JOSEPH BRANT MEMORIAL HOSPITAL

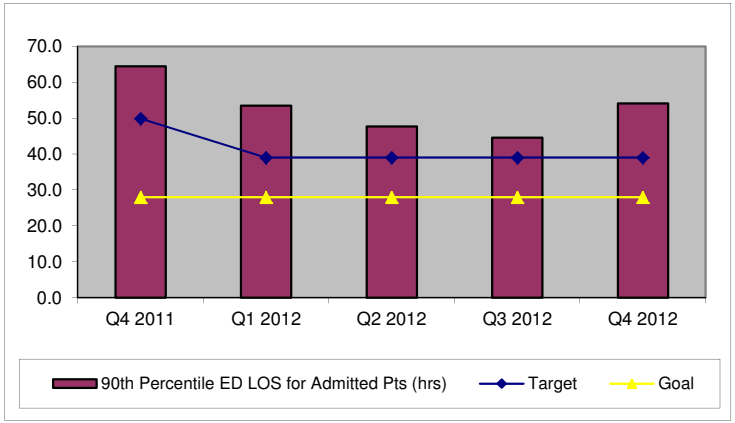
Strategic Scorecard
Q4 2012/2013
(May 2013)

Core Strategy	Measures	Freq	Current	Previous	Target 2012/13	Goal	Status
Quality / Safety Excellence	Patient Flow (90th Percentile ED LOS for Admitted Patients)	Q	54.1	44.6	<=39.0	<=28.0	R
	Hospital Standard Mortality Ratio	Q	82	79	<=85	<=65	G
	Hand Hygiene Compliance Before Patient Contact	Q	86%	84%	>=85%	1.00	G
	Call Button Response Inpatient Satisfaction	Q	N/A	58.8%	>=70%	100%	R
Exceptional Customer Service	Measures	Freq	Current	Previous	Target	Goal	Status
	Patient Satisfaction - Overall Hospital Recommendation (In-Patient)	Q	N/A	58.0%	>=70%	100%	R
Inspired People & Teamwork	Measures	Freq	Current	Previous	Target	Goal	Status
	Sick Time (days per employee)	Q	9.8	10.0	8.0	8.0	R
	Injuries On Duty (IOD) Frequency	Q	1.17	0.00	1.00	0.00	R
Leading Performance	Measures	Freq	Current	Previous	Target	Goal	Status
	Total Operating HSAA Margin	Q	0.29%	0.24%	-0.34%	0.00%	G
Innovation	Measures	Freq	Current	Previous	Target	Goal	Status
	To be revised						

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:	Q4 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 (Q4 is subject to data refresh for Jan 2013 corrections)

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
44.6	54.1	39.0	Increasing

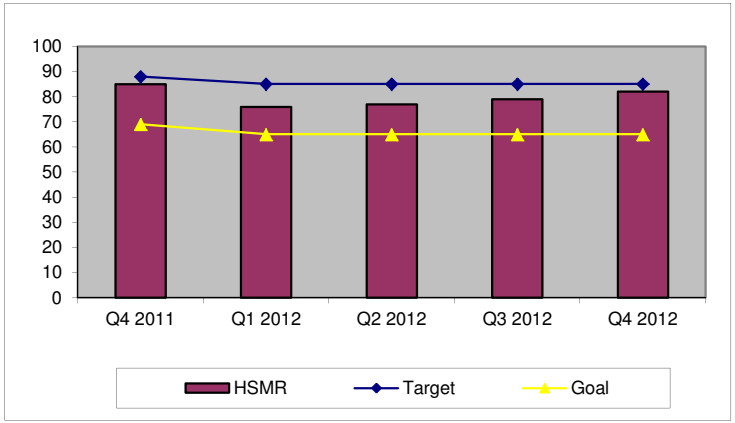
Analysis & Progress:
Results demonstrate a 21.3% increase in 90th percentile admitted LOS as compared to previous quarter performance. A discrepancy was noted in our internal metric reporting for January 2013 that is being rectified through CCO data re-submission but is reflected in this rate.
A 23.4% increase was seen this quarter in patients requiring isolation precautions in ED. The results demonstrate the highest isolation burden seen in Fiscal Year 12/13. The isolation challenges resulted in delayed patient flow for the admitted isolated and non-isolated patient. In January 2013, 3 patient care units were also in outbreak status which negatively contributed to organizational patient 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 , 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:

Demonstrate reduction in visit presentation and/or admission volume for patients connected with Rapid Response Transition Team as identified in ED frequent user review.
Partner with CCAC to measure admission avoidance impact of implementation of ED RAI screener during nursing primary assessment. Identify opportunities to increase referrals.
Audit triage classifications to ensure right patient is streamed to right service area and seen according to true triage classification.
Review and revise organizational bed management policy. Implement “Take One” strategy in to routine operations.
Sustain dedicated ED physician in EMAaT to continue to positively influence ED performance metrics and patient experience.

