



		Fiscal Year: April 1, 2011 to March 31, 2012				
#	Metric	Target	Q1	Q2	Q3	Q4
#1 Defining What we Do	% of milestones completed for a process to articulate a new vision of ambulatory care at HDH	100% by March 31, 2012	N/A	N/A		
	<b>Comments:</b> Project Charter developed. 8 outcomes have been defined; all outcomes are expected to be completed in Q4.					
#2 Excellent Care, Excellent Experience	% patients who would recommend HDH to others	75%	50.0%	Data Not Available		
	Overall quality of care - % positive score	84%	87.5%	Data Not Available		
	<b>Comments:</b> 50% of patients responded that they would "definitely" recommend HDH. 46% responded they would "probably" recommend HDH.					
#3 Enabling and Developing our People	Voluntary turnover rate	4.5 - 6%	4.6%	5.25%		
	Employee/Physician Engagement survey indicator	Survey was mailed to Staff and Physicians on October 21st 2011.	Data not available.	Data not available.		
	% staff completing patient safety education	75% by March 31, 2012	19%	28.0%		
	<b>Comments:</b> Patient Safety 101 course released June 2011. Quarterly milestones: Q1= 20%; Q2 = 40%; Q3 = 60%; Q4 = 75%					
#4 Advancing Research & Education	% of milestones completed for the development of a research institute	100%				
	<b>Comments:</b> 2 of 2 milestones scheduled for completion in Q1 were achieved; 0 milestones were scheduled for completion in Q2; 3 milestones are scheduled for completion in Q3 and 5 milestones in Q4.					
#5 Enhancing Performance, Accountability & Quality	Total Margin	>0%	-1.7%	-0.09		
	Current Ratio	>0.46	0.46	0.45		
	Reinvestment in assets	>9 % by March 31, 2012	1.9%	4.5%		
	% RCA conducted on all Severity level 3 and 4 events as required	75%	N/A	100%		
	% RCA recommendations implemented	75%	N/A	95%		
	Operating Margin on track with budget	Green = 0 to -.15% Yellow = -0.16% to -0.39%; Red = > -0.4%				
<b>Comments:</b> 2 Level 3 events reported in Q1. Neither required RCA.						
#6 Purposeful Partnerships	% of existing partnerships documented and evaluated using criteria	100% by March 31, 2012	Data not available	Data not available		
	<b>Comments:</b> Draft inventory of partnerships completed					

## HDH Scorecard Definitions

### Definitions

#### **Metric**

Each metric measures a key element in relation to achievement of a particular strategic direction

#### **Data Source**

<b>Defining What We Do</b>	<p><b>% of milestones completed for a process to articulate a new vision of ambulatory care at HDH</b></p> <p>Measures progress towards the completion of a process to articulate a new vision of ambulatory care</p> <p>The calculation is defined as predetermined milestones that have been completed</p> <p>Example: 40% of the milestones have been completed</p> <p>This is a measure focusing on the completion of the process required to develop a new vision of ambulatory care</p>	Project
<b>Excellent Care, Excellent Experience</b>	<p><b>% of patients who would recommend HDH to others.</b></p> <p>Measures that we are providing services that patients would recommend to others</p> <p>Green = 75% or higher; Yellow = 71.5% - 74.9%; Red = &lt;75%</p> <p>The calculation is defined as the percentage of patients who answer "definitely yes" to the question "would you recommend HDH?" (NRC Picker Survey).</p> <p>Example: 80% of patients would recommend HDH to others</p>	NRC Picker
	<p><b>Overall quality of care - % positive score</b></p> <p>Measures the percentage of respondents that rate the overall quality of care as positive (NRC Picker Survey).</p> <p>Green = 84% or higher; Yellow = 79.8% - 83.9%; Red = &lt;79.8%</p> <p>This calculation is defined as the percentage of patients who indicate "good", "very good" or "excellent" on the question, "Overall, how would you rate the quality of care received?"(NRC Picker Survey ).</p> <p>Example: 85% of patients gave a positive rating to the quality of care received</p> <p>Target - based on Ontario Teaching Hospital average for 2010-11</p> <p><i>Exception</i></p> <p><i>Explanation of any exceptions to target (colour coded yellow or red)</i></p>	NRC Picker
<b>Enabling and Developing our People</b>	<p><b>Voluntary turnover rate</b></p> <p>Measure is considered to be a proxy for employee satisfaction</p> <p>The calculation is a % defined as the # of employees leaving voluntarily divided by total employees x 100</p> <p>Example: the turnover rate was 5%</p> <p>The benchmark is the OHA sponsored PWC Saratoga HR survey. The HDH target of 4.5% - 6% reflects the 10th - 25th percentile of responses.</p> <p><i>Exception</i></p> <p><i>Explanation of any exceptions to target (colour coded yellow or red)</i></p>	HRIS
	<p><b>Employee/Physician Engagement survey indicator</b></p> <p>Measure is considered to be a proxy for employee satisfaction</p> <p>Calculation TBD</p> <p>Example: the engagement indicator was 60%</p> <p>HDH intends to conduct the first iteration of this survey in October and expect to have results in November/Devenber. Survey will provide benchmarking opportunities.</p> <p><i>Exception</i></p> <p><i>Explanation of any exceptions to target (colour coded yellow or red)</i></p>	
	<p><b>% of staff completing patient safety education</b></p> <p>Measures that staff are completing required patient safety education</p> <p>Target for Q1 = 20%; Q2 = 40%; Q3 = 60%; Q4 = 75%; Green = target achieved; Yellow = Target - 10% lower than target; Red = &gt; 10% from target</p> <p>The calculation is defined as the number of people completing patient safety education courses divided by the number of staff that have been assigned patient safety education courses.</p> <p>Example: 60% of staff have completed required patient safety education.</p> <p><i>Exception</i></p> <p><i>Explanation of any exceptions to target (colour coded yellow or red)</i></p>	LMS
<b>Advancing Research &amp; Education</b>	<p><b>% of milestones for each quarter completed for the development of a research institute</b></p> <p>Measures progress towards the completion of the development of a research institute. There are 10 milestones: 2 for completion in Q1; 3 in Q3 and 5 in Q4</p> <p>The calculation is defined as predetermined elements of the development of the research institute that have been completed</p> <p>Example: 40% of the development has been completed</p> <p>This is a measure focusing on the development of the research institute</p> <p><i>Exception</i></p> <p><i>Explanation of any exceptions to target (colour coded yellow or red)</i></p>	Project

