CAPITAL HEALTH’S STRATEGIC INDICATORS REPORT
January 2013

Prepared for the Board of Directors and the Quality and Patient Safety Committee of the Board
Prepared by Decision Support
January 28, 2013
1 Table of Contents and Indicator Summary

The indicators in this report are summarized in the table below. A short description of the current status is also provided. Note the icons below used in the summary. A summary that is specific to the progress towards the 2012/13 targets of the 2013 Milestones (updated December 2012) can be found in Appendix A. A summary of indicators related to patient safety can be found in Appendix B and a summary of indicators related to access (wait times) can be found in Appendix C.

- ✔ Meeting target or on track to meet target
- ✖ Not meeting or will not meet target
- △ Caution – needs work to meet target
- ➡ Trending toward target
- ✭ New to the current version of the report
- ◆ Being tracked but with no established target or standard.

*Click on an indicator name to go directly to that section*

<table>
<thead>
<tr>
<th>Target</th>
<th>Indicator Name</th>
<th>Status / Comment</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td>Elimination of Shadow Charts</td>
<td>Shadow chart elimination increased from 29% in Q1 to 30% in Q2, but is still short of the 2012/13 target of 100%.</td>
<td>10</td>
</tr>
<tr>
<td>✖</td>
<td>Surgery Cancellation Rates</td>
<td>For Apr.–Nov. 2012, the average monthly resource-related cancellation rate was 1.9%. This falls just short of the 2012/13 target of 1.7%</td>
<td>11</td>
</tr>
<tr>
<td>✖</td>
<td>Wait Times - Elective CT</td>
<td>The average wait time for November 2012 was 30 days—just over the 28-day target. The wait has been at or below the target for the previous four months.</td>
<td>14</td>
</tr>
<tr>
<td>✖</td>
<td>Wait Times - Elective MRI</td>
<td>In November 2012, the average wait time for MRI was 226 days—just over eight times longer than the target of 28 days.</td>
<td>16</td>
</tr>
<tr>
<td>✔ ✔</td>
<td>Wait Times - Radiotherapy Treatment</td>
<td>Not meeting target for intermediate cases, but these are showing improvement. Urgent cases were better than target for the months of May to September 2012 and slightly short of the target for October and November.</td>
<td>18</td>
</tr>
<tr>
<td>✖ ✖ ✖</td>
<td>Wait Times – Orthopedic Surgery</td>
<td>For Q1–Q2 of 2012/13, none of the three orthopedic procedures is meeting the target.</td>
<td>21</td>
</tr>
<tr>
<td>✖</td>
<td>Wait Times – Cataract Surgery</td>
<td>For Q1 and Q2 of 2012/13, the target of 100% was not met.</td>
<td>23</td>
</tr>
<tr>
<td>Target</td>
<td>Indicator Name</td>
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</tr>
<tr>
<td>❧</td>
<td>Wait Times – Coronary Artery Bypass Graft Surgery</td>
<td>As of the January 2013 version of this report, this indicator has been removed temporarily while it undergoes revisions. It will be returned when the revisions have been completed.</td>
<td>25</td>
</tr>
<tr>
<td>✔️</td>
<td>Wait Times - Open Heart Surgery</td>
<td>Meeting target for urgent cases. Not meeting target for scheduled and semi-urgent cases.</td>
<td>26</td>
</tr>
<tr>
<td>❧</td>
<td>Wait Times – Emergency Department 90th Percentile Wait Times for Admitted Patients</td>
<td>DGH and QEII each have 90th percentile waits that are well over the target of 8 hours.</td>
<td>28</td>
</tr>
<tr>
<td>❧</td>
<td>Wait Times - Average Time from Triage to Physician in the Emergency Department</td>
<td>For CTAS Level III, all sites have wait times longer than the target of 30 minutes.</td>
<td>30</td>
</tr>
<tr>
<td>△</td>
<td>Patient Appointment No Show &amp; Cancellation Rates</td>
<td>Needs work to meet the 2012/13 target (surgery data still not extracted from PHS). Examples of rates in Mental Health and the Dept. of Medicine are provided.</td>
<td>32</td>
</tr>
<tr>
<td>△</td>
<td>Length of Stay - Percentage of Case Mix Groups Meeting Expected Length of Stay Target</td>
<td>For April to October of 2012/13, 50% of CMGs had an ALOS less than or equal to the ELOS. This is short of the 2012/13 target of 100%. There has essentially been no change since the 2009/10 baseline.</td>
<td>36</td>
</tr>
<tr>
<td>△</td>
<td>Length of Stay - Number of Conservable Days</td>
<td>Using April to October of 2012/13 as an estimate for the full fiscal year puts the total conservable days at a 16% increase over the 2009/10 baseline.</td>
<td>38</td>
</tr>
<tr>
<td>❧</td>
<td>Length of Stay - Average Length of Stay and Expected Length of Stay Comparison</td>
<td>For April to October of 2012/13, the difference between ALOS and ELOS was 0.3 days—on par with 2011/12 and falling short of the target of 0.</td>
<td>40</td>
</tr>
<tr>
<td>△</td>
<td>Occupancy Rates</td>
<td>For Apr.–Nov., the total occupancy rates for QEII &amp; DGH were above the 2012/13 target of 90%; however, improvements can be seen compared to 2011/12.</td>
<td>42</td>
</tr>
<tr>
<td>✔️ ✔️</td>
<td>Incidence and Transmission Rates - MRSA</td>
<td>Better than the 2009 national rates for both incidence and transmission.</td>
<td>45</td>
</tr>
<tr>
<td>✔️</td>
<td>Incidence Rate - VRE</td>
<td>Better than the 2009 national rate, but notable increase can be seen in recent quarters.</td>
<td>48</td>
</tr>
<tr>
<td>✔️</td>
<td>Infection Rate - C. difficile</td>
<td>Better than the 2009 national rate.</td>
<td>50</td>
</tr>
<tr>
<td>✔️</td>
<td>Hand Hygiene Compliance</td>
<td>The 2012 calendar-year audit shows CDHA is better than the 2008 Ontario hand hygiene compliance rate but decreased from the 2011 CDHA audit rate.</td>
<td>52</td>
</tr>
<tr>
<td>❧</td>
<td>Emergency Department - Percentage of Patients Left Without Being Seen</td>
<td>No sites are meeting the target of 2% or less.</td>
<td>53</td>
</tr>
<tr>
<td>❧</td>
<td>Long Term Care - Patients Placed and Waiting to be Placed</td>
<td>Above target of 75 patients waiting to be placed.</td>
<td>55</td>
</tr>
<tr>
<td>✔️</td>
<td>Code Blue Count (Impact of Quick Response Team)</td>
<td>For the time period of April to September, the average number of code blues per month was 2.2—better than the target of 3.</td>
<td>58</td>
</tr>
<tr>
<td>Target</td>
<td>Indicator Name</td>
<td>Status / Comment</td>
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<td>------</td>
</tr>
<tr>
<td>✔️</td>
<td>Hospital Standardized Mortality Ratio</td>
<td>CDHA’s HSMR for 2011/12 is on par with the 2009/10 national average.</td>
<td>60</td>
</tr>
<tr>
<td>✔️</td>
<td>Patient Experience Survey</td>
<td>The percent of positive responses met the 90% target for 2007/08–2011/12, except for inpatients in 2011/12, where the percentage of positive responses was only 88%.</td>
<td>62</td>
</tr>
<tr>
<td>❌</td>
<td>Patient Safety Culture</td>
<td>No target set. 2012 survey shows improvement over 2010.</td>
<td>64</td>
</tr>
<tr>
<td>❌</td>
<td>Completion of Patient Safety Training</td>
<td>For April to September 2012, only 22% completed at least one patient safety training course.</td>
<td>66</td>
</tr>
</tbody>
</table>

### Sustainability

| ✔️     | Access to a Primary Health Care Team | In 2011/12, there were 34% of family physicians that practice within an interdisciplinary team. This exceeds the 2012/13 target of 25%. | 68   |
| ✔️     | Increased Investment in Primary Care & Care of the Elderly | Additional investment money in the amount of $402,000 has been authorized for the 2012/13 fiscal year, thus the $286,563 target for 2012/13 has been exceeded. | 70   |
| ❌     | Percentage of Alternate Level of Care Beds Vacated and Closed Permanently | As of January 8th, 2013, there was a decrease of 40% of beds from the 2009/10 baseline. This is short of the 2012/13 target of a 75% decrease. | 71   |
| ❌     | Improved Metabolic Targets for Pre-Diabetes and Diabetes | The target will have to be revised as it does not reflect the trends observed in the diabetes population in NS. Work is underway with DMC & DCPNS to identify new, more meaningful milestones/indicators that will be a better reflection of the DMC care delivery. | 72   |
| ❌     | Admissions for Identified Chronic Diseases | Using Apr–Oct. of 2012/13 to extrapolate to a full fiscal year, it looks as if there will be a 2% decrease—just short of the target of a 3% decrease. | 73   |
| ❌     | Readmission Rates for Cohorts with Complex Chronic Disease | For Apr–Oct 2012, the readmission rate for all three diseases combined was 8%. This is an increase of 8.4% from the 2009/10 baseline. | 77   |
| ✔️     | Nursing Home Patients Seen in the Emergency Department | For Apr-Nov 2012, an average of 30 nursing home patients presented to the ED each month. This is so far exceeding the goal of a reduction to 33 per month for 2012/13. | 81   |
| ❌     | Length of Stay - Average Length of Stay for Patients Discharged to Long Term Care | No target. Fluctuations seen from month to month, especially at the NSH. | 83   |

### Transformational Leadership

<p>| ❌     | Absenteeism | For Apr. to Nov. of 2012/13, average sick hours were 5% higher than the baseline—falling short of the target of a 10% decrease. | 85   |</p>
<table>
<thead>
<tr>
<th>Target</th>
<th>Indicator Name</th>
<th>Status / Comment</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅</td>
<td>Overtime – Percent of Overtime Hours Worked</td>
<td>Percentage overtime for Apr.–Nov. of 2012/13 has decreased by 35% from the baseline. This is surpassing the target of a 10% decrease.</td>
<td>87</td>
</tr>
<tr>
<td>🟡</td>
<td>Recruitment for Hard-to-Fill Positions</td>
<td>Recruitment is generally meeting the target, but nursing positions are becoming more difficult to fill for ICU, ED, ORs, Rehab, Supportive Care Services, &amp; PACU with impacts on staff &amp; bed closures. Initiatives are underway to address this &amp; future occurrences.</td>
<td>88</td>
</tr>
<tr>
<td>🔄</td>
<td>Alignment of Medical Departments and Operational Structures</td>
<td>Trending towards the 2012/13 target.</td>
<td>90</td>
</tr>
<tr>
<td>🟡</td>
<td>Compliance with Performance Evaluation Process</td>
<td>Improving slightly from previous years but still far short of the 2012/13 target.</td>
<td>91</td>
</tr>
<tr>
<td>🔄</td>
<td>Formal Leaders Demonstrate Transformational Leadership Capabilities</td>
<td>This year, findings indicate leader performance has risen on all three dimensions: Being (72.1%), Caring (71.7%) and Doing (72.1%). Overall, 2012 results fall just shy of the interim target of 75% established for fiscal year 2011/12.</td>
<td>93</td>
</tr>
<tr>
<td>✦</td>
<td>Employee Survey</td>
<td>Pride, trust in peers, and spiritual wellness are areas to celebrate. Some of the areas for improvement include psychological safety, involvement in decision making, &amp; trust in management.</td>
<td>95</td>
</tr>
<tr>
<td>✦</td>
<td>Physician Survey</td>
<td>Of the 6 sections presented in this report, trust in colleagues and respect had the highest percentage of favourable responses, while trust in Capital Health management and engagement with Capital Health had the lowest.</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td><strong>Citizen Engagement and Accountability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>❌</td>
<td>Receipt of Health Passport</td>
<td>MyHealth Passport has been available on the CDHA public website since Sept. 2011. There has been positive consumer feedback regarding the tool. Primary Care has been approached again to become the system owner.</td>
<td>99</td>
</tr>
<tr>
<td>✅</td>
<td>Influence Change in Three Major Public Policies</td>
<td>On track to meet the 2012/13 target. All policies are progressing as expected.</td>
<td>100</td>
</tr>
<tr>
<td>🟡</td>
<td>Access for Underserved / Vulnerable Groups</td>
<td>Indicator is under development. Work is underway to improve access for several underserved/vulnerable groups.</td>
<td>101</td>
</tr>
<tr>
<td>🟡</td>
<td>Patient Involvement in Patient Care Committees</td>
<td>The proportion of quality teams with patient or family representatives rose to 64% from 55% in May 2012. This is still short of the 2012/13 target of 100%.</td>
<td>102</td>
</tr>
<tr>
<td>❌</td>
<td>Immunization Rate - Capital Health Flu Campaign</td>
<td>Not meeting target of 70%. 2011/12 is higher than the 2010/11 rate.</td>
<td>103</td>
</tr>
<tr>
<td>Target</td>
<td>Indicator Name</td>
<td>Status / Comment</td>
<td>Page</td>
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</tr>
<tr>
<td>✔</td>
<td>Models of Care Implementation in Patient Care Service Areas</td>
<td>The 2012/13 target of implementation in 75% of patient care service areas has been exceeded.</td>
<td>105</td>
</tr>
<tr>
<td>▼</td>
<td>Service Duplication &amp; Fragmentation in Ambulatory Services</td>
<td>This Milestone is currently on hold</td>
<td>106</td>
</tr>
<tr>
<td>▼</td>
<td>Ambulatory Care Visits</td>
<td>This Milestone is currently on hold</td>
<td>107</td>
</tr>
<tr>
<td>✔</td>
<td>Capacity and Use of Web-Based Technologies</td>
<td>In Q2 of 2012/13, the number of external web hits increased by 30% over the Q4 2009/10 baseline—surpassing the 2012/13 target of a 25% increase.</td>
<td>110</td>
</tr>
<tr>
<td>✔</td>
<td>Patient Registration in STAR</td>
<td>The capture of all registrations in STAR is currently being overseen. Addictions is a concern and a review is underway.; however, it is not targeted to be complete by 2013. Public Health continues an upward trend for meeting this target.</td>
<td>111</td>
</tr>
<tr>
<td>✔</td>
<td>Patient Appointments Self-Managed Through Technology</td>
<td>The automated telephone appointment reminder system currently makes 27,000 calls per month, and it is estimated that 26% of patients registering for outpatient clinics do so using registration kiosks.</td>
<td>112</td>
</tr>
<tr>
<td>✔</td>
<td>Resource the Information Management Strategic Plan</td>
<td>The business planning process has secured 2.5 million+ to start work on an EMR. Proposals are underway to secure funding from other sources for additional projects.</td>
<td>113</td>
</tr>
<tr>
<td></td>
<td>Research Funds from Grants &amp; Contracts</td>
<td>Both grants and contracts are up from the previous year.</td>
<td>114</td>
</tr>
</tbody>
</table>

**Appendices**

APPENDIX A: Summary of Milestone Progress with Respect to 2012/13 Targets

APPENDIX B: Patient Safety Scorecard

APPENDIX C: Access (Wait Times) Scorecard

APPENDIX D: Strategic Streams and Qmentum Quality Dimensions

APPENDIX E: Quality and Patient Safety Framework

APPENDIX F: Contributors
2 INTRODUCTION

Capital Health’s Strategic Indicator Report is a stimulus for quality improvement as it provides multi-year data on key indicators identified by Capital Health stakeholders. Over the summer and fall of 2009, leaders within Capital Health were asked to identify strategic indicators which would aid in their work to fulfill “Our Promise” to become a world-leading haven for people-centred health, healing, and learning. This process resulted in the creation of the Capital Health Indicator Development document which itemizes indicators by five Strategic Streams:

1. Person-Centred Health Care
2. Sustainability
3. Transformational Leadership
4. Citizen Engagement & Accountability
5. Innovation & Learning

Appendix D provides a detailed description of the strategic streams (as well as the eight Qmentum Quality Dimensions outlined by Accreditation Canada). Capital Health’s Strategic Indicators Report is organized around these five streams as is the Capital Health Milestones for 2013, and the Quality and Patient Safety Framework (Appendix E). For additional information on Capital Health’s “Our Promise”, please visit the Capital Health website at www.ourpromise.ca.

Each of the indicators in this report is described in detail in its own description table which includes:

- Indicator name
- The associated Strategic Stream
- Status – whether or not the goal is being met
- Trend – a short description of the recent or long term pattern of the indicator, if applicable
- Formula – an explanation of how the indicator is calculated
- Description – background information presented to help understand the indicator and the targets
- Analysis and Progress – a summary of the trend of the indicator and how it compares to the target
- Source – the origin of the data used to calculate the indicator and the source for the analysis and progress update
- Frequency tracked – how often the indicator is reported
- Last Updated – the date of the last update to the indicator and/or analysis and progress
- Accountability – the names of VPs, directors, and other people who share responsibility for reaching the targets
- Next Update Expected – estimated time frame for the next update
Throughout the report, the following icons appear above selected indicator description tables:

The **star icon** identifies indicators that are **new** to the current version of this report.

The **2013 Milestone icon** identifies indicators that are part of the **Our Promise: 2013 Milestones**

The **Our Promise icon** specifies an **evidence of transformation** indicator.

The **Patients First icon** specifies a **patient safety** indicator.

Indicator selection is based on the Capital Health Milestones for 2013 and the Capital Health Indicator Development document. Many of the indicators in these two documents are still in the development stage as indicator definitions, inclusion and exclusion criteria, and data sources are still being identified. As these elements are completed for each of the indicators, they will be added to the Capital Health’s Strategic Indicators Report.

This report provides a consistent set of key strategic indicators and an analysis of the results. All indicators will be reported in each publication, although some indicators will be updated less frequently. For example, data from Capital Health’s Flu Campaign is available annually; however, the indicator will remain in each publication. This will ensure regular, consistent access to key strategic indicators. Where possible, indicators are reported at the district level to provide an overall picture of district-wide activities. The Capital Health Strategic Indicators Report will be posted on the Capital District Health Authority’s website to ensure easy and broad access.
**Data Quality and Revisions**

The numbers presented in the graphs, tables, and narratives of this report come from a variety of sources. Every effort is made to ensure the data are accurate at the time of publication. Each publication only provides updated data for the most recently available time periods. Data from past time periods are not revised each time the report is published, so changes or corrections made to historical source data are not reflected in this report. Historical changes are carried over to the report when indicator definitions or data collection methods are changed. It should be noted that when such changes are made, they are not made to older versions of this report.

**External Links**

This report may provide links to other Internet sites only for the convenience of readers. Capital Health is not responsible for the availability or content of these external sites and cannot guarantee that the information is current or accurate. This information is provided as a public service. Readers should verify the information before acting on it. Capital Health does not endorse, warrant or guarantee the products, services or information described or offered at any other Internet sites. Capital Health does not assume and is not responsible for any liability whatsoever arising from the linking to any linked website, the operation or content (including the right to display such information) of any linked website, or for any of the information, interpretation, comments, or opinions expressed in any linked website. Any comments or inquirries regarding the linked websites are to be directed to the organization operating the website.

**Contributors**

This report would not be possible without the contributions of data, background information, and insights provided by many people at Capital Health. A list of those who are to be acknowledged for their valued contributions are listed in Appendix F.
3 Indicators

3.1 Person-Centered Health Care

This section contains indicators focused on measuring patient and family satisfaction, whether care makes sense to patients and families, if citizens access services they need, and whether citizens get safe, quality, and compassionate care.

3.1.1 Elimination of Shadow Charts

<table>
<thead>
<tr>
<th>Strategic Stream: Person-Centered Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status: Will not meet the 2012/13 target</td>
</tr>
<tr>
<td>Trend: progressed has reached a plateau</td>
</tr>
</tbody>
</table>

Formula: Number of service areas transitioned away from shadow charts divided by the number of service areas identified as having shadow charts.

Description: Shadow charts are health records maintained at the service level separate from the organizational central patient record. They pose a risk to patient care as they may contain pertinent health information not widely available to all practitioners. The maintenance of shadow charts also consumes valuable time, resources, and space that should be directed toward clinical services.

Capital Health’s Our Promise Milestone target is to ensure all pertinent patient information is maintained in the organization’s central health record by eliminating shadow charts by 25% by 2010/11, by 50% by 2011/12, and by 100% by fiscal year 2012/13.

Analysis and Progress: Total service areas identified for shadow chart elimination to date are 68. The previous milestone update (Sept 2012) showed milestone tracking at 29%, 1% increase has been noted within the last reporting period bringing the target completion for this milestone to 30%. This milestone will not meet the target of 100% elimination for fiscal 2012/13.

Meetings continue with service areas to assist with chart management as requested. Progress is not meeting target and needs work to achieve milestone target for 2012/2013. Senior clinical leaders have been in contact with Health Information Services and are working collaboratively and creatively to make progress. Technology remains a challenge for some areas awaiting implementation of an electronic medical record to support removal of shadow charts.

Source: eHealth/Medical Services

Frequency Tracked: Quarterly

Last Updated: December 2012

Accountability: Amanda Whitewood & Ray LeBlanc

Next Update Expected: March 2013
### 3.1.2 Surgery Cancellation Rates

<table>
<thead>
<tr>
<th><strong>Strategic Stream:</strong> Person-Centered Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status:</strong> △ Caution – needs work to meet the 2012/13 target</td>
</tr>
<tr>
<td><strong>Trend:</strong> Resource- and patient-related cancellations are showing a recent increase to above target (unfavourable).</td>
</tr>
</tbody>
</table>

**Formula:** The cancellation rate (%) is calculated by dividing the number of patient- or hospital-related cancellations by the total number of elective surgical cases and then multiplying by 100. All ORs and services at the QEII, Dartmouth General, and Hants are included.

**Description:** Cancelled surgeries are classified into two categories: 1) those cancelled for reasons originating in the hospital (resource related or preventable) and 2) those cancelled for reasons originating from the patient. Cancellations related to booking errors, change of dates, wrong patient scheduled, duplicate booking at other hospitals, booked in error, surgery already performed, received earlier booking, or for coordination with other appointments are excluded from the calculations.

The *Our Promise: 2013 Milestone* is to decrease *preventable* (resource-related) cancellations by 25% by 2010/11 (target 2.6%), by 35% by 2011/12 (target 2.3%) and by 50% by 2012/13 (target 1.8%). January 2010 has been designated as the baseline (cancellation rate of 3.4%).

