation, a concern was identified during the last quarter in the reconciliation of the volumes which has been linked to the use of two different coding systems for the procedures. One being used by the OR PICIS electronic system and the other by the ministry. KGH continues to work very closely with the SELHIN to address this problem to ensure that fiscal recognition is given for this year's completed volumes.

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

Indicator: Kidney Transplants



	Actual	Target
12-Q4	4	**3**
13-Q1	2	**2**
13-Q2	1	**2**
13-Q3	2	**2**
13-Q4	1	**3**

Interpretation - Patient And Business:

Kidney transplant numbers are driven most significantly by the availability of organs donated through deceased patients.

Actions & Monitoring Underway to Improve Performance:

We have been able to respond appropriately to organ availability and support the transplantation for patients in our local region.

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

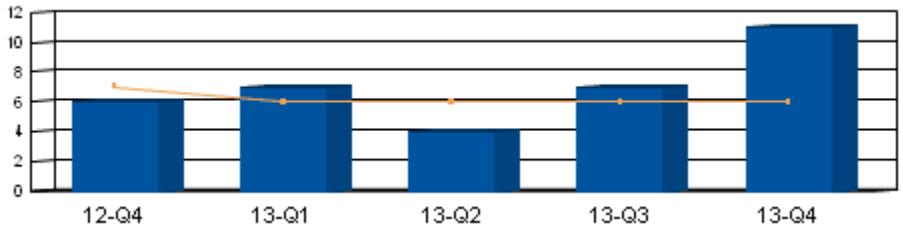
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Stem Cell Transplants



	Actual	Target
12-Q4	6	**7**
13-Q1	7	**6**
13-Q2	4	**6**
13-Q3	7	**6**
13-Q4	11	**6**

Interpretation - Patient And Business:

At the end of F12/13, KGH performed 29 stem cell transplants, exceeding its target volumes for the year

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

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?**
   Led by the Open Source Order Set Committee, many programs and services have developed comprehensive, best practice order sets.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   A focus on quality and safety has been the major driver for up take by the programs\.

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?**

   Acquisition and implementation of Entry Point, an electronic repository of Order Sets, will be a major initiative for ensure the viability of the Order Set project.

Kingston General Hospital

MS #16

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

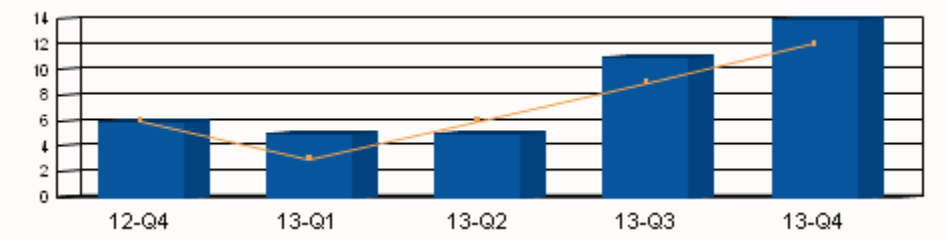
Kingston General Hospital

MS #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-Q4	6	**6**
13-Q1	5	**3**
13-Q2	5	**6**
13-Q3	11	**9**
13-Q4	14	**12**

Interpretation - Patient And Business:

A very successful uptake by programs to implement OS.

Actions & Monitoring Underway to Improve Performance:

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.

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

Overall staff satisfaction rating improve by 20%

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

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? Launch of the scheduling project continues to be green and is on track for the upcoming fiscal year. Sick time has increased to 11.12 average sick days however the number of incidents remains stable and the overall average is lower than at Q4 one year ago (11.42). Overtime has not changed significantly in the last two quarters. Hot spot areas include Neonatal and regular Intensive Care Units and Pediatrics.

2. What are the contributing factors to the current performance of the indicators for this milestone? There are a number of elements impacting this milestone. The Q3 increased sick time (reported last quarter) impacted the rolling 12 month average. A number improvements related to filling vacancies which have a direct impact on overtime were not in place at the beginning of the quarter. Completion of Phase 2 of the Scheduling project, including review of master rotations, impact analysis and 250 staff involved in focus groups and interviews to determine best approaches to change and adoption of new technology. *N.B. Removal of carpets, extension of hours for Tim's and creation of medication rooms are also impacting on staff satisfaction.*

3. Are we on track to meet the milestone by year end. We are unable to measure this percentage increase as the PULSE Survey was not conducted. However, one of the supporting indicators for the milestone is green and the others are yellow with an upward trend. While the 10.5 average sick day target for this fiscal year was not achieved; the number of employees in the attendance program decreased by 7.6%; new wellness activities are underway and review/adaption of existing attendance program to enhance effectiveness. "Your health matters" program piloted with Environmental Services staff.

4. What specific actions, initiatives or projects are planned/underway to ensure this milestone is met? Two funded projects were completed: One focused attention on mental health in the workplace which accounts for 20-25% of our absences. Delivered "leading with mental health in mind"; launched wellness website and on-line "Together We're Better-Intercultural Interactions at KGH", re-opened the staff Wellness Centre and created peer partners to assist staff with issues related to mental health, harassment and bullying. Redesign of recruitment, including the establishment of internal transfer "movement survey"; reduced the Time to fill from 100 days to 54 days; 90 day turnover rate reduced from 7.5% in 2012 to 4% in 2013.

Kingston General Hospital

MS #17

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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	N/A	G	G	G	↑
		Percent of Overtime Hours	Y	Y	Y	Y	Y	↑
		Percent Sick Time Hours	Y	Y	Y	R	Y	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

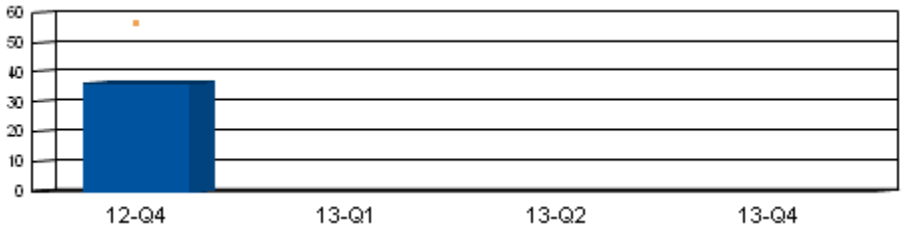
Kingston General Hospital

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
12-Q4	36	**56**
13-Q1		
13-Q2		
13-Q4		

Interpretation - Patient And Business:

Survey not completed this fiscal year. Preparation has begun for Q1 Engagement Survey in fiscal 2013-14.

Actions & Monitoring Underway to Improve Performance:

Performance on this indicator did not take place this year. Leadership decision made to delay participation in the two surveys: Patient Safety and Accreditation - new staff began in Q2 who are responsible for these areas and conflicting demands on staff required delay in this activity. Planning underway to launch staff and physician engagement survey May 27- June 15 with Four Phase action plan to follow.

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: • Q1 – Survey results received and incorporated into the Mock Accreditation processes (Green) Q2 - Survey results communicated formally in the organization (Green) Q3 - Input obtained from key stakeholder group and Executive Management Committee approved Action Plan Q4 - Survey and comunication plan approved and survey conducted end of February

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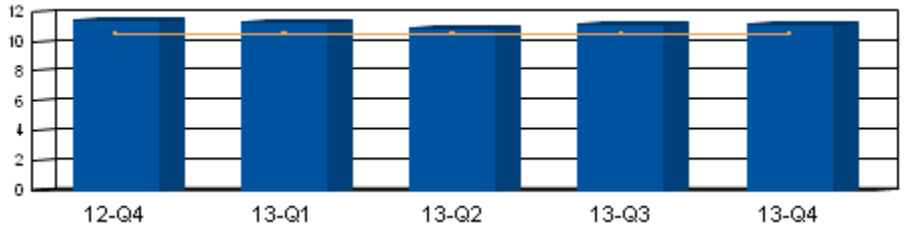
Indicator: Average Sick Days per Eligible Employee Per Year



	Actual	Target
12-Q4	11.4	**10.5**
13-Q1	11.3	**10.5**
13-Q2	10.9	**10.5**
13-Q3	11.1	**10.5**
13-Q4	11.1	**10.5**

Interpretation - Patient And Business:

Although the rolling average for the end of the third quarter was 11.05, it rose up to 11.14 at the end of February, settling at 11.12 for the end of the fiscal year. This is not at target levels, however the number of incidents remains stable and the overall average is lower than at Q4 one year ago (11.42). The rolling average for CUPE continues the downward trend ending March at 12.30. This is the lowest average in CUPE in twelve and one half (12 ½) years. This represents a drop from last year of 2.28 days.

Actions & Monitoring Underway to Improve Performance:

Two funded projects from the Healthy Work Environments fund (HWE) occurred during the quarter and will continue into the next quarter. In particular one project focussed attention on mental health which accounts for 20-25% of our absences. We had leading with mental health in mind training for leaders, launched a wellness website, re-opened the staff Wellness Centre and created Peer Partners to assist staff with issues related to mental health, harassment and bullying.

