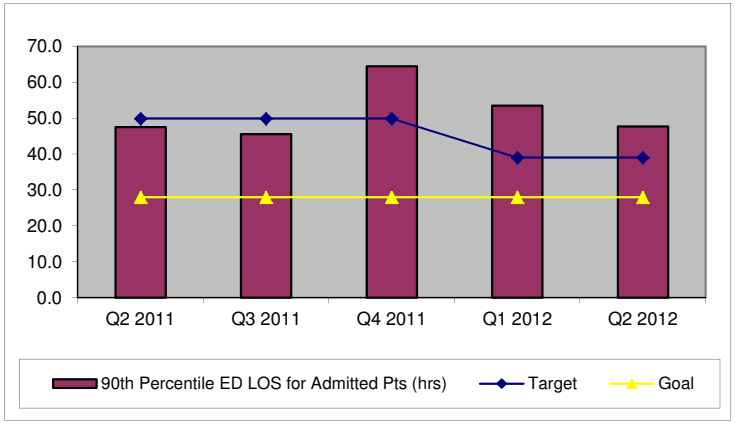
JOSEPH BRANT MEMORIAL HOSPITAL

Strategic Scorecard
Q2 2012/2013
(January 2013)

Core Strategy	Measures	Freq	Current	Previous	Target 2012/13	Goal	Status
Quality / Safety Excellence	Patient Flow (90th Percentile ED LOS for Admitted Patients)	Q	47.7	53.5	<=39.0	<=28.0	R
	Hospital Standard Mortality Ratio	Q	77	76	<=85	<=65	G
	Hand Hygiene Compliance Before Patient Contact	Q	66%	71%	>=85%	1.00	R
	Call Button Response Inpatient Satisfaction	Q	N/A	53.3%	>=70%	100%	R
Exceptional Customer Service	Measures	Freq	Current	Previous	Target	Goal	Status
	Patient Satisfaction - Overall Hospital Recommendation (In-Patient)	Q	N/A	65.1%	>=70%	100%	Y
Inspired People & Teamwork	Measures	Freq	Current	Previous	Target	Goal	Status
	Sick Time (days per employee)	Q	10.5	11.3	8.0	8.0	R
	Injuries On Duty (IOD) Frequency	Q	1.12	2.68	1.00	0.00	Y
Leading Performance	Measures	Freq	Current	Previous	Target	Goal	Status
	Total Operating HSAA Margin	Q	-0.10%	0.04%	-0.34%	0.00%	G
Status	***At or better than target***		***Below Target***		***Not meeting target***		

Performance Measure:	Patient Flow (90th Percentile ED LOS for Admitted Patients)
Success Factor:	Quality & Safety
Period:	Q2 2012/2013

Formula:
90th percentile wait time in hours from triage to left emergency room (ER) for all admitted ER patients.



Data Source: CCO iPort

Description:
90th percentile wait time in hours from triage to left emergency room (ER) for all admitted ER patients.

The target (39 hours) reflects the HSAA year-to-date expectation.

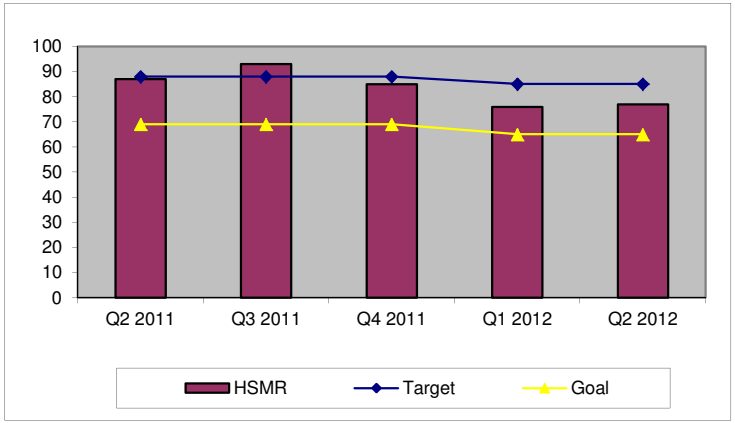
Prior Period	This Period	Target	Trend
53.5	47.7	39.0	Decreasing

Analysis & Progress:
10.4 % reduction in 90th percentile LOS as compared to previous quarter performance.
Total ED volume and % admitted comparable to previous quarter results.
A decrease in ED isolation demands was noted which contributed to enhanced bed flow
This metric is a collective indicator of many factors: patient length of stay on inpatient units, efficient patient movement processes, number of ALC in acute beds hence blocking their turnover, effectiveness of community support programs and CCAC, and overall hospital capacity. Delays or ineffectiveness in any of the above create backlogs in the ED.