## HDH Scorecard Definitions

<b>Enhancing Performance, Accountability &amp; Quality</b>	<b>Total Margin</b>	<p>Measures that the hospital is not operating a deficit, which is not allowed under the HSAA.</p> <p>The calculation is defined as the Revenue from hospital operations plus other votes divided by the Expenses from hospital operations (MIS calculation provided by the LHIN). Is typically expressed as a %.</p> <p>Example: Any year-end operating deficit would be a negative total margin</p> <p>This is a measure indicating compliance with the HSAA and is strategic in the sense that deficits are not sustainable.</p>	GP
	<i>Exception</i>	<i>Explanation of any exceptions to target (colour coded yellow or red)</i>	
	<b>Current Ratio</b>	<p>Measure is similar to working capital. Working capital is a \$ amount whereas current ratio is a ratio of current assets divided by current liabilities.</p> <p>The calculation is defined as the ratio of current assets divided by current liabilities. Most organizations have a current ratio greater than 1. A current ratio less than 1 indicates that an organization may not have sufficient funds to meet its short term obligations.</p> <p>Example: A current ratio of .35 means that an organization only has \$.35 in short term assets to meet each \$1.00 of short term obligations, which is not desirable.</p> <p>This is a measure indicating compliance with the HSAA and is strategic in the sense that the finance position of a hospital needs to be sustainable.</p>	GP
	<i>Exception</i>	<i>Explanation of any exceptions to target (colour coded yellow or red)</i>	
	<b>Reinvestment in assets</b>	<p>Measures that the hospital is making sufficient investments in its equipment and infrastructure.</p> <p>The calculation is defined as the % of annual investment divided by the total asset base of the hospital, and should be sufficient to keep the asset base intact and keep pace with the amortization of the asset base, especially in regards to medical equipment and IT infrastructure. Building structures typically have a longer useful life than the amortization rate.</p> <p>Example: If a hospital invested \$2M and had an asset base of \$100M, it would be investing at the rate of 2%.</p> <p>This is a measure of a hospitals ability to maintain its equipment and building infrastructure.</p>	GP
<i>Exception</i>	<i>Explanation of any exceptions to target (colour coded yellow or red)</i>		
	<b>% Root Cause Analyses (RCA) conducted on all Severity level 3 and 4 events.</b>	<p>Measures that the hospital analyzes contributing factors and causes of serious and critical events</p> <p>The calculation is defined as the # of RCA conducted (when appropriate)/ the # of Actual Serious (Level 3) and Critical (Level 4) Events X 100 in this quarter</p> <p>Green = 75% or more; Red = performance lower than this; Green is assigned when there were no reported events that warranted RCA</p> <p>Example: A review to determine root causes and contributing factors was conducted on 80% of Level 3 and 4 adverse events.</p> <p>This is a measure of the hospital's commitment to learn from adverse events in order to prevent similar events from occurring again.</p>	SAFE
	<i>Exception</i>	<i>Explanation of any exceptions to target (colour coded yellow or red)</i>	
	<b>% RCA recommendations implemented</b>	<p>It measures the extent to which endorsed recommendations have been acted upon in the current fiscal year.</p> <p>Green = 75% or more; Red = performance lower than this; Green is assigned when there were no reported events requiring RCA or generating recommendations</p> <p>The calculation is defined as the % of endorsed recommendations from RCAs that have been implemented in this fiscal year.</p> <p>Example: 80% of RCA recommendations made in Fiscal 11-12 have been implemented so far.</p> <p>This is a measure of the recommendations to improve safety that have been implemented.</p>	SAFE
<i>Exception</i>	<i>Explanation of any exceptions to target (colour coded yellow or red)</i>		
<b>Purposeful Partnerships</b>	<b>% of existing partnerships documented and evaluated using criteria</b>	<p>Measures that current partnership arrangements have been documented and reviewed against criteria</p> <p>The calculation is defined as the # of partnerships reviewed against criteria divided by the total # of partnerships documented</p> <p>Example: 80% of partnerships documented have been reviewed against criteria.</p> <p>This is a measure that indicates the number a partnerships measured against criteria, criteria which would indicate the positive nature of a particular partnership arrangement.</p>	Project
<i>Exception</i>	<i>Explanation of any exceptions to target (colour coded yellow or red)</i>		