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

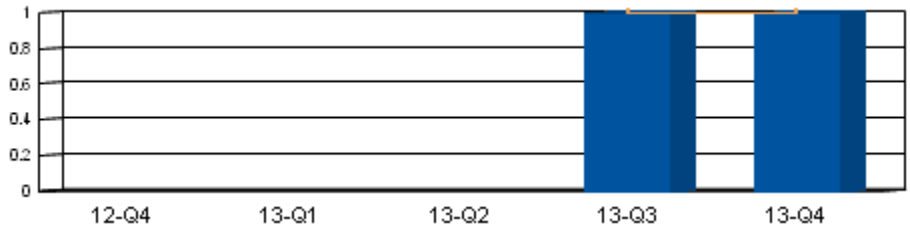
Kingston General Hospital

MS #17

People

Overall staff satisfaction ratings improve by 20%

Indicator: Launch the Staff Scheduling Project



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

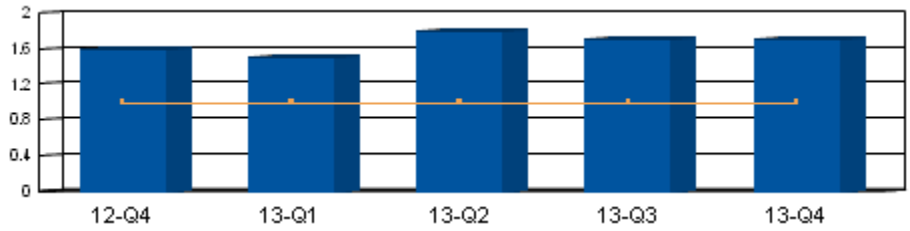
Interpretation - Patient And Business:

The project was kicked off in August with hiring of a project manager; Sept/March was Phase 2 which was discovery where we explored and mapped current state processes in the scheduling office. Phase 3 began in Q1 this year which is Creation of future state- requirements definition that will be complete by August 31;. Once that has been signed off with a complete statement of work the design phase (4) will be happening and implementation after that.. this is planned for Sept to March Phase 4 and then March to end of July 2014 is roll out phase 5.

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-Q4	1.6	**0.99**
13-Q1	1.5	**0.99**
13-Q2	1.8	**0.99**
13-Q3	1.7	**0.99**
13-Q4	1.7	**0.99**

Interpretation - Patient And Business:

Overtime has not changed significantly in the last two quarters. Hot spot areas include NICU, Pediatrics and the ICUs.

Actions & Monitoring Underway to Improve Performance:

The scheduling and time capture project will assist in some of the issues related to overtime. Several areas are currently looking at alternate schedules and rotations including reviewing K2ICU.

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%

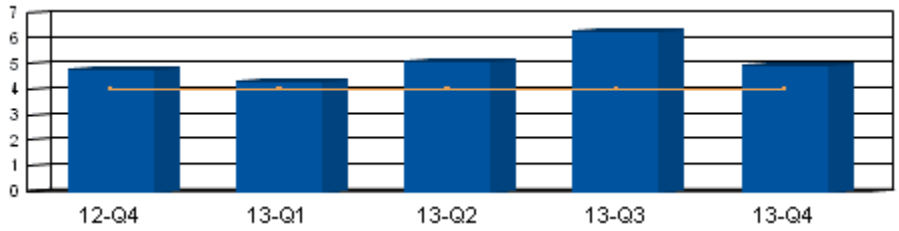
Kingston General Hospital

MS #17

People

Overall staff satisfaction ratings improve by 20%

Indicator: Percent Sick Time Hours



	Actual	Target
12-Q4	4.8	**4**
13-Q1	4.3	**4**
13-Q2	5.1	**4**
13-Q3	6.3	**4**
13-Q4	4.9	**4**

Interpretation - Patient And Business:

Sick time variances in hours and dollars finished the year strongly in the fourth quarter after a disappointing Q3. The highest variances of sick time hours reside in direct patient care areas such as the surgical, oncology, and critical care programs.

Actions & Monitoring Underway to Improve Performance:

Two funded projects from the Healthy Work Environments fund (HWE) occurred during the quarter and will continue into the next quarter. In particular one project focused attention on mental health which accounts for 20-25% of our absences. It is expected that improved recruitment, retention, scheduling and engagement will have a positive impact on reducing sick time.

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%

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?** There was an achievement of green status at the end of Q4, with only three red indicators which were: 1) incident investigation completion by management, 2) needlestick injuries (*41% were hypodermic needles, other themes were overfilled containers, recapping, failure to initiate safety mechanism, and failure of the device*); and 3) incidence of health care claims (*25 in Q4: Falls 5:; MSIs 8; Occupational exposure – meningococcal 6; Physical Violence 4*).

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Ministry of Labour Orders were not received, improvement to other targets such as: 21 days that management responds to JSHC identified hazards (*highest compliance to-date);* Days lost due to workplace injury/illness; Incidence of MSIs, and Respirator Fit Testing and Training (*employees now receive an email reminder 60 days in advance of their fit testing and training due and again at 30 days if not completed*). We met the target for quarterly management inspections through communication reinforcement at Leaders Forums, HR Advisor X-Changes and one-on-one. There were only 4 lost time MSIs claims this fiscal year which was a 73% reduction from last fiscal year. We have been successful in challenges to WSIB claims which then has a direct positive correlation for NEER rebates and negative correlation for increased health care claims.

3. **Are we on track to meet the milestone by year end?**
   Yes, the Q4 result was a green status.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Occupational Health, Safety and Wellness team continues to reach out 1:1 with managers/supervisors to review incident investigation expectations, tools, and information that is required. Development of an online Joint Health and Safety Committee inspection form to enable timely receipt and follow-up by managers, follow-up on every needlestick injury. Increased tactical focus for the upcoming year will be needles stick injuries, falls, MSIs and physical violence.

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Kingston General Hospital

MS #18

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

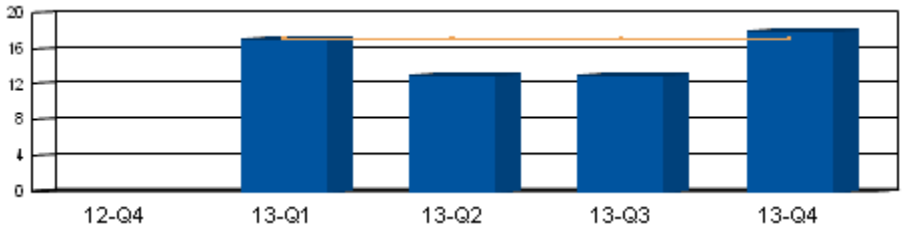
Kingston General Hospital

MS #18

People

Health and Safety Scorecard targets are met

Indicator: Number of Health & Safety Scorecard Target Indicators Met



	Actual	Target
12-Q4		
13-Q1	17	**17**
13-Q2	13	**17**
13-Q3	13	**17**
13-Q4	18	**17**

Interpretation - Patient And Business:

18 measures on/approaching target (green & yellow).

3 indicators in red at end of Q4 including:
-incidence of needlestick injuries
-percent completion of management incident investigations, and
-number of WSIB health care claims.

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

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**	**Yellow**

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? We did not launch the engagement initiative this year due to recalibration related to capacity of organization and resources. However, the survey tools were selected and contract in place; agreement to include physicians and implementation plan finalized; subsequently the supporting indicator for engagement is yellow. The completion rate for mandatory online training remains steady at 94%.

2. What are the contributing factors to the current performance of the indicators for this milestone? Review of competing priorities, monies and resources postponed the launch date for the engagement initiatives and engagement surveys until spring 2013.

3. Are we on track to meet the milestone by year end? We did not meet the engagement metric for Q4 for action plans to be in place, however, a number of "engagement" activities initiatives have been underway. We have continued to leverage usage of the online learning management system, including a recent launch of manager online onboarding, which ensures that leaders understand KGH's approach for quality, safety and improvement initiatives, amongst other items. The CEO engaged staff via departmental level town-halls in Q4. Some frontline staff have received training in continuous improvement and participated in continuous improvement events/activities and departmental/unit safety committees.

4. What specific actions, initiatives or projects are planned/underway to ensure this milestone is met? A five phase action plan has been finalized that will result in data shared across the hospital; engagement action plans developed at the team level and engagement training for leaders. Engagement action plan template has been incorporated into the revised version of the 2014 Performance Agreements for the KGH Leadership Group. Completed redesign of new staff orientation which will be launched May 2013. Continuance of the patient experience advisor led staff sessions which enables staff to hear from patients about their treatment experience in their unit, and identify opportunities for improvement and sustainment of what is working well. The hospital conducted the first "KGH Community Celebration" week in January and three Awards of Excellence were given out to recognize teams who exhibited excellence in delivering Care, Leadership or Knowledge to achieve our Mission and enable our aim of "Outstanding Care, Always".

Kingston General Hospital

MS #19

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
People	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	R	R	Y	↑
		Percent of Staff that Complete Mandatory Online Training Programs	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 ↓

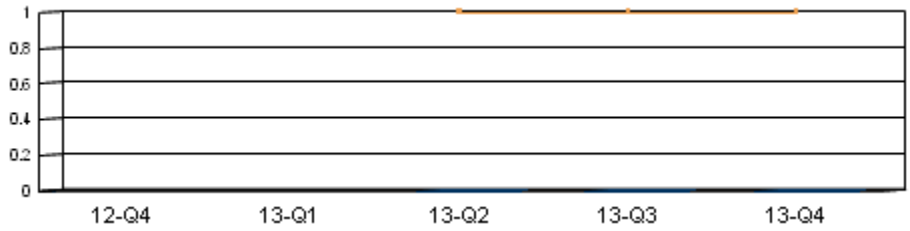
Kingston General Hospital

MS #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
12-Q4		
13-Q1		
13-Q2	0	**1**
13-Q3	0	**1**
13-Q4	0	**1**

Interpretation - Patient And Business:

Engagement survey planning has begun - Dates established for May 27- June 15, 2013. Survey to be followed by results review and share by Q2; Q3 and 4 will begin training. Engagement Action Plan format is incorporated into new Performance Agreement tool for all Leaders for 2013-14.

Actions & Monitoring Underway to Improve Performance:

Launch 2013-14 .