**Analysis and Progress:** The graph below shows monthly cancellation rates for the most recent two-year period. The targets for resource-related cancellations for 2010/11 and 2011/12 were met. For April to November 2012, the average monthly resource-related cancellation rate was 1.9%. This is just over the 2012/13 target of 1.7% (unfavourable).

Following the graph is a table showing a breakdown by facility of the patient- and resource-related surgical cancellation rates and total surgeries for two recent months.

The main contributing factors for resource-related cancellations in November 2012 at the HI site were 11 emergency bumps (main services were cardiovascular and orthopedics) and 6 cases requiring further evaluation. At the VG, the key drivers for cancellations in November were lack of elective time for 15 cases and 9 cases required further evaluation. At the DGH, the key driver was emergency bumps – 9 cases combined in orthopedics and urology.

Strategies to reduce cancellations: In November, the VG & HI still had a few room closures due to staffing shortages. The staffing complement is slowly improving. OR volumes were back to normal levels in December. Pre-admission processes will be reviewed to see if there is an opportunity to reduce cancellations related to patients requiring further evaluation. The QEII OR executive recently reviewed waitlist case volumes and OR time allocation. At this point there is no capacity in the system to decrease waitlist time.

<table>
<thead>
<tr>
<th><strong>Source:</strong> HBI, Karen Mumford</th>
<th><strong>Frequency Tracked:</strong> Monthly</th>
<th><strong>Last Updated:</strong> January 2013</th>
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</thead>
<tbody>
<tr>
<td><strong>Accountability:</strong> Paula Bond, Karen Mumford, All Surgical District Department Chiefs</td>
<td><strong>Next Update Expected:</strong> February 2013</td>
<td></td>
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</tbody>
</table>
### Patient- and Hospital-Related Surgical Cancellation Rates & Total Surgeries for Recent Months

<table>
<thead>
<tr>
<th>Facility</th>
<th>October 2012</th>
<th>November 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient-Related Cancellations</td>
<td>Resource-Related Cancellation</td>
</tr>
<tr>
<td>HI</td>
<td>0.4%</td>
<td>2.8%</td>
</tr>
<tr>
<td>VG</td>
<td>1.0%</td>
<td>1.5%</td>
</tr>
<tr>
<td>DGH</td>
<td>2.5%</td>
<td>2.2%</td>
</tr>
<tr>
<td>HCH</td>
<td>0.0%</td>
<td>4.8%</td>
</tr>
</tbody>
</table>
### 3.1.3 Wait Times - Elective CT

**Strategic Stream:** Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status:</th>
<th>Not meeting target</th>
<th>Trend:</th>
<th>Wait times decreasing</th>
</tr>
</thead>
</table>

**Formula:** Weighted average wait time for elective CT, at QEII, DGH, and Cobequid combined (weighted as 23% cranial, 7% spine, 19% chest, 25% musculoskeletal, and 25% abdominal).

**Description:** Computed tomography (CT) is a special radiographic technique that uses a computer to assimilate multiple x-ray images into a two-dimensional cross-sectional image. This can reveal many soft tissue structures not shown by conventional radiography. Scans may also be dynamic in which movement of a dye within the body is tracked. The machine rotates 180 degrees around the body sending a thin x-ray beam at 160 different points. Using the same dosage of radiation as that of a conventional x-ray, an entire slice of the body is made visible with about 100 times more clarity.

The five types of elective CT used to calculate the wait time are: cranial, spine, chest, musculoskeletal, and abdominal. Wait times have been converted to calendar days. The elective CT wait times are weighted based on volume of procedures as suggested by the Department of Health (see weights above under “Formula”). The target wait time for CT is 28 days.

**Analysis and Progress:** The graphs below show the wait times and patient volumes for elective CT at Capital Health. This is the weighted average for the QEII, Dartmouth General, and the Cobequid Community Health Centre combined. The average wait time for November 2012 was 30 days—just over the target wait time; although the wait has been at or below the target for the previous four months.

Capital Health received funding from the Department of Health and Wellness to replace an end-of-life CT scanner at the Halifax Infirmary site of the QEII. The new scanner has been up and running since March 31, 2011.

To see recent wait times for elective CT at all locations in Nova Scotia click [here](#).

**Source:** Diagnostic Imaging  
**Frequency Tracked:** Monthly  
**Last Updated:** January 2013  
**Accountability:** Barbara Hall, David Barnes, Susan Delaney  
**Next Update Expected:** February 2013
Wait Times & Patient Volumes for Elective CT at Capital Health

![Graph showing wait times and patient volumes for elective CT at Capital Health. The graph includes a line indicating the target wait time of 28 days and a line representing patient volumes.]
### 3.1.4 Wait Times - Elective MRI

<table>
<thead>
<tr>
<th>Strategic Stream: Person-Centered Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status:</strong> Not meeting target</td>
</tr>
</tbody>
</table>

**Formula:** Weighted average time from referral until procedure is performed (weighted as 72% of neuro scan wait times, 15% of bone scan wait times, and 13% of body scan wait times).

**Description:** Magnetic Resonance Imaging (MRI) is a special imaging technique used to image internal structures of the body, particularly the soft tissues. MRI uses a powerful magnet, radio frequency waves, and computers to produce detailed images of the body in any plane. It provides much greater contrast between the different soft tissues of the body than does computed tomography (CT), making it especially useful in neurological (brain), musculoskeletal, cardiovascular and oncological (cancer) imaging.

The 3 types of MRI used to calculate the wait time are body, bone, and neurological. The wait time does not include those QEII patients who have elective MRI procedures performed at the IWK. The Department of Health has required weighting of the average by volume of procedures. The target wait time is 28 days.

**Analysis and Progress:** During much of 2008, the average wait time for an elective MRI was longer than 200 days. This was due to staff shortages and the unavailability of trained MRI technologists across Canada. Throughout most of 2009, elective MRI average wait times shortened significantly and in November 2009 was 52 days. This was due to Capital Health investing in training 3 technologists which brought the staff complement back to funded levels. At the end of 2009 and into 2010, the wait time was lengthening. In July 2010, the wait time jumped up to 132 days as there was once again a vacancy (maternity leave) that management was unable to fill. Staff summer vacations also contributed to the longer waits. There was a resignation in October 2010 that remained unfilled until Capital Health was able to recruit a technologist in March 2011. On February 1st, 2012 an MRI technologist required surgery and will be off work for at least five months. And, once again, trained staff cannot be found to fill this vacancy. This highlights the overall shortage of trained MRI technologists.

In November 2012, the average wait time for MRI was 226 days—just over eight times longer than the target of 28 days.

To see recent wait times for elective MRI at locations in Nova Scotia click [here](#).

**Source:** Diagnostic Imaging  
**Frequency Tracked:** Monthly  
**Last Updated:** December 2012  
**Accountability:** Barbara Hall, David Barnes, Susan Delaney  
**Next Update Expected:** January 2013
Wait Times & Patient Volumes for MRI at the QEII

- **Wait Time (Calendar Days)**
- **Patient Volumes**
- **Target (28 Days)**

![Graph showing wait times and patient volumes for MRI at the QEII.](image-url)
### 3.1.5 Wait Times - Radiotherapy Treatment

**Strategic Stream:** Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status:</th>
<th>Trends:</th>
<th>Formula:</th>
<th>Description:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Meeting target (urgent)</td>
<td>see graphs</td>
<td>Wait time, in days, from date of referral to date of procedure. Values shown are the average wait times for a one-month period.</td>
<td>In radiotherapy (also called radiation therapy), high-energy rays are used to damage cancer cells and stop them from growing and dividing. Target wait times for radiotherapy treatment are based on acuity level. Patients are assigned to an acuity level based on assessment by a radiation oncologist, a specialist in radiation therapy. Assessment criteria and target wait times for each acuity level are shown in the following table:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acuity Level</th>
<th>Sample Assessment Criteria</th>
<th>Target Wait Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent</td>
<td>Acute superior vena cava obstruction, spinal cord compression or airway obstruction.</td>
<td>24 hours</td>
</tr>
<tr>
<td>Urgent</td>
<td>Subacute neurological dysfunction, tumor hemorrhage or severe, uncontrolled pain.</td>
<td>7 days</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Children, inpatients in hospital for radiation services or having head and neck tumors.</td>
<td>14 days</td>
</tr>
<tr>
<td>Standard</td>
<td>Conditions of the T1 larynx, lymphoma, gastrointestinal tract, or central nervous system.</td>
<td>21 days</td>
</tr>
</tbody>
</table>

**Analysis and Progress:** The two graphs below show the average monthly wait times for patients in the urgent and intermediate categories. Patient volumes are also shown.

Wait times for *urgent* cases have been mostly hovering around the target of 7 days, and were below the target for the months of May to September 2012 and only slightly over in October and November 2012. Wait times for *intermediate* cases have been consistently longer than the target of 14 days, although there has been a decreasing trend (favourable) in 2012.

To see recent wait times for radiotherapy treatment at locations across Nova Scotia click [here](#).

---

**Data Source:** Cancer Care Program Project Office  
**Frequency Tracked:** Monthly  
**Last Updated:** January 2013  
**Accountability:** Paula Bond, Drew Bethune, Vickie Sullivan  
**Next Update Expected:** February 2013
Wait Times and Patient Volumes for Radiotherapy Treatment - *Urgent*

![Graph showing wait times and patient volumes for urgent cases](image-url)
Wait Times and Patient Volumes for Radiotherapy Treatment - *Intermediate*

[Graph showing wait times for intermediate cases with target of 14 days, along with volumes of patients starting treatment.]

Capital Health’s Strategic Indicators Report, January 28, 2013
### 3.1.6 Wait Times – Orthopedic Surgery

**Strategic Stream: Person-Centered Health Care**

| Status: | Not meeting the 2012/13 target for any of the orthopedic procedures being tracked. |
| Trend: | See graph |

**Formula:** The number of patients who had their procedure done in a given month who waited less than or the same as the national benchmark time frame, divided by the total number of patients who had the procedure completed in the same month, multiplied by 100.

**Description:** Hip replacement is a surgical procedure in which the hip joint is replaced by a prosthetic implant. This is generally done to relieve arthritis pain or fix severe physical joint damage as part of hip fracture treatment. Knee replacement is a surgical procedure to replace the weight-bearing surfaces of the knee joint to relieve the pain and disability of osteoarthritis. It may be performed for other knee diseases such as rheumatoid arthritis and psoriatic arthritis. Hip fracture repair is a procedure to fix a fracture of the femur bone (thigh bone) near the hip joint. In the vast majority of cases, a hip fracture is a due to a fall or minor trauma in someone with weakened osteoporotic bone. Most hip fractures in people with normal bone are the result of high-energy trauma such as car accidents.1

The nationally recognized target wait times for these procedures are: hip replacement: 26 weeks; knee replacement: 26 weeks; hip fracture repair: 48 hours.

According to the *Our Promise: 2013 Milestones*, the goal is to increase the percentage of patients who have their surgical procedures within the target wait times to 10% by 2010/11, to 50% by 2011/12, and to 100% by 2012/13.

**Analysis and Progress:** The graph below shows the quarterly percentages of patients who had their orthopedic procedures within the target wait times. A breakdown by procedure is shown. It can be seen that all three procedures were well above the target of 10% for 2010/11 (favourable). Hip replacements exceeded the target of 50% for 2011/12 with the exception of Q3. Knee replacements fell short of the 2011/12 target except in Q2. Hip fracture repairs exceeded the 2011/12 target of 50%. So far in 2012/13, no procedures are meeting the target of 100%.

For joint surgeries, the numbers completed over the past two quarters have been fairly consistent – mostly related to staffing challenges placing limits on total number per day that can be performed. Recruitment and training remain key priorities in perioperative. Other strategies to try and increase joints being actively explored include a blitz – a focus on joint surgeries in orthopedics for 1-2 weeks prior to the end of March.

With respect to fractured hips, the OR Executive has approved new strategies to improve access for orthopedic trauma to be implemented in early 2013. A pathway has been drafted and will be presented to surgical grand rounds this month.

Overall, the target of 100% is unrealistic within next several months and should be reevaluated.

To see recent wait times for orthopedic surgeries across Nova Scotia, click on the following links: knee replacement, hip replacement.

| Data Source: PAR NS, Discharge Abstract Data | Frequency Tracked: Quarterly | Last Updated: January 2013 |
| Accountability: Paula Bond | | Next Update Expected: February 2013 |

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Capital Health’s Strategic Indicators Report, January 28, 2013
Percentage of Patients Who Waited Less Than or Equal to the National Benchmark Times for Orthopedic Procedures - Capital Health

- Hip Fracture Repair
- Hip Replacement
- Knee Replacement
- Milestone Targets

Proportion of Patients

Q1 2010/11 | Q2 2010/11 | Q3 2010/11 | Q4 2010/11 | Q1 2011/12 | Q2 2011/12 | Q3 2011/12 | Q4 2011/12 | Q1 2012/13 | Q2 2012/13
### 3.1.7 Wait Times – Cataract Surgery

**Strategic Stream:** Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status:</th>
<th>Not meeting the 2012/13 target</th>
<th>Trend:</th>
<th>slowly decreasing (unfavourable)</th>
</tr>
</thead>
</table>

**Formula:** The number of patients who had their procedure done in a given quarter who waited less than or equal to the national benchmark time frame, divided by the total number of patients who had the procedure completed in the given month, multiplied by 100.

**Description:** Cataract surgery is the removal of a clouded lens (or cataract) from the eye to improve vision.

The nationally recognized benchmark wait time for cataract surgery is 16 weeks.

According to the *Our Promise: 2013 Milestones*, the goals are to increase the percentage of people who have their cataract surgery within the benchmark wait time to 10% by 2010/11, to 50% by 2011/12, and to 100% by 2012/13.

**Analysis and Progress:** The graph below shows the quarterly percentages of patients who had their cataract surgery within the benchmark wait time of 16 weeks. It can be seen that the target of 10% was met for 2010/11. More recently, the 50% target for 2011/12 was also met. In Q1 and Q2 of 2012/13, the target of 100% was not met.

The waitlist for cataract surgery has grown by 9.7% over the past year. The demand is growing faster than the ability to complete procedures due to resource constraints. There are more than 2,400 patients waiting for cataract surgery at CDHA.

Due to staffing challenges, Ophthalmology reduced OR time by four rooms for the month which negatively impacted the number of cataract surgeries performed. Discussions are actively taking place with the ophthalmology team to develop a plan to perform more cataract surgeries per day in an OR through efficiencies. Implementation is planned for February/March. Other discussions are taking place with key stakeholders & the Department of Health and Wellness to look at other potential models to perform more surgeries with the same funding.

To see recent wait times for cataract surgery at different locations across Nova Scotia click [here](#).

**Data Source:** PAR NS  
**Frequency Tracked:** Quarterly  
**Last Updated:** December 2012  
**Accountability:** Paula Bond  
**Next Update Expected:** February 2013
Percentage of Patients Who Waited Less Than or Equal to the National Benchmark Time for Cataract Surgery - Capital Health

- Cataract Surgery
- Milestone Targets
3.1.8 Wait Times – Coronary Artery Bypass Graft Surgery

As of the January 2013 version of this report, this indicator has been removed temporarily while it undergoes revisions. It will be returned when the revisions have been completed.
### 3.1.9 Wait Times - Open Heart Surgery

**Strategic Stream:** Person-Centered Health Care

| Status: | ☑ Meeting target for urgent cases  | ☐ Not meeting target for scheduled or semi-urgent cases  |
| Trend: | See graph | |

**Formula:** Average wait time for open heart surgery procedures.

**Description:** The graph below shows the average and target wait times for urgent, semi-urgent and scheduled open heart surgery procedures. Coronary artery bypass graft and valve replacements are included in the open heart surgery procedure grouping (previous versions of this report mentioned pacemaker insertions were included in this group, but this was incorrect).

The targets for open heart surgery procedures are:

- **Urgent** – 7 days
- **Semi-Urgent** – 21 days
- **Scheduled** – 42 days

**Analysis and Progress:** Wait Times for open heart surgery are shown in the graph below. For *urgent* cases, the average wait time has consistently remained under the seven-day target.

The average wait times for *scheduled* cases have been longer than the target of 42 days for May to November 2012.

*Semi-urgent* cases have had wait times that have been longer than the target of 21 days for the months of April to November 2012.

Note: there is no average wait time measure for scheduled cases in December 2010 because no such procedures were performed during that time period.

**Source:** Heart Health Program  
**Frequency Tracked:** Monthly  
**Last Updated:** January 2013

**Accountability:** Paula Bond, Karen MacRury-Sweet, Karen Mumford  
**Next Update Expected:** February 2013
Wait Times For Open Heart Surgery
QEII Health Sciences Centre

- **Scheduled**
- **Semi-Urgent**
- **Urgent**

<table>
<thead>
<tr>
<th>Wait Time (Days)</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 Days</td>
<td></td>
</tr>
<tr>
<td>7 Days</td>
<td></td>
</tr>
<tr>
<td>21 Days</td>
<td></td>
</tr>
</tbody>
</table>

## 3.1.10 Wait Times – Emergency Department 90th Percentile Wait Times for Admitted Patients

### Strategic Stream:  Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status:</th>
<th>Not meeting target</th>
<th>Trend: DGH showing improvement</th>
</tr>
</thead>
</table>

**Formula:** 90th percentile emergency department wait time from time of triage to time of admission for admitted patients.  Clinical Decision Unit patients are excluded.

**Description:** In 2010, the Institute of Clinical Evaluative Sciences (ICES) identified the emergency department (ED) 90th percentile length of stay for admitted patients as the most important strategic indicator for quality in the ED, and, in fact, as a surrogate marker of overall hospital functioning. The 90th percentile wait time is the time in which 90% of patients end up waiting.

Patients waiting in the ED for admission to an inpatient unit increase the overall ED wait times, increase the percentage of patients leaving the ED without being seen, increase ambulance offload intervals, and are associated with more adverse events, increased mortality, increased inpatient lengths of stay, and increased overall costs.

The goal is to have the 90th percentile wait time meet the target of 8 hours—as outlined in *Better Care Sooner*, the plan to improve emergency care in Nova Scotia.

### Analysis and Progress:

The graph below shows the 90th percentile wait times from triage to admission for the QEII and the Dartmouth General. Both sites have 90th percentile waits that are well over the target of 8 hours.

In January 2012, two initiatives started to increase capacity within the Dartmouth ED: 1) expanded hours on the minor side. There was previously only staffing until 7:00 pm. Now it is staffed until 11:00 pm; and 2) trial period of a chair zone which will be staffed by an LPN. This will care for Level 4s and 5s, or stable level 3s. This will be staffed from 11:00 am to 7:00 pm.

<table>
<thead>
<tr>
<th>Source:</th>
<th>EDIS</th>
<th>Frequency Tracked: Monthly</th>
<th>Last Updated: January 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability:</td>
<td>Barbara Hall, Sandra Janes, David Petrie, Samuel Campbell</td>
<td></td>
<td>Next Update Expected: February 2013</td>
</tr>
</tbody>
</table>
90th Percentile Wait Times for the Time from Triage to Admission
QEII and Dartmouth General Emergency Departments

- DGH
- QEII
- Target (8 hrs)
### 3.1.11 Wait Times - Average Time from Triage to Physician in the Emergency Department

**Strategic Stream:** Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status:</th>
<th>Trend: See graph and analysis below</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not meeting target</td>
<td></td>
</tr>
</tbody>
</table>

**Formula:** Average emergency department wait time from time of triage to time seen by a physician for CTAS level III.

**Description:** A triage system is a method of assigning priorities to patients. The Canadian Triage & Acuity Scale (CTAS) is based on establishing a relationship between a group of sentinel events, which are defined by the ICD-9 diagnosis at discharge from the emergency department (or from an inpatient database) and the “usual” way these patients present. The triage scale is related to the time to be seen by a physician, as most decisions about investigation and initiation of treatment do not occur until the physician sees the patient or has the preliminary results to recommend a course of action.

The following is a brief description of each CTAS level along with target times*:

- **CTAS Level I** cases are Resuscitation – Threat to life – Target Time: immediate
- **CTAS Level II** cases are Emergent – Conditions are a potential threat to life – Target Time: 15 minutes
- **CTAS Level III** cases are Urgent – Conditions that could potentially progress to a serious problem – Target Time: 30 minutes
- **CTAS Level IV** cases are Less Urgent – Target Time: 1 hour
- **CTAS Level V** cases are Non-Urgent – Target Time: 2 hours

*Target times come from the Canadian Association of Emergency Physicians

It should be noted, in some cases, certain patient work up is done at the time of triage or while the patient is in the waiting room and aspects of treatment can happen prior to being seen by a physician.

**Analysis and Progress:** The graph below shows the average wait times from triage to physician for CTAS Level III. A breakdown by emergency department site is provided. All sites have wait times longer than the target of 30 minutes.

In January 2012, two initiatives have started that will increase capacity within the Dartmouth ED: 1) expanded hours on the minor side. There was previously only staffing until 7:00 pm. Now it is staffed until 11:00 pm; and 2) trial period of a chair zone which will be staffed by an LPN- this will care for Level 4's & 5's or stable level 3's. This will be staffed 11:00 am to 7:00 pm.

**Source:** EDIS

**Frequency Tracked:** Monthly

**Last Updated:** January 2013

**Accountability:** Barbara Hall, Sandra Janes, David Petrie, Samuel Campbell

**Next Update Expected:** February 2013
### 3.1.12 Patient Appointment No Show & Cancellation Rates

**Strategic Stream:** Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status:</th>
<th>Caution – needs work to meet the 2012/13 target (surgery data still not extracted from PHS)</th>
<th>Trend:</th>
<th>Stable at 5.5% in Medicine clinics. Benchmark across the country is 5%.</th>
</tr>
</thead>
</table>

**Formulae:**

- No shows: number of no show appointments divided by the number of scheduled appointments, multiplied by 100.
- Cancellations: number of cancelled appointments divided by the total number of scheduled appointments multiplied by 100. Rates are broken down by institution-related & patient-related reasons. Currently, the Department of Medicine excludes cancelled appointments from the denominator for no shows (see the definition on the following page).

**Description:** Failed appointments have an adverse impact on treatment outcomes, clinic productivity, student learning experiences and resource utilization. Appointment cancellations are broken into two categories: patient-initiated and service-initiated. Both need to be addressed to reduce waste. Appointment no shows are missed appointments with no prior communication from the patient. The goal of this milestone work is to address both. This Milestone is meant to apply to all ambulatory care areas.