Actions:
Identify Q2 12/13 patients with high ED utilization (visit and admission) to identify and create community resource and partnership opportunities to avoid ED visit (compare to11/12 FY results)
Monitor Early Intervention Screener compliance and evaluate effectiveness of early CCAC referral.
Continue to work with external partners to optimize CCAC Rapid Referral and Transition Team resource.
Tracking of projects and impact is daily at the Daily Performance Action Team (DPAT) Meetings held 4 days per week
ED Core Team provides operational and strategic leadership for initiatives

Performance Measure:	Hospital Standard Mortality Rate
Success Factor:	Quality & Safety
Period:	Q2 2012/2013

Formula:
Hospital Standardized Mortality Ratio. Number of observed in hospital deaths over the number of expected in hospital deaths.



Data Source: Canadian Institute for Health Information

Description:

Hospital Standardized Mortality Ratio. Number of observed in hospital deaths over the number of expected in hospital deaths. This indicator is standardized to reflect the current mortality experience in Canada.

Prior Period	This Period	Target	Trend
76	77	85	Decreasing

Analysis & Progress

The HSMR is trending favorably this quarter.

The Canadian Institute for Health Information (CIHI) is changing the methodology used to calculate the HSMR to more accurately reflect improvements in hospitals' HSMR results across Canada. Results from 2011/12 have been recalculated using the new baseline methodology and hospitals have been provided with results for previous quarters using both new and old methodologies (new methodology on scorecard). On a go-forward basis, only results using the new methodology will be provided as of the new reporting year for April 1, 2012. JBMH continues to monitor the HSMR for changes to be able to respond accordingly.

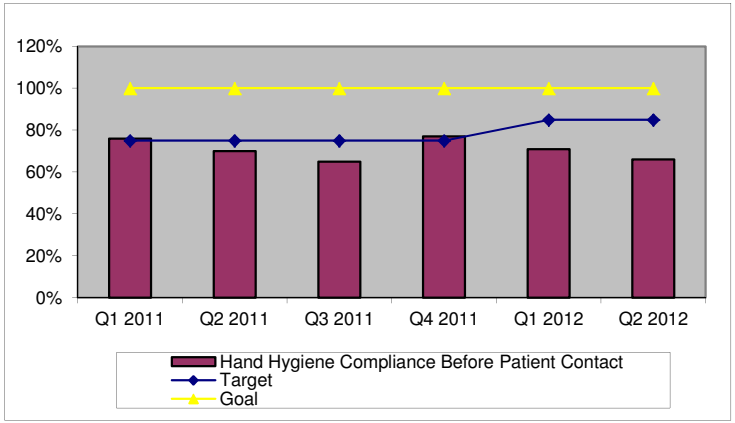
Actions:

A process is being developed to conduct standardized death reviews in all medical departments. Death reviews currently take place, however by standardizing the approach there will be improved comparability from quarter to quarter. This work remains in progress.

Target Date: ongoing

Performance Measure:	Hand Hygiene Compliance Before Patient Contact
Success Factor:	Quality & Safety
Period:	Q2 2012/2013

Formula:
Number of times hand hygiene performed before initial patient contact given number of initial patient contact encounters.



Data Source: Infection Control Audits

Description:

Number of times hand hygiene performed before initial patient contact given number of initial patient contact encounters.

This indicator is one of the four moments in which providers are to perform hand hygiene in order to minimize the spread of infections

Prior Period	This Period	Target	Trend
71%	66%	85%	Decreasing

Analysis & Progress:

Hand hygiene rates before patient contact has declined in this quarter. Sufficient numbers of audits have been performed and trials of electronic technologies to support more rapid data turnaround are in progress. New strategies for weekly reporting of hand hygiene audit results are in place.