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: Q1 - N/A Q2 - Engagement Strategy completed , approved by Executive Management Committee and budget assigned Q3 - Selection of survey modality/vendor and implementation plan finalized to launch “leading for engagement” Q4 –Training and action planning by teams

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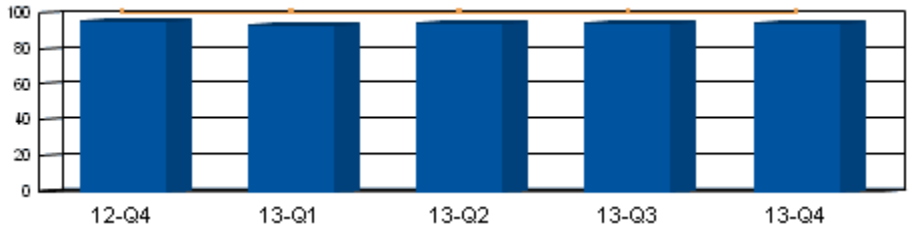
Indicator: Percent of Staff that Complete Mandatory Online Training Programs



	Actual	Target
12-Q4	95	**100**
13-Q1	93	**100**
13-Q2	94	**100**
13-Q3	94	**100**
13-Q4	94	**100**

Interpretation - Patient And Business:

AODA completion is at 98%; MSI at 89%; WHMIS is at 93%; WVH 97%; overall completion is 94.35%

Actions & Monitoring Underway to Improve Performance:

Completion of MSI training needs to have more attention. Suggest lab time tour in new Orientation program launching May 1, will provide opportunity to reiterate importance to new staff and give them actual time to start it /complete it during first days.

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 l 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%

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?**
   100% of managers have been trained.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The coordination/facilitation by the new Director, Quality, Patient Safety and Risk Management. Flexibility of sessions and follow-up by the team that leaders were scheduled and support for their learning.

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

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Recently launched manager online onboarding ensures that new leaders receive training within first 6 months of hire.

Kingston General Hospital

MS #20

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

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

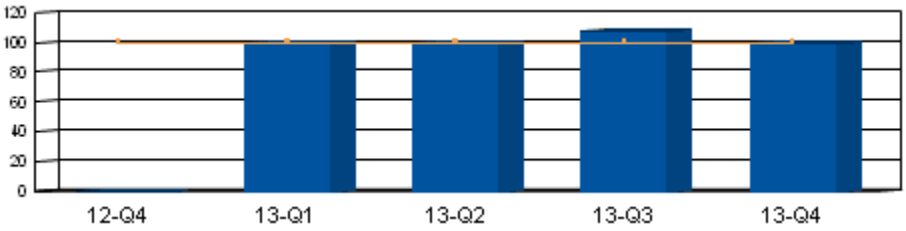
Kingston General Hospital

MS #20

Processes

100% of KGH managers complete continuous improvement training

Indicator: Percent of Management Staff Completing Mandatory Process Improvement Training



	Actual	Target
12-Q4	0	**100**
13-Q1	100	**100**
13-Q2	100	**100**
13-Q3	108	**100**
13-Q4	100	**100**

Interpretation - Patient And Business:

100 percent completion

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.

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**	**Yellow**

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?** Our stretch goal for Q4 had been to obtain approval from Ministry to move on to Stage 2 planning by March 31, 2013. We did not achieve this goal. Completion of the master plan and program, and developing support of the foundation, Queens, and SE LHIN to ensure submission of the Stage 1 documents were completed. On February 25, 2013, the SE LHIN Board approved the Stage 1 documents for submission to the MoHLTC (Ministry). The material s were submitted in March 2013.

   We met with the Ministry on April 22, 2013 to provide an orientation to our submission and toured Ministry staff through the KGH site on May 6, 2013. Work will continue into Fiscal 2014 and it is clear the time line while influenced by us, is of course subject to at MoHLTC process.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Work within KGH progressed as expected and stayed on schedule obtaining approval in November from the KGH Board. Meeting schedules within Queens (approved in December) delayed submission to the SE LHIN (missing November SE LHIN Board Meeting) and getting on February SE LHIN Board meeting, adding another 2 months delay from our desired time line. This moved our planned submission time to the Ministry from December to March.

3. **Are we on track to meet the milestone by year end?** As noted above, while we made significant progress and met our internal deliverables, supporting approvals were required before we could submit to the Ministry. Therefore Ministry approval to move to Functional Planning phase (Stage 2 of Ministry process) could not been received by year end.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** We are continuing to support the Ministry in their review of our submission in hopes that approval will be forthcoming, but there is a lot of political and fiscal constraints effecting Ministry process. We are therefore considering our options and looking at whether we could commence some functional planning to minimize the impact of delays in obtaining approvals on our overall timelines.

Kingston General Hospital

MS #21

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

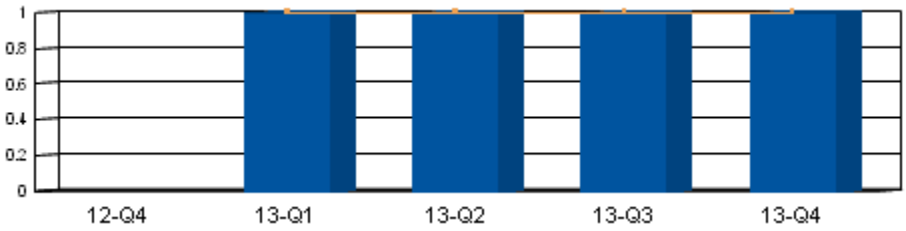
Kingston General Hospital

MS #21

Facilities

Phase 2 redevelopment functional programming commences

Indicator: Phase 2 Redevelopment Project Targets are Met



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

Interpretation - Patient And Business:

The Stage One Proposal was endorsed by the LHIN at its Board meeting in February. The MOHLTC is now reviewing the submission.

Actions & Monitoring Underway to Improve Performance:

MOHLTC approval is required prior to proceeding with the development of the "Stage Two: Functional Program". The JPO is working with each program to structure their programming/planning teams, identify research/best practice opportunities, and efficiency reviews prior to commencement of programming.

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.

Carpets are removed from 75% of patient areas

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

Indicator
Quarterly Carpet Removal Targets are Met

1. **What is our actual performance on each of the indicators for this milestone as listed above?** Phase 1 of the carpet removal is complete and Phase 2 of carpet removal began on schedule. Overall 73% of the targeted areas of the hospital were completed to finish Phase 1. This includes 9 inpatient areas. In Phase 2 we have 2 more inpatient , two main corridors, and ambulatory clinic areas to complete. Outside of the project our facilities department has also completed several small projects in clinical support and office areas to remove carpets as well.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** As previously reported, this project has been well organized and credit is due to many areas of the hospital for the coordination and execution. JPO and Facilities are both providing leadership and support , but many other areas provide support as well (Environmental Services, Information Services, Materials Management, Pharmacy, Laboratories, Portering, etc.).

3. **Are we on track to meet the milestone by year end?** The milestone for 2013 was met.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** The carpet removal project continues into fiscal 2014. The RFP for Phase 2 is complete and is within budget and desired time lines. Phase 2 moves have commenced in April 2013 and at this time we are confident that the target to complete Phase 2 this year will be met. We now have a lot of experience decanting and completing carpet removal.

Kingston General Hospital

MS #22

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

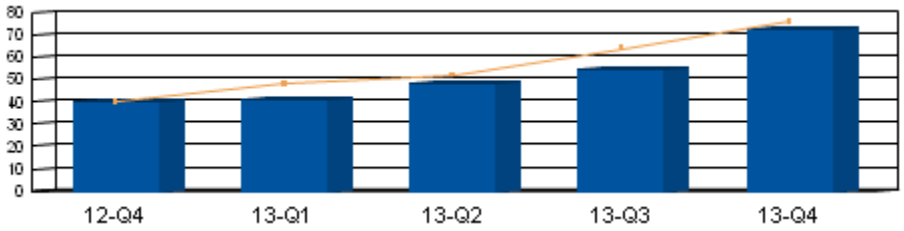
Kingston General Hospital

MS #22

Facilities

Carpets are removed from 75% of patient areas

Indicator: Quarterly Carpet Removal Targets are Met



	Actual	Target
12-Q4	40	**40**
13-Q1	41	**48**
13-Q2	48	**52**
13-Q3	55	**64**
13-Q4	73	**76**

Interpretation - Patient And Business:

Phase 1B is now complete. Phase 2 is underway and on target for completion this fiscal year. The project is currently 73% complete and is under budget.

Actions & Monitoring Underway to Improve Performance:

The project budget and schedule will continue to be monitored for compliance.

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%)

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?** In Q4 we achieve our best result to date 47% (March hit 52%), however we are still significantly below our goal of 80%. The progress continues to be steady, but slow. In Q4 of 2012 our result was 43%, and the April 2013 result just in was 58%. Trending is going the right way as new tools and understanding roll out across the hospital.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** We have implemented this last year some technology to assist physicians monitor their outstanding discharges (Inbox notifications). This has helped support improving results, however it has been insufficient to address the majority of outstanding reports.

3. **Are we on track to meet the milestone by year end?** We did not meet this goal. We will continue to focus on this goal in fiscal 2014,

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** Joint Quality and Utilization Improvement Committee has undertaken to oversee strategies to improve performance on this target. JQUIC will review the data and information available from the Inbox reports and develop new strategies to support improvement. To support JQUIC, reports have been developed to monitor department and individual physician performance.

