Consolidated Strategic Plan: 2013 - 2016

Prepared By:

Whaley & Company

Board Approved
NWHC April 10, 2014
GMCH April 8, 2014
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</table>
1. Introduction

1.1 Background and Rationale

North Wellington Health Care (responsible for the hospital sites in Mt. Forest and Palmerston) and the Groves Memorial Community Hospital in Fergus have been working closely together as an administrative Alliance since 2005. The two hospital corporations, with a single senior management team – the Wellington Health Care Alliance (WHCA) - have made great strides with their partnership over the last few years. The most recent review of the Alliance\(^1\) concluded that the 3 main strengths of the Alliance are:

- Has provided the opportunity to attract leadership expertise, specialized clinicians and specialized services because it allows for share costs, an increased critical mass of staff, resources, and patients, and the creation of unified recruitment strategies;
- A rural centre of excellence has been developed, and a stronger voice and vision for rural health care is possible; and
- Operational efficiencies have been found through shared services and committees, standardization, common policies and procedures, and increased purchasing and negotiating power.

Participants in this external review also identified the following 3 opportunities for the Alliance to pursue:

- Maintain and enhance current services while attracting new services.
- Develop creative structures and approaches in governance, leadership, and care delivery (e.g. campus model) to more fully accomplish the intention of the Alliance.
- Create a more integrated system of rural health through the exploration of additional community partnerships.

Although there have been many commonalities between the plans and strategic priorities of the two corporations, the hospitals over the years have maintained separate strategic plans. With the LHIN’s ongoing push for greater integration including the recent review of integrating health services in rural Wellington, the boards and senior management team decided to work towards a consolidated strategic plan to demonstrate their ongoing commitment to creating a more integrated system of rural health services for the residents of Centre and North Wellington.

\(^1\) Donna Cripps and Emily Christoffersen, “Evaluation of Wellington Health Care Alliance”, (Hamilton Health Sciences), September, 2010
1.2 Overview of Our Hospital Corporations

North Wellington Health Care (NWHC) is a recognized, innovative regional provider of primary and secondary health services to the people of North Wellington County and surrounding areas including south Grey County. The NWHC delivers high quality health care services to the people of the area through two fully-accredited hospital sites in Mount Forest and Palmerston, with 15 acute beds at each site. The combined referral population of the two hospital sites is 19,000. The Corporation employs more than 200 highly skilled staff, with 190 dedicated volunteers supporting the organization in a variety of ways, and has an active medical staff of 13 family physicians and general practitioners across both sites. Physician specialist clinics and satellite oncology and dialysis clinics are an integral component of NWHC’s motto – Quality Care Close to Home.

NWHC Vision-Mission:
We are a dynamic organization that is dedicated to quality and passionate about improving the health status of our community.

Our collective energy and commitment will build a centre of excellence in rural health.

Every day, we will each contribute toward creating a friendly and positive place to work and receive care.

Groves Memorial Community Hospital (GMCH) is a highly respected, rural, acute-care facility providing a wide range of services. GMCH serves a referral population of approximately 28,000. The hospital currently operates 44 beds, with over 230 staff and support from over 300 volunteers. Over 30 active family physicians and general practitioners, along with a handful of specialists, work as part of the care delivery team to support the wide array of patient services offered at GMCH.

GMCH Mission: Groves Memorial Community Hospital, a rural hospital, enables people to achieve optimal health through a range of integrated health services provided by a committed team working with a network of partners.

GMCH Vision: Our vision at Groves Memorial Community Hospital is to be a leader in the provision of excellent, compassionate, rural health care.

A strong sense of community is part of the unique quality of service provided by staff at all 3 hospital sites.