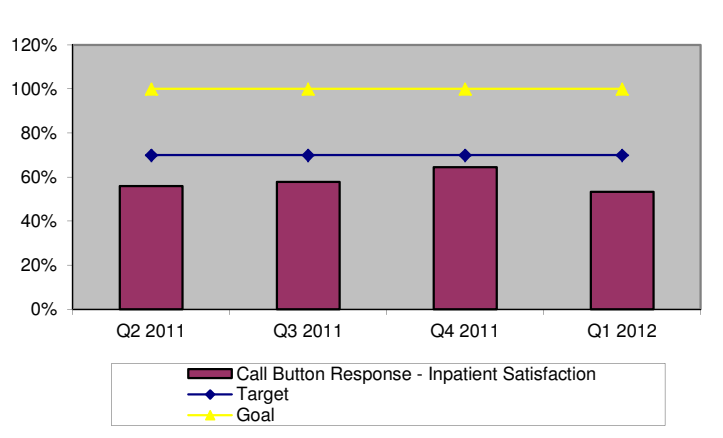
Actions:

Hand hygiene results are regularly reported to the patient care units, Infection Control Committee and MAC. Reports have previously occurred on a quarterly basis with weekly reporting now in place.
A revitalized Steering Committee is now in place to support increased awareness and attention to hand hygiene; and hand hygiene remains a priority on the annual QIP.
The Hand Hygiene Steering Committee with support from Infection Prevention and Control on best practices will continue to drive improvements in hand hygiene results.

Target date: Ongoing

Performance Measure:	Call Button Response Inpatient Satisfaction
Success Factor:	Quality & Safety
Period:	Q2 2012/2013

Formula:
Number "Definitely Yes" responses to patient satisfaction question, "In general, after you used the call button, was the time you waited for help reasonable?" given all surveys.



Data Source: NRC Picker Patient Satisfaction Surveys

Description:
Number "Definitely Yes" responses to patient satisfaction question, "In general, after you used the call button, was the time you waited for help reasonable?" given all surveys.

This indicator contributes to overall inpatient satisfaction which is considered a 'big dot' metric. This is one element of improvement which can contribute to overall patient satisfaction.

Prior Period	This Period	Target	Trend
53.3%	N/A	70%	Increasing

Analysis & Progress:
Due to timing associated with data from NRC Picker Patient Satisfaction Surveys, the results do not reflect interventions in this area. While we continue to trend high level call bell response time satisfacton through NRC Picker Patient Satisfaction Surveys, we are also tracking internal results obtained through a call bell response time improvement initiative. As part of a broader nursing strategy, dedicated support for the ongoing monitoring and review of call bell response time data in more real time will be available in the next quarter.

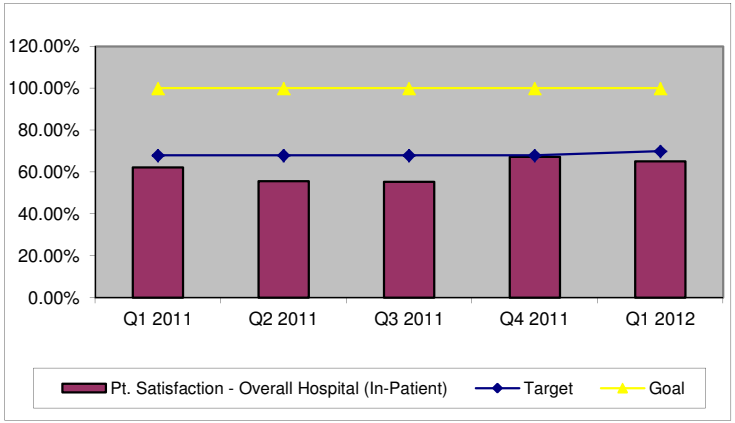
Actions:
Continue to roll-out the call bell response time project through all in patient areas; intentional rounding and communication techniques to provide support to patients and minimize call bell usage.

Lead: Quality and Performance Improvement Specialist

Target Date: ongoing roll-out and measurement of response times post improvement cyclesnication techniques provide support to patients and minimize call bell usage

Performance Measure:	Patient Satisfaction - Overall Hospital (In-Patient)
Success Factor:	Quality & Safety
Period:	Q2 2012/2013

Formula:
Number of “Definitely Yes” responses to patient satisfaction question "Would you recommend this hospital to your friends and family?" given all inpatient surveys.



Data Source: NRC Picker Survey Results

Description:
Number of “Definitely Yes” responses to patient satisfaction question "Would you recommend this hospital to your friends and family?" given all inpatient surveys.

This indicator measures the degree to which patient's are satisifed with their inpatient experience. It takes into account a patient's total experience, from time of admission to time of discharge, and all elements throughout their stay (i.e. cleanliness, care, attitude of providers).