Performance Measure:	Hospital Standard Mortality Rate
Success Factor:	Quality & Safety
Period:	Q4 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
79	82	85	Stable

Analysis & Progress

The HSMR remains below target for 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.

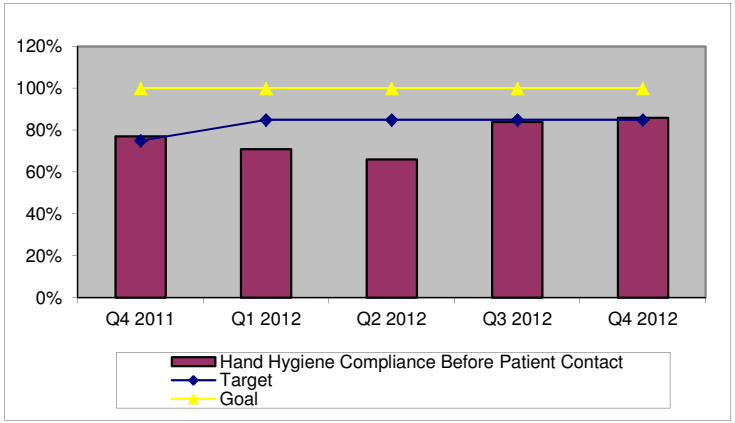
Actions:

Departmental death reviews and reviews of high harm incidents take place for learning and applications of best practices in the management of patient care.

Target Date: ongoing

Performance Measure:	Hand Hygiene Compliance Before Patient Contact
Success Factor:	Quality & Safety
Period:	Q4 2012/13

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
84%	86%	85%	Increasing

Analysis & Progress:

Hand hygiene rates before patient contact has increased in this quarter and is above target. Weekly reporting of hand hygiene results before patient contact at the Quality Wall has been a significant driver behind this improved performance. The Hand Hygiene Steering Committee has also implemented numerous strategies to engage staff and patients in required hand hygiene practices.

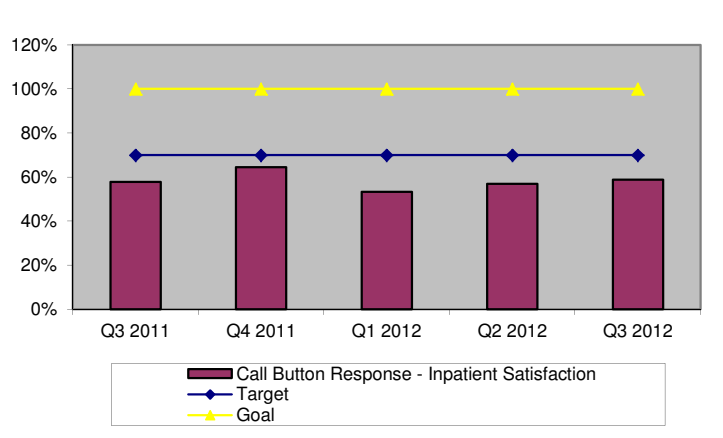
Actions:

Hand hygiene results are regularly reported to the patient care units, Infection Control Committee and MAC. Weekly reporting at the centralized Quality Wall and on patient care units is 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 Controlwill continue to drive improvements and best practices in hand hygiene so results exceed targets.

Target date: Ongoing

Performance Measure:	Call Button Response Inpatient Satisfaction
Success Factor:	Quality & Safety
Period:	Q4 2012/13

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
58.8%	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. NRC Picker results for call bell wait times being reasonable improved by 1.8% over Q2.