Capital Health’s Our Promise Milestone target is to decrease patient appointment no shows and cancellation rates by 25% in 2010/11, 35% by 2011/12, and reaching 50% by 2012/13.

**Analysis and Progress:** This information is entered into PHS by booking clerks for all clinics on the 4th floor of the HI site. This information is presently reported for medicine but not surgery or orthopedic clinics. The DOM has a dedicated IT person who monitors the data to ensure accuracy, cleans the data and then extracts this information for a quarterly report.

Sample data from the Department of Medicine and Mental Health are presented below.

<table>
<thead>
<tr>
<th>Source: Decision Support</th>
<th>Frequency Tracked: Variable</th>
<th>Last Updated: October 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability: Paula Bond</td>
<td></td>
<td>Next Update Expected: January 2013</td>
</tr>
</tbody>
</table>
No Shows and Cancellations – Sample Data

To highlight some of the leading work already done in this area, graphs of no shows and cancellations for the Department of Medicine and for Mental Health are shown below. Note the results for the two departments are not directly comparable due to differences in the methods of data collection and reporting.

For Mental Health Community Teams, no shows and cancellations are calculated as the number of no shows or cancellations for new appointments divided by the total number of scheduled new appointments, multiplied by 100. Only patient-related cancellations are counted. Cancellations due to resource-related reasons, such as unavailability of a practitioner, are considered rescheduled rather than cancelled and so are not reported. Results shown are for all community teams combined. The New First Visit/Service Access initiative for the Community Mental Health Teams was put in place May 1, 2011, which changed the service access process and therefore may contribute to a difference in the no shows and cancellations from that point on.

In the Department of Medicine, cancellations are calculated as the number of cancelled visits divided by the number of attended appointments and cancellations and no shows (total booked appointments), multiplied by 100. Cancellations also include rescheduled appointments. Patient-related cancellations and resource-related cancellations are reported separately. No shows are calculated as the number of no shows divided by the number of attended appointments and no shows. Cancellations are excluded from the denominator. No shows and cancellations have been collected from patient appointments for any physician who is actively part of the Department of Medicine. Strict reconciliations are completed each day for no show and cancellation data for any clinic location under a Department of Medicine Manager. If a Department of Medicine physician sees patients at a location outside these locations, the data may not undergo the same scrutiny.

Patient and resource-related reasons used in Mental Health and in the Department of Medicine are shown alongside the respective graphs below. The graphs were last updated in November 2012. The next graphs update will be for the February 2013 version of this report.
Mental Health New Appointment No Shows & Cancellations

Patient Cancellation Reasons:
- patient declined
- patient/family reasons
- admitted to hospital
- appointment no longer required
- being seen privately
- no response
Department of Medicine Appointment No Shows & Cancellations

Percent of Appointments

Patient-Related Reasons:
• coordinating multiple appointments
• feeling better/worse
• work
• weather concerns
• transportation
• financial
• emergencies
• the patient feels the appointment is no longer necessary

Resource-Related Reasons:
• practitioner unavailable
• patient admitted to hospital
• facility unavailable
• waiting for test results
• referral redirected to community physician
• written advice provided to the referring physician regarding care for the patient

- Patient-Related Cancellations
- Resource-Related Cancellations
- Patient No Shows

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### 3.1.13 Length of Stay - Percentage of Case Mix Groups Meeting Expected Length of Stay Target

**Strategic Stream:** Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status: △ Caution – needs work to meet the 2012/13 target</th>
<th>Trend: No changes since 2009/10 baseline.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formula:</strong> The number of case mix groups (CMGs) for which the average length of stay (ALOS) is equal to or less than the expected length of stay (ELOS) divided by the total number of CMGs (typical cases only).</td>
<td></td>
</tr>
<tr>
<td><strong>Description:</strong> The percent of CMGs meeting the ELOS target includes typical cases only. All cases are considered typical except patients who sign themselves out against medical advice, patients who transfer to or from another acute care facility, patients with long stays, and deaths. The Our Promise Milestone goals are to have the ALOS meet the ELOS for 40% of CMGs by 2010/11, for 70% of CMGs by 2011/12, and for 100% of CMGs by 2012/13. The baseline year is 2009/10. The goal is to accomplish these targets without increasing readmission rates. Readmissions include patients readmitted to hospital within 28 days of discharge and patients admitted within 7 days of day surgery. This indicator includes QEII, DGH, HCH, NSH, ECFH and the Tri-facilities.</td>
<td></td>
</tr>
<tr>
<td><strong>Analysis and Progress:</strong> The graph below shows the percent of CMGs that meet the ELOS targets. For the baseline year 2009/10, 52% of CMGs (253 of 487 CMGs) had an ALOS that was less than or equal to the ELOS (53.3% of individual cases). This was on par with the percent of CMGs for the previous two years. In 2010/11, 49% of CMGs (236 out of 479 CMGs) had an ALOS that was less than or equal to the ELOS (47% of individual cases). The 2010/11 target was met. In 2011/12, 50% of CMGs had an ALOS less than or equal to the ELOS (244 out of 490 CMGs; 48% of individual cases). This was short of the 2011/12 target of 70%. For April to October of 2012/13, 50% of CMGs had an ALOS less than or equal to the ELOS (234 out of 470 CMGs; 47% of individual cases). This is short of the 2012/13 target of 100%. In the 2009/10 baseline year, the unplanned readmission rate was 6.3% (typical cases only). In 2010/11, the readmission rate was 6.8%. For 2011/12, the readmission rate was 6.4%. For April–October 2012, the readmission rate was 7.1%.</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Discharge Abstract Database  
**Frequency Tracked:** Monthly  
**Last Updated:** January 2013  
**Accountability:** Paula Bond  
**Next Update Expected:** February 2013
Percentage of CMGs Meeting ELOS Targets at CDHA

Typical Cases Only

Typical Cases Only

Fiscal Year

2010/11 Baseline 2010/11 2011/12 2012/13

% of CMGs Meeting ELOS Targets

- Actual
- Milestone Targets

2010/11 Target Exceeded

Short of 2011/12 Target

Apr. to Oct. Only

2009/10 Baseline

52% 49% 50% 50%

40%

70%

100%
3.1.14  Length of Stay - Number of Conservable Days

**Strategic Stream:** Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status: △ Caution – needs work to meet the 2012/13 target</th>
<th>Trend: see graphs</th>
</tr>
</thead>
</table>

**Formula:** Average length of stay (ALOS) minus the expected length of stay (ELOS) multiplied by the total number of cases.

**Description:** The target for the 2010/11 fiscal year is a reduction of 2% from the 2009/10 baseline year. The target for 2011/12 is a reduction of 4% and the target for 2012/13 is a reduction of 5%.

**Analysis and Progress:** Conservable days for typical cases are shown in the graph below.

To meet the 2010/11 target, conservable days needed to decrease by at least 2%. In 2010/11, conservable days increased by 35%. To meet the 2011/12 target, conservable days needed to decrease by 4%. The result was there was an increase of 19% from the 2009/10 baseline. This is an improvement over 2010/11, but is still short of the 2011/12 target.

Using April to October of 2012/13 as an estimate for the full fiscal year puts the total conservable days at a 16% increase over the 2009/10 baseline.

It should be noted that variation from year to year can occur not only as a result of changes in the average lengths of stay but also as a result of year-to-year adjustments in expected lengths of stay, as determined by the Canadian Institute for Health Information. And as such, if the expected length of stay decreases for a given case mix group, the conservable days for a given facility can increase despite the average length of stay remaining unchanged.

**Source:** Discharge Abstract Database

**Frequency Tracked:** Monthly

**Last Updated:** January 2013

**Accountability:** Paula Bond

**Next Update Expected:** February 2013
Conservable Days for *Typical Cases* at CDHA

- **2009/10 Baseline:** 6,514
- **2010/11:** 8,813 (Target: 2% reduction, Actual: 35% increase)
- **2011/12:** 7,736 (Target: 4% reduction, Actual: 19% increase)
- **2012/13 April-October:** 6,253 (Target: 5% reduction, Estimate for Full Fiscal Year: 16% increase)

Bar chart showing actual conservable days and milestone targets for each fiscal year.
3.1.15 Length of Stay - Average Length of Stay and Expected Length of Stay Comparison

**Strategic Stream:** Person-Centered Health Care

- **Status:** Not meeting target
- **Trend:** April to October of 2012/13 have the same difference as seen for 2011/12

**Formula:** Average length of stay (ALOS) compared to expected length of stay (ELOS) (typical cases only).

**Description:** ALOS compared to ELOS for the past three fiscal years. Data includes typical cases only. Lengths of stay are measured in days.

The ALOS target is to reach the ELOS for typical cases (ALOS minus ELOS is less than or equal to zero).

Typical cases include all patients except the following:
- Patients who sign themselves out against medical advice
- Patients who transfer to or from another acute care facility
- Patients with long stays
- Deaths

Includes the QEII, Dartmouth General, Hants Community Hospital, Nova Scotia Hospital, East Coast Forensic Hospital, and the Tri-facilities (Twin Oaks Memorial, Musquodoboit Valley Memorial, and Eastern Shore Memorial Hospitals).

**Analysis and Progress:** The ALOS and ELOS, as well as total cases for recent fiscal years, are shown in the table below.

For fiscal year 2011/12, ALOS and ELOS both decreased from the 2010/11 values and the difference decreased to 0.3 days; however, this difference is the same as it was in 2008/09 and 2009/10.

For April to October of 2012/13, the difference between ALOS and ELOS was 0.3 days. This is on par with 2011/12.

**Source:** Discharge Abstract Database

**Frequency Tracked:** Monthly

**Last Updated:** January 2013

**Accountability:** Paula Bond

**Next Update Expected:** February 2013
Average Length of Stay and Expected Length of Stay Comparison for Capital Health *(Typical Cases Only)*

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total Typical Cases</th>
<th>ALOS (days)</th>
<th>ELOS (days)</th>
<th>Difference (days) (ALOS – ELOS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007/08</td>
<td>23,867</td>
<td>6.7</td>
<td>6.5</td>
<td>0.2</td>
</tr>
<tr>
<td>2008/09</td>
<td>24,169</td>
<td>6.4</td>
<td>6.1</td>
<td>0.3</td>
</tr>
<tr>
<td>2009/10</td>
<td>24,024</td>
<td>6.3</td>
<td>6.0</td>
<td>0.3</td>
</tr>
<tr>
<td>2010/11</td>
<td>23,651</td>
<td>6.4</td>
<td>6.0</td>
<td>0.4</td>
</tr>
<tr>
<td>2011/12</td>
<td>23,515</td>
<td>6.2</td>
<td>5.9</td>
<td>0.3</td>
</tr>
<tr>
<td>2012/13 Apr.–Oct. Only</td>
<td>13,918</td>
<td>6.2</td>
<td>5.9</td>
<td>0.3</td>
</tr>
</tbody>
</table>
### 3.1.16 Occupancy Rates

**Strategic Stream: Person-Centered Health Care**

<table>
<thead>
<tr>
<th>Status: △ Caution – needs work to meet the 2012/13 target</th>
<th>Trend: Improvement over 2011/12 can be seen</th>
</tr>
</thead>
</table>

**Formula:** Occupancy rate is patient days (census days) divided by available hospital days, multiplied by 100. Total occupancy rates do not include long term care/transitional care. This is because the occupancy rate target for long term care is 99% which differs from the milestone target occupancy rates.

**Description:** Occupancy rate is used to show the actual utilization of the hospital for a given period of time and has a direct affect on inpatient and emergency department flow. Occupancy rates are also calculated for individual units and services. It is important to accurately record the number of available hospital beds in order to calculate the occupancy rate. The following is a sample calculation:

\[
\text{Occupancy Rate} = \frac{\text{Patient Days (census)}}{\text{Available Hospital Days}} \times 100 = \frac{27,078}{28,654} \times 100 = 94.5\%
\]

Capital Health’s Our Promise Milestone targets are to decrease the occupancy rate to 92% by 2010/11, to 91% by 2011/12, and to 90% by 2012/13.

**Analysis and Progress:** The graphs below show the yearly occupancy rates for services at the QEII and the Dartmouth General. The total occupancy rates for each of the QEII and the DGH were above the 2010/11 target of 92% (unfavorable). The following services were below the 2010/11 target of 92% (favorable) for 2010/11: QEII Surgical, QEII ICU, and DGH ICU/CCU. All other services were above the target (unfavourable). In 2011/12, the same services exceeded the target of 91%; however, the totals for the DGH and the QEII were still above this target (unfavourable).

For April to November 2012, the same services are above and below the target, but many services are showing improvements over 2011/12. This trend extends to the hospital totals as well.

It should be noted the occupancy rates for QEII psychiatry from 2007 to 2010 are an underestimate because they had four beds that were listed as “open” in the STAR system, but weren’t actually available for use. An estimated correction would put all the psychiatry occupancy rates higher than the 92% target for these time periods. The bed counts were corrected in STAR in January 2011 and so occupancy rates for psychiatry after this date reflect the true situation on the service.

**Source:** STAR  
**Accountability:** Paula Bond  
**Frequency Tracked:** Monthly  
**Last Updated:** January 2013  
**Next Update Expected:** February 2013
QEII Service Occupancy Rates

Milestone Target for 2012/13 is 90% or less

Occupancy Rate

- Medical
- Surgical
- ICU
- Psychiatric
- Palliative
- Rehabilitation
- Chronic Care
- Total (Excluding LTC)

DGH Occupancy Rates

Milestone Target for 2012/13 is 90% or less

Occupancy Rate

- 2008/09
- 2009/10
- 2010/11
- 2011/12
- 2012/13 (Apr to Nov)

- 3 West - Surg/FM
- 3 East - FM/Pall Care
- ICU/CCU
- FM/Int Med
- Total (Excluding Transitional Care)
### 3.1.17 Incidence and Transmission Rates - MRSA

**Strategic Stream:** Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status: ✔ Meeting targets for incidence and transmission</th>
<th>Trend: decreasing</th>
</tr>
</thead>
</table>

**Formula:** Total cases of MRSA divided by the total patient days multiplied by 1,000 (for a per 1,000 patient days rate). **Note:** as of the June 2012 version of this report, the rates have been changed from per 1,000 admissions to per 1,000 patient days.

**Description:** Methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant enterococcus (VRE) are two of the most significant antibiotic-resistant organisms that can cause healthcare-associated infections. If an infection occurs, antibiotic treatment choices are limited and the infection may be more difficult to treat.

In the health care setting, the primary modes of MRSA transmission are the unwashed hands of caregivers, breaches in isolation precautions, and patient contact with contaminated and improperly cleaned communal equipment. MRSA is not airborne. MRSA does not cause one specific type of infection, but it may cause a variety of infections such as pneumonia, surgical wound infection, and urinary tract infection. Patients who have MSRA are cared for in strict isolation—in a single room, and with dedicated equipment not used for other patients. Careful hand hygiene before and after contact with the positive patient or their environment is one of the most important control measures for health care providers in preventing MRSA transmission.

The surveillance for these incidence and transmission rates includes the HI, VG, 9 Abbie Lane, VMB 3 East, and the Rehabilitation Centre, with the exception of Q4 2009/10 onward which also includes the Dartmouth General and Hants Community Hospitals (Haliburton Place excluded). Incidences are those cases that are identified at the hospital while transmissions are those cases that are acquired while in hospital.

**Analysis and Progress:** A summary of quarterly MRSA incidence and transmission rates can be seen in the two graphs below. In 2009, according to the Canadian Nosocomial Infection Surveillance Program (CNISP) of the Public Health Agency of Canada, the national MRSA incidence rate was 1.24 per 1,000 patient days and the national transmission rate was 0.59 per 1,000 patient days.

Both the incidence rates and the transmission rates were below their respective 2009 CNISP national rates for all time periods shown in the graph. Incidence rates at Capital Health continue to decrease and transmission rates have fluctuated in recent quarters.

**Source:** Infection Control

**Frequency Tracked:** Quarterly

**Last Updated:** October 2012

**Accountability:** Catherine Gaulton, Mary Ellen Gurnham, Lynn Johnston

**Next Update Expected:** Winter 2013
Note: as of the June 2012 version of this report, the rates have been changed from per 1,000 admissions to per 1,000 patient days.
Note: as of the June 2012 version of this report, the rates have been changed from per 1,000 admissions to per 1,000 patient days.

### Quarterly MRSA Transmission Rates at Capital Health

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2009 CNISP Rate (0.59)</th>
<th>Capital Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 2009/10</td>
<td>0.59</td>
<td>0.40</td>
</tr>
<tr>
<td>Q3 2009/10</td>
<td>0.59</td>
<td>0.50</td>
</tr>
<tr>
<td>Q4 2009/10</td>
<td>0.59</td>
<td>0.70</td>
</tr>
<tr>
<td>Q1 2010/11</td>
<td>0.59</td>
<td>0.60</td>
</tr>
<tr>
<td>Q2 2010/11</td>
<td>0.59</td>
<td>0.50</td>
</tr>
<tr>
<td>Q3 2010/11</td>
<td>0.59</td>
<td>0.40</td>
</tr>
<tr>
<td>Q4 2010/11</td>
<td>0.59</td>
<td>0.37</td>
</tr>
<tr>
<td>Q1 2011/12</td>
<td>0.59</td>
<td>0.29</td>
</tr>
<tr>
<td>Q2 2011/12</td>
<td>0.59</td>
<td>0.46</td>
</tr>
<tr>
<td>Q3 2011/12</td>
<td>0.59</td>
<td>0.32</td>
</tr>
<tr>
<td>Q4 2011/12</td>
<td>0.59</td>
<td>0.53</td>
</tr>
<tr>
<td>Q1 2012/13</td>
<td>0.59</td>
<td>0.38</td>
</tr>
</tbody>
</table>
### 3.1.18 Incidence Rate - VRE

**Patient Safety Indicator**

**Strategic Stream:** Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status:</th>
<th>Meeting target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend:</td>
<td>Increasing.</td>
</tr>
</tbody>
</table>

**Formula:** The number of VRE transmissions divided by total inpatient days, multiplied by 10,000 to get a rate per 10,000 patient days.

**Note:** as of the June 2012 version of this report, the rates have been changed from per 1,000 admissions to per 10,000 patient days.

**Description:** Methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin resistant enterococcus (VRE) are two of the most significant antibiotic-resistant organisms that may cause healthcare-associated infections. If an infection occurs, antibiotic treatment choices are limited and the infection can be more difficult to treat. In eastern Canada, the VRE rate continues to be lower than in central and western Canada.

VRE is spread in health care settings primarily by the hands of health care workers, from breaches in isolation precautions, and from contact with contaminated equipment, or other surfaces. It is not airborne. VRE can cause a variety of infections, most commonly surgical site and urinary tract infections. Patients who have VRE are cared for in strict isolation—in a single room with dedicated equipment that is not used for other patients. Careful hand hygiene before and after contact with the infected patient or their environment is the most important control measure in preventing transmission.

The surveillance for these incidence rates includes the HI, VG, 9 Abbie Lane, VMB 3 East, and the Rehabilitation Centre, with the exception of 2010 & 2011 which also includes the Dartmouth General and Hants Community Hospitals (Haliburton Place excluded).

**Analysis and Progress:** A summary of quarterly VRE incidence rates can be seen in the graph below. According to the Canadian Nosocomial Infection Surveillance Program (CNISP) of the Public Health Agency of Canada, the most recent national rate was 6.4 per 10,000 patient days (2009).

The rates have been far below the 2009 national rate, but a notable increase can be seen from Q2 2011/12 to Q1 2012/13.

<table>
<thead>
<tr>
<th>Source:</th>
<th>Infection Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency Tracked:</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Last Updated:</td>
<td>October 2012</td>
</tr>
</tbody>
</table>

**Accountability:** Catherine Gaulton, Mary Ellen Gurnham, Lynn Johnston

**Next Update Expected:** Winter 2013
Quarterly VRE Incidence Rates at Capital Health

Note: as of the June 2012 version of this report, the rates have been changed from per 1,000 admissions to per 10,000 patient days.
### 3.1.19  Infection Rate - C. difficile

**Patient Safety Indicator**

**Strategic Stream:** Person-Centered Health Care

**Status:** ✔ Meeting target  
**Trend:** Decreasing

**Formula:** Total cases of *C. difficile* divided by the total patient days, multiplied by 1,000, to get a rate per 1,000 patient days.  

**Note:** as of the June 2012 version of this report, the rates have been changed from per 1,000 admissions to per 1,000 patient days.

**Description:** *Clostridium difficile* or *C. difficile* is a bacterium that causes diarrhea and more serious intestinal conditions such as colitis. It is the most common cause of infectious diarrhea in hospitalized patients in the industrialized world. It is also one of the most common infections in hospitals and long-term care facilities (reference: Public Health Agency of Canada (PHAC)).

The use of antibiotics increases the chances of developing *C. difficile* diarrhea. Treatment with antibiotics alters the normal levels of good bacteria found in the intestines and colon. When there are fewer of these good bacteria, *C. difficile* can thrive and produce toxins that can cause an infection. The combination of the presence of *C. difficile* in hospitals and other health care settings, and the number of people receiving antibiotics in these venues can lead to frequent outbreaks (reference: PHAC). In these situations, *C. difficile* infections can be limited through careful use of antibiotics and the use of routine infection control measures. The PHAC has developed infection control guidelines for use by the provinces, territories, and health care organizations.

The surveillance for these infection rates includes the HI, VG, 9 Abbie Lane, VMB 3 East, and the Rehabilitation Centre, with the exception of 2010 & 2011 which also includes the Dartmouth General and Hants Community Hospitals (Haliburton Place excluded).

**Analysis and Progress:** The *C. difficile* hospital infection rates are shown in the graph below. The most recent national rate reported by the Canadian Nosocomial Infection Surveillance Program (CNISP) of the PHAC was 0.6 per 1,000 patient days (2009).

The rate at Capital Health has remained well below the 2009 national rate.