Kingston General Hospital

MS #23

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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	G	G	G	G	↑
		Implementation of an Order Management System for Labs on All Inpatient Areas (% Completion).	G	G	G	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

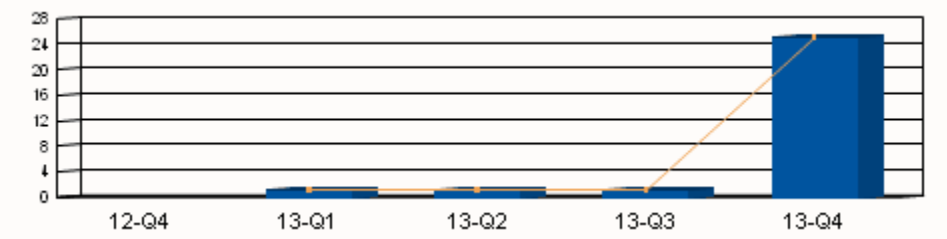
Kingston General Hospital

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-Q4		
13-Q1	1	**1**
13-Q2	1	**1**
13-Q3	1	**1**
13-Q4	25	**25**

Interpretation - Patient And Business:

Project on target. We only installed in ER A,C and D before the end of March, with the install on K4 and D4ICU postponed until early April (3rd and 10th respectively) due to March Break and Easter all falling within a very short time of each other.They went live on April 3rd and 10th.

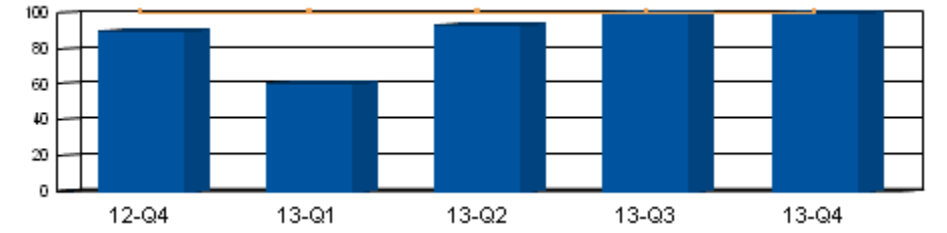
Note that result and target data for Q4 are %s of total cabinet costs for entire project.

Actions & Monitoring Underway to Improve Performance:

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-Q4	90	**100**
13-Q1	60	**100**
13-Q2	93	**100**
13-Q3	100	**100**
13-Q4	100	**100**

Interpretation - Patient And Business:

All inpatient units are 'live" with unit lab order entry. In Q4 F'13, the Renal unit went live with unit lab order entry. Work is well underway with the outpatient clinics remaining at FAPC. ER is also targeted for a late fall implementation.

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)

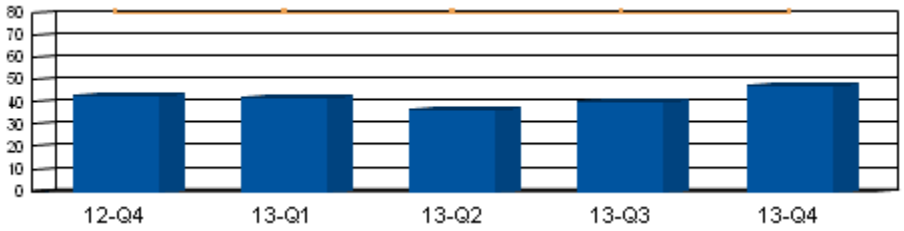
Kingston General Hospital

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-Q4	43	**80**
13-Q1	42	**80**
13-Q2	37	**80**
13-Q3	40	**80**
13-Q4	47	**80**

Interpretation - Patient And Business:

Fourth quarter results of 47% represents a 7% gain over the previous quarter. March's performance of 52% is the best monthly record since establishing and tracking this indicator. Another 11% were completed over the 72 hour target but within 120 hours. This represents an opportunity to shift this volume within the established target. Overall chart deficiencies remain within target supporting more timely completion of year end data submissions.

Actions & Monitoring Underway to Improve Performance:

Health Information Services and Medical Administration continue to sanction as per policy. The Joint Quality and Utilization Improvement Committee (JQUIC) continues to monitor department and individual physician performance. Efforts will now be focused on analyzing and interpreting the data available from the implementation of the inbox technology to identify strategies to improve performance.

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%

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?** We achieved our $15 million target for capital spending in Fiscal 2013. Our ongoing success in meeting this target has given our Capital Committee increasing capacity to address the ongoing demands across the hospital. We still have a large backlog, but in 2012-13 we allocated - $3.5 to Information Management, $2.5 to infrastructure (building), and $8.0 million to equipment .

   Some examples of equipment purchases the funds have permitted us to complete this year include: a SPEC CT (Nuclear Medicine camera), Automated Drug Cabinets (XX), Ventilators (8),Ultra sound Machines (4), a ECG Machine, a Breast Milk Scanning System, a Laser for Prostate Treatment, Electric Beds (2), Labour Beds (8) , Cribs (2), Sterilizer, Exam Tables (20), Syringe Pumps (7), Liquid Based Cytology System, Microscopes (4), Freezers (8), Serofuges (5), Copper lined Incubators (2), Telemetry System, chairs for patient rooms (245), bed side and over bed tables (127), infusion pumps (340), vocera badges (250), stackable chairs (101), and we were able to address several ergonomic chairs for staff and minor equipment for clinical floors (Thermometers, blanket warmers, lifts, reclining chairs, bariatric walkers, IV poles). Some of the purchases were completed in 2013 and many are work in progress that will be completed (delivered)in the upcoming months.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** As reported in Q3, the ongoing due diligence of our CFO and Capital Committee have maintained a constant vigilance including looking for opportunities to augment the capital budget. Funds have been secured through operational efficiencies found during the year, foundations, and grants (such as Hospital Infrastructure Renewal Fund (HIRF).

3. **Are we on track to meet the milestone by year end?** The target was met.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** This milestone continues into Fiscal 2014 and we plan to continue to pursue both operational efficiencies and external sources of funds to meet the target. Efforts are already underway to align this activities with the Capital Committee and Budget processes.

Kingston General Hospital

MS #24

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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)	G	G	G	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 ↓

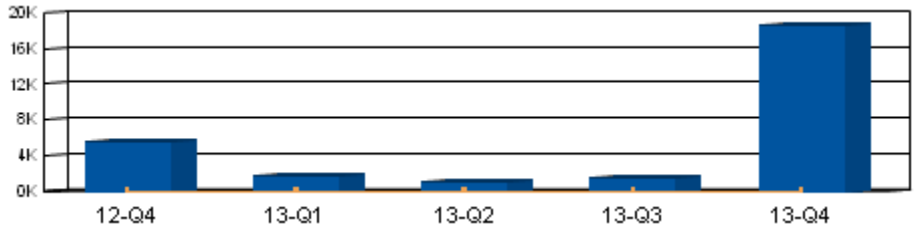
Kingston General Hospital

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-Q4	5,532	**0**
13-Q1	1,651	**0**
13-Q2	941	**0**
13-Q3	1,411	**0**
13-Q4	18,555	**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.

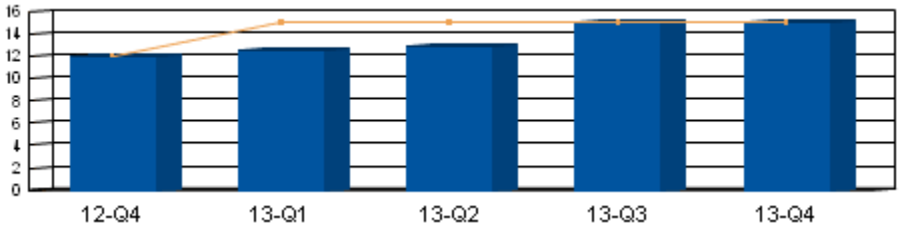
Actions & Monitoring Underway to Improve Performance:

The year-end results indicate a total margin of $22 million (before building amortization). Hospital operational activities contribute approximately $6 million, and one-time non-operational revenue contributed approximately $8 million. The remainder is due to favourable net amortization expense aligned with timing issues on capital investment.

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-Q4	12.0	**12**
13-Q1	12.5	**15**
13-Q2	12.9	**15**
13-Q3	15.0	**15**
13-Q4	15.0	**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 achieved the targeted $15.0 capacity for investment in capital for fiscal 2013 including the support from the Ministry Health Infrastructure Renewal Fund, the Kingston General Hospital Foundation, and the Kingston General Hospital Auxiliary.

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

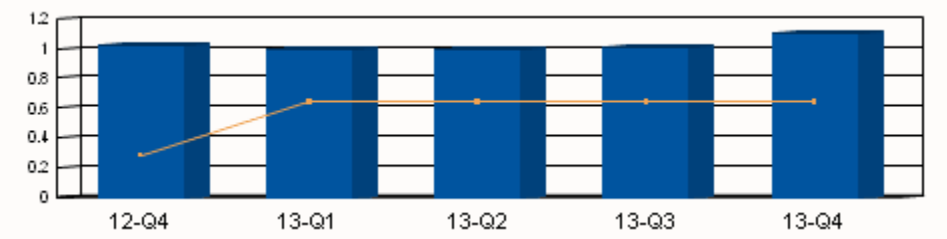
Kingston General Hospital

MS #24

Finances

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

Indicator: Current Ratio



	Actual	Target
12-Q4	1.02	**0.28**
13-Q1	0.99	**0.64**
13-Q2	0.99	**0.64**
13-Q3	1.01	**0.64**
13-Q4	1.10	**0.64**

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.