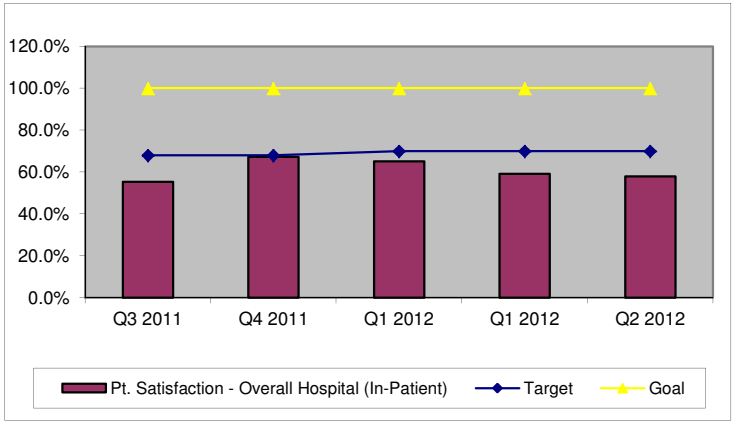
Actions:
Continue to roll-out the call bell response time project through all in patient areas; intentional rounding and communication techniques to provide support to patients and minimize call bell usage.

Lead: Quality and Performance Improvement Specialist

Target Date: ongoing roll-out and measurement of response times post improvement cycles

Performance Measure:	Patient Satisfaction - Overall Hospital (In-Patient)
Success Factor:	Quality & Safety
Period:	Q4 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
58.0%	N/A	70%	Decreasing

Analysis & Progress:

"Big dot" indicator scores for inpatient results in the categories of "all dimensions of care combined: and "overall rating of care" remain within the Ontario Community Hosptial Average (OCHA) score. Scale scores for other dimensions show similar consistency and remain within the OCHA as well. Timing of results from NRC Picker remains an issue as our results are often 2 or 3 quarters behind the current reporting quarter.

Actions:

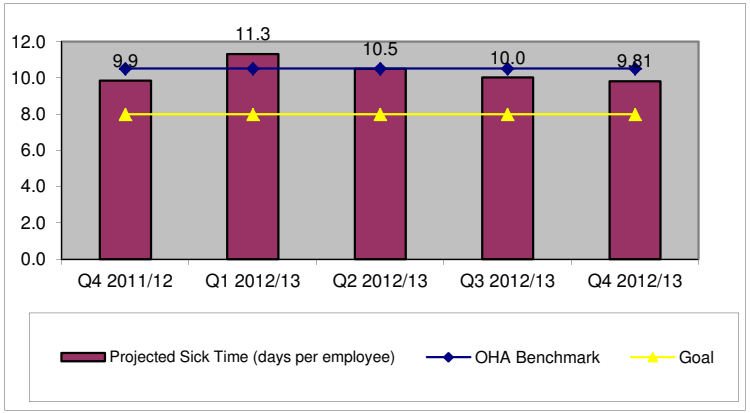
Communication and customer service training has been completed is the Emergency Department and will expand beyond the ED to include all patient care areas to set service expectations.

Leads: Inpatient managers and directors

Target Date: ongoing

Performance Measure: Sick Time (days per employee)
Success Factor: Inspired People & Teamwork
Period: Q4 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.

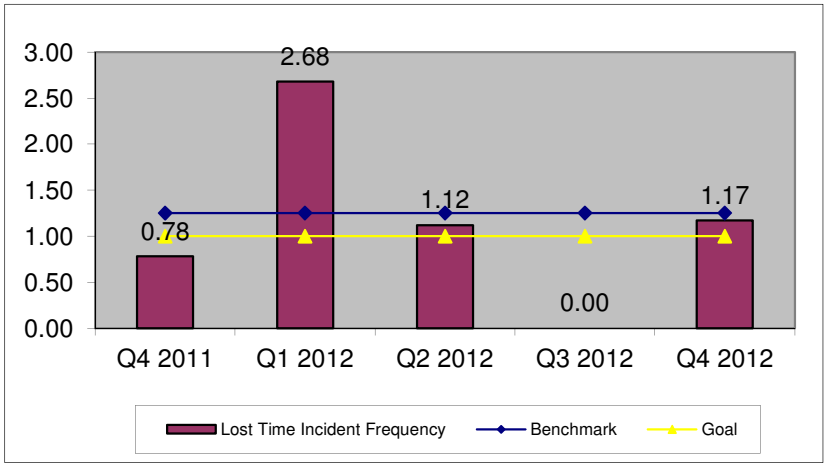
Prior Period	This Period	Goal	Trend
10.0	9.81	8.0	decreasing slightly

Analysis & Progress:
With 2011/12 quarterly results at 9.3, 8.1, 9.3 and 9.9 respectively, 2012/13 results are slightly worse year of year with Q4 being an exception. The fourth quarter of fiscal 2012/13 experienced a decrease of 2% in total sick hours over the previous quarter. This decrease should be considered favourable due to the fact that Q3 and Q4 fall within the traditional flu season at JBH. In particular, the past flu season resulted in more reported cases of flu than in the previous two years. The majority , more than 80%, of the total sick days per employee are between 1-3 days in length. The remaining 20% represent severe long term illness usually in excess of 7 or more days.