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2 Planning Decision and Support Tool (PDST), Health Data Branch, Ministry of Health and Long Term Care [www.hsimi.on.ca](http://www.hsimi.on.ca)
In terms of hospital utilization trends over time, inpatient days at all 3 sites are declining due to increased ambulatory care activity and reductions in length of hospital stay. Emergency department visits remain fairly constant over time with Groves Memorial Community Hospital averaging 30,000 ER visits per year and the 2 North Wellington Healthcare sites with a combined total of about 20,000 ER visits per year.

1.3 Accomplishments from Previous Strategic Plan

Our new consolidated plan builds on many accomplishments from our previous plan some of which are listed below. While the definite advances on capital projects at each of the three sites are notable achievements, service delivery, patient satisfaction and quality/safety results are fuller measures of operational success.

Table 1 - Selected Indicators of Success

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Errors/100 admissions</td>
<td>7.70</td>
<td>4.62</td>
<td>7.27</td>
<td>5.97</td>
</tr>
<tr>
<td>Patient Satisfaction - NCR Picker (ER)</td>
<td>91.45%</td>
<td>93.6%</td>
<td>90.3%</td>
<td>92.0%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>57.25%</td>
<td>85.0%</td>
<td>55.0%</td>
<td>74.0%</td>
</tr>
<tr>
<td>Hard-to-Fill Staff Vacancy Rates</td>
<td>24.0%</td>
<td>0%</td>
<td>2.4%</td>
<td>2.27%</td>
</tr>
<tr>
<td>HSMR$^3$</td>
<td>108</td>
<td>96</td>
<td>88</td>
<td>71</td>
</tr>
<tr>
<td>----------</td>
<td>-----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Staff Absentee Days (avg for full-time staff)</td>
<td>9.3</td>
<td>4.52</td>
<td>6.7</td>
<td>9.2</td>
</tr>
</tbody>
</table>

(Note: fuller detail from the 2012-13 corporate scorecards is available in Appendix A)

Organizational Health impacts are best measured through staff feedback. When the last survey was conducted in November 2012, the Organizational Health survey results indicate a marked improvement over the 2010-13 strategic plan timeframe, resulting in no ‘red flag’ areas using this tool (see Appendix B).

Ongoing accreditation status along with improved use of students and trainees in a number of disciplines over the past three years are also noteworthy accomplishments.

These operational results have occurred while continuing to improve financial status and at least balancing, if not running surpluses each year.

2. Local, Regional and Provincial Planning Priorities

2.1 Health System Transformation in Ontario

The provincial government’s ‘transformation agenda’ which has been widely articulated by the Ministry of Health and Long-Term Care and the LHINs over the last eight years and includes the following key strategies:

- The creation of Local Health Integration Networks with the legislative mandate to plan, manage, integrate and fund health services for 14 new regions in the province of Ontario;

- Increased emphasis on accountability including the introduction of funding accountability agreements between LHINs and health service providers;

- Increased emphasis on performance measurement and reporting, with special attention to quality and cost-effective service delivery;

- Increased investments in primary care, community based and home care services (e.g. Aging at Home, Family Health Teams etc.);

- Increased emphasis on disease prevention and health promotion based on a Population Health framework that focuses on the determinants of health$^4$;

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$^3$ Hospital Standardized Mortality Ratio (HSMR) is the ratio of the actual number of acute in-hospital deaths to the expected number of in-hospital deaths. Target rate for this indicator is below 100.
✓ Introduction of chronic disease management strategies;

✓ Stronger commitment to continuous quality improvement through the passage of the *Excellent Care for All Act* (2011) and the requirement for all hospitals to have Quality Committees and develop annual Quality Improvement Plans; and ultimately,

✓ The development of a more integrated system of health services where patients and clients experience a more coordinated and consumer friendly system.