Prior Period	This Period	Target	Trend
65.1%	N/A	70%	Stable

Analysis & Progress:

Scale scores for inpatient results in the categories of “respect for patient preferences” and “coordination of care” remains at or above the Ontario average score; other dimensions remain consistent or show slight improvement. Timing of results from NRC Picker remains an issue as our results are often 2 or 3 quarters behind the current reporting quarter.

Actions:

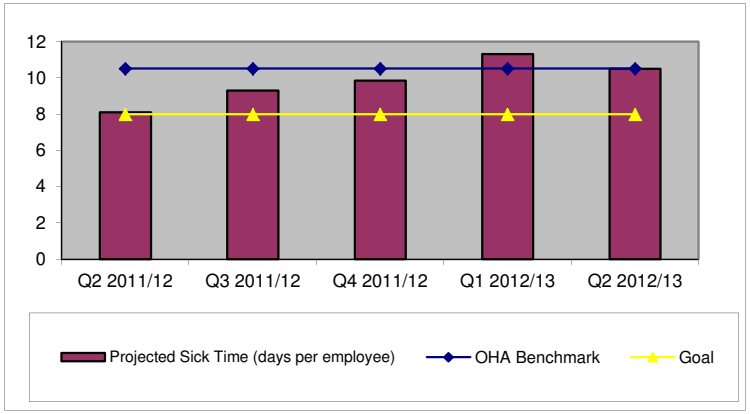
Communication and customer service training has been completed is the Emergency Department and will expand beyond the ED to include all patient care areas to set service expectations.

Leads: Inpatient managers and directors

Target Date: ongoing

Performance Measure: Sick Time (days per employee)
Success Factor: Inspired People & Teamwork
Period: Q2 2012/2013

Formula:
Sick time (days per employee) is calculated by taking the total sick hours over the eligible sick full - time equivalents, divided by 7.5 hours per day. The projection is calculated using the ratio of sick time incurred in prior fiscal year.



Data Source: JBMH Meditech Payroll

Description:
Sick time is measured by average paid days lost per employee. It is an indicator of absenteeism costs and employee engagement. Days lost due to absenteeism leads to replacement costs, overtime costs, lower productivity and an increased risk to quality. With respect to employee engagement, absenteeism is an indicator of the employee's health and well-being, which may be reflective of stress factors in the workplace.

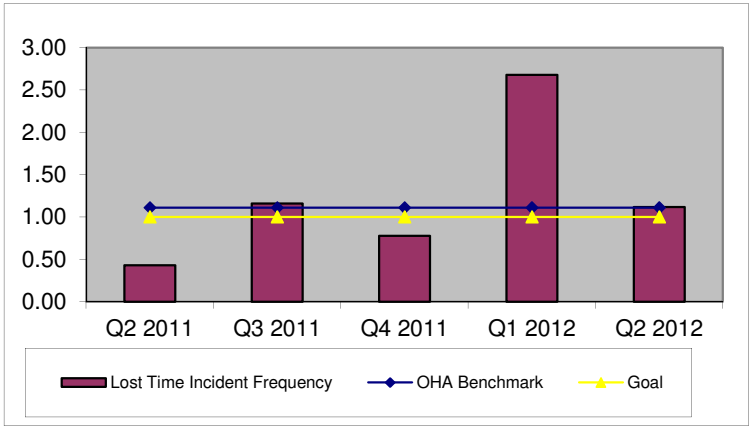
Prior Period	This Period	Goal	Trend
11.3	10.5	8.0	decreasing slightly

Analysis & Progress:
The second quarter of fiscal 2012/13 experienced a decrease of 7% in total sick hours over the previous quarter. The second quarter of fiscal 2012/13 experienced a increase of 23% in total sick hours over the 2nd quarter of the prior year while the number of eligible employees as only increased 6%. This has resulted in a projected sick days per employee of 10.5 days.

Actions:
Since April 1, 2012, the following actions have been taken to meet our sick time corporate target of 8.0 days per employee:
1. Targets – Corporate sick time targets are set by benchmarking to the OHA data.
2. Departmental sick time targets are calculated using a weighted average based on eligible employees in each group.
3. Finance Reporting Tools – quarterly report on sick time absences by employee will be generated and provided to managers/directors to assist with managing attendance on an individual basis.
4. Attendance Management Program & Labour Relations - Provided training to managers/directors on Attendance Management, commenced the process of addressing attendance issues and progressing any sick time abuse issues to the Labour Relations stream more frequently and where required.
5. Action Planning – in conjunction with HR, departments will be developing local action plans implemented, reviewed and updated on a quarterly basis or on an as needed basis.
6. In this FY 12-13, we will have internalized our Occupational Health Department and are exploring a contract with an Occupational Health Physician resulting in consistent, appropriate management of sick absences and in a timely manner.