## HDH Quality Improvement Plan Definitions

<u>Definitions</u>	<u>Metric:</u>	Each metric measures a key element in relation to achievement of a particular strategic direction	<u>Data Source</u>
<b>Safety</b>	<b>Hand hygiene compliance before patient contact</b>	Measures progress towards the completion of a process to articulate a new vision of ambulatory care  The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - 2009/10, consistent with publicly reportable patient safety data.  <i>Exception</i>	Project
	<b>Medical Reconciliation</b>	Measure is # of eligible clients receiving services in the quarter and receiving formal medication reconciliation divided by total # of eligible clients who have been admitted to the service for the quarter. The target at HDH  <i>Exception</i>	
<b>Effectiveness</b>	<b>Total Margin</b>	Measures that the hospital is not operating a deficit, which is not allowed under the HSAA.  The calculation is defined as the Revenue from hospital operations plus other votes divided by the Expenses from hospital operations plus other votes (MIS calculation provided by the LHIN). Is typically expressed as a %.  <i>Example</i> : Any year-end operating deficit would be a negative total margin  This is a measure indicating compliance with the HSAA and is strategic in the sense that deficits are not sustainable.  <i>Exception</i>	GP
<b>Access</b>	<b>UCC Wait Time: 90% UCC LOS for non-admitted low acuity (CTAS 4,5)</b>	Measures the LOS where 9 out of 10 non-admitted uncomplicated patients (CTAS 4 and 5) completed their visits  <i>Example</i> : 90% of non-admitted patients with CTAS Levels 4 and 5 are treated within 5.8 hours  <i>Explanation of any exceptions to target (colour coded yellow or red)</i>	NACRS, CIHI
	<b>UCC Wait Time: 90% UCC LOS for non-admitted low acuity (CTAS 1,2,3)</b>	Measures the LOS where 9 out of 10 non-admitted complex patients (CTAS 1,2, and 3) completed their visits  <i>Example</i> : 90% of non-admitted patients with CTAS Levels 1, 2, and 3 are treated within 10.3 hours  <i>Explanation of any exceptions to target (colour coded yellow or red)</i>	NACRS, CIHI
	<b>Cataract Surgery : 90% wait time</b>	<i>Explanation of any exceptions to target (colour coded yellow or red)</i>  Measures time between a patient's and surgeon's decision to proceed with surgery and the time the procedure is conducted. The 90% is the point at which 90% of patients received their treatment while the other 10% waited longer. The 90% is an actual time and is not estimated.  <i>Example</i> : 90% of patients underwent cataract surgery within 97 days of the decision to proceed.  <i>Exception</i>	NACRS, CIHI
	<b>Hip Surgery: 90% wait time</b>	Measures time between a patient's and surgeon's decision to proceed with surgery and the time the procedure is conducted.  <i>Example</i> : 90% of patients underwent hip surgery within 127 days of the decision to proceed.  <i>Exception</i>	
	<b>Knee Surgery: 90% wait time</b>	Measures time between a patient's and surgeon's decision to proceed with surgery and the time the procedure is conducted.  <i>Example</i> : 90% of patients underwent knee surgery within 123 days of the decision to proceed.  <i>Exception</i>	
	<b>CT Scan: 90% wait time</b>	Measures wait time from when a diagnostic scan is ordered until the exam is conducted. This interval is  <i>Example</i> : 90% of patients received their CT scan with 29 days.  <i>Exception</i>	
	<b>Patient Centred</b>	% patients who would recommend HDH to others  <i>Exception</i>	Measures that we are providing services that patients would recommend to others Green = 75% or higher; Yellow = 71.5% - 74.9%; Red = <75% The calculation is defined as the percentage of patients who answer "definitely yes" to the question "would you recommend this hospital to others?"  <i>Example</i> : 80% of patients would recommend HDH to others  <i>Explanation of any exceptions to target (colour coded yellow or red)</i>