Last year, the Ministry of Health and Long Term Care released its latest *Health Action Plan* which contains the following 3 priorities:

1. Keeping Ontario Healthy
2. Faster Access To Stronger Family Health Care
3. Right Care, Right Time, Right Place

Within these priorities, implementation details are being developed and rolled out for the following new Ministry strategies:

✓ Seniors Care Strategy (including more funding for home and community-based care)

✓ Health Links Strategy (for patients with complex chronic care issues)

✓ Moving Routine Procedures Out of Hospital to Community-based Clinics

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4 A **Population Health** approach recognizes that any analysis of the health of the population must extend beyond an assessment of traditional health status indicators like death, disease and disability. A Population Health approach establishes indicators related to mental and social well-being, quality of life, life satisfaction, income, employment and working conditions, education and other factors known to influence health (Public Health Agency of Canada)
Against the backdrop of the Province’s deficit reduction strategies, the Ministry of Health and Long Term Care continues the implementation of health system funding reform (HSFR) through the introduction of patient-based funding. There are two key components to HSFR for hospitals:

- Organizational-level funding using the Health Based Allocation Model (HBAM); and
- Quality-Based Procedures (QBPs) where funding is allocated to specific procedures based on a "price X volume" approach using evidence-based allocations to targeted clinical groups.

The HSFR implementation schedule for hospital budgets is as follows:

<table>
<thead>
<tr>
<th>HSFR Component</th>
<th>2012-13</th>
<th>2013-14</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Funding</td>
<td>54%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>HBAM Funding</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>QBP Funding</td>
<td>6%</td>
<td>15%</td>
<td>30%</td>
</tr>
</tbody>
</table>

For 2012-13, QBP funding was implemented for the following procedures:

- Joint (hip and knee) replacements
- Cataracts
- Chronic kidney disease

For 2013-14, QBP funding is targeted for the following additional procedures:

- GI Endoscopy
- Chemotherapy – Systemic Treatment
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Stroke
- Vascular (Non-Cardiac)

QBPs are also being introduced with clinical handbooks to ensure that funding is aligned with evidence-based best practices.
2.2 Planning Priorities for Waterloo Wellington LHIN

The Waterloo Wellington LHIN has recently released its 2013-2016 Integrated Health Services Plan (IHSP). The plan outlines 3 strategic priorities and one strategic enabler:

<table>
<thead>
<tr>
<th>LHIN Priorities</th>
<th>Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhancing Your Access to Primary Care</td>
<td>More Waterloo Wellington residents report their physical and mental health is very good or excellent.</td>
</tr>
<tr>
<td></td>
<td>More residents have a primary care provider.</td>
</tr>
<tr>
<td></td>
<td>Fewer Emergency Department visits for non-urgent cases that could have been seen in a primary care setting.</td>
</tr>
<tr>
<td></td>
<td>Improved health in the population of Waterloo Wellington.</td>
</tr>
<tr>
<td>Creating a More Seamless and Coordinated Healthcare Experience</td>
<td>Greater satisfaction with the care you receive.</td>
</tr>
<tr>
<td></td>
<td>Fewer people making repeat visits to the Emergency Department for care.</td>
</tr>
<tr>
<td></td>
<td>Fewer people going back to the hospital after they have</td>
</tr>
</tbody>
</table>
### LHIN Priorities vs Performance Measures

<table>
<thead>
<tr>
<th>LHIN Priorities</th>
<th>Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>been discharged.</td>
<td></td>
</tr>
<tr>
<td>Fewer days spent in the hospital when you should be receiving care elsewhere.</td>
<td></td>
</tr>
</tbody>
</table>

**Leading a Quality Healthcare System Using Evidence-based Practice**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>You will know the next steps in your care. They will be based on consistently used evidence-based care pathways.</td>
<td>Safer healthcare, including improved patient safety in hospitals.</td>
</tr>
<tr>
<td>Better health outcomes when you receive care through organized regional programs.</td>
<td>You will spend less time in Emergency Departments.</td>
</tr>
<tr>
<td>Diagnostic and surgical procedures are performed within the clinically recommended timeframe.</td>
<td></td>
</tr>
</tbody>
</table>