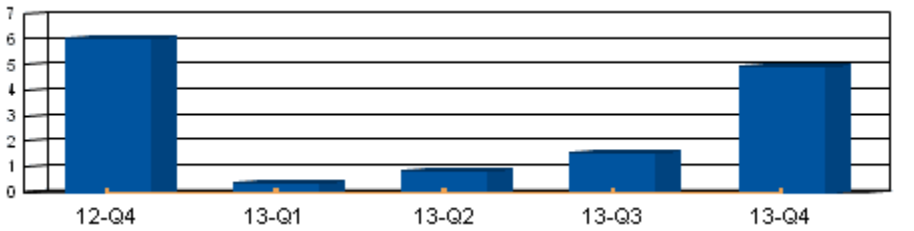
Actions & Monitoring Underway to Improve Performance:

The current ratio for fiscal 2013 exceeded the target. The increased ratio is reflective of a favourable operating variance to plan on hospital operations and the receipt of $7 million in Working Capital Deficit Relief funding from the Ministry. Timing differences on the utilization of restricted funds held for capital investment also contribute.

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-Q4	6.03	**0**
13-Q1	0.33	**0**
13-Q2	0.80	**0**
13-Q3	1.55	**0**
13-Q4	4.97	**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:

The year-end results indicate a total margin of $22 million (before building amortization). Hospital operational activities contribute approximately $6 million, and one-time non-operational revenue contributed approximately $8 million. The remainder is due to favourable net amortization expense aligned with timing issues on capital investment.

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

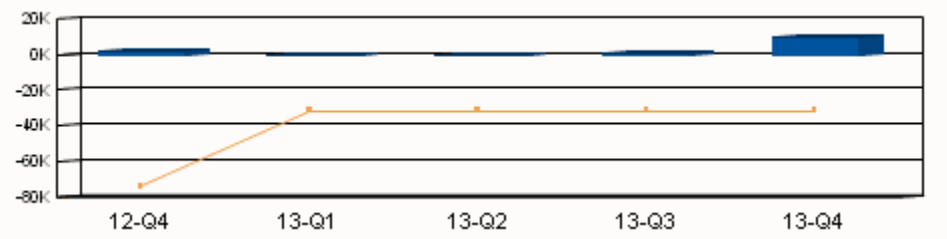
Kingston General Hospital

MS #24

Finances

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

Indicator: Working Capital ($000's)



	Actual	Target
12-Q4	2,035	**-74000**
13-Q1	-601	**-31500**
13-Q2	-481	**-31500**
13-Q3	610	**-31500**
13-Q4	10,071	**-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 current ratio for fiscal 2013 exceeded the target. The increased ratio is reflective of a favourable operating variance to plan on hospital operations and the receipt of $7 million in Working Capital Deficit Relief funding from the Ministry. Timing differences on the utilization of restricted funds held for capital investment also contribute.

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)

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?

We will measure staff satisfaction with communications at KGH through the 2013 Employee and Physician Engagement Survey, which will be implemented in May. A question to measure the effectiveness of our current communications vehicles and employee preferences has been added to the engagement survey. The information gathered from the survey will be used to make improvement in our current corporate communications practices.

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

A number of initiatives aligned with our KGH 2015 outcome (to engage and report openly) were completed in Q4, i.e., social media policy, new KGH Connect website, etc., More are listed in the Portfolio highlights.

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

N/A

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

The Communications and Public Affairs improvement priorities in the ACP 2013-14 include building leadership capacity for effective communications, and the development of a new website, which will ultimately improve staff satisfaction with communications at KGH.

Kingston General Hospital

MS #25

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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	R	R	R	Y	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

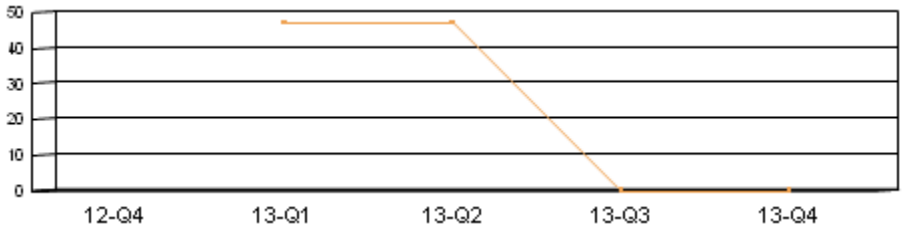
Kingston General Hospital

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-Q4		
13-Q1	47	
13-Q2	47	
13-Q3	0	
13-Q4	0	

Interpretation - Patient And Business:

The Worklife Pulse survey was not implemented in light of the proposed Q1- 2013-14 Employee and Physician Engagement Survey. Therefore, results to measure this indicator are not available. In Q4 the Communications and Public Affairs team developed an extensive program for the KGH hosted conference: Transforming the Patient Experience on May 9 & 10, 2013. A comprehensive marketing and communications program including advertising, social media tools, online registration and conference related material was developed as part of the KGH Connect brand. The conference is designed to bring healthcare professionals together to exchange knowledge about patient- and family-centered care strategies. The staff social media policy was launched in Q4. Training workshops on the use of social media were made available for staff. In addition, two websites were created and launched to promote mental health awareness in our workplace and on cultural diversity education for staff.

Actions & Monitoring Underway to Improve Performance:

A question to measure employee communications satisfaction has been included on the upcoming Employee Engagement Survey. The question is designed to measure the effectiveness of our current communications vehicles and employee preference. Information gathered will inform the design of our internal communications programs.

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

Strategy Performance Report - Fiscal 2012/13 Q4

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
KGH 2015	100% Accreditation Canada Requirements are Met with an Unconditional Three-Year Award	100% Accreditation Canada Requirements Met	N/A	G	G	G	G	↑
	Quality Improvement Plan Targets are Met	Number of Quality Improvement Plan Goals for Change Met	N/A	Y	Y	G	G	↑
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	N/A	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	G	G	Y	G	G	↑
	The number of new patients who acquire infections in our hospital is reduced by 10%	Number of New Cases of Hospital Acquired Infection	R	G	R	R	G	↑
	KGH overall average length of stay is better than expected length of stay	Average # ALC Patients per Day	G	R	R	R	R	↓
		Overall - Acute Average Length of Stay vs ELOS Variance in Days - QIP *	G	Y	Y	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	Y	R	R	R	↓
	Clinical services meet the provincial wait time target	Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (Excluding Cancer Surgery)	R	R	Y	Y	Y	↑
	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	R	Y	Y	G	↑

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
Cultivate patient oriented research	Clinical research space at KGH increases by 25%	Percent Increase of Externally Funded Research Dollars at KGH	G	N/A	G	G	G	↑
		Square Footage of Clinical Research Space at KGH	N/A	N/A	N/A	Y	Y	↑
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	G	G	G	G	↑
	Evidence-based guidelines are adopted in 12 clinical areas	Number of Clinical Areas that have Implemented Open Source (OS)	G	G	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"	R	N/A	N/A	N/A	N/A	
	Health and Safety Scorecard targets are met	Number of Health & Safety Scorecard Target Indicators Met	N/A	G	R	R	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	R	R	Y	↑
Processes	100% of KGH managers complete continuous improvement training	Percent of Management Staff Completing Mandatory Process Improvement Training	R	G	G	G	G	↑
Facilities	Phase 2 redevelopment functional programming commences	Phase 2 Redevelopment Project Targets are Met	N/A	G	G	G	Y	↑
	Carpets are removed from 75% of patient areas	Quarterly Carpet Removal Targets are Met	G	Y	G	Y	G	↑
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)	G	G	G	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	R	R	R	Y	↑

↑ Indicates improving performance to target over the past 5 quarters

↓ Indicates worsening performance to target over the past 5 quarters

Kingston General Hospital

QIP - Fiscal 2012/13 Q4

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
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?	Y	G	G	G	N/A	↑
		Percent of Clinical Programs that Have Conducted at Least One Patient and Family Feedback Forum *	N/A	G	G	G	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	G	G	G	G	↑
		Implementation of Surgical Safety Check List	G	G	G	G	G	↑
		Percent Mortality Reviews Completed with Review of Record Level HSMR Data *	R	R	R	N/A	N/A	↓
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) *	Y	R	R	R	R	↑
		Hospital Standardized Mortality Ratio (HSMR)	G	G	G	R	N/A	↓
		Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey *	G	Y	Y	Y	N/A	↑
		Percent of Recommendations Considered and Acted Upon as per Critical Incident Investigations *	N/A	G	G	G	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 *	Y	Y	G	Y	G	↑
		Percent of Sepsis Cases Reviewed by Department Head *	N/A	N/A	N/A	N/A	N/A	
		C-Difficile (Reported Quarterly)	R	Y	R	R	Y	↑
		Hand Hygiene Compliance *	G	Y	Y	G	Y	↑
	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	Y	Y	G	Y	↑

			12-Q4	13-Q1	13-Q2	13-Q3	13-Q4	
		Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile *	G	R	Y	G	G	↑
		Readmission Rate Within 30 Days for Selected CMG's to Any Facility *	Y	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	Y	R	R	R	↓
		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	
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	R	Y	Y	G	↑
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

Occupational Health and Safety Scorecard Q4 F2013

			12-Q1	12-Q2	12-Q3	12-Q4
Health and Safety	Health & Safety	OHS - # MOL Orders Issued	G	G	R	G
		OHS - 21 Day Management Response to JHSC Identified Hazards	R	R	R	Y
		OHS - Cases of Possible/Confirmed Cases of Occupational Illness Reported to MOL	G	G	G	Y
		OHS - Completion of Pre-Placement Health Screening	G	G	G	G
		OHS - Days Lost Due to Workplace Injury/Illness	G	R	R	Y
		OHS - High Risk Occupational Exposures Reported to MOL	Y	G	G	G
		OHS - Incidence of all MSI Injuries (MSI's)	Y	R	R	Y
		OHS - Incidence of Needlestick Injuries (NSIs)	Y	R	R	R
		OHS - Incident Investigations Complete	R	R	R	R
		OHS - JHSC Monthly Workplace Inspections	G	G	G	G
		OHS - Lost Time Injury/Illness Claims	G	G	G	G
		OHS - Management Workplace Inspections	R	R	R	G
		OHS - Mandatory Safety Training	Y	Y	Y	Y
		OHS - MOL Reported Critical Injury	G	G	G	G