**Source:** Infection Control  
**Frequency Tracked:** Quarterly  
**Last Updated:** October 2012  
**Accountability:** Catherine Gaulton, Mary Ellen Gurnham, Lynn Johnston  
**Next Update Expected:** Winter 2013
Quarterly *C. difficile* Incidence Rates at Capital Health

Note: as of the June 2012 version of this report, the rates have been changed from per 1,000 admissions to per 1,000 patient days.
3.1.20 Hand Hygiene Compliance

What is being measured?
Measuring adherence and providing feedback with accepted hand hygiene practices is an important quality improvement tool. The Accreditation Canada Qmentum Program now includes hand hygiene audits as one of the required organizational practices within the Infection Prevention and Control Standards. As a part of Accreditation, Capital Health is required to audit compliance with hand hygiene practices, share these results, and use the results to make improvements to current practices. The audit (and compliance) is based on the Four Moments for Hand Hygiene, the times at which hand hygiene should occur:

1. Before initial patient/patient environment contact
2. Before aseptic procedure
3. After body fluid exposure risk
4. After patient/patient environment contact

Why is it important?
Promoting hand hygiene is considered the cornerstone of infection prevention and control programs and of preventing healthcare-associated infections. The World Health Organization has suggested improvements in hand hygiene compliance can prevent 50% of hospital-associated infections, making it the single most important practice in reducing the rate of such infections. As caregivers move from patient to patient and room to room caring for people, their hands pick up microorganisms which can cause infections. Hand hygiene works by interrupting this transmission of microorganisms.

How are we doing?
In 2010 the overall rate of compliance was 44% (baseline). In 2011 the overall rate was 66%, a great improvement over the rate in 2010. Both years are shown to have better (higher) rates than the overall Ontario health care provider rate of less than 40%.

What are we doing about this?
A targeted focus on Hand Hygiene practices will continue. Ongoing efforts include advancing staff and physician training across Capital Health. Patients are being educated through pamphlets and signage and are encouraged to wash hands when visiting the organization. A multi-modal campaign is ongoing and includes:

- Launch of new LMS (SHN) training module
- 2012/13 Hand Hygiene campaign (poster, screen saver, etc.)
- Targeted intervention for work groups
- Stop-Clean your hands day!
- Placement of alcohol-based hand rub product available at point of care
- Continued use of the automated hand hygiene audit tool
- Educational supports through videos, guides, and additional information on the IPAC intranet site
- Facilitated access to compliance reports and enhanced the data available for front line leaders
- Just-in-time feedback to front line staff

Hand Hygiene Compliance at Capital Health

Capital Health’s Strategic Indicators Report, January 28, 2013
# 3.1.21 Emergency Department - Percentage of Patients Left Without Being Seen

**Strategic Stream:** Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not meeting target</td>
<td>See the graph</td>
</tr>
</tbody>
</table>

**Formula:** Number of patients who left the emergency department without being seen by a physician divided by the total number of emergency registrations.

**Description:** Each month, hundreds of patients who arrive at emergency departments across Capital Health subsequently leave without being seen by a physician. While many of these patients may have symptoms or conditions that can be safely dealt with by alternative means, it is a concern that someone with a significant problem may leave and the consequences could be serious. At the Dartmouth General, a discharge planning nurse keeps a record of patients who leave without being seen and calls patients to provide follow up suggestions. The count of patients who left without being seen does not include those patients who were seen by a nurse in the emergency department instead of being seen by a physician.

The target is to keep walkouts below 2% all across Capital Health.

**Analysis and Progress:** The graph below shows the percent of patients who left the emergency department without being seen (all triage acuity levels combined). A breakdown by emergency department site is shown. All sites are over the target of 2%.

A failure modes and effects analysis process is being applied to the issue of patients leaving without being seen to see if there are root causes, and to determine the factors that influence patients’ decisions to leave which will help focus on the development of solutions.

In January, two initiatives have started that will increase capacity within the Dartmouth General ED: 1) expanded hours on the minor side. This was previously only staffed until 7:00 pm and now it is staffed until 11:00 pm; and 2) trial period of a chair zone which will be staffed by an LPN- this will care for Level 4’s & 5’s or stable level 3’s. This will be staffed from 11:00 am to 7:00 pm.

**Source:** EDIS  
**Frequency Tracked:** Monthly  
**Last Updated:** January 2013

**Accountability:** Barbara Hall, Sandra Janes, David Petrie, Samuel Campbell  
**Next Update Expected:** February 2013
Percentage of Emergency Patients Leaving Without Having Been Seen by a Physician
### 3.1.22 Long Term Care - Patients Placed and Waiting to be Placed

**Strategic Stream:** Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status:</th>
<th>Not meeting the target</th>
<th>Trend:</th>
<th>See graphs</th>
</tr>
</thead>
</table>

**Formula:** Number of patients placed and number of patients awaiting placement in long term care (LTC) facilities. Includes patients at all Capital Health sites.

**Description:** These graphs represent LTC patients from all Capital Health facilities—both acute care and mental health LTC patients are included. At any one time, patients who require care—but not acute care—may occupy a substantial number of beds in hospital facilities. Often they cannot be discharged from hospital until alternate services, such as residential care, are available. For this reason, a measure of the number of patients waiting to be placed is a measure of appropriate hospital utilization and the ability to respond to client needs.

Once a patient’s application is approved, he or she remains on a waitlist until a bed in the appropriate type of facility becomes available, unless their medical status changes. The application process involves a standardized provincial application, consisting of both health and financial assessments.

**Analysis and Progress:** The graphs below show the number of Capital Health patients *placed* and *waiting to be placed* into LTC facilities. In November 2012, the total number of patients at all Capital Health facilities who were waiting to be placed in LTC facilities was 206. This is **above the target of 75**.

In order to meet the LTC needs of their patient population, the Mental Health Program works with the Department of Health and Wellness (DoHW) for traditional LTC (nursing home) placements, as well as with the Department of Community Services (DCS) for non-traditional LTC placements such as Adult Residential and Small Options. DCS operates under a different set of rules & guidelines than DoHW and in a more risk averse and cautious manner. This results in Mental Health experiencing a much higher percentage of beds being occupied by patients awaiting placement, by comparison.

Lengths of stay are only a snapshot of what is documented in the LTC/ALC database at the time of publication of this report. November 2012 data were extracted on December 11th, 2012.

In Capital Health, as of January 2nd, 2013, there were 848 people in the community waiting to be placed in LTC facilities. The number of people waiting in the community during the same time last year (January 4th, 2011) was 616 (source: Department of Health and Wellness SEAscape database).

<table>
<thead>
<tr>
<th>Data Source:</th>
<th>Site Coordinators</th>
<th>Frequency Tracked:</th>
<th>Monthly</th>
<th>Last Updated:</th>
<th>January 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability:</td>
<td>Barbara Hall</td>
<td>Next Update Expected:</td>
<td>February 2013</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Capital Health Patients Placed in LTC
November 2010 to November 2012

Number of Patients
QEII
DGH
Hants
Mental Health
Tri-Facilities
### 3.1.23 Safer Healthcare Now!

<table>
<thead>
<tr>
<th>3.1.23.1 Code Blue Count (Impact of Quick Response Team)</th>
<th>Patient Safety Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Stream:</strong> Person-Centered Health Care</td>
<td></td>
</tr>
<tr>
<td>Status: ☑ Meeting target</td>
<td>Trend: variation</td>
</tr>
<tr>
<td><strong>Formula:</strong> The count of inpatient code blues per month at the Dartmouth General Hospital (DGH)</td>
<td></td>
</tr>
<tr>
<td><strong>Description:</strong> The Quick Response Team (QRT) (sometimes referred to as a rapid response team or a medical emergency team in other institutions) is a medical team designed to prevent patients from deteriorating to the point of requiring a code blue. A code blue is defined as the need for a response to a known or suspected cardio-respiratory arrest. A QRT was implemented at the DGH unit by unit in late 2005 until full implementation was reached in January 2006. The QRT at DGH is comprised of a physician, an ICU nurse, and a respiratory therapist. The QRT is called upon when a staff member is worried about a patient or when a patient meets specified clinical criteria indicating physiological instability that may lead to an arrest. When called, the team assists the staff member caring for the patient in assessing and stabilizing the patient’s condition. The QRT members also take on the role of educator and support to the staff. If the circumstances warrant, the QRT may recommend the transfer of the patient to a higher level of care and may help facilitate this transfer. In 2005, the average number of code blues per month was 5.62. The goal was to decrease the number of code blues by 50% or to three or fewer per month.</td>
<td></td>
</tr>
<tr>
<td><strong>Analysis and Progress:</strong> The graph below shows the monthly counts of code blues at the DGH. In 2011/12, the target was met, with the exception of January and February. For the time period of April to September, the average number of code blues per month was 2.2—exceeding the target of 3; however, September 2012 had 4 code blues. The DGH has been designated as a mentor in the Safer Healthcare Now! mentor network for facilities implementing similar response teams. Discussions are underway to implement a response team at the QEII.</td>
<td></td>
</tr>
<tr>
<td><strong>Source:</strong> Performance Excellence</td>
<td><strong>Frequency Tracked:</strong> Quarterly</td>
</tr>
<tr>
<td><strong>Accountability:</strong> QRT Code Committee, Heather Francis, Matt Watson</td>
<td><strong>Next Update Expected:</strong> February 2013</td>
</tr>
</tbody>
</table>
Count of Code Blues at the Dartmouth General
March 2010 to March 2012

- Actual Code Blues
- Target (3)
3.1.24 Hospital Standardized Mortality Ratio | Patient Safety Indicator

**Strategic Stream:** Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status: ✔ Meeting target (using the 2009/10 national average)</th>
<th>Trend: 2011/12 is on par with the 2009/10 national average</th>
</tr>
</thead>
</table>

**Formula:** Hospital standardized mortality ratio (HSMR) is the ratio of actual deaths to expected deaths, multiplied by 100. This indicator is calculated by the Canadian Institute for Health Information (CIHI). It is adjusted based on several factors.

**Description:** HSMR is a key indicator that can help support efforts to improve patient safety and quality of care. The HSMR compares the actual number of deaths in a hospital with the average Canadian experience, after adjusting for several factors that may affect in-hospital mortality rates, such as differences in age, sex, length of stay, admission category (planned vs. urgent/emergent), diagnosis group, selected comorbidities, and transfer from another acute care institution. CIHI calculates the ratios using data submitted from hospitals across the country. It only includes the 72 diagnosis groups that account for the top 80% of in-hospital deaths in Canada. The ratio provides a starting point to assess mortality rates and identify areas for improvement, which may help to reduce hospital deaths from adverse events.

Fiscal year 2009/10 is the baseline year in which the national average has been designated as 100. As such, an HSMR greater than 100 suggests the local mortality rate is higher than the national experience in 2009/10 (unfavourable). Conversely, HSMR scores less than 100 suggest the local mortality rate is lower than the national experience in 2009/10 (favourable). The baseline year used to be 2004/05 but in 2012, CIHI recalculated HSMR scores to use the 2009/10 national average as the baseline. With hospitals across the country improving their mortality rates over the past several years, the upward shift of the new HSMR scores is not a surprise since the new national average baseline “raised the bar” for hospitals across the country.

**Analysis and Progress:** The graph below shows the HSMR for CDHA for fiscal years 2007/08 to 2011/12. In fiscal years 2007/08 to 2009/10, CDHA had HSMRs that were statistically significantly worse than the 2009/10 national average (i.e. greater than 100), but had HSMRs that were on par with the 2009/10 national average (i.e. less than 100) for fiscal years 2010/11 and 2011/12.

<table>
<thead>
<tr>
<th>Source: CIHI, Decision Support</th>
<th>Frequency Tracked: Quarterly</th>
<th>Last Updated: October 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accountability:</strong></td>
<td></td>
<td>Next Update Expected: Winter 2013</td>
</tr>
</tbody>
</table>
Hospital Standardized Mortality Ratio at CDHA

= Statistically significantly different from the 2009/10 national average HSMR of 100 (red reference line)
3.1.25  Patient Experience Survey

<table>
<thead>
<tr>
<th>Strategic Stream: Person-Centered Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status:</strong></td>
</tr>
<tr>
<td>Trend:</td>
</tr>
</tbody>
</table>

**Formula:** Number of “agree” or “disagree” responses in a dimension divided by the total number of responses in a particular dimension, multiplied by 100 to get a percentage.

**Description:** As a commitment to quality improvement for patients and their families, CDHA requires feedback on an ongoing basis. Throughout the year, patients in inpatient, ambulatory and rehabilitation services are randomly sampled to partake in the patient satisfaction survey and the results are reported annually. The survey results can be used to identify strengths and opportunities for quality improvement initiatives and accreditation requirements. The satisfaction target has been set at 90%. The data presented here are an overall summary of the responses to all questions on the Inpatient and Outpatient/Ambulatory Patient Satisfaction Surveys. Mental Health and Emergency Department patients are not included; they are surveyed separately using a different tool.

**Analysis and Progress:** The graph below shows the percentage of “agree” and “disagree” responses for the CDHA Patient Experience Survey for fiscal year 2011/12 with a breakdown by dimension of patient experience. The positive response target of 90% was exceeded in five out of eight dimensions. At an organizational level, patients rated “Quality of Care Received”, as well as “Recommendation of the Hospital” at over 95% satisfaction. “Opportunity to Ask Questions Regarding Condition” and “Trust and Confidence in Healthcare Professionals” both rated at about 96% positive responses. This fiscal year marked significant improvements in the survey questions on “Cultural Values Taken into Account” and “Diversity Status Respected and Valued by Hospital Staff” (97% positive responses for each question in both ambulatory care and inpatient surveys). The positive responses to the question regarding “Knowing How to Express a Complaint” were up to 90% from 61% last year for ambulatory care and up to 88% from 64% for inpatients. This can be largely attributed to the establishment of a central call-in phone line that is lead by Patient Representative Services.

Opportunities for improvement were observed within the “Continuity and Coordination of Care” dimension. Improvements in care-team discussions with patients prior to discharge for the purposes of validating any required support at home that may be required according to a patient’s care plan, as well as the exchange of information related to monitoring for problems following a hospital visit or stay. Related quality improvements are currently underway, including an EXTRA Fellowship with the Canadian Health Services Research Foundation. Within the “Concern for Safety” dimension, areas for improvement include care-team communication with patients regarding possible side effects of drugs before administering new medications. As well, survey results indicated developmental opportunities to ensure patients and their families understand how to keep safe while in our care.

**Source:** CDHA Patient Satisfaction Survey  
**Frequency Tracked:** Yearly  
**Last Updated:** October 2012  
**Accountability:** Catherine Gaulton  
**Next Update Expected:** Summer 2013
Patient Experience Survey Results: Inpatient & Ambulatory Services
April 2011 to March 2012

Proportion of Responses

Target = 90%

Dimension of Patient Experience

Overall Assessment Accessibility of Services Emergency Department* Continuity and Coordination of Care Care Received From Health Professionals Respect for Rights Concern for Safety Facility Environment

Disagree Agree
### Patient Safety Culture

**Strategic Stream:** Person-Centered Health Care

<table>
<thead>
<tr>
<th>Status</th>
<th>No target</th>
<th>Trend: 2010 shows improvement over 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formula:</strong></td>
<td>Percent of responses to each possible answer for the Patient Safety Culture survey question related to overall grade on patient safety.</td>
<td></td>
</tr>
<tr>
<td><strong>Description:</strong></td>
<td>The CDHA Patient Safety Culture Survey was first completed in 2006 (2082 respondents) and was conducted again in 2010 (3290 respondents). It consisted of 40+ questions about the culture around patient safety at Capital Health. Respondents were asked to choose one of six possible answers for each question. The survey question of interest here is “Please give the organization an overall grade on patient safety” with the following possible answers: Excellent, Very Good, Acceptable, Poor, Failing, and N/A. Note that the 2006 survey did not provide the “N/A” option.</td>
<td></td>
</tr>
</tbody>
</table>

**Analysis and Progress:** The graph below shows the percentage of responses for each of the possible answers for the question related to overall grade on patient safety. In both 2006 and 2010, the majority of the responses fell under the “Very Good” and “Acceptable” response categories. In 2010, there was a decrease in the percent of “Acceptable”, “Poor”, and “Failing” responses and an increase in the “Excellent” and “Very Good” responses as compared to 2006.

In 2012, the percentages for “Excellent” and “Very Good” increase further from 2010. The responses for “Acceptable” and “Poor” continue to decrease. Responses for “Failing” are low and holding steady.

**Source:** Patient Safety Culture Reports (2006, 2010)  
**Frequency Tracked:** Every two years  
**Last Updated:** October 2012

**Accountability:** Catherine Gaulton  
**Next Update Expected:** 2014
Overall Grade on Patient Safety from Recent Capital Health Patient Safety Culture Surveys

<table>
<thead>
<tr>
<th>Grade</th>
<th>2006</th>
<th>2010</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>4%</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>Very Good</td>
<td>29%</td>
<td>40%</td>
<td>43%</td>
</tr>
<tr>
<td>Acceptable</td>
<td>50%</td>
<td>44%</td>
<td>41%</td>
</tr>
<tr>
<td>Poor</td>
<td>14%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Failing</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>
### 3.1.27 Completion of Patient Safety Training

<table>
<thead>
<tr>
<th>Strategic Stream: Person-Centered Health Care</th>
<th>Patient Safety Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status: ❌ Not meeting target</td>
<td>Trend: Decreasing rates</td>
</tr>
</tbody>
</table>

**Formula:** The number of employees who completed *at least one* patient safety course, divided by the total number of Capital Health employees, multiplied by 100.

**Description:** A required organizational practice (ROP) is an essential practice organizations must have in place to enhance patient/client safety and minimize risk. One of Accreditation Canada’s ROPs is the delivery of client safety training and education at least annually to employees. To fulfill this ROP, CDHA requires all employees and volunteers to annually complete at least one patient safety course. Most employees can fulfill this requirement by completing one of the six online patient safety courses using the Learning Management System (LMS). Others, such as volunteers, are provided the training as part of orientation packages and presentations.

The following employee types are included in the denominator for this rate calculation: confidential exclusion, executive, management, NS labour standard, NSGEU healthcare, NSGEU nursing, NSGEU office & clerical, NSGEU support services, NSNU nursing, residents (PARI-MP), physicians, research, clinical clerks, volunteers, and academic learners. Employees on leave are excluded. It should be noted that clinical clerks, volunteers, and academic learners do not have access to the LMS. The employee count for 2012/13 came from the most recent data available in July 2012.

Completion of courses through LMS is tracked, but delivery of presentations and orientation packages to individuals is not. Such packages are delivered to CDHA volunteers on a consistent basis, so an estimate of an 80% completion rate has been used for volunteers.

**Analysis and Progress:** The graph below shows the percentage of CDHA employees, medical staff, learners, and volunteers who completed at least one patient safety course in recent fiscal years. For April to September of 2012, the rate was 22%.

**Sources:** LMS, People Services, Medical Services Information System, CDHA Annual Report

**Frequency Tracked:** Quarterly  **Last Updated:** November 2012

**Accountability:** Catherine Gaulton  **Next Update Expected:** February 2013
Percentage of CDHA Employees, Medical Staff, Learners, and Volunteers Having Completed at Least One Patient Safety Training Course

- 2009/10: 30%
- 2010/11: 31%
- 2011/12: 25%
- 2012/13: 22%
3.2 Sustainability

This section contains a number of indicators focused on measuring health of the population (population health indicators), stewardship role of public resources and impact on the environment, and safety of physical spaces and equipment.

### 3.2.1 Access to a Primary Health Care Team

**Strategic Stream:** Sustainability

<table>
<thead>
<tr>
<th>Status:</th>
<th>Has met the 2012/13 target</th>
<th>Trend: n/a</th>
</tr>
</thead>
</table>

**Formula:** % of family physicians that are practicing as part of an interdisciplinary team (working with a Family Practice Nurse (FPN), or a Nurse Practitioner (NP) only).

**Description:** To help ensure patients have access to the appropriate resource within their community health setting. The *Our Promise Milestones* are to support accessibility to primary health care interdisciplinary teams by 10% in 2010/11, 15% by 2011/12, and 25% by 2012/13. Interdisciplinary Primary Health Care Teams are defined as including a nurse or other health professional (e.g. dietician or nutritionist) or both at their medical doctor’s office or health clinic.

**Analysis and Progress:** Primary Health Care continues to support the family practice nurse initiative. As demonstrated in the table below, the target for this milestone for the period 2011-2013 has been met (33.6% in 2011/12). However, the future expansion and enhancement of this milestone of great relevance for a sustainable healthcare system is funding and resource allocation dependent.

**Source:** Primary Health Care  
**Frequency Tracked:** Quarterly  
**Last Updated:** September 2012

**Accountability:** Barbara Hall  
**Next Update Expected:** n/a (target has been met)
## Progress for Access to a Primary Health Care Team

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Description &amp; Source</th>
<th>Time Period</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborative Practice Incentive Program</td>
<td>Learners in CDHA list from RNPDC and collaborating physicians</td>
<td>2011 - Present</td>
<td>109 Family Physicians submissions for this incentive indicating collaborative practice involvement</td>
</tr>
<tr>
<td>Family Practice Nurses</td>
<td>Learners in CDHA list from RNPDC and collaborating physicians</td>
<td>Current list</td>
<td>12 Family Physicians identified through this process</td>
</tr>
<tr>
<td>Nurse Practitioner listing</td>
<td>CRNNS website</td>
<td>Current list</td>
<td>14 Family Physicians working with 8 NPs from CFB Halifax and Bedford</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>13 Family Physicians working with NPs from Northwood and Bedford</td>
</tr>
<tr>
<td>Total in collaborative practice in Capital Health</td>
<td></td>
<td></td>
<td>148 Family Physicians</td>
</tr>
<tr>
<td>Total in Capital Health</td>
<td></td>
<td></td>
<td>440 Family Physicians</td>
</tr>
<tr>
<td>% Family Physicians working in collaborative practice in Capital Health</td>
<td></td>
<td>2011-2012</td>
<td>33.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2010-2011</td>
<td>20%</td>
</tr>
</tbody>
</table>
### 3.2.2 Increased Investment in Primary Care & Care of the Elderly

**Strategic Stream:** Sustainability

<table>
<thead>
<tr>
<th>Status</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Has met the 2012/13 target</td>
<td>Increasing</td>
</tr>
</tbody>
</table>

**Formula:** n/a

**Description:** Capital Health needs to invest in community supports and resources to better meet patient needs and gain service efficiencies.

The 2013 Milestone Target is to have a 1% increase in investment per year. The baseline is the 2009/10 budget for Capital Health services: Primary Care, Continuing Care, and Outpatient Geriatric services which totaled: $28,091,680. The 2010/11 target is a 1% increase over the baseline budget which equals an increase of $280,916. The 2011/12 target is a 1% increase over 2010/11 which translates into an increase of $564,643 over the 2009/10 baseline and $283,726 over 2010/11. The 2012/13 target is a 1% increase over 2011/12 which translates into an increase of $851,206 over the baseline and $286,563 over 2011/12.