Performance Measure:	Injuries On Duty (IOD) Frequency
Success Factor:	Inspired People & Teamwork
Period:	Q2 2012/2013

Formula:
The Injury on Duty Frequency Rate (LTIFR) is calculated by multiplying the number of Lost Time Injuries by 200,000 and dividing the product by the number of hours worked



Data Source: JBMH Parklane / JBMH Budget Variance Hours

Description:
The Injury on Duty Frequency Rate (LTIFR) is a safety performance measure of incident or accident prevention and the effectiveness of injury management. These are work-related incidents that require medical treatment and result in time lost from work of one full shift or more. Incidents are not included until the Workmen's Safety Insurance Board (WSIB) confirms they are an approved lost time claim. A safe workplace is a key priority. An injury could have long term detrimental health and psychologica effects on employees and affect their engagement in the workplace. The LTIFR is an indicator of the effectiveness of safe work places and job safety tools. A high LTIFR would require a review and actions to reduce the number of injuries.

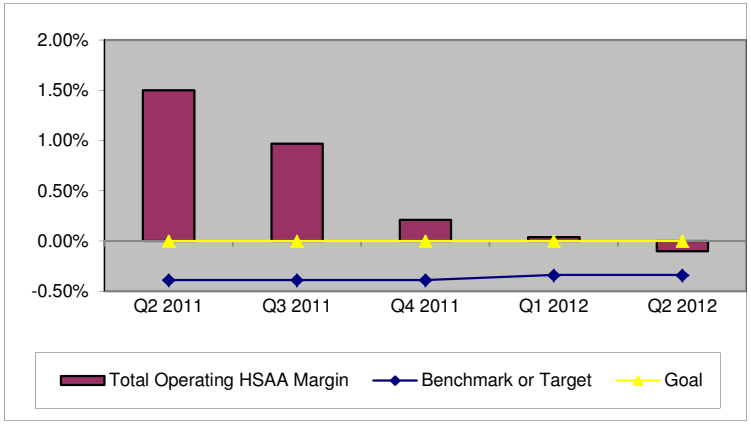
Prior Period	This Period	Goal	Trend
2.68	1.12	1	decreasing

Analysis & Progress:
JBMH's Q2 year to date result of 1.12 indicates a decrease in lost time injuries from 7 injuries in Q1 to 3 injuries in Q2. This can be attributed to the familiarization of the new Employee Heatlth staff with the processes involved and the issues faced by JBMH employees. Further process improvements, the addition of occupational health physician services and the increased knowledge of staff concerns related to disabilities will result in further decreases in the Injury on Duty Frequency Rate.

Actions:
1. Continue the emphasis on Early and Safe Return To Work and Modified Duty strategies.
2. Review improvement opportunities.
3. Investigate the addition of occupational health physician services.
4. Accident investigation training for managers and directors.
5. Continue to challenge WSIB claims.
6. Involve WSIB case managers and WSIB return-to-work specialists in difficult cases.
7. Provide Occupational Health and Safety Certification training to managers and directors.

Performance Measure:	Total Operating HSAA Margin
Success Factor:	Leading Performance
Period:	Q2 2012/2013

Formula:
Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.



Data Source: JBMH Quaterly HAPS Submission

Description:
Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense on a cumulative basis, excluding the impact of facility amortization, in a given year.

This indicator measures our operating financial performance and is considered a 'big dot' indicator that is monitored by the LHIN and internal stakeholders. Unforeseen changes in either operating expenditures or funding will impact this metric.

Prior Period	This Period	Target	Trend
0.04%	-0.10%	-0.34%	In line with budgeted target

Analysis & Progress:

The YTD Margin for Q2 was -0.10% and Q1 was 0.04% in 2012/13. Financial performance is being monitored closely by the departments and JBMH is expecting to meet the H-SAA budgeted margin of -0.34%.

Actions:
The total operating H-SAA margin is monitored on a monthly basis. Mitigating strategies include discussions with internal and external stakeholders to ensure results remain on target.

Leads: FInance and Decision Support

TImelnes: Ongoing