### Strategic Enabler vs Levers for Change

<table>
<thead>
<tr>
<th>Strategic Enabler</th>
<th>Levers for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accelerating System Change</td>
<td>We need to accelerate system change to build knowledge and skills capacity throughout the system in four key areas:</td>
</tr>
<tr>
<td></td>
<td>• Leadership through Good Governance</td>
</tr>
<tr>
<td></td>
<td>• Quality</td>
</tr>
<tr>
<td></td>
<td>• Resident-Centred Care</td>
</tr>
<tr>
<td></td>
<td>• Integrations: organizational collaboration</td>
</tr>
</tbody>
</table>

It is important to both corporations that we are aligned with the strategic priorities and integration strategies of the Waterloo Wellington LHIN. We committed to this by way of board-approved motions when we began our strategic planning process in 2012 (see Appendix C).

Our corporations have also been active participants in the LHIN’s regional clinical services planning and as part of that process we have been playing a collaborative leadership role in the implementation of the LHIN’s rural services integration report. In support of a rural Wellington integration strategy, we signed a new Memorandum of Understanding (MOU) in June 2013 with our Wellington service provider partners (see Appendix D) that supports greater collaboration between health care organizations so we can better serve the residents of rural Wellington.

#### 3. Our Planning Process

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5 Nan Brooks and Dr. Peter McPhedran, “Rural Wellington Health Services Integration Report”, Winter 2013
The corporations retained the services of Whaley & Company to facilitate the development of a consolidated plan based on the following process steps.

<table>
<thead>
<tr>
<th>Planning steps</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Planning ‘Kick-Off’ Meetings</td>
<td>June 2012</td>
</tr>
<tr>
<td>CEO ‘Town Hall’ Meetings with Staff</td>
<td>Summer 2012</td>
</tr>
<tr>
<td>Strategic Planning Workshops for Boards</td>
<td>Oct. 2012</td>
</tr>
<tr>
<td>Joint Boards Education/Visioning Session</td>
<td>Nov. 2012</td>
</tr>
<tr>
<td>NWHC Board Strategic Planning Session</td>
<td>March 2013</td>
</tr>
<tr>
<td>Joint Board Strategic Planning Session</td>
<td>May 2013</td>
</tr>
<tr>
<td>Develop Draft Strategic Directions</td>
<td>June 2013</td>
</tr>
<tr>
<td>Board, Staff Consultation on Draft Directions</td>
<td>Summer 2013</td>
</tr>
<tr>
<td>Revise Draft Strategic Directions</td>
<td>Aug – Sept. 2013</td>
</tr>
<tr>
<td>Develop Draft Strategic Plan</td>
<td>October 2013</td>
</tr>
</tbody>
</table>

The project was launched in the summer of 2012 and got as far as a joint board visioning session in November 2012. At that time, the joint planning process was temporarily suspended so that both corporations could devote the appropriate amount of time and energy to the LHIN’s ‘Rural Wellington Health System Review’ process. Once that report was completed and reviewed by the LHIN and participating health care organizations, the strategic planning process was resumed in March 2013. A joint board planning session, held in May 2013, led to a set of draft strategic directions which were revised over the summer based on input from staff and board representatives. This consolidated strategic plan was prepared in October 2013 with a final review conducted by both boards in November. Final approval of the plan will take place in December 2013, subject to Key Performance Indicators (KPI”s) with finalization of full plan in spring 2014.
4. What We Heard From Our Stakeholders

4.1 Town Hall Consultations

Over the summer months, the CEO met with staff and other internal stakeholders in a series of ‘town hall’ meetings. There was broad support for the 4 key strategic directions and the following specific strategies:

- Increase safe medication administration
- Support LEAN tools
- Implement best practices
- Support a senior friendly environment
- Enhance IT services and programs

There were also constructive discussions with staff about ongoing improvement strategies for making our two organizations ‘healthy workplaces’ and ‘employers of choice’ (see Appendix E).