**Analysis and Progress:** Through the 2010/11 business planning process $440,000 was committed for fiscal 2010/11 to support the Community Master Plan implementation.

Targeted investment money in the amount of $690,000 has been authorized for the 2011/12 fiscal year, thus the 2011/12 target has been met.

Additional investment money in the amount of $402,000 has been authorized for the 2012/13 fiscal year, thus the $286,563 target for 2012/13 has been exceeded. This total comes from the combination of investments in the Primary Care Community Master Plan, and the transfer of community placement staff (and associated funding) from the Department of Health and Wellness to CDHA. This figure accounts for the small decrease in funding (-$6,902) from the 2011/12 amount allocated for the Primary Care Community Health Teams.

**Source:** Barbara Hall

**Frequency Tracked:** Yearly (with each budget)

**Last Updated:** September 2012

**Accountability:** Barbara Hall

**Next Update Expected:** n/a (Target met)
### 3.2.3 Percentage of Alternate Level of Care Beds Vacated and Closed Permanently

**Strategic Stream:** Sustainability

<table>
<thead>
<tr>
<th>Status:</th>
<th>Trend: Slowly trending in the right direction (decreasing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formula:</td>
<td>Number of transitional care or alternate level of care (ALC) beds at Capital Health vacated and closed permanently, divided by the total number of ALC beds available at the end of 2009/10.</td>
</tr>
<tr>
<td>Description:</td>
<td>To help ensure patients with ALC needs are cared for in facilities that are specifically designed to meet the needs of this population, the Our Promise Milestones are to vacate and close permanently 40% of ALC beds by 2010/11, 60% by 2011/12, and 75% by 2012/13. Also, part of the goal is to reinvest the resources freed up as a result of the bed closures. This goal does not include mental health. The baseline year is 2009/10.</td>
</tr>
</tbody>
</table>

**Analysis and Progress:** The baseline against which percent closure is measured is the total transitional care beds at all Capital Health facilities at the end of 2009/10 (see table below), which was 110. In 2010/11, the target of closing 40% of beds was not met. As of April 5th, 2012, there were 69 transitional care beds. This is a decrease of 41 beds or 37% since 2009/10 – so the target of a 60% decrease was not met for 2011/12. As of January 8th, 2013, there was a decrease of 40% from the 2009/10 baseline. This is short of the 2012/13 target of a 75% decrease.

<table>
<thead>
<tr>
<th>Facility</th>
<th>2009/10 (Baseline)</th>
<th>January 8, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>QEII</td>
<td>59</td>
<td>19</td>
</tr>
<tr>
<td>Dartmouth General</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td>Hants Community</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Twin Oaks Memorial</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Musquodoboit Valley Memorial</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Eastern Shore Memorial</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>110</strong></td>
<td><strong>66</strong></td>
</tr>
<tr>
<td>Percentage Decrease from Baseline</td>
<td>n/a</td>
<td>40%</td>
</tr>
</tbody>
</table>

Resources have been freed up and some have been applied to creating the virtual bed program in the community. The business plan for DGH proposes some of the transitional care beds be converted to acute care beds to increase much needed acute care capacity. In order to do so, more community capacity must be created. Several provincial initiatives are underway to improve access to community options over the coming year.

**Source:** STAR  
**Frequency Tracked:** Monthly  
**Last Updated:** January 2013  
**Accountability:** Barbara Hall  
**Next Update Expected:** February 2013
### 3.2.4 Improved Metabolic Targets for Pre-Diabetes and Diabetes

**Strategic Stream: Sustainability**

<table>
<thead>
<tr>
<th>Status:</th>
<th>Δ Caution: awaiting 2012/13 data &amp; revisions to Milestone targets. DMC Team and DCPNS are currently developing meaningful targets that reflect DMC service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend:</td>
<td>n/a</td>
</tr>
</tbody>
</table>

**Formula:** Number of patients with diabetes mellitus in whom the last hemoglobin A1C (HbA1C) was ≤ 7% in the past 15 months divided by the number of Diabetes Care Program of Nova Scotia registered patients.

**Description:** To improve outcomes in patients with pre-diabetes and diabetes. The *Our Promise Milestones* are to improve outcomes by 10% in 2010/11, 30% by 2011/12, and 50% by 2012/13. Outcomes include the achievement of metabolic targets for glucose levels in patients involved with management programs. *Milestone targets will be revised to identify more meaningful milestone targets to track health outcomes in patients with pre-diabetes and diabetes.*

**Analysis and Progress:** Data provided from a report from Diabetes Care Program of Nova Scotia (DCPNS) for patients visiting a Diabetes Management Centre (DMC) within CDHA (Bayer's Road and Cobequid only). The following data are from the outcomes report including newly diagnosed patients only:

In 2009, there were 1225 adults seen in a Capital Health DEC with newly diagnosed diabetes. To be included in the DCPNS Registry Report, these newly diagnosed patients had to have at least two visits within a specified timeframe after their initial visit to the DEC. The first follow-up visit had to occur within the first 3-month period and the second visit between 8 and 15 months after the initial visit. In all, 345 newly diagnosed cases met the criteria for inclusion.

**2010-2011 results: 18.4%**

**2009-2011 Results:** HbA1C < 7% pre (value in first 3-month period) 53.5% (2009-2010); HbA1C < 7% post (value in 8-15 month period) 71.9% (2010-2011); Improvement of 18.4%.

*The trends in results for 2009-2011 of 18.4% individuals meeting A1C target post intervention are consistent with results observed in 2008-2010 of 18.8%. We anticipate this trend to continue for the A1C target. We will thus identify other suitable targets, outlined in evidence to show future improvements in health outcomes post intervention.*

**Other results:** An improvement was also noted in LDL-C lab results for patients pre-post. At the initial visit, 38.6% of patients had an LDL-C<2.5 mmol/l at their compared to 61.5% at their post visit.

**Access to data:** A request for an updated report (2012-13) has been requested from DCPNS but a response has not yet been received. The use of Millennium data is also being explored, but this has been slowed by competing reporting priorities.

<table>
<thead>
<tr>
<th>Source:</th>
<th>Primary Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency Tracked:</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Last Updated:</td>
<td>December 2012</td>
</tr>
<tr>
<td>Accountability:</td>
<td>Barbara Hall</td>
</tr>
<tr>
<td>Next Update Expected:</td>
<td>March 2013</td>
</tr>
</tbody>
</table>
### 3.2.5 Admissions for Identified Chronic Diseases

<table>
<thead>
<tr>
<th>Strategic Stream: Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status:</strong> △ Caution: Needs work to meet the 2012/13 target</td>
</tr>
</tbody>
</table>

**Formula:** Count of hospital admissions where the most responsible diagnosis was chronic obstructive lung disease (COPD); diabetes; or heart failure and pulmonary edema. Admissions to all CDHA facilities are included.

**Description:** This indicator is a count of the hospital admissions for which the most responsible diagnosis was chronic obstructive lung disease (COPD); diabetes; or heart failure and pulmonary edema (combined). This excludes admissions for cardiac procedures, deaths before discharge, and patients 75 years or older. These are diseases that can be effectively managed through appropriate ambulatory care. While not all admissions can be avoided, effective community based chronic disease prevention and management programs, self management initiatives, primary care and ambulatory care may prevent the onset of chronic disease, or control or prevent an acute episode or exacerbation.

According to the *Our Promise: 2013 Milestones*, the goal is to reduce hospital admissions for identified chronic disease by 1% in 2010/11, by 2% in 2011/12 and by 3% by 2012/2013. The baseline year is 2009/10.

**Analysis and Progress:** The counts of admissions for each of the three chronic diseases listed above are shown in separate graphs below. Each graph shows the total admissions for the 2006/07 to 2012/13 fiscal years, as well as the target admission counts based on percent reductions from the baseline year (2009/10).

With a 2.8% reduction in 2010/11, the first-year target of a 1% reduction was met. In 2011/12, for all three diseases combined, there was an increase of 5% over the baseline year. This was short of the 2011/12 target of a 2% decrease. Individually, none of the diseases met the target. Heart failure/pulmonary edema was the biggest contributor to missing the target for 2011/12.

Using April to October of 2012/13 to extrapolate to a full fiscal year, it looks as if the 2012/13 reduction will be 2%. This is just short of the 3% reduction target. Looking at the diseases separately, both diabetes and COPD are doing very well, while heart failure/pulmonary edema is slightly behind target at this point.

This is linked as a target in the Community Master Plan for Primary Health Care but funding will not allow specific focus on initiatives this year.

**Data Source:** Discharge Abstract Database  
**Frequency Tracked:** Monthly  
**Last Updated:** January 2013

**Accountability:** Barbara Hall  
**Next Update Expected:** February 2013
Hospital Admissions for COPD
2006/07 to 2012/13 and Milestone Targets

Fiscal Year

Count of Admissions

- Actual
- Milestone Targets

Estimate for full fiscal Year: 365
April to Oct. Only

2006/07: 413
2007/08: 358
2008/09: 385
2009/10 Baseline: 377
2010/11: Milestone Targets 372, Estimate 373
2011/12: Milestone Targets 369, Estimate 390
2012/13: 366
Hospital Admissions for Diabetes
2006/07 to 2012/13 and Milestone Targets

Fiscal Year

Count of Admissions

2006/07 107
2007/08 124
2008/09 136
2009/10 Baseline 102
2010/11 86
2011/12 102
2012/13 99

Actual
Milestone Targets

Estimate for full fiscal Year: 94
April to Oct. Only
Hospital Admissions for Heart Failure & Pulmonary Edema
2006/07 to 2012/13 and Milestone Targets

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Actual</th>
<th>Milestone Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>227</td>
<td></td>
</tr>
<tr>
<td>2007/08</td>
<td>175</td>
<td></td>
</tr>
<tr>
<td>2008/09</td>
<td>226</td>
<td></td>
</tr>
<tr>
<td>2009/10 Baseline</td>
<td>201</td>
<td></td>
</tr>
<tr>
<td>2010/11</td>
<td>203</td>
<td>199</td>
</tr>
<tr>
<td>2011/12</td>
<td>222</td>
<td>197</td>
</tr>
<tr>
<td>2012/13</td>
<td>195</td>
<td>121</td>
</tr>
</tbody>
</table>

Estimate for full fiscal Year: 207
April to Oct. Only

Capital Health’s Strategic Indicators Report, January 28, 2013
### 3.2.6 Readmission Rates for Cohorts with Complex Chronic Disease

**Strategic Stream: Sustainability**

<table>
<thead>
<tr>
<th>Status: △ Caution: Needs work to meet the 2012/13 target</th>
<th>Trend: Heart failure/pulmonary edema is the offender</th>
</tr>
</thead>
</table>

**Formula:** Total readmissions divided by the total number of admissions with the same most responsible diagnosis in the same time period, multiplied by 100.

**Description:** This includes readmissions that occur within 28 days of discharge from acute care and within 7 days of day surgery. Readmissions to all CDHA facilities are included. Data are presented for chronic obstructive lung disease (COPD); diabetes; and heart failure or pulmonary edema (combined). Cardiac procedures, deaths before discharge, and patients 75 years or older have been excluded.

Patient readmissions may be linked to factors related to the initial hospital stay, prescribing of and compliance with post discharge therapy, or follow-up care in the community. In many cases, readmission can be due to factors outside the influence of the hospital, but high readmission rates should be a trigger for hospitals and primary health care providers to examine carefully their practices, including the possibility of discharging patients too soon and relationships with community-based care providers.

According to the *Our Promise: 2013 Milestones*, the goals are to reduce hospital readmission rates by 3% in 2010/11, by 5% in 2011/12 and by 10% by 2012/2013. The baseline year is 2009/10.

**Analysis and Progress:** The readmission rates for each of the three chronic diseases listed above are shown in separate graphs below. Each graph shows the readmission rate for the 2006/07 to 2012/13 fiscal years, as well as the target readmission rates based on percentage reductions from the baseline year (2009/10).

In 2010/11, for all diseases combined, the readmission rate decreased by 2.7%, almost meeting the first-year target of 3%. In 2011/12, the readmission rate for diabetes met the 2011/12 target, but the rates for COPD and heart failure/pulmonary edema did not. Also for this same time period, all three diseases combined showed a 16% increase over the baseline. This is far over the 2011/12 target of a 5% decrease from the 2009/10 baseline. The major contributor to this was heart failure/pulmonary edema.

For April–October 2012, the readmission rate for all three diseases combined was 8%. This is an increase of 8.4% from the 2009/10 baseline—falling short of the target of a 10% decrease. The main contributor to this is the high heart failure/pulmonary edema readmission rate.

<table>
<thead>
<tr>
<th>Data Source: Discharge Abstract Database, Decision Support</th>
<th>Frequency Tracked: Monthly</th>
<th>Last Updated: January 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accountability:</strong> Barbara Hall</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Hospital Readmission Rate for COPD
2006/07 to 2012/13 and Milestone Targets

2006/07: 10.2%
2007/08: 6.4%
2008/09: 7.5%
2009/10 Baseline: 8.2%
2010/11: 9.1%
2011/12: 8.7%
2012/13: 8.0%

April-October Only:
2006/07: 12%
2007/08: 8%
2008/09: 6%
2009/10: 4%
2010/11: 2%
2011/12: 0%
2012/13: 0%

Actual

Milestone Targets

Fiscal Year

Capital Health’s Strategic Indicators Report, January 28, 2013
Hospital Readmission Rates for Diabetes
2006/07 to 2012/13 and Milestone Targets

Readmission Rate

- Actual
- Milestone Targets

Fiscal Year

- 2006/07
- 2007/08
- 2008/09
- 2009/10 Baseline
- 2010/11
- 2011/12
- 2012/13

Milestone Targets

- Apr-Oct Only

- 2006/07: 7.5%
- 2007/08: 2.4%
- 2008/09: 11.0%
- 2009/10: 4.9%
- 2010/11: 4.7%
- 2011/12: 3.9%
- 2012/13: 4.4%
Hospital Readmission Rates for Heart Failure & Pulmonary Edema - 2006/07 to 2012/13 and Milestone Targets

Fiscal Year

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Milestone Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>9.7%</td>
<td></td>
</tr>
<tr>
<td>2007/08</td>
<td>8.0%</td>
<td></td>
</tr>
<tr>
<td>2008/09</td>
<td>11.1%</td>
<td></td>
</tr>
<tr>
<td>2009/10 Baseline</td>
<td>7.0%</td>
<td></td>
</tr>
<tr>
<td>2010/11</td>
<td>6.8%</td>
<td></td>
</tr>
<tr>
<td>2011/12</td>
<td>6.6%</td>
<td></td>
</tr>
<tr>
<td>2012/13</td>
<td>11.6%</td>
<td></td>
</tr>
</tbody>
</table>

April-October Only

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>9.7%</td>
</tr>
<tr>
<td>2007/08</td>
<td>8.0%</td>
</tr>
<tr>
<td>2008/09</td>
<td>11.1%</td>
</tr>
<tr>
<td>2009/10</td>
<td>7.0%</td>
</tr>
<tr>
<td>2010/11</td>
<td>4.3%</td>
</tr>
<tr>
<td>2011/12</td>
<td>6.6%</td>
</tr>
<tr>
<td>2012/13</td>
<td>6.3%</td>
</tr>
</tbody>
</table>
### 3.2.7 Nursing Home Patients Seen in the Emergency Department

#### Strategic Stream: Sustainability

<table>
<thead>
<tr>
<th>Status:  ✔ Meeting the 2012/13 target</th>
<th>Trend: Monthly average is steady</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formula: Number of nursing home patients seen in the emergency department (ED) in a one-month period</td>
<td></td>
</tr>
</tbody>
</table>

**Description:** According to the *Our Promise: 2013 Milestones*, the goals are to decrease the volume of nursing home patients seen in the ED by 10% in 2010/11, by 15% in 2011/12 and by 25% by 2012/2013. The baseline is the 2009/10 fiscal year, but since collection of these data only commenced in December 2009, a monthly average for the period of January to March 2010 is used as the baseline measure (average of 44 patients per month). The reduction of 10% for the 2010/11 fiscal year translates into a target of 40 nursing home patients per month. The reduction of 15% for the 2011/12 fiscal year translates into a target of 37 patients per month. The reduction of 25% for the 2012/13 fiscal year translates into a target of 33 patients per month.

**Analysis and Progress:** The graph below shows the monthly counts of nursing home patients seen in all EDs at Capital Health.

The target of 40 was met for 2010/11 when the monthly average was 33. In 2011/12, the target of 37 patients per month (a 15% decrease from baseline) was surpassed, with an average of 31 patients per month (a 30% decrease from baseline).

In April to November of 2012/13, an average of 30 nursing home patients presented to the ED each month. This is so far exceeding the goal of a reduction to 33 per month for 2012/13. However, there was a jump up to 43 patients for the month of October.

**Source:** EDIS, Decision Support  
**Frequency Tracked:** Monthly  
**Last Updated:** January 2013  
**Accountability:** Barbara Hall  
**Next Update Expected:** February 2013
Number of Nursing Home Patients Seen in Emergency Departments per Month

Number of Patients

Nursing Home Patients Seen in Emergency

Milestone Targets
3.2.8 Length of Stay - Average Length of Stay for Patients Discharged to Long Term Care

**Strategic Stream:** Sustainability

**Status:** No Target

**Trend:** See graph below

**Formula:** Average length of stay (days) in hospital for patients discharged to a long term care (LTC) facility

**Description:** The wait times reported below are for Department of Health and Department of Community Services’ patients. The Continuing Care Branch within the Department of Health includes patients who are 65 years of age or over or are under 65 years of age and have nursing level care needs. Halifax Services for Patients with Disabilities within the Department of Community Services includes any patient who is under 65 years of age and requires support / supervision but not nursing level care. Together, they reflect the average wait times for people placed in long term care facilities during that month.

**Analysis and Progress:** The graph below shows the average length of stay for patients discharged to LTC.

The average length of stay of the mental health population (NSH) is quite variable. This is due to the lower monthly number of patients being placed and the potential for much longer lengths of stay. In order to meet the LTC needs of their patient population, the Mental Health Program works with the Department of Health and Wellness (DoHW) for traditional LTC (nursing home) placements, as well as with the Department of Community Services (DCS) for non-traditional LTC placements such as Adult Residential and Small Options. DCS operates under a different set of rules & guidelines than DoHW and in a more risk averse and cautious manner. This results in Mental Health experiencing a much higher percentage of beds being occupied by patients awaiting placement, by comparison.

The gaps shown in the graph lines are associated with months in which no patients were discharged to long term care facilities.

It should be noted that lengths of stay are only a snapshot of what is documented in the LTC/ALC database at the time of extraction of data from the database. November 2012 data were extracted on December 11th, 2012.

**Source:** Social Work

**Frequency Tracked:** Monthly

**Last Updated:** January 2013

**Accountability:** Barbara Hall

**Next Update Expected:** February 2013
Average Length of Stay for Patients Discharged to Long Term Care
November 2009 to November 2012

The gaps shown in the graph lines are associated with months in which no patients were discharged to long term care facilities.
3.3 Transformational Leadership

This section contains information and indicators related to employee satisfaction, physician engagement and satisfaction, and quality of work life.

### 3.3.1 Absenteeism

**Strategic Stream: Transformational Leadership**

<table>
<thead>
<tr>
<th>Status:</th>
<th>Caution: Needs work to meet the 2012/13 target</th>
<th>Trend: Same as 2011/12 and 2010/11.</th>
</tr>
</thead>
</table>

**Formula:** Average sick hours used per eligible employee per month. Sick hours include paid sick time (NSNU employees), paid general illness (all other employees), short term illness, and grandfather illness long term disability at 100%.

**Description:** According to the *Our Promise: 2013 Milestones*, the goals are to reduce absenteeism by 5% in 2010/11, by 7% in 2011/12 and by 10% by 2012/2013.

**Analysis and Progress:** A graph of the average sick hours per eligible employee at CDHA is shown below.

In 2010/11, average sick hours increased 2.8% from the baseline year and the target was not met. For the full 2011/12 fiscal year, average sick hours were 3.0% higher than the baseline. For April to November of 2012/13, average sick hours were 5% higher than the baseline—falling short of the target of a 10% decrease.

Healthy Workplace along with Wellness and Safety services have combined forces to provide educational programs for frontline managers to enable them to recognize signs of workplace fatigue attributed to stress. An October 2011 workshop on mental health at work was scheduled as education for senior leaders. Communications have been sent to employees thanking them for their attendance, while ensuring accountability around sick time usage.

People Services has also teamed up with Wellness and Safety to help deliver education opportunities to assist managers with the utilization of employment contracts around culpable sick time, improving accessibility by means of identification/promotion of services. Relevant quality operational indicators are being identified and will be used to determine the best services available to meet these goals.

**Source:** People Services  
**Frequency Tracked:** Monthly  
**Last Updated:** January 2013

**Accountability:** Kathy MacNeil  
**Next Update Expected:** February 2013
Average Monthly Paid Sick Hours per Eligible Employee at CDHA
2009/10 to 2012/13 Year to Date and Milestone Targets

The 2010 Human Resources National Benchmarking Network national average was 5.9 hrs/month.

- Baseline (Average of 2008 to 2010): 6.83
- 2010/11: 7.02 (6.49), Milestone Targets Apr. to Nov. Only: 6.15
- 2011/12: 7.04 (6.35)
- 2012/13: 7.15

Actual vs Milestone Targets.
### 3.3.2 Overtime – Percent of Overtime Hours Worked

**Strategic Stream:** Transformational Leadership

<table>
<thead>
<tr>
<th>Status</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Meeting the 2012/13 target so far</td>
<td>Same as previous year</td>
</tr>
</tbody>
</table>

**Formula:** Total hours worked overtime divided by the total hours worked, multiplied by 100.

**Description:** According to the *Our Promise: 2013 Milestones*, the goals are to reduce overtime by 5% in 2010/11, by 7% in 2011/12 and by 10% by 2012/2013. The baseline year is 2009/10, in which 2.1% of worked hours were overtime hours.

**Analysis and Progress:** The graph below shows the percentage of overtime worked at CDHA for the fiscal years 2006/07 to 2012/13 and milestone targets. In 2010/11, 1.58% of hours worked were overtime hours. This was a decrease of 25%—surpassing the target of a 5% decrease.