Actions:
The following actions have been taken to meet our sick time corporate target of 8.0 days per employee:
1. In March 2013, the "Attendance Policy" was reviewed by Operations Committee and SLT and enhancements made to the "Sick Time Reporting Procedure". These changes improved employee and manager accountability through direct phone contact at the time of the sick call - *Completed.*
2. Accountability checklists and a variety of Attendence Awareness tools were created to support the managers when meeting with employees.- *Completed.*
3. Human resource Business Partners attend Steps 2 and 3 of our AAP to support the managers to change employee behaviour. - *Implemented.*
4. Human resources has added a Physician trained specifically in Occupational Health medicine to support our in-house Employee Health Specialist/Nurses.- *Completed.*
5. Targets – Corporate sick time targets are set by benchmarking to the OHA data. - *Completed.*
6. Departmental sick time targets are calculated using a weighted average based on eligible employees in each group. - *Completed.*
7. 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. - *Implemented*
8. 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. - *Implemented*
9. In February 2013, all Directors began to report out on sick time on a weekly basis at our Quality Wall presentations. This has significaltly improved accountability and visibility of this metric. - *Implemented*

Performance Measure: Injuries On Duty (IOD) Frequency
Success Factor: Inspired People & Teamwork
Period: Q4 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: JBH Parklane / JBH 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 Workplace 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.

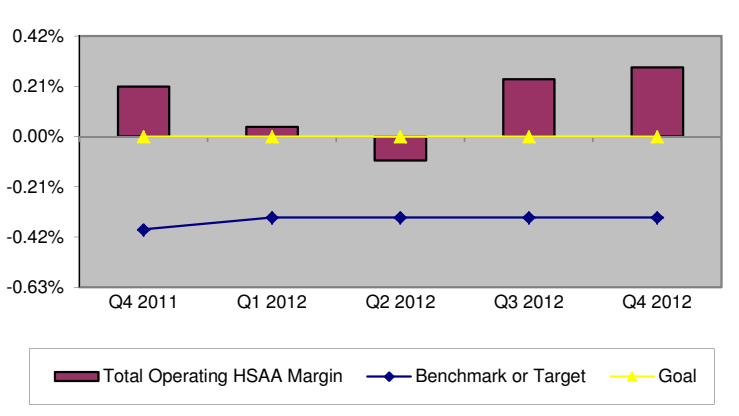
Prior Period	This Period	Target	Trend
0.00	1.17	1	Increasing

Analysis & Progress:
JBH's Q4 result of 1.17 represents a 3 month period with 3 lost time incidents. Two of the three incidents involved non-occupational underlying conditions. The final Year-To-Date LTIFR for 2012/13 is 1.2, 0.4 greater than 2011/12 and representing an increase of 5 lost time injuries year over year. For 2011/12, quarterly results were 0.78, 0.43, 1.16, and 0.78 respectively. A trend analysis over the last two years shows fairly consistent results with normal variability ranging between 0 to 3 lost time injuries, with the exception of Q1 with 7 lost time injuries, due to the transition of staff in the Employee Health Services office. The department moved from an agency staffed model to an internally staffed model in order to improve accountability. For 2012/13, majority of the lost time injuries (46%) were attributable to musculoskeletal injuries.

Actions:
1. Continue the emphasis on Early and Safe Return To Work and Modified Duty strategies - *Implemented.*
2. Investigate the addition of occupational health physician services. In December 2012, we hired Dr. Michael Markus, Consultant in Occupational Medicine. - *Implemented.*
3. Accident investigation training for managers and directors - *Completed.*
4. Continue to challenge questionable WSIB claims - *Implemented.*
5. Involve WSIB case managers and WSIB return-to-work specialists in difficult cases. - *Implemented.*
6. Provide Occupational Health and Safety Certification training to managers and directors - *Implemented as required.*

Performance Measure:	Total Operating HSAA Margin
Success Factor:	Leading Performance
Period:	Q4 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: JBH 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
0.24%	0.29%	-0.34%	Exceeded budgeted target

Analysis & Progress:

The 2012/13 YTD H-SAA Margin for Q4 was 0.29% and Q3 was 0.24%. Financial performance continued to improve during the last quarter of the fiscal year as ongoing monitoring and management by all programs ensued. JBH has met the annual 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