				12-Q1	12-Q2	12-Q3	12-Q4
Health and Safety	Health & Safety		OHS - MSI Lost Time Injury Claims (LTIs)	G	G	G	G
			OHS - Respirator Fit Testing & Training Completion	R	R	Y	Y
			OHS - WSIB Healthcare Claims	Y	R	R	R
			OHS - WSIB NEER Performance Index - 2008	Y	Y		
			OHS - WSIB NEER Performance Index - 2009	Y	Y	Y	
			OHS - WSIB NEER Performance Index - 2010	G	G	G	
			OHS - WSIB NEER Performance Index - 2011	G	G	G	
			OHS - WSIB NEER Performance Index - 2012			G	

Indicates worsening performance to target over the past 5 quarters

Indicates improving performance to target over the past 5 quarters

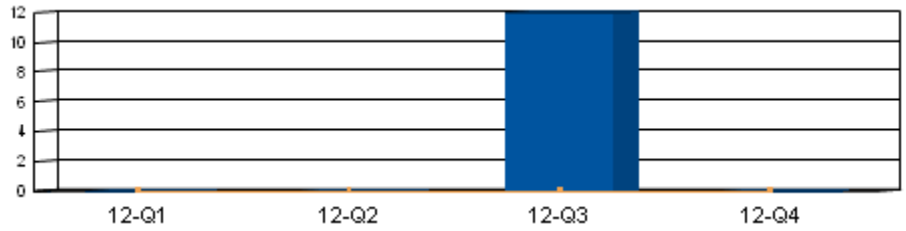
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - # MOL Orders Issued



	Actual	Target
12-Q1	0	0
12-Q2	0	0
12-Q3	12	0
12-Q4	0	0

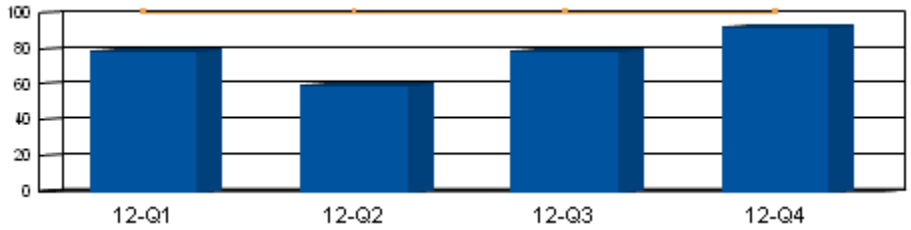
Interpretation - Patient And Business:

No MOL visits in Q4

Definition: Orders of compliance issued to the Employer by the Ministry of Labour (MOL) when contraventions of the Occupational Health & Safety Act and/or its Regulations are identified at the time of a site visit/inspection.

Target: 2012/13 Target: 0

Indicator: OHS - 21 Day Management Response to JHSC Identified Hazards



	Actual	Target
12-Q1	78	100
12-Q2	59	100
12-Q3	78	100
12-Q4	92	100

Interpretation - Patient And Business:

Highest compliance to date is Q4.

Definition: Where the hospital's Joint health & Safety Committee (JHSC) identifies hazards and makes recommendations for their control/correction, a response from management outlining the action to be taken is required within 21 days in accordance with the Occupational Health & Safety Act.

Target: 2012/13 Target: 100%

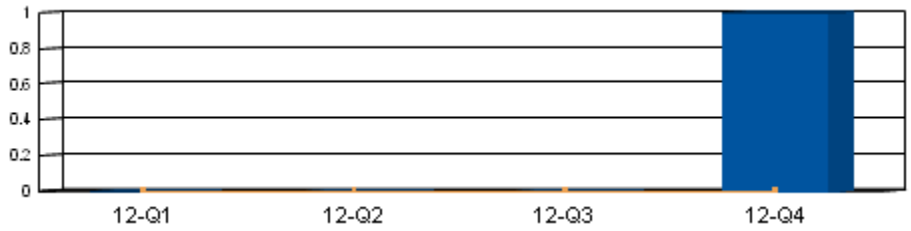
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Cases of Possible/Confirmed Cases of Occupational Illness Reported to MOL



	Actual	Target
12-Q1	0	0
12-Q2	0	0
12-Q3	0	0
12-Q4	1	0

Interpretation - Patient And Business:

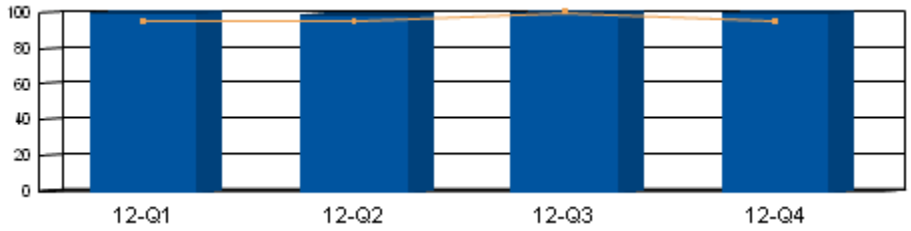
Occupational reaction/illness

Actions & Monitoring Underway to Improve Performance:

Definition: This indicator measures the number of occupationally acquired illnesses reported by workers to the Employer; notice to the Ministry of Labour (MOL) is required within 4 days as per the Occupational Health & Safety Act for all occupational illnesses whether confirmed or not.

Target: 2012/13 Target: 0

Indicator: OHS - Completion of Pre-Placement Health Screening

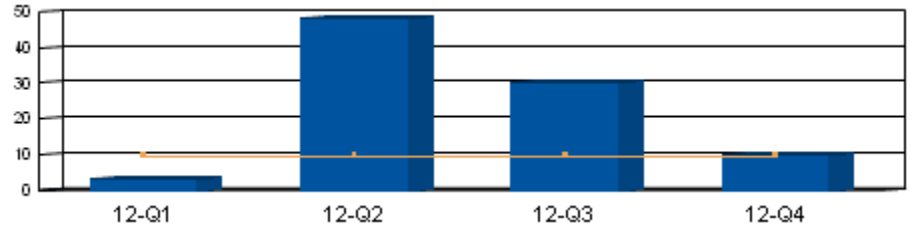


	Actual	Target
12-Q1	100	95
12-Q2	99	95
12-Q3	100	100
12-Q4	100	95

Definition: Completion of pre-placement medical screening in all new employees to the hospital; pre-screening is a condition of employment at KGH and required under the Public Hospitals Act.

Target: 2012/13 Target: 95%

Indicator: OHS - Days Lost Due to Workplace Injury/Illness



	Actual	Target
12-Q1	3	9.5
12-Q2	48	9.5
12-Q3	30	9.5
12-Q4	10	9.5

Interpretation - Patient And Business:

2 LTIs each resulted in 1 day of lost time; the 3rd LTI (patient handling related) resulted in 5 days of lost time and the violence related LTI resulted in 3 days of lost time.

Definition: Initial number of days lost from work due to a new workplace injury or illness; this does not include lost time that may be incurred later on once the worker has returned to work.

Target: 2012/13 Target: 10% Reduction (38 Days)

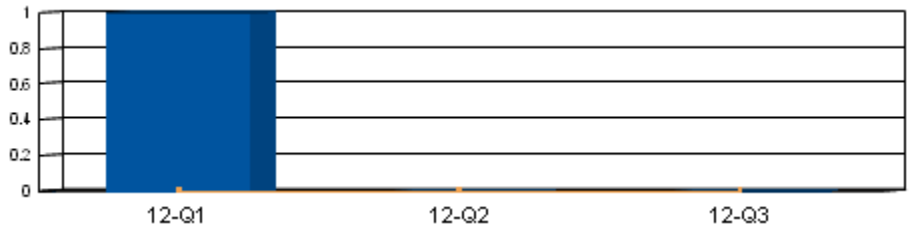
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - High Risk Occupational Exposures Reported to MOL

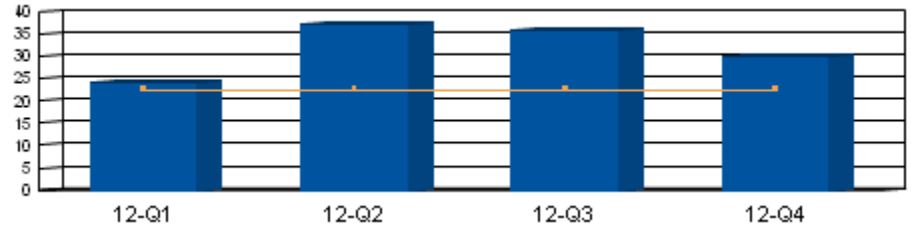


	Actual	Target
12-Q1	1	0
12-Q2	0	0
12-Q3	0	0

Definition: Number of occurrences where one or more workers have had an unprotected occupational exposure(s) to a potentially infectious agent and the agent has the potential to cause occupational illness in the worker(s).

Target: 2012/13: 0

Indicator: OHS - Incidence of all MSI Injuries (MSI's)



	Actual	Target
12-Q1	24	22.5
12-Q2	37	22.5
12-Q3	36	22.5
12-Q4	30	22.5

Interpretation - Patient And Business:

60 % of MSIs were patient handling related and 40% due to all other causes. 6 MSIs resulted in WSIB Health Care claims. 2 MSIs accounted for 2 of the 4 lost time injury claims in Q4.

Critical Care Program had the highest incidence of MSIs at 9 (7 patient handling; 2 other causes), followed by Medicine (6)

Actions & Monitoring Underway to Improve Performance:

MSI prevention is a tactic for 2013-14

Definition: Total number of occupational related musculoskeletal injuries (MSIs) reported by workers in the Safe Reporting Tool.