For 2011/12, the percentage of overtime hours worked was 1.32%. This was a 37% decrease from the baseline—surpassing the 2011/12 target of a 7% decrease. For April to November of 2012/13, the percentage of overtime hours worked was 1.36%, a decrease of 35% from the baseline. If this trend continues for the rest of the fiscal year, the target of a 10% reduction will be surpassed.

Over the last several years there have been several initiatives put in place to help reduce OT such as increased hiring of grad nurses in 2008, 2009 and 2010; increased education on understanding of financials; central staffing office; and stream-lined staffing processes at the QEII.

<table>
<thead>
<tr>
<th>Source: People Services</th>
<th>Frequency Tracked: Monthly</th>
<th>Last Updated: January 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability: Kathy MacNeil</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Next Update Expected: February 2013 |
3.3.3 Recruitment for Hard-to-Fill Positions

**Strategic Stream: Transformational Leadership**
Status: △ Caution: needs work to meet the 2012/13 target

Trend: There has been an increase in the time required to fill vacancies due to business planning and trying to reduce hiring rather than lack of applicants. There has been an increasing difficulty in the hiring of LPNs.

**Formula:** The number of employees recruited to specified hard-to-fill positions divided by the number of specified hard-to-fill positions referred to the recruitment team

**Description:** According to the *Our Promise: 2013 Milestones*, the goals are to improve recruitment by 10% in 2010/11, by 30% in 2011/12, and by 50% by 2012/2013. The baseline year is 2009/10. The information related to hard-to-fill positions is one component of this measure.

Targeted hard-to-fill positions include:

- Nurses (particularly in specialty areas such as emergency, perioperative, critical care, and in locations outside Metropolitan Halifax)
- Healthcare professions that require specialty / post graduate or additional studies (ORTs + perfusionist)
- Managerial positions (Chief Medical Physicist)

**Analysis and Progress:** The procedure for handling hard-to-fill positions continues, i.e., conducting a focused search if a position remains unfilled after the posting obligations have been met in accordance with our collective agreements.

Nursing positions in the ICUs, EDs, ORs and PACU have been identified as a staffing concern and have been referred for additional recruitment efforts. While hires have been taking place, vacancies continue to arise in these areas in addition to existing vacancies and focused, on-going efforts are being applied to address the staffing issue. These efforts include:

1. Advertising using paid and free resources online to ensure higher visibility for CDHA vacancies (ORNAC, NENA, NAPANC, CACCN, UK agencies list, LinkedIn groups, job boards)
2. Sponsorship staff education RNPDC for FT and PT programs (8 ENP FT + 2 ENP PT + 1 OR PT + 2 OR tech LPN nurses)
3. Participating in job fairs and exhibitions
4. New nursing graduates 2013 posting preparation (survey to learn projected hiring needs & expected supernumerary – awaiting approval)
5. Exploring possibilities with various staffing/recruitment offices focusing on local talent

In Recruitment overall, as of September 30, 2012, there were 290 open positions—5 of which were opened in 2011. Three of these pooling postings and 2 are hard to fill positions. There have been 1,128 postings opened so far in 2012 (379 Nursing, 469 LPN & Healthcare, 90 Support, 130 Office & Clerical, 17 excluded, 18 managerial, 25 Research & Other). Of the 1,128 postings opened in 2012 only 50 of them exceed the 90 days of the hard-to-fill definition.

**Source:** People Services  
**Frequency Tracked:** Quarterly  
**Last Updated:** December 2012

**Accountability:** Kathy MacNeil  
**Next Update Expected:** March 2013
### 3.3.4 Alignment of Medical Departments and Operational Structures

**Strategic Stream:** Transformational Leadership

<table>
<thead>
<tr>
<th>Status:</th>
<th>Trending towards target</th>
</tr>
</thead>
</table>

**Formula:** The number of medical departments aligned with operations.

**Description:** According to the *Our Promise: 2013 Milestones*, the goal is to have 40% of medical department structures aligned with operations by 2010/11, 60% by 2011/12, and 100% by 2012/2013. Aligning medical and operational structures will facilitate organizational change and support achievement of organizational goals.

**Analysis and Progress:** Physician Services in consultation with physician leaders has determined that five Key strategic initiatives must be implemented and be achieving set targets as a condition of meeting this milestone. Those 5 areas are:

1. Departmental Governance, Structure, payment principles and accountability aligned with the CDHA as required
2. Leadership accountabilities defined and assessed with a process in place to address performance and ongoing development (leadership development, Co-leadership Implementation)
3. Departmental Search and Survey process alignment
4. Academic Funding Plan Framework redesign work
5. Departmental Quality activities aligned with organizational practices and priorities

Activities and achievements to date tell us that we are on target to meet the 2013 milestone target of 100% alignment of department structures and operations with CDHA organizational goals.

**Performance Measures/Indicators:**

- 100% of Medical Departments are constituted and operate in accordance to the CDHA Medical Staff Bylaws
- 17 out of 20 co-leaders reported co-leadership relationships have advanced. Specifically, decision making, trust between co-leaders, shared vision and accountabilities, frequency of meetings and increased appreciation and respect of one another.
- 26 physicians enrolled in second cohort of the FATT physician leadership program.
- 86% of available seats in the second Cohort of FATT Leadership Program were filled.
- 100% of physicians in Cohort 3 completed the FATT leadership program.
- 97% of participants in FATT leadership program reported they were “overall satisfied with the program”
- 100% of medical departments requiring a survey have been completed.
- 93% of medical departments requiring a survey are completed on time in accordance with the survey cycle.
- 70% of medical divisions within departments requiring a survey have been completed.
- 45% of medical divisions within departments requiring a survey are completed on time in accordance with the survey cycle. (others were stalled for justified reasons)
- 100% of AFP departments have a Practice Plan reviewed by the District to ensure alignment with organizational priorities
- 75% of non-AFP departments have a practice plan (or equivalent) demonstrating alignment with CDHA organizational priorities.

**Source:** Physician Services

**Frequency Tracked:** Variable

**Last Updated:** December 2012

**Accountability:** Ray LeBlanc (Interim VP Medicine)

**Next Update Expected:** March 2013
### 3.3.5 Compliance with Performance Evaluation Process

**Strategic Stream: Transformational Leadership**

<table>
<thead>
<tr>
<th>Status</th>
<th>Trend: Slowly increasing (favourable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formula: All employees with performance appraisals completed plus those not yet due, divided by the total number of active employees (then multiplied by 100 to get a percentage).</td>
<td></td>
</tr>
<tr>
<td><strong>Description:</strong> According to the <em>Our Promise: 2013 Milestones</em>, the goals are to bring compliance with performance appraisals to 25% in 2010/11, to 75% in 2011/12, and to 100% by 2012/2013.</td>
<td></td>
</tr>
</tbody>
</table>

Performance appraisals should be completed for union-member employees a minimum of every two years. In September 2010 the organization began to require performance appraisals annually for excluded confidential and management employees. Performance appraisals are only recorded as received when they are placed in the employee's file.

**Analysis and Progress:** Management and confidential excluded employees are required to have a completed performance appraisal on file before merit increases are processed.

The quarterly performance appraisal progress report is distributed following the end of each quarter. This distribution provides managers, directors, and VPs with a status report and assists with quarterly planning. Scorecard results are also posted in the intranet.

To increase the number of actual performance appraisals being done, and to ease the administrative burden associated with the process, which is all manual, a shortened revised Performance tool, that was developed in conjunction with operations managers, was posted on the Internet for use as of June 2011, and the operations groups are now using it to complete the appraisals with their staff. HR consultants continue to support managers in completing the process and with ongoing training.

A shared accountability between People Services (process) and Transformation Network Team (content) supported by Performance Excellence to create web-based (Select Survey) performance tools and processes for management and excluded/union positions. This project incorporates Capital Health's leadership capabilities into the tools, allowing for ease of distribution, completion and collation at no additional cost to better strengthen achievement of the milestones within the Transformational Leadership strategic stream. Plans are to prototype the new tools with VP and Director levels in February/March 2012 with an organizational rollout in early 2012-13.

The graph below shows the percentage of performance appraisals completed for fiscal years 2010/11 to 2012/13. The target of 25% for 2010/11 was exceeded. In 2011/12, 38% of performance appraisals were completed—falling short of the 75% target. For the first six months of 2012/13, the percentage was 40%—short of the 2012/13 target of 100%.

**Source:** People Services  
**Frequency Tracked:** Quarterly  
**Last Updated:** November 2012  
**Accountability:** Kathy MacNeil  
**Next Update Expected:** February 2013
Staff Performance Reviews Completed at CDHA
Fiscal Years 2010/11 to 2012/13 and Milestone Targets

- **Actual**
- **Milestone Targets**

### Reviews Completed

- **2010/11**
  - 32%
  - 25%

- **2011/12**
  - 38%
  - 75%

- **2012/13**
  - 40%
  - 100%

Milestone Targets:
- April 1st to October 9th
3.3.6 Formal Leaders Demonstrate Transformational Leadership Capabilities

**Strategic Stream: Transformational Leadership**

<table>
<thead>
<tr>
<th>Status:</th>
<th>Trending toward the 2012/13 target</th>
<th>Trend: Positive / on track. See graph and analysis.</th>
</tr>
</thead>
</table>

**Formula:** The number of leaders demonstrating transformational leadership capabilities as defined by My Leadership within the time period.

**Description:** According to the *Our Promise: 2013 Milestones*, the goal is to have 50% of leaders consistently demonstrating the My Leadership transformational leadership capabilities by 2010/11, 75% by 2011/12, and 90% by 2012/13. Results are based on evaluations pre/post organizational change.

**Analysis and Progress:** Progress continues in Being, Caring, and Doing transformational leadership capabilities among formal leaders. In the 2011 report, increases were noted in two of three dimensions of transformational leadership (Being and Doing), and a slight decrease in Caring as compared to the 2009 employee survey results. Because Capital Health did not administer an organizational-wide Employee Survey in 2012, 240 randomly selected employees were surveyed to check progress toward this milestone. Findings indicate leader performance has risen on all three dimensions: Being (72.1%), Caring (71.7%) and Doing (72.1%). Overall, 2012 results fall just shy of the interim target of 75% established for fiscal year 2011/12 (see graph below). Because 2012 levels are derived from a smaller sample size than 2009 and 2011, there is an inherent threat to the validity of these results.

To date, Capital Health’s programs of leadership and management development for formal leaders have essentially been designed and delivered separately. To address this disconnect, a project team has been established with the goal of developing and implementing an integrated leader development program for formal leaders at Capital Health. The new program will be aligned with our leadership framework and will support the development of specific job-related competencies, for the sake of supporting advancement of the transformational leadership milestone and contributing to organizational performance.

The My Leadership program for front line staff continues to grow and to show positive impact. One thousand employees in 44 teams have completed the program, and another 1,135 in 42 teams are currently engaged in it. Participant evaluations continue to show positive responses on measures such as “I understand the need for change in health care and why I need to be part of that” and “I understand what it means to be a leader and that it’s going to take all of us as leaders to succeed.”

**Source:** Neale Bennet

**Accountability:** Kathy MacNeil

**Frequency Tracked:** Variable

**Last Updated:** December 2012

**Next Update Expected:** March 2013
Capital Health Employee Survey Results

- 2012/13 Milestone: 90%
- 2011/12 Milestone: 75%
- 2010/11 Milestone: 50%

Percentage Scoring Above 3/5

- Being: 63.8%, 66.1%, 72.0%
- Caring: 65.0%, 64.2%, 72.0%
- Doing: 65.6%, 69.7%, 72.0%
### 3.3.7 Employee Survey

**Strategic Stream:** Transformational Leadership

<table>
<thead>
<tr>
<th>Status: No set target</th>
<th>Trend: see graph</th>
</tr>
</thead>
</table>

**Formula:** Percentage of favorable, neutral, and unfavorable responses in a given section of the survey

**Description:** At Capital Health, we have made a promise to be a world-leading haven for people-centred health, healing, and learning. We can only achieve Our Promise if each of us experiences Capital Health as a rewarding, satisfying, and healthy place to work. That’s why every two years, an employee survey is conducted. The survey, conducted in February 2011, allows the measurement of progress and the answers the following questions: How are we doing? Where could we be doing better? What will we celebrate?

The response rate was 46%.

**Analysis and Progress:** The graph below shows a selection of the results of the 2009 and 2011 Capital Health Employee Surveys. The selection of results presented in this report are meant to highlight a sample of areas to be celebrated and areas where improvements could be made.

From the graph it can be seen that both pride and trust in peers had very high percentages of favorable responses in both 2009 and 2011. Spiritual wellness was not part of the 2009 survey, but had a very high percentage of favorable responses in 2011. Some of the areas for improvement include psychological safety, involvement in decision making, and trust in management.

Teams throughout Capital Health will receive team reports in June 2011, have conversations, and implement action on ways to improve their workplace. This process is the most meaningful for staff as each unit or department is unique and will have unique interests and ideas that the organizational response to survey results may not address. The 2011 survey team will make one to two recommendations based on analysis of the organizational survey results—looking at statistical and practical significance of the results and the relationships among the survey measures. The team will look for leverage opportunities based on this analysis and the prospect of alignment with existing or planned strategies within Capital Health and our larger community.

**Source:** People Portfolio  
**Frequency Tracked:** Every two years  
**Last Updated:** June 2011

**Accountability:** Kathy MacNeil  
**Next Update Expected:** 2013
Selected Results From the 2009 & 2011 Employee Surveys

<table>
<thead>
<tr>
<th>Category</th>
<th>2009 (%)</th>
<th>2011 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pride</td>
<td>92%</td>
<td>95%</td>
</tr>
<tr>
<td>Trust in Peers</td>
<td>79%</td>
<td>78%</td>
</tr>
<tr>
<td>Spiritual Wellness 2009</td>
<td>8%</td>
<td>13%</td>
</tr>
<tr>
<td>Spiritual Wellness 2011</td>
<td>9%</td>
<td>13%</td>
</tr>
<tr>
<td>Psychological Safety 2009</td>
<td>3%</td>
<td>12%</td>
</tr>
<tr>
<td>Psychological Safety 2011</td>
<td>85%</td>
<td>39%</td>
</tr>
<tr>
<td>Decision Making 2009</td>
<td>37%</td>
<td>19%</td>
</tr>
<tr>
<td>Decision Making 2011</td>
<td>47%</td>
<td>41%</td>
</tr>
<tr>
<td>Trust in Management 2009</td>
<td>34%</td>
<td>30%</td>
</tr>
<tr>
<td>Trust in Management 2011</td>
<td>38%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Spiritual Wellness was not part of the 2009 survey.
Psychological Safety was not part of the 2009 survey.
### 3.3.8 Physician Survey

**Strategic Stream:** Transformational Leadership

<table>
<thead>
<tr>
<th>Status: No set target</th>
<th>Trend: n/a</th>
</tr>
</thead>
</table>

**Formula:** Percentage of favorable, neutral, and unfavorable responses in a given section of the survey.

**Description:** The 2011 Capital Health Physician Survey was created by Physician Services in consultation with several department chiefs, and the presidents of both DMSA and DMAC. In January and February 2011, physicians from all medical staff categories (active, resident, fellow, associate, consulting, courtesy, clinical associate, clinical trainee, and locum tenens) were invited to complete a survey. The survey data were collected through ClearPicture, an independent survey firm. The response rate was 54%.

The information uncovered through this survey process will assist Capital Health in further developing and strengthening relationships with physicians for the sake of improved patient centered care.

**Analysis and Progress:** The graph below shows the results for six selected sections of the physician survey. Of the six shown, trust in colleagues and respect had the highest percentages of favorable responses, while trust in Capital Health management and engagement with Capital Health had the lowest percentages of favorable responses. Transformational leadership and co-leadership fell in between.

Initiatives such as Co-Leadership have been established to increase physician involvement in leadership at Capital Health. Co-Leadership work focuses on improving relationships for the sake of improved performance. Novel development work was recently presented at the Canadian Association for Health Services and Policy Research Annual Conference. The Fully at the Table program is still offered and is the focus of a national research investigation exploring ways to advance leadership for the sake of improving health care.

**Source:** Physician Services  
**Frequency Tracked:** Every two years  
**Last Updated:** June 2011

**Accountability:** Ray LeBlanc  
**Next Update Expected:** 2013
Selected Results from the 2011 Capital Health Physician Survey

- **Trust Colleagues**: 87% Favorable, 9% Neutral, 4% Unfavorable
- **Respect**: 69% Favorable, 20% Neutral, 11% Unfavorable
- **Evidence of Transformational Leadership**: 59% Favorable, 24% Neutral, 17% Unfavorable
- **Co-Leadership**: 51% Favorable, 23% Neutral, 26% Unfavorable
- **Trust Capital Health Management**: 37% Favorable, 34% Neutral, 29% Unfavorable
- **Engagement with Capital Health**: 35% Favorable, 28% Neutral, 37% Unfavorable
3.4 Citizen Engagement and Accountability

This section contains a number of indicators focused on measuring levels to which patients/families are involved in decision-making, demonstrated openness and transparency as an organization and; progress on actions taken to effect societal change.

### 3.4.1 Receipt of Health Passport

<table>
<thead>
<tr>
<th>Strategic Stream: Citizen Engagement and Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status: △ Caution: needs work to meet the 2012/13 target</td>
</tr>
</tbody>
</table>

**Formula:** Monitoring is currently in development

**Description:** Health Passports are designed to assist patients in understanding and communicating their health status. Passports are ideally developed before patients interact with healthcare providers. Capital Health will promote passports by assisting patients to develop, own and maintain their own health information through the use of MyHealth Passports. The use of a passport should improve patient self confidence in managing chronic disease.

The goals, as outlined in the *Our Promise: 2013 Milestones*, have been amended to target community clinics rather than non-palliative discharges. Adoption objectives are under review.

**Analysis and Progress:** The Health Passport Steering Committee has determined passports are best suited for chronic disease populations in clinics and the community. Capital Health and the IWK have partnered with the SickKids Hospital in Toronto to share their existing web-based patient passport site. Capital Health officially launched its MyHealth Passport in September 2011 with presentations during Capital Health Community Days and internal information sessions. The link has been added to the public site and posters distributed broadly. There has been positive consumer feedback regarding the tool.

Efforts will now focus on communication and engagement of groups that are best positioned to promote the passport (e.g. community and primary health care). Both Public Health and Primary Care have been approached to be clinical leads/owners of this initiative but neither group feels they have the capacity to take this role on at this time. Primary care has been approached again regarding feasibility of being the system owner. A meeting to take place to discuss this with Primary Care.

**Source:** Finance & Decision Support  
**Frequency Tracked:** Quarterly  
**Last Updated:** December 2012  
**Accountability:** Paula Bond  
**Next Update Expected:** March 2013
### 3.4.2 Influence Change in Three Major Public Policies

<table>
<thead>
<tr>
<th>Strategic Stream: Citizen Engagement and Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status:</strong> On track to meet the 2012/13 target</td>
</tr>
<tr>
<td><strong>Trend:</strong> work is ongoing</td>
</tr>
</tbody>
</table>

**Formula:** Number of major public policies influenced through Capital Health advocacy.

**Description:** Adoption of patient-centered, health-prevention public policies aimed at improving patient health. The *Our Promise: 2013 Milestones* goals are to influence one major policy by 2010/11, a second by 2011/12, and a third by 2012/13. The targeted policies are: tobacco use, food security, nutrition in schools/day care settings.

**Analysis and Progress:** All policies are progressing as expected and are on target. Specific updates for this quarter:

- **Healthy Eating:** School Food and Nutrition Policy - There is currently a group assembled to review the existing policy with the conversations to date largely focused on the nutrient criteria; there is still work to complete in this area. The goal is to have a revised policy ready for the 2013-14 school year. In the interim, we continue to support the schools in implementation of the policy. ACT for Food Security - The case communities assessments & work has been done to finalize the policy landscape paper as well as the midterm report for the research funders. Child Care Healthy Food Policy - Public Health continues to support the centres with implementation. Education sessions have been held in conjunction with the Department of Community Services and resources have been developed to assist centres with meeting the standards. The Department of Health and Wellness is in the process of updating Strive for Five to meet the food and beverage criteria and hope to roll that out in the Spring with training. The Department is also looking at grant opportunities for licensed child care centres.

- **Tobacco:** Within the provincial and district Tobacco Reduction Strategy and as a member of Smoke-Free Nova Scotia, Public Health has been working since 2007 to increase access to smoke-free multi-unit housing for our citizens and all Nova Scotians. As a result of work that has been ongoing for a few years, for the first time ever effective September 2012 the Registrar of Condominiums, Service NS will permit: “developers to make new condominium developments 100% smoke-free, including exclusive use units, balconies, decks and patios, common elements and the entire property. Existing multi-unit condominium corporations will now be able to enact declaration amendments that restrict smoking or ban it entirely in the common elements and exclusive use common elements (balconies, decks and patios) of the building.” Previously condominium developers, corporations and owners had no legal recourse to make multiunit condominiums smoke-free. Thus people could have bought housing that would endanger their health as a result of second and third-hand smoke from a neighbouring unit. Currently staff at the Registrar’s office are adding NS content to a “smokefreehousingns” website for landlords, tenants, condominiums developers, corporations and owners that has been adapted by Public Health for Smoke Free NS. Once complete a provincial workgroup, including stakeholders, will come together to develop a capacity building and website launch strategy and implementation plan.

- **Alcohol:** Capital Health (Addictions Prevention & Treatment Services & Public Health) provided evidence & support to Dalhousie University as they responded to a request for campaign promotions from the Nova Scotia Liquor Commission (NSLC). As a result, Dalhousie declined the partnership with NSLC. This had an additional effect on other universities in the province who utilized the evidence to make similar decisions. Capital Health (Addictions Prevention & Treatment Services and Public Health) participated in a community conversation on the Culture of Alcohol in September. Dr. Gaynor Watson-Creed provided a presentation. It was an interactive community discussion to gain perspectives on how alcohol is viewed and used. Over 40 citizens were in attendance, including the Minister of Finance, representatives from legal, justice, small business owners, bar industry and youth.

**Source:** Public Health

**Frequency Tracked:** Quarterly

**Last Updated:** December 2012

**Accountability:** Barbara Hall, Gaynor Watson-Creed

**Next Update Expected:** March 2013
### 3.4.3 Access for Underserved / Vulnerable Groups

**Strategic Stream:** Citizen Engagement and Accountability

<table>
<thead>
<tr>
<th>Status:</th>
<th>Caution: measurement of indicator is in progress</th>
<th>Trend: n/a</th>
</tr>
</thead>
</table>

**Formula:** Indicator is under development. Each year, identify all programs and targeted groups that are under consideration; report on those programs that are to be implemented/continued within that year.