4.2 Our Partners’ Priorities

We continue to be active participants in the full range of clinical service planning activities with other providers in the Waterloo Wellington LHIN. There are a number of planning committees and working groups where we are able to share our priorities and at the same time, learn about the priorities of our regional hospital partners. This ongoing dialogue confirms the importance of a separate planning strategy for ‘Rural’ within the LHIN’s regional services plan. The following timetable for the implementation of 17 regional clinical programs has been adopted by the Waterloo Wellington CEO group and submitted to the LHIN.

<table>
<thead>
<tr>
<th>Regional Program</th>
<th>Program Lead</th>
<th>Implementation Timetable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions/Mental Health</td>
<td>Homewood</td>
<td>Summer 2013</td>
</tr>
<tr>
<td>Cancer</td>
<td>GRH</td>
<td>In place but further alignment required</td>
</tr>
<tr>
<td>Cardiac</td>
<td>SMGH</td>
<td>Summer 2013</td>
</tr>
<tr>
<td>Childbirth &amp; Neonatal</td>
<td>CMH</td>
<td>2014</td>
</tr>
<tr>
<td>Children’s</td>
<td>CMH</td>
<td>2014</td>
</tr>
<tr>
<td>Complex Continuing Care</td>
<td>SJHCG</td>
<td>In place but further alignment required</td>
</tr>
<tr>
<td>Critical Care</td>
<td>SMGH</td>
<td>Summer 2013</td>
</tr>
<tr>
<td>Emergency</td>
<td>GGH</td>
<td>Summer 2013</td>
</tr>
<tr>
<td>Laboratory Medicine</td>
<td>SMGH</td>
<td>2015</td>
</tr>
<tr>
<td>Medical Imaging</td>
<td>CMH/GGH</td>
<td>2014</td>
</tr>
<tr>
<td>Medicine</td>
<td>GGH</td>
<td>2014</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>GMCH/NWHC</td>
<td>2013 (partial); 2015 (all areas)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>SJHCG</td>
<td>Completed and fully aligned</td>
</tr>
<tr>
<td>Renal</td>
<td>GRH</td>
<td>In place but with further alignment</td>
</tr>
<tr>
<td>Regional Program</td>
<td>Program Lead</td>
<td>Implementation Timetable</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Rural</td>
<td>GMCH/NWHC</td>
<td>In place but with further alignment required</td>
</tr>
<tr>
<td>Stroke</td>
<td>GRH</td>
<td>2015</td>
</tr>
<tr>
<td>Surgery</td>
<td>GRH</td>
<td>2013 (partial); 2015 (all areas)</td>
</tr>
</tbody>
</table>

The diagram below highlights the accountability structure for these regional programs in terms of Sponsor Organizations and Program Councils.
5. Strategic Directions

5.1 Mission, Vision and Four Strategic Pillars

Strategic Plan: 2013–2016

Quality Care, Close to Home
Caring together for healthier Rural Wellington residents

North Wellington Health Care and Groves Memorial Community Hospital are committed to working together to achieve and support healthy rural communities, in collaboration with our partners. This overarching population health goal is based on the mission and vision of both corporations, and is consistent with recommendations of the 2013 Rural Wellington Health Services Integration report.

Our new consolidated strategic plan is consistent with the Waterloo Wellington Local Health Integration Network (WWLHIN) priorities of Leading a Quality Healthcare System Using Evidence based Practice, Creating a More Seamless and Coordinated Healthcare Experience, Enhancing Access to Primary Care and Accelerating System Change while developing stronger and broader alignment with our partners including hospital foundations.

Strategic Directions for 2013-16

North Wellington Health Care and Groves Memorial Community Hospital, jointly have adopted the following Strategic Directions within four key areas as organizations committed to innovation. We will strive to achieve a balance of all four priority areas as we move forward with implementation.