Target: 2012/13 Target: <=90

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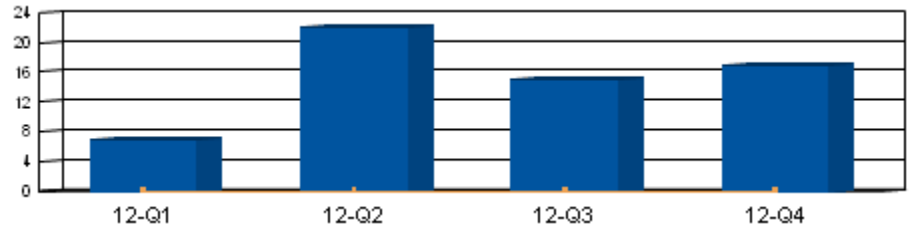
Indicator: OHS - Incidence of Needlestick Injuries (NSIs)



	Actual	Target
12-Q1	7	0
12-Q2	22	0
12-Q3	15	0
12-Q4	17	0

Interpretation - Patient And Business:

41% of NSIs involved the hypodermic needle as the type of needle/sharp.

35% of NSIs occurred in the Medicine Program.
Common themes: overfilling/jammed sharp container (N=2), recapping (2), failure to activate safety mechanism (3), failure in device (2),

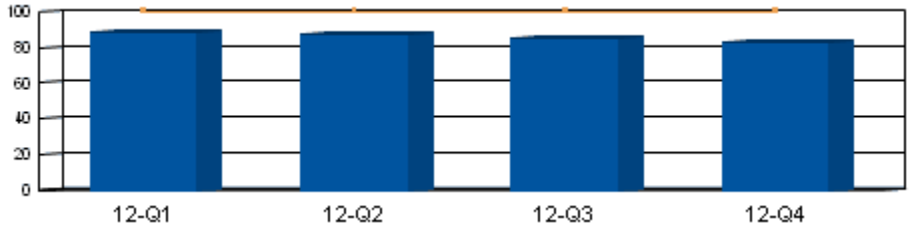
Actions & Monitoring Underway to Improve Performance:

NSI prevention is a tactic for 2013-14.

Definition: Total number of needlestick injuries reported by workers in the Safe Reporting Tool; does not include other non-needle sharps-related injuries.

Target: 2012/13: 0

Indicator: OHS - Incident Investigations Complete



	Actual	Target
12-Q1	89	100
12-Q2	87	100
12-Q3	85	100
12-Q4	83	100

Interpretation - Patient And Business:

Jan 91%
Feb 87%
Mar 70%

March (year end) lowest level of compliance all year.

Definition: Completion rate for management/supervisor investigation of workplace incidents/injuries reported by employees in the Safe Reporting Tool. Investigation ensures work related hazards are understood and controlled to prevent incident/injury recurrence.

Target: Target 2012/13: 100%

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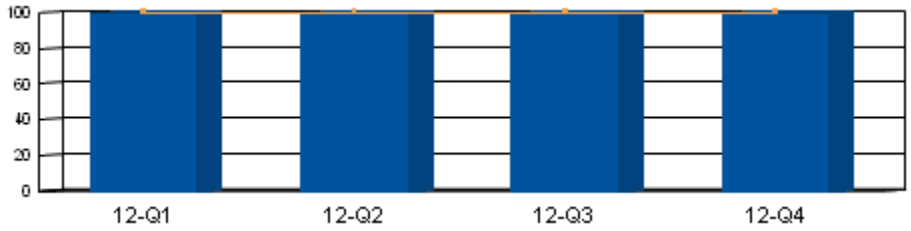
Indicator: OHS - JHSC Monthly Workplace Inspections

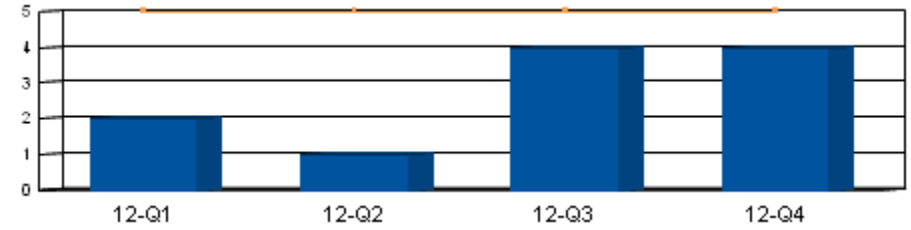


	Actual	Target
12-Q1	100	100
12-Q2	100	100
12-Q3	100	100
12-Q4	100	100

Definition: Compliance by the Joint Health & Safety Committee (JHSC) in the completion of workplace inspections; physical inspections of the workplace are required monthly as per the Occupational Health & Safety Act.

Target: Target 2012/13: 100%

Indicator: OHS - Lost Time Injury/Illness Claims



	Actual	Target
12-Q1	2	5
12-Q2	1	5
12-Q3	4	5
12-Q4	4	5

Interpretation - Patient And Business:

4 LTIs in Q4; 2 were MSIs, 1 was due to an occupational exposure/reaction, and the other was in relation to physical violence.

Total of 11 LTIs for fiscal 2012-13. This is a 56% reduction from fiscal 2011/12 (N= 25 LTI claims).

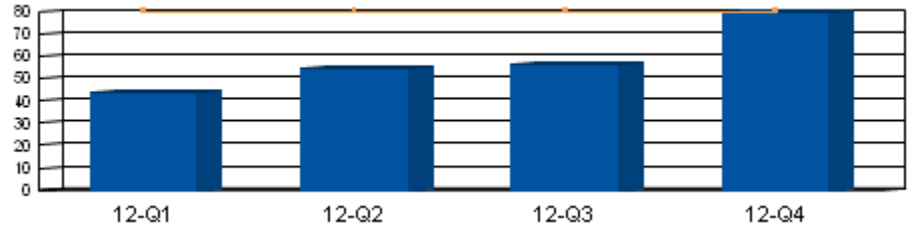
Actions & Monitoring Underway to Improve Performance:

total of

Definition: Number of claims reported to the Workplace Safety & Insurance Board (WSIB) where a worker lost one or more shifts due to any workplace injury or illness, beyond the first day of injury/illness. Not all lost time claims are necessarily approved by the WSIB.

Target: Target 2012/13: <= 19

Indicator: OHS - Management Workplace Inspections



	Actual	Target
12-Q1	44	80
12-Q2	55	80
12-Q3	56	80
12-Q4	80	80

Definition: Management/supervisor compliance in the completion of quarterly inspections required as part of the hospital's Hazard Recognition & Control program.

Target: Target 2012/13: 80%

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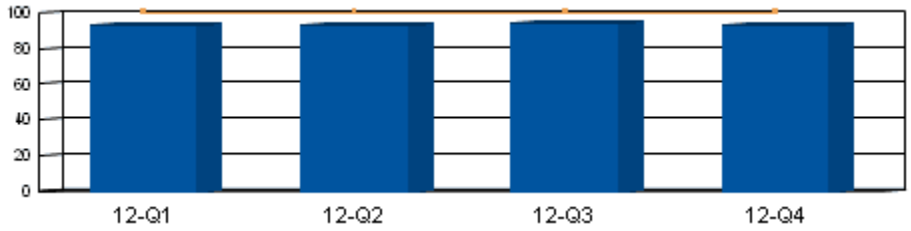
Indicator: OHS - Mandatory Safety Training

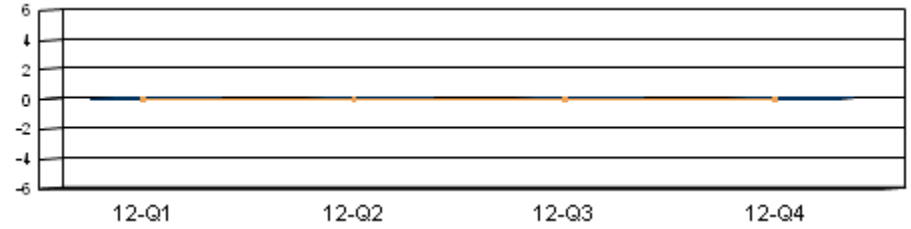


	Actual	Target
12-Q1	93	100
12-Q2	93	100
12-Q3	94	100
12-Q4	93	100

Definition: Employee completion of health & safety training deemed as mandatory; this includes Workplace Violence & Harassment Prevention, Musculoskeletal Injury (MSI) Prevention, and for some workers, WHMIS training.

Target: Target 2012/13: 100%

Indicator: OHS - MOL Reported Critical Injury

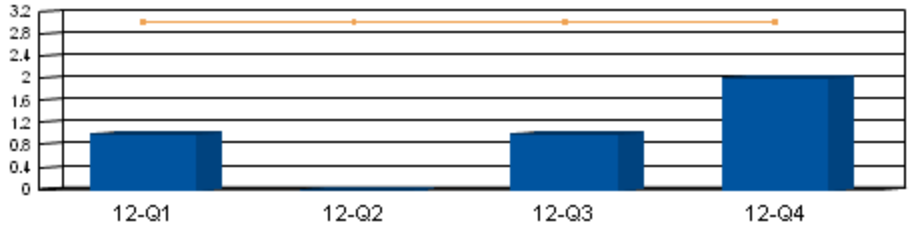


	Actual	Target
12-Q1	0	0
12-Q2	0	0
12-Q3	0	0
12-Q4	0	0

Definition: Injuries that meet the definition of "critical injury" under the Occupational Health & Safety Act that require notice to the Ministry of Labour (MOL).