**Description:** Vulnerable groups are defined as per the social determinants of health (income, education, culture, and gender). This work is targeting groups such as: Gay, Lesbian, Bisexual, Transgender, Intersex (Pride Health); Homeless (Insecurely housed or street workers); African Nova Scotia Communities; New Immigrant Populations; Mental Health. The *Our Promise: 2013 Milestone* goals are to improve access for vulnerable and underserved groups by 10% in 2010/11, by 15% in 2011/12, and by 25% in 2012/13.

**Analysis and Progress:**

**PrideHealth program update:**
- Held 28 Health Promotion Activities between July 2011 and June 2012. These are for both internal (Capital Health and the IWK Health Centre) and external audiences.
- Our Clinical Nurse Specialist are active in the community with regular hours four different community locations and treated 492 people in the fiscal year 2011/12.

**African Nova Scotia Communities:**

**Project proposal under review:** Expanded Services Proposal for the Community Health and Wellness Centre in North Preston and the surrounding communities of East Preston, Cherry Brook, and Lake Loon. With the only physician providing services to these four communities retiring on August 1st, 2012, an opportunity exists to design a new primary health care model to better meet the needs of the community. **Partners:** Primary Health Care, IWK Health Centre and Dalhousie Family Medicine. **Anticipated outcome:** Enhance wellness promotion & coordination, chronic disease management, team approach and access – alignment of outcomes with Primary Health Care Community Master Plan.

**Homeless (Insecurely housed or street workers), New Immigrant Populations and other updates of relevance to the milestone:** CDHA is supporting programs such as Mobile Outreach Street Health & wellness clinics in underserved areas such as North Preston. Primary Health Care is working with Community Health Board coordinator and Cobequid Community Health Centre to plan a health forum in Pockwock/Lucasville. Work to support new immigrant populations began in 2012. Primary Health Care received Department of Health NS Diversity Fund grant money and will be coordinating program & service delivery to off-reserve First Nations communities in 2011.

<table>
<thead>
<tr>
<th>Source:</th>
<th>Frequency Tracked: Quarterly</th>
<th>Last Updated:</th>
<th>Next Update Expected:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Care</td>
<td></td>
<td>December 2012</td>
<td>March 2013</td>
</tr>
</tbody>
</table>

**Accountability:** Barbara Hall
3.4.4 Patient Involvement in Patient Care Committees

**Strategic Stream:** Citizen Engagement and Accountability

<table>
<thead>
<tr>
<th>Status</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs work to meet the 2012/13 target.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Formula:** Percent of patient care committees with at least one patient representative.

**Description:** Patient representation is required on Quality and Patient Safety Committees and accreditation teams. **Note:** Previous reports identified only the number of accreditation teams with patient representation. Quality and Patient Safety Committees are now responsible for accreditation; however, there are also accreditation teams in areas that have no Quality and Patient Safety Committee.

The *Our Promise: 2013 Milestones* goals are to have 70% of patient care committees with at least one patient representative by 2010/11, 90% by 2011/12, and 100% by March 2013.

The Engagement Policy (CH-70-080) requires patient representation on patient care committees and accreditation teams.

**Analysis and Progress:** The original milestone defined *patient care committees* as accreditation teams, and the baseline measure was that 32 of 40 teams (80%) had a patient representative. At the milestone refresh, the definition of *patient care committees* was expanded to include all quality and patient safety committees and councils. This change, combined with focused efforts to develop new quality and patient safety teams over the past two years, has resulted in almost double the number of patient care committees in the organization from 40 to 75. Currently, 48 of the 75 teams (64%) incorporate patient or family representation. The denominator (75) is comprised of 65 quality teams or committees related to individual units/departments/services and 10 councils or committees based on similar services or location. The denominator will fluctuate as teams reorganize due to structural changes within the organization.

The organization’s goal is to engage patients and families in a way that is both meaningful and sustainable. To support this, six introductory citizen engagement workshops were booked between June and November 2012 to help new and existing teams constructively integrate patient and family representatives. One more has been scheduled for January 2013. Pre-workshop knowledge assessments conducted with participants have demonstrated 96% of participants are aware of the organization’s engagement policy, 71% have read the policy, and 63% understand their role in citizen engagement. An ongoing evaluation of the sessions is underway. Follow-up support is available to teams that self-identify as needing assistance incorporating health care experience representatives into their teams and quality and patient safety improvement processes.

**Source:** Performance Excellence

**Frequency Tracked:** Quarterly

**Last Updated:** December 2012

**Accountability:** Chris Power, Geoff Wilson

**Next Update Expected:** March 2013
3.4.5 Immunization Rate - Capital Health Flu Campaign

**Strategic Stream: Citizen Engagement and Accountability**

**Status:** ☹️ Not meeting target  
**Trend:** Improvement over the 2010/11 flu season

**Formula:** The number of Capital Health-paid workers receiving immunizations, divided by the total number of Capital Health-paid workers, multiplied by 100.

**Description:** The Department of Health made health care workers a key component of the annual influenza immunization program in the year 2000. Capital Health has been striving to increase the numbers of employees, volunteers, and students who are immunized each fall. Receiving the flu shot is important for all health care workers and caregivers who come in close contact with patients. It is a precaution taken to protect all patients, especially those who are over age 65 with weaker immune systems, and patients of any age with a chronic illness. The H1N1 Pandemic in the fall of 2009 resulted in an urgent need for those working in healthcare to be immunized.

**Analysis and Progress:** The following table shows a breakdown of the number of Capital Health workers who received flu vaccines in the 2009/10 to 2011/12 flu seasons. It should be noted the seasonal flu vaccine and the H1N1 flu vaccine were administered separately in 2009/10 and so are reported separately as two numbers. In 2010/11 and 2011/12, flu vaccines (including H1N1) were combined as a single administration, so only a single number is reported under the name, “seasonal flu vaccine.”

<table>
<thead>
<tr>
<th>Group</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Health-paid workers who received the H1N1 flu vaccine</td>
<td>7,264</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Capital Health-paid workers who received the seasonal flu vaccine</td>
<td>5,642</td>
<td>4,037</td>
<td>5,028</td>
</tr>
<tr>
<td>Total Capital Health-paid workers</td>
<td>11,610</td>
<td>11,051</td>
<td>11,042</td>
</tr>
<tr>
<td>Total non-Capital Health-paid workers (staff physicians, students,</td>
<td>2,257</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>volunteers, contacted workers, etc.) who received the H1N1 flu vaccine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total non-Capital Health-paid workers (staff physicians, students,</td>
<td>1,557</td>
<td>965</td>
<td>1,017</td>
</tr>
<tr>
<td>volunteers, contacted workers, etc.) who received the seasonal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>flu vaccine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Capital Health workers who received the H1N1 flu vaccine</td>
<td>9,521</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Total Capital Health workers who received the seasonal flu vaccine</td>
<td>7,199</td>
<td>5,002</td>
<td>6,045</td>
</tr>
</tbody>
</table>

The graph below shows the percentage of Capital Health-paid workers who were immunized in the 2009/10 to 2011/12 flu seasons. Non-Capital Health-paid workers are not shown on the graph because the denominator required for the calculation of percent (total non-Capital Health-paid workers) is difficult to determine. Efforts continue towards attaining and exceeding the national healthcare industry target of 70% immunization.

**Source:** Occupational Health  
**Frequency Tracked:** Annually  
**Last Updated:** March 2012  
**Accountability:** Kathy MacNeil  
**Next Update Expected:** March 2013
Percent of Capital Health-Paid Staff Immunized
2009/10 to 2011/12 Flu Seasons

- Seasonal Flu Vaccine
- H1N1 Flu Vaccine

Target: 70%

In 2010/11 and 2011/12, flu vaccines (including H1N1) were combined as a single administration, so only a single rate is reported under the name, “seasonal flu vaccine.”
3.5 Innovation and Learning

This section contains indicators related to grants and contracts, alternate revenue sources, technological innovation, business plan engagement, and multidisciplinary teams.

3.5.1 Models of Care Implementation in Patient Care Service Areas

<table>
<thead>
<tr>
<th>Strategic Stream: Innovation and Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status:</strong>  ✔ Has met the 2012/13 target !!</td>
</tr>
</tbody>
</table>

**Formula:** Number of units that have implemented Model of Care (MoC) divided by the total number of units, multiplied by 100.

**Description:** Models of Care implementation is the differentiation of practice among nursing professionals.

The Our Promise Milestones are to have MoC reviews completed in 38% of acute and sub-acute inpatient units by 2010/11, in 56% of units by 2011/12, and in 75% of units by 2012/13.

**Analysis and Progress:** MoC implementation has been implemented in more than 75% of in-patient units, thus this milestone has been achieved. Furthermore, five (i.e., physiotherapy, occupational therapy, dietary, recreational therapy, and pharmacy) of eight additional health care disciplines have completed work to differentiate practice within their disciplines.

Analysis of in-patient units and MoC work has led to an innovative approach to more fully realize Our Promise of a People-Centred Haven of Health. Specifically, a cross-organizational team led by Professional Practice and consisting of employees representing acute, sub-acute, and critical care units, finance, performance excellence, transformation, learning and development, citizen engagement, and decision support, have designed processes to: (1) understand the needs of patients from the perspective of patients and families, (2) determine which of these patient needs should be addressed during an acute care in-patient stay, (3) identify the disciplines and optimal team mix required to meet these needs with special consideration of the role of patients and families, and (4) develop collaborative team processes needed to enact care teams. This work, the Collaborative Care Initiative (CCI), is currently underway. A recommendation for a new milestone relating to CCI is being developed.

**Source:** Professional Practice

**Frequency Tracked:** Quarterly

**Last Updated:** September 2012

**Accountability:** Mary Ellen Gurnham

**Next Update Expected:** n/a (2013 milestone reached)
### 3.5.2 Service Duplication & Fragmentation in Ambulatory Services

**Strategic Stream:** Innovation and Learning

<table>
<thead>
<tr>
<th>Status:</th>
<th>Caution – needed work to meet the 2011/12 target</th>
<th>Trend:</th>
<th>n/a</th>
</tr>
</thead>
</table>
| **Formula:** | Under construction | **Description:** Patients are not served well by fragmentation and duplication of fundamental services. Reduction will be in ambulatory clinics that treat similar/same patient populations with the similar/same desired outcomes. Every attempt will be made to develop care teams focused on one-stop service to patients with co-morbidities and eliminating non-value added processes. This Milestone is meant to apply to all Ambulatory Care areas.

The Our Promise Milestones are to eliminate service duplication and fragmentation in ambulatory care services by 10% in 2010/11, by 40% in 2011/12, and by 100% in 2012/13.

**Analysis and Progress:** This work is being overseen by the Ambulatory Redesign Task Force. The VPs of Person-Centred Health are poised to activate with their directors and managers, the actual plan to attain these targets. They will report progress through the Ambulatory Care Council.

The patient registration kiosk project is an important part of this Milestone. Kiosk implementation work is complete for the HI site, with plans to consider implementation for OT/PT. Kiosk implementation is also complete for certain clinics at the VG site. The target has been met for this period and there is a trend of continued deployment where needed.

**Source:** Raymond LeBlanc

**Frequency Tracked:** on hold

**Last Updated:** March 2012

**Accountability:** Paula Bond

**Next Update Expected:** not certain – on hold
### 3.5.3 Ambulatory Care Visits

**Strategic Stream:** Innovation and Learning

<table>
<thead>
<tr>
<th>Status</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not known</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Description: The Our Promise Milestones are to reduce ambulatory care visits by 10% in 2010/11, by 15% in 2011/12, and by 20% in 2012/13. This is to be done by increasing primary care capacity.

Reduction in ambulatory clinics will be achieved by reviewing appropriateness of visits and targeting return visits. This will be achieved through better integration with the Primary Care services which to date has been a parallel process.

Analysis and Progress: This work is being overseen by the Ambulatory Redesign Task Force. The VPs of Person-Centred Health are poised to activate with their directors and managers, the actual plan to attain these targets. They will report progress through the Ambulatory Care Council.

To provide an idea of the volumes of ambulatory visits at Capital Health, the two graphs shown below plot the monthly number of visits at each facility in Capital Health. Because of the great difference in scale, the QEII and the Dartmouth General are shown on a separate graph.

**Source:**

- Frequency Tracked: on hold
- Last Updated: November 2010

**Accountability:** Paula Bond

- Next Update Expected: not certain – on hold
Ambulatory Care Visits by Facility

Visits

QEII

Dartmouth

### 3.5.4 Capacity and Use of Web-Based Technologies

**Strategic Stream: Innovation and Learning**

<table>
<thead>
<tr>
<th>Status:</th>
<th>✔ Meeting the 2012/13 target</th>
<th>Trend: See “Analysis and Progress” below</th>
</tr>
</thead>
</table>

**Formula:** Number of external web hits in the current time frame divided by the number of external web hits from the Q4 2009/10 baseline.

**Description:** Increased capacity and use of web-based technology will enable integration of information and improved flow capacity. It will also enhance the patient experience by providing remote access to functions such as registration and scheduling. There will also be increased access to pertinent health information supporting patient self-confidence and self-management of health matters.

The Our Promise Milestones are to increase use of web-based technologies by 10% in 2010/11, by 15% in 2011/12, and by 25% in 2012/13.

**Analysis and Progress:** With 696,713 external web hits in Q4 of 2009/10 as a baseline, the number of hits increased by 14% in Q4 2010/11 to surpass the target of a 10% increase. In Q4 of 2011/12, the number of external web hits increased to just over 1 million—an increase of 46% over the 2009/10 baseline, far surpassing the target of a 15% increase. In Q2 of 2012/13, the number of hits was 902,843 which is an increase of 30% over the Q4 2009/10 baseline. This is surpassing the 2012/13 target of a 25% increase.

In Q2 of 2012/13, the following changes were implemented: expanded use of the maps and media (photos and videos) enhancements. This quarter also included work to further enhance the CDHA website. The enhancement, to be delivered in Q3, includes: incorporating Google Translate (multilingual translations); new templates (more options for content contributors) and more work on visual hierarchy (improving page layout). In keeping with transparency, more content previously intended for the intranet is now available on the CDHA public site.

**Source:** eHealth

**Frequency Tracked:** Quarterly

**Last Updated:** December 2012

**Accountability:** Amanda Whitewood

**Next Update Expected:** March 2013
### 3.5.5 Patient Registration in STAR

**Strategic Stream:** Innovation and Learning

<table>
<thead>
<tr>
<th>Status:</th>
<th>On track to meet the 2012/13 target</th>
<th>Trend:</th>
<th>improving</th>
</tr>
</thead>
</table>

**Formula:** Number of service areas transitioned to STAR registration divided by the number of service areas initially identified as not compliant.

**Description:** The Our Promise Milestone is to have 70% of Capital Health patient interactions registered in STAR by 2010/11, 85% by 2011/12, and 100% by 2012/13.

This milestone will enable patient tracking and a complete patient record. eHealth knows of 25 service areas that are non-compliant, but are also looking to services to make the connection to become compliant.

**Analysis and Progress:** Public Health is continuing a push to register additional clinics, as agreed at a recent meeting, with another pilot currently active. Addictions is currently investigating current enterprise systems and once this evaluation is completed, the plan is to move from their own provincial ASSist system to all enterprise systems within Capital Health. This work is still underway; however, it will not be complete within the 2013 timeline. The pilot for lab drop-off specimens did occur and worked quite well. Lab Services’ business overview of the process is pending. This overview will ensure process can be expanded to all Drop-Off’s in a seamless manner.

<table>
<thead>
<tr>
<th>Source:</th>
<th>eHealth</th>
<th>Frequency Tracked: Quarterly</th>
<th>Last Updated:</th>
<th>December 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability:</td>
<td>Amanda Whitewood</td>
<td>Next Update Expected:</td>
<td>March 2013</td>
<td></td>
</tr>
</tbody>
</table>
### 3.5.6 Patient Appointments Self-Managed Through Technology

**Strategic Stream:** Innovation and Learning

| Status: | On track to meet the 2012/13 target | Trend: | n/a |

**Formula:** Number of current opportunities for self management divided by the number of previous opportunities for self management

**Description:** Increased capacity and use of technology will enhance the patient experience by supporting functions such as automated appointment reminders and registration check-in. There will also be increased access to pertinent health information supporting patient self confidence and self management of health matters.

The Our Promise Milestones are to increase opportunities for patients to self-manage appointments through the use of technologies by 0% in 2010/11, by 15% in 2011/12, and by 25% in 2012/13.

**Analysis and Progress:** There is continued uptake of automated telephone appointment reminders being setup by individual clinics directly. As of November 2012, there are a total of 43 clinics taking advantage of the appointment reminder service from Voice Services to deliver over 27,000 reminder calls per month.

There is also a continued roll-out of self-registration kiosks at the VG site as well as at Cobequid. It is currently estimated that 26% of patients registering for outpatient clinics do so using registration kiosks. [17,500 kiosk registrations per month x 12 months ÷ 799,292 outpatient clinic visits per year x 100% = 26.3% outpatient visits registered using kiosks in a one-year period]

Note: Patient self registration would be a feature that might come with a provincial patient health record, such as Relay Health, which is currently being piloted.

**Source:** eHealth

**Frequency Tracked:** Quarterly

**Last Updated:** December 2012

**Accountability:** Amanda Whitewood

**Next Update Expected:** March 2013
### 3.5.7 Resource the Information Management Strategic Plan

**Strategic Stream:** Innovation and Learning

<table>
<thead>
<tr>
<th>Status:</th>
<th>Met the 2011/12 target</th>
<th>Trend:</th>
<th>n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formula:</strong></td>
<td>n/a</td>
<td><strong>Description:</strong></td>
<td>Increased capacity and use of technology will improve service delivery, support evidence-based decision making and enhance the patient experience. The Our Promise Milestones are to resource the Capital Health Information Management Strategic Plan with $400,000 by 2010/11, $600,000 by 2011/12, and with $800,000 by 2012/13.</td>
</tr>
<tr>
<td><strong>Analysis and Progress:</strong></td>
<td>Tangible Capital Asset submission has been sent to the Department of Health and Wellness for computerized physician order entry (CPOE) funding. A proposal is in final stages for submission to Canada Health Infoway for Ambulatory Care electronic medical record (EMR). An RFP draft is ready to be shared with internal stakeholders to finalize needs so that it can be released to implement CPOE, electronic clinical documentation, and positive patient identification.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The business planning process has secured just over 2.5 million to enable the beginning of the EMR work at Capital Health.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>While a bit behind schedule, it is very exciting to see this work start to come together.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** eHealth  
**Frequency Tracked:** Quarterly  
**Last Updated:** May 2012  
**Accountability:** Amanda Whitewood  
**Next Update Expected:** Winter 2013
### 3.5.8 Research Funds from Grants & Contracts

**Strategic Stream:** Innovation and Learning

<table>
<thead>
<tr>
<th>Status: No target</th>
<th>Trend: Both grants and contracts are up from the previous year.</th>
</tr>
</thead>
</table>

**Formula:** Total new dollars in grant and contract research received during the period

**Description:** Research Services provides research infrastructure and administrative support to over 150 researchers including budget and contract negotiation for clinical trials, ethical review, and human resources administration as well as a comprehensive education and quality program. Research Services manages more than 1,380 active research projects which includes contract and grant funded research, and is responsible to ensure that all legal, financial, and ethical requirements and approvals for research at Capital Health are fulfilled. There are 260 research employees who are often integral members of the interdisciplinary healthcare teams providing quality patient-centered care at Capital Health.

**Analysis and Progress:** Total research funds broken down into grants and contracts are shown in the graph below.

More large granting opportunities are available as a national trend. Capital Health researchers have been the recipients of several of these large grants. Additional project management resources have been provided to ensure these projects are successful at every level.

**Source:** Centre for Clinical Research  
**Frequency Tracked:** Annually  
**Last Updated:** July 2012

**Accountability:** Raymond LeBlanc, Lisa Underwood  
**Next Update Expected:** Summer 2013
### Total Research Funds from Grants and Contracts

**Capital Health - Fiscal Years 2002/03 to 2011/12**

<table>
<thead>
<tr>
<th>Year</th>
<th>Grants</th>
<th>Contracts</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002/03</td>
<td>$4,602,772</td>
<td>$5,853,207</td>
<td>$10,455,979</td>
</tr>
<tr>
<td>2003/04</td>
<td>$5,500,127</td>
<td>$5,299,324</td>
<td>$10,799,451</td>
</tr>
<tr>
<td>2004/05</td>
<td>$6,450,879</td>
<td>$5,308,993</td>
<td>$11,759,872</td>
</tr>
<tr>
<td>2005/06</td>
<td>$6,178,201</td>
<td>$4,723,990</td>
<td>$10,902,191</td>
</tr>
<tr>
<td>2006/07</td>
<td>$7,139,344</td>
<td>$4,756,286</td>
<td>$11,895,630</td>
</tr>
<tr>
<td>2007/08</td>
<td>$10,145,552</td>
<td>$5,586,147</td>
<td>$15,731,699</td>
</tr>
<tr>
<td>2008/09</td>
<td>$9,993,550</td>
<td>$5,004,082</td>
<td>$14,997,632</td>
</tr>
<tr>
<td>2009/10</td>
<td>$8,580,795</td>
<td>$6,095,198</td>
<td>$14,675,993</td>
</tr>
<tr>
<td>2010/11</td>
<td>$9,485,073</td>
<td>$4,739,574</td>
<td>$14,224,647</td>
</tr>
<tr>
<td>2011/12</td>
<td>$10,369,811</td>
<td>$6,891,709</td>
<td>$17,261,520</td>
</tr>
</tbody>
</table>

---

**Graph:**

The graph illustrates the total research funds from grants and contracts for Capital Health from fiscal years 2002/03 to 2011/12. The funds are categorized by year and types of funding (Grants, Contracts, and Total). The data shows a steady increase in research funds over the years, with the highest total reported in 2011/12.
APPENDIX A: Summary of Milestone Progress with Respect to 2012/13 Targets

The following table is a Milestone-specific update to Q2 of 2012/13 and this version was current as of the December 2012 version of the report.

<table>
<thead>
<tr>
<th>Milestone</th>
<th>VP Accountability</th>
<th>2012/13 Target</th>
<th>2012/13 Q2 Progress</th>
<th>Last Status Update</th>
<th>Trend</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% Elimination of shadow charts</td>
<td>Amanda Whitewood</td>
<td>100%</td>
<td></td>
<td>November 2012</td>
<td>Will not meet target</td>
<td>Tracking of shadow chart elimination by individual services increased from 29% in Q1 to 30% in Q2, and service areas continue to engage in discussions.</td>
</tr>
<tr>
<td>↓ Preventable surgical cancellations by 50%</td>
<td>Paula Bond</td>
<td>50%</td>
<td></td>
<td>November 2012</td>
<td>In progress</td>
<td>For Apr.-Oct. 2012, the average monthly resource-related cancellation rate decreased from the 2009/10 baseline by 45%. This falls just short of the 2012/13 target of a 50% decrease.</td>
</tr>
<tr>
<td>Wait time measures meet/exceed national standards</td>
<td>Paula Bond</td>
<td>100%</td>
<td></td>
<td>November 2012</td>
<td>Concern</td>
<td>Meeting Targets: CT, urgent radiotherapy, urgent open heart surgery. Not Meeting Targets: MRI, intermediate radiotherapy, hip fracture repair, hip replacement, knee replacement, cataract surgery, scheduled &amp; semi-urgent open heart surgeries, ED - triage to physician and triage to admission.</td>
</tr>
<tr>
<td>↓ no shows &amp; cancellations by 50%</td>
<td>Paula Bond</td>
<td>50%</td>
<td></td>
<td>October 2012</td>
<td>Variable</td>
<td>Surgery cancellations targets being exceeded (71% decrease). Mental Health patient-related cancellations met the target, but no-shows did not. Dept. of Medicine cancellation rates decreased by 14% from with the 2009/10 Q4 baseline. No shows decreased by 21%.</td>
</tr>
<tr>
<td>ALOS vs. ELOS met for all CMGs</td>
<td>Paula Bond</td>
<td>100%</td>
<td></td>
<td>November 2012</td>
<td>Needs work</td>
<td>For the first six months of 2012/13, 50% of CMGs had an ALOS less than or equal to the ELOS. This is short of the 2012/13 target of 100%. There has essentially been no change since the 2009/10 baseline.</td>
</tr>
<tr>
<td>↓ conservable days by 5% for typical cases (high control)</td>
<td>Paula Bond</td>
<td>5%</td>
<td></td>
<td>November 2012</td>
<td>Needs work</td>
<td>Using the first six months of 2012/13 as an estimate for the full fiscal year puts the total conservable days at a 19% increase over the 2009/10 baseline.</td>
</tr>
<tr>
<td>↓ occupancy rate to 90%</td>
<td>Paula Bond</td>
<td>90%</td>
<td></td>
<td>October 2012</td>
<td>Concern</td>
<td>For Apr.-Sept. 2012, the total occupancy rates for QEII &amp; DGH were above the 2012/13 target of 90%. Some improvements can be seen over 2011/12.</td>
</tr>
<tr>
<td><strong>Milestone</strong></td>
<td><strong>VP Accountability</strong></td>
<td><strong>2012/13 Target</strong></td>
<td><strong>2012/13 Q2 Progress</strong></td>
<td><strong>Last Status Update</strong></td>
<td><strong>Trend</strong></td>
<td><strong>Summary</strong></td>
</tr>
<tr>
<td>---------------</td>
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<td>--------------------------</td>
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<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>25% CH population have access to a primary health team</td>
<td>Barbara Hall</td>
<td>25%</td>
<td></td>
<td>August 2012</td>
<td>2013 target reached</td>
<td>The target for this milestone for the period 2011-2013 has been met; however, the future expansion &amp; enhancement of access to a primary health team is largely dependent on appropriate funding &amp; resource allocation.</td>
</tr>
<tr>
<td>Increased investment in primary care &amp; care of the elderly</td>
<td>Barbara Hall</td>
<td>+1% over 2011/12</td>
<td></td>
<td>August 2012</td>
<td>2013 target reached</td>
<td>Additional investment money in the amount of $402,000 has been authorized for the 2012/13 fiscal year, thus the $286,563 target for 2012/13 has been exceeded.</td>
</tr>
<tr>
<td>75% of ALC beds vacated closed - resources reinvested</td>
<td>Barbara Hall</td>
<td>75%</td>
<td></td>
<td>December 2012</td>
<td>Needs work</td>
<td>As of December 3rd, 2012, there was a decrease of 39% of beds from the 2009/10 baseline. This is short of the 2012/13 target of a 75% decrease</td>
</tr>
<tr>
<td>Improved metabolic targets pre-diabetes &amp; diabetes</td>
<td>Barbara Hall</td>
<td>50%</td>
<td></td>
<td>November 2012</td>
<td>Will not meet target</td>
<td>The target will have to be revised as it does not reflect the trends observed in the diabetes population in NS. New milestones will be identified to demonstrate improvements in health outcomes post intervention. Work is underway with DMC team and DCPNS to identify meaningful milestones that will be a better reflection of the DMC care delivery.</td>
</tr>
<tr>
<td>3% ↓ in hospital admissions for identified chronic diseases</td>
<td>Barbara Hall</td>
<td>3%</td>
<td></td>
<td>November 2012</td>
<td>On track</td>
<td>Using Apr–Sep. of 2012/13 to extrapolate to a full fiscal year, it looks as if there will be a 5% decrease, exceeding the target of a 3% decrease.</td>
</tr>
<tr>
<td>10% ↓ readmit rates for cohorts with complex chronic disease</td>
<td>Barbara Hall</td>
<td>10%</td>
<td></td>
<td>November 2012</td>
<td>Needs work</td>
<td>For Apr–Sep 2012, the readmission rate for all three diseases combined was 7.8%. This is an increase of 6% from the 2009/10 baseline.</td>
</tr>
<tr>
<td>25% ↓ in volume of nursing home patients seen in the ED</td>
<td>Barbara Hall</td>
<td>25%</td>
<td></td>
<td>October 2012</td>
<td>On target</td>
<td>For Apr–Sept 2012, an average of 29 nursing home patients presented to the ED each month. This is so far exceeding the goal of a reduction to 33 (~25% from baseline) per month for 2012/13.</td>
</tr>
<tr>
<td>10% improvement in absenteeism</td>
<td>Kathy MacNeil</td>
<td>10%</td>
<td></td>
<td>November 2012</td>
<td>Worsening</td>
<td>For Apr. to Oct. of 2012/13, average sick hours were 5% higher than the baseline—falling short of the target of a 10% decrease.</td>
</tr>
<tr>
<td>10% improvement in overtime</td>
<td>Kathy MacNeil</td>
<td>10%</td>
<td></td>
<td>December 2012</td>
<td>On target</td>
<td>Percentage overtime for Apr–Oct. of 2012/13 is has decreased by 35% from the baseline. This surpasses the target of a 10% decrease.</td>
</tr>
<tr>
<td>Improved overall recruitment rates</td>
<td>Kathy MacNeil</td>
<td>50%</td>
<td></td>
<td>November 2012</td>
<td>Worsening</td>
<td>Recruitment is generally meeting the target, but nursing positions are becoming more difficult to fill for ICU, ED, ORs, Rehab, Supportive Care Services, &amp; PACU with impacts on staff &amp; bed closures. Initiatives are underway to address this &amp; future occurrences.</td>
</tr>
<tr>
<td>Medical Department structures &amp; operations aligned to achieve</td>
<td>Ray LeBlanc</td>
<td>100%</td>
<td></td>
<td>December 2012</td>
<td>On target</td>
<td>Various initiatives are currently underway in key areas of AFP’s, Search &amp; Survey, and leadership development that indicate trending</td>
</tr>
<tr>
<td><strong>Milestone</strong></td>
<td><strong>VP Accountability</strong></td>
<td><strong>2012/13 Target</strong></td>
<td><strong>2012/13 Q2 Progress</strong></td>
<td><strong>Last Status Update</strong></td>
<td><strong>Trend</strong></td>
<td><strong>Summary</strong></td>
</tr>
<tr>
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<td>-----------------------</td>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>Organizational goals</td>
<td></td>
<td></td>
<td></td>
<td>October 2012</td>
<td>Needs work</td>
<td>towards the 2012/13 target.</td>
</tr>
<tr>
<td>100% compliance with performance evaluation process</td>
<td>Kathy MacNeil</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td>As of Oct. 9th, only 40% of performance reviews were completed. This is short of the 2012/13 target of 100%.</td>
</tr>
<tr>
<td>90% of formal leaders consistently demonstrate transformational leadership competencies</td>
<td>Kathy MacNeil</td>
<td>90%</td>
<td></td>
<td>November 2012</td>
<td>In progress</td>
<td>Leader performance has risen on all three dimensions: Being (71.7%), Caring (71.7%) and Doing (72.1%). Overall, 2012 results fell just shy of the interim target of 75% established for fiscal year 2011/12.</td>
</tr>
<tr>
<td>Receipt of health passport</td>
<td>Paula Bond</td>
<td>50%</td>
<td></td>
<td>December 2012</td>
<td>In progress</td>
<td>MyHealth Passport has been available on the CDHA public website since Sept. 2011. There has been positive consumer feedback regarding the tool. Primary Care has been approached again to become the system owner.</td>
</tr>
<tr>
<td>Influenced change in 3 major public health policies</td>
<td>Barbara Hall</td>
<td>+3 policies</td>
<td></td>
<td>November 2012</td>
<td>On target</td>
<td>All policies are progressing as expected.</td>
</tr>
<tr>
<td>25% ↑ access initiatives for underserved/vulnerable groups</td>
<td>Barbara Hall</td>
<td>25%</td>
<td></td>
<td>November 2012</td>
<td>Needs work</td>
<td>Work is underway to improve access for several underserved/vulnerable groups. Currently identified target will require funding support and engagement of multiple stakeholders and is viewed outside the sole control of PHC teams. Relevant indicators that can better reflect the efforts of PHC teams are under development.</td>
</tr>
<tr>
<td>100% patient involvement in patient care committees</td>
<td>Chris Power</td>
<td>100%</td>
<td></td>
<td>November 2012</td>
<td>Needs work</td>
<td>The proportion of quality teams with patient or family representatives stands at 64%, up from 55% in May 2012.</td>
</tr>
<tr>
<td>Model of Care review complete in 75% of patient care services</td>
<td>Paula Bond</td>
<td>75%</td>
<td></td>
<td>August 2012</td>
<td>2013 Target Reached</td>
<td>Model of Care has been implemented in 90% of in-patient units. Further, five of eight additional health care disciplines have completed work to differentiate practice within their disciplines.</td>
</tr>
<tr>
<td>Eliminate service duplication &amp; fragmentation in ambulatory services</td>
<td>Paula Bond</td>
<td>100%</td>
<td></td>
<td>September 2011</td>
<td>Milestone on hold</td>
<td></td>
</tr>
<tr>
<td>20% ↓ of ambulatory care RETURN visits</td>
<td>Paula Bond</td>
<td>20%</td>
<td></td>
<td>September 2011</td>
<td>Milestone on hold</td>
<td></td>
</tr>
<tr>
<td>25% ↑ in use of web-based technologies</td>
<td>Amanda Whitewood</td>
<td>25%</td>
<td></td>
<td>November 2012</td>
<td>On target</td>
<td>In Q2 of 2012/13, the number of external web hits increased by 30% over the Q4 2009/10 baseline—surpassing the 25% target.</td>
</tr>
<tr>
<td>100% patient interactions registered in STAR</td>
<td>Amanda Whitewood</td>
<td>100%</td>
<td></td>
<td>December 2012</td>
<td>Improving</td>
<td>The capture of all registrations in STAR is currently being overseen. Addictions is a concern and a review is underway; however, it is not targeted to be complete by 2013. Public Health continues an upward trend for meeting this target.</td>
</tr>
<tr>
<td>25% patient appointments self-managed through technology</td>
<td>Amanda Whitewood</td>
<td>25%</td>
<td></td>
<td>December 2012</td>
<td>On track</td>
<td>The automated telephone appointment reminder system currently makes 27,000 calls per month, and it is estimated that 26% of...</td>
</tr>
<tr>
<td>Milestone</td>
<td>VP Accountability</td>
<td>2012/13 Target</td>
<td>2012/13 Q2 Progress</td>
<td>Last Status Update</td>
<td>Trend</td>
<td>Summary</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>----------------</td>
<td>---------------------</td>
<td>--------------------</td>
<td>-------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Resourced the Information Management Strategic Plan</td>
<td>Amanda Whitewood</td>
<td>800k</td>
<td>Green</td>
<td>May 2012</td>
<td>In Progress</td>
<td>The business planning process has secured 2.5 million+ to start work on an EMR. Proposals are underway to secure funding from other sources for additional projects.</td>
</tr>
</tbody>
</table>
APPENDIX B: Patient Safety Scorecard

### LEGEND
- Not meeting/will not meet target
- Caution: needs work to meet target
- Meeting target or on track to meet target
- No established target

#### Table B1: Scorecard for Quarterly-Trending Indicators

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Target</th>
<th>Q2 09/10</th>
<th>Q3 09/10</th>
<th>Q4 09/10</th>
<th>Q1 10/11</th>
<th>Q2 10/11</th>
<th>Q3 10/11</th>
<th>Q4 10/11</th>
<th>Q1 11/12</th>
<th>Q2 11/12</th>
<th>Q3 11/12</th>
<th>Q4 11/12</th>
<th>Q1 12/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Acquired Infections</td>
<td>MRSA Transmission (per 1000 patient days)</td>
<td>&lt; 0.59</td>
<td>0.4</td>
<td>0.5</td>
<td>0.7</td>
<td>0.6</td>
<td>0.5</td>
<td>0.4</td>
<td>0.37</td>
<td>0.29</td>
<td>0.46</td>
<td>0.32</td>
<td>0.53</td>
<td>0.38</td>
</tr>
<tr>
<td></td>
<td>C. difficile Incidence (per 1000 patient days)</td>
<td>&lt; 0.6</td>
<td>0.30</td>
<td>0.30</td>
<td>0.27</td>
<td>0.30</td>
<td>0.25</td>
<td>0.22</td>
<td>0.27</td>
<td>0.29</td>
<td>0.33</td>
<td>0.14</td>
<td>0.21</td>
<td>0.20</td>
</tr>
<tr>
<td></td>
<td>VRE Incidence (per 10,000 patient days)</td>
<td>&lt; 6.4</td>
<td>0.18</td>
<td>0.18</td>
<td>0.25</td>
<td>0.25</td>
<td>0.00</td>
<td>0.00</td>
<td>0.13</td>
<td>0.00</td>
<td>0.00</td>
<td>0.79</td>
<td>0.66</td>
<td>2.97</td>
</tr>
<tr>
<td>DGH Quick Response Team</td>
<td>DGH Code Blue Count (Average codes per month)</td>
<td>&lt; 3</td>
<td>2</td>
<td>2</td>
<td>3.3</td>
<td>2.3</td>
<td>1.3</td>
<td>0.7</td>
<td>1.6</td>
<td>1.3</td>
<td>2.3</td>
<td>1.7</td>
<td>3.3</td>
<td>2.3</td>
</tr>
</tbody>
</table>

#### Table B2: Scorecard for Calendar Year Annually-Trending Indicators

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Target</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand Hygiene</td>
<td>Compliance Before Patient Contact</td>
<td>40%</td>
<td></td>
<td>29%</td>
<td>54%</td>
<td>46%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Compliance After Patient Contact</td>
<td>40%</td>
<td></td>
<td>55%</td>
<td>75%</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overall Compliance</td>
<td>40%</td>
<td></td>
<td>44%</td>
<td>66%</td>
<td>61%</td>
<td></td>
</tr>
</tbody>
</table>

#### Table B3: Scorecard for Fiscal Year Annually-Trending Indicators

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Target</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>Hospital Standardized Mortality Ratio (HSMR)</td>
<td>≤ 100</td>
<td>109 *</td>
<td>113 *</td>
<td>105</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Patient Safety Culture Survey</td>
<td>“Excellent” &amp; “Very Good” Responses</td>
<td></td>
<td>47%</td>
<td></td>
<td>51%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Acceptable” Responses</td>
<td></td>
<td>44%</td>
<td></td>
<td>41%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Poor” and “Failing” Responses</td>
<td></td>
<td>10%</td>
<td></td>
<td>9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total of “Excellent”, “Very Good”, and “Acceptable” Responses Combined</td>
<td>90%</td>
<td>91%</td>
<td></td>
<td>92%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Patient Safety Training</td>
<td>Percentage Completion</td>
<td>100%</td>
<td>30%</td>
<td>31%</td>
<td>25%</td>
<td>22% (Q1–Q2)</td>
<td></td>
</tr>
</tbody>
</table>

* Statistically significantly higher than the national average of 100
### APPENDIX C: Access (Wait Times) Scorecard

<table>
<thead>
<tr>
<th>Treatment / Procedure</th>
<th>Target Wait Time</th>
<th>Wait Times for November 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Computed Tomography (CT)</td>
<td>28 days</td>
<td>capital health: 30 days</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging (MRI)</td>
<td>28 days</td>
<td>QEII: 266 days</td>
</tr>
<tr>
<td>Radiotherapy – Intermediate Cases</td>
<td>14 days</td>
<td>QEII: 16 days</td>
</tr>
<tr>
<td>Radiotherapy – Urgent Cases</td>
<td>7 days</td>
<td>QEII: 8 days</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>100% of cases completed within 26 weeks</td>
<td>Capital Health: 63% of cases completed within target (Q2 2012/13)</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>100% of cases completed within 26 weeks</td>
<td>Capital Health: 43% of cases completed within target (Q2 2012/13)</td>
</tr>
<tr>
<td>Hip Fracture Repair</td>
<td>100% of cases completed within 48 hours</td>
<td>Capital Health: 54% of cases completed within target (Q2 2012/13)</td>
</tr>
<tr>
<td>Cataract Surgery</td>
<td>100% of cases completed within 16 weeks</td>
<td>Capital Health: 47% of cases completed within target (Q2 2012/13)</td>
</tr>
<tr>
<td>Open Heart Surgery – Urgent Cases</td>
<td>7 days</td>
<td>QEII: 3 days</td>
</tr>
<tr>
<td>Open Heart Surgery – Semi-Urgent Cases</td>
<td>21 days</td>
<td>QEII: 29 days</td>
</tr>
<tr>
<td>Open Heart Surgery – Scheduled Cases</td>
<td>42 days</td>
<td>QEII: 60 days</td>
</tr>
<tr>
<td>ED – 90th Percentile Wait Time from Triage to Admission</td>
<td>8 hours</td>
<td>QEII: 29 hours</td>
</tr>
<tr>
<td>ED – Average Wait Time from Triage to Physician: CTAS Level 3 (Urgent)</td>
<td>30 minutes</td>
<td>DGH: 140 minutes</td>
</tr>
</tbody>
</table>

**Performance LEGEND**
- Not meeting or will not meet target
- Caution: needs work to meet target
- Meeting target or on track to meet target

Table C1: Target and Actual Wait Times for Key Treatments/Procedures at Capital Health
APPENDIX D: Strategic Streams and Qmentum Quality Dimensions

This report has been organized around Capital Health’s Five Strategic Streams:

1. **Person-Centered Health Care** – Person-centered health welcomes the patient as a full-fledged member of the health care team, respects their ownership and rights to their own health, and recognizes that a healthy person needs a healthy community. Capital health will care for the whole person before us with our hearts, as well as our hands and minds.

2. **Sustainability** - Capital Heath is transforming health care today because we want to be here for the people of our communities for a very long time. We are working to ensure our workforce will be sufficient to care for those we serve; buildings will be designed with the needs of patients citizens and the environment in mind; and all of this will happen on a budget that will not break the bank.

3. **Transformational Leadership** - Capital Heath invites every person to share their talents, act with passion and purpose, listen deeply, grow relationships, take risks and embrace tension to co-create a world-leading haven for people-centered health, healing and learning. We will focus on matching peoples’ passion, talents and sense of purpose to the work rather than just focusing on the technical aspects of the job. We will create a culture and environment that fosters joy, pride, trust, and respect.

4. **Citizen Engagement & Accountability** - Capital Health is opening our doors, our minds, and our ears to connect with what communities really need. We are committed to a health system where each of us shares in the accountability for our individual health, the health of our health system and that of our community.

5. **Innovation & Learning** - Capital Health will contribute to a better tomorrow as lifelong learners, educators of the next generation, and researchers of new frontiers in health and healing. We will keep the spark of curiosity alive, and encourage it in everyone—whether they're at the bedside, in the boardroom, or in the lab. Constantly asking why will help us find a better way.

In addition, each indicator found within Capital Health’s Strategic Indicators Report falls into one of the eight Qmentum quality dimensions outlined by Accreditation Canada (http://www.accreditation.ca/en/default.aspx). The quality dimensions are listed below.
Qmentum Quality Dimensions:

- **Population Focus** - working with communities to anticipate and meet needs
- **Accessibility** - providing timely and equitable services
- **Safety** - keeping people safe
- **Worklife** - supporting wellness in the work environment
- **Client-centred services** – putting clients and families first
- **Continuity of Services** – experiencing coordinated and seamless services
- **Effectiveness** - doing the right thing to achieve the best possible results
- **Efficiency** - making the best use of resources
APPENDIX E: Quality and Patient Safety Framework

The Integrated Quality and Patient Safety Framework shown on the right outlines the quality and patient safety structure, functions, responsibilities and accountabilities at Capital Health. The framework is not a stand alone document – it is supported by Our Promise, Our Declaration of Health, the Patient Safety Plan, Our 2013 Milestones, our Strategic Indicators Reporting Framework, Capital Health Ethics Framework, Research Ethics Framework, and many other educational offerings and research opportunities. It provides information and guidance to the organization for selection and measurement of our achievements in service quality, care outcomes, and risk mitigation. It is not intended to be a detailed procedure for designing or implementing quality and patient safety initiatives. The framework is reviewed on a regular basis to ensure continued alignment with the vision mission and strategic direction of Capital Health.

This framework was developed in 2010 and first appeared in the October 2010 version of this report—replacing the Framework for Developing and Reporting of Operational Measures.

OUR FOUNDATION: Capital Health is an academic health sciences network providing timely access to advanced patient care, leading edge research and training for the current and the next generation of health care professionals.

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APPENDIX F: Contributors

Many people contributed to the preparation of this report. In particular:

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Their contributions of data, background information, and insights enrich this report and are gratefully acknowledged.