Target: Target 2012/13: 0

Indicator: OHS - MSI Lost Time Injury Claims (LTIs)



	Actual	Target
12-Q1	1	3
12-Q2	0	3
12-Q3	1	3
12-Q4	2	3

Interpretation - Patient And Business:

2 MSIs resulted in a total of 6 lost work days in Q4.

Total of 4 MSIs resulting in LTI claims for fiscal 2012-13. This is a 73% reduction over fiscal 2011/12 (N= 15)

Definition: Number of claims reported to the Workplace Safety & Insurance Board (WSIB) where a worker lost one or more shifts due to a workplace musculoskeletal injury (MSI), beyond the first day of injury/illness. Not all MSI lost time claims are necessarily approved by the WSIB.

Target: Target 2012/13: 10

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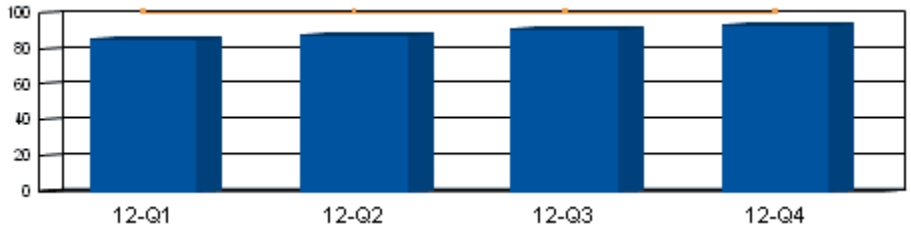
Indicator: OHS - Respirator Fit Testing & Training Completion

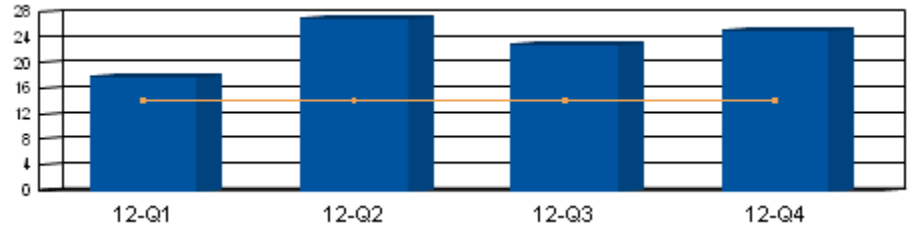


	Actual	Target
12-Q1	85	100
12-Q2	87	100
12-Q3	91	100
12-Q4	93	100

Definition: Completion of employee fit testing and training for those workers who may be required to don a tight fitting respirator as part of their work assignment; is required every 2 years.

Target: Target 2012/13: 100%

Indicator: OHS - WSIB Healthcare Claims



	Actual	Target
12-Q1	18	14
12-Q2	27	14
12-Q3	23	14
12-Q4	25	14

Interpretation - Patient And Business:

Causes are as follows:

Patient handling MSIs- 4
All other MSIs-4
Physical violence-4
Occupational Exposures (meningococcal) -6
Slips/trips/falls- 5
Struck/contact by- 2

Definition: Number of claims reported to the Workplace Safety & Insurance Board (WSIB) where a worker sought health care treatment from a health care provider, as a result of a workplace injury or illness. Excludes first aid and assessments completed as part of the hospital's post exposure surveillance program. Not all health care claims are necessarily approved by the WSIB.

Target: Target 2012/13: <= 54

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Occupational Health and Safety Scorecard

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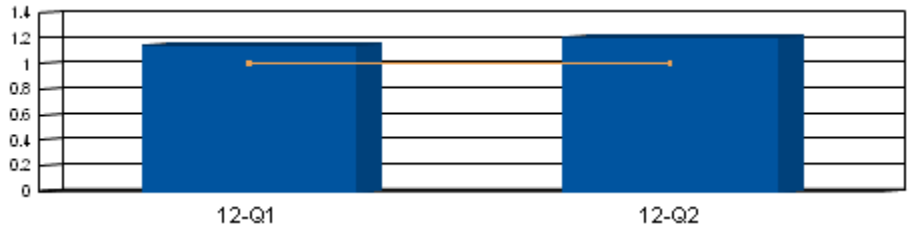
Indicator: OHS - WSIB NEER Performance Index - 2008

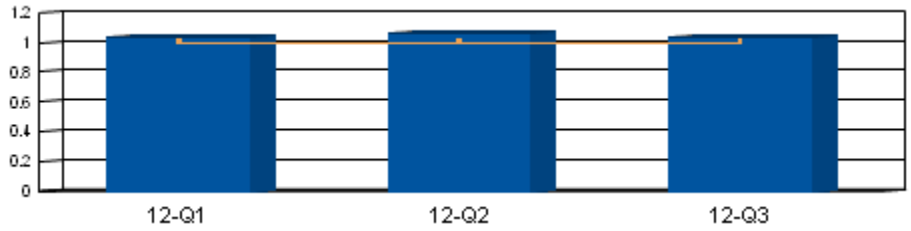


	Actual	Target
12-Q1	1.15	1
12-Q2	1.21	1

Definition: Is an indicator of hospital performance in relation to workplace injury/illness costs; specifically, it is a ratio of actual costs to expected costs; where actual cost are > expected costs, the performance index will be greater than 1; where actual costs are < expected costs, the performance index will be less than 1. Is calculated for previous 4 accident years.

Target: Target 2012/13: < 1

Indicator: OHS - WSIB NEER Performance Index - 2009

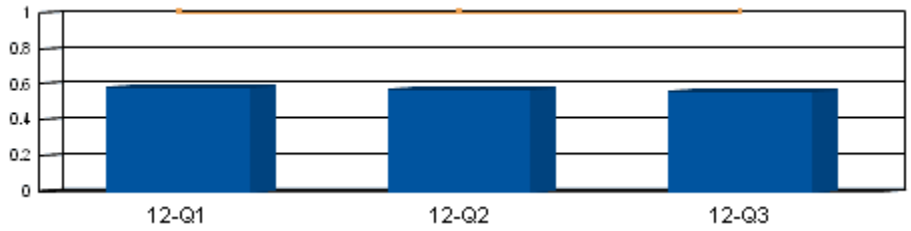


	Actual	Target
12-Q1	1.04	1
12-Q2	1.06	1
12-Q3	1.04	1

Definition: Is an indicator of hospital performance in relation to workplace injury/illness costs; specifically, it is a ratio of actual costs to expected costs; where actual cost are > expected costs, the performance index will be greater than 1; where actual costs are < expected costs, the performance index will be less than 1. Is calculated for previous 4 accident years.

Target: Target 2012/13: < 1

Indicator: OHS - WSIB NEER Performance Index - 2010



	Actual	Target
12-Q1	0.58	1
12-Q2	0.57	1
12-Q3	0.56	1

Definition: Is an indicator of hospital performance in relation to workplace injury/illness costs; specifically, it is a ratio of actual costs to expected cost;; where actual cost are > expected costs, the performance index will be greater than 1; where actual costs are < expected costs, the performance index will be less than 1. Is calculated for previous 4 accident years.

Target: Target 2012/13: < 1

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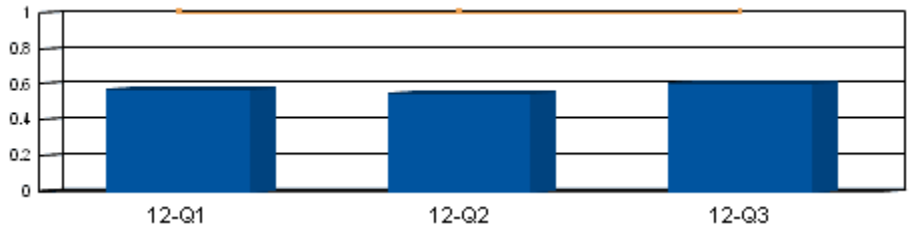
Indicator: OHS - WSIB NEER Performance Index - 2011

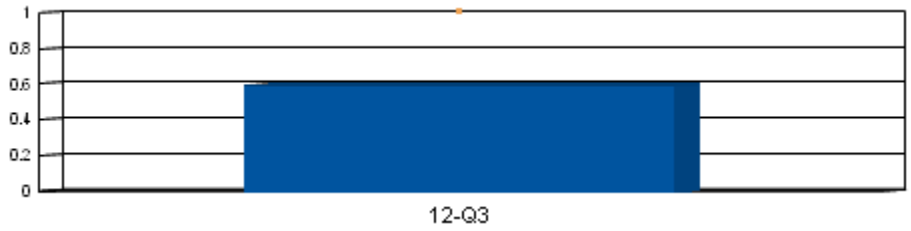


	Actual	Target
12-Q1	0.57	1
12-Q2	0.55	1
12-Q3	0.6	1

Definition: Is an indicator of hospital performance in relation to workplace injury/illness costs; specifically, it is a ratio of actual costs to expected costs; where actual cost are > expected costs, the performance index will be greater than 1; where actual costs are < expected costs, the performance index will be less than 1. Is calculated for previous 4 accident years.

Target: Target 2012/13: < 1

Indicator: OHS - WSIB NEER Performance Index - 2012



	Actual	Target
12-Q3	0.59	1

Definition: Is an indicator of hospital performance in relation to workplace injury/illness costs; specifically, it is a ratio of actual costs to expected costs; where actual cost are > expected costs, the performance index will be greater than 1; where actual costs are < expected costs, the performance index will be less than 1. Is calculated for previous 4 accident years.

Target:

Kingston General Hospital

Occupational Health and Safety Scorecard

Status:

Currently Not Available

	Green-Meet Acceptable Performance Target
	Red-Performance is outside acceptable target range and require
	Yellow-Monitoring Required, performance approaching
	Blue-Project Completed

Glossary Of Acronyms