Advancing BEST PATIENT CARE (Best Practice and Patient Outcomes)
Realizing BEST SYSTEM (System Innovation and Change)
Optimizing BEST ORGANIZATION (Organizational Health)
Ensuring BEST FINANCIAL POSITION (Financial Health)
To achieve this goal we will:

- Adopt best practices and promote evidence informed decision making
- Implement process improvement strategies and continue building a culture of quality and patient safety

**Performance Targets:**
In three years, we will have achieved/accomplished:

- Reduced adverse events for patients including falls and medication errors
- Positive trends in relevant WWLHIN indicators
  - Emergency room length of stay for admitted, complicated and uncomplicated patients
  - Readmissions for certain medical conditions, mental health and substance abuse
  - Advocate for rural Wellington residents for improvement in other WWLHIN indicators

**Realizing BEST SYSTEM (System Innovation and Change)**

**Our Goal: Create a More Seamless/Coordinated Healthcare Experience for Better Health of Rural Wellington Residents**

To achieve this goal we will:

- Advance Capital Projects to enable the creation of vibrant Rural Health Care Hubs focused on integration
- Build healthier communities by working with our partners to create a seamless continuum of care
- Enhance Information Technology (IT) to support a better integrated patient health record and innovative and more efficient business practices for staff
- Enhance access to specialty and primary care
- Improved accreditation status

**Performance Targets:**
In three years, we will have achieved/accomplished:

- Electronic Medical Record (EMR) advancement and alignment with healthcare partners
- Accreditation level achieved
- Progress on capital projects
- Regional initiatives to advance health status of rural residents
- Positive trends in all relevant WWLHIN indicators
  - Emergency visits best seen elsewhere
  - New Users of Clinical Connect
  - Acute Alternate Level of Care, Best cared for in another setting
  - Wait times for CT
  - Advocate for rural Wellington residents for improvement in other WWLHIN indicators
To achieve this goal we will:

- Provide a Safe, Healthy and Respectful Workplace
- Develop and implement a Human Resources Plan based on best-practice retention and recruitment strategies

**Performance Targets:**

In three years, we will have achieved/accomplished:

- High staff, physician and volunteer satisfaction and engagement scores

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**Ensuring BEST FINANCIAL POSITION** (Financial Health)

*Our Goal: Achieve a Balanced and Sustainable Financial Position*

To achieve this goal we will:

- Facilitate best patient care by exercising responsible fiscal management
- Ensure sustainability of patient services as we proactively adapt to changes in funding
- Develop corporate risk management strategies (financial, clinical, HR) that proactively respond to internal changes and external pressures

**Performance Targets:**

In three years, we will have implemented:

- Meet Health Service Accountability Agreement (HSAA) obligations, including a balanced budget for each year
- Develop a Rolling 5 Year Financial Viability Plan
- Develop a Risk Management Plan and contingency plans

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A newly developed LHIN 'resident-focused dashboard' (see Appendix F) and provider based scoreboard (Appendix G), will allow us to track our progress in relation to the LHIN's performance indicators over the next few years.
APPENDIX A – Corporate Scorecards for GMCH and NWHC, 2012-13
## CORPORATE SCORECARD

**FY 2012-2013**

### BEST SYSTEM - System Innovation & Change

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>ANNUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation Canada Status</td>
<td>3 Year Award</td>
<td></td>
<td></td>
<td></td>
<td>2014</td>
</tr>
<tr>
<td>Ontario Laboratory Accreditation Status</td>
<td>4 Year Award</td>
<td></td>
<td></td>
<td></td>
<td>2016</td>
</tr>
<tr>
<td>Health Care Provider Learners</td>
<td>Staff/Clinicians/Nurses/Other</td>
<td></td>
<td></td>
<td></td>
<td>11%</td>
</tr>
<tr>
<td>Failure Mode &amp; Effects Analysis (FMEA)/year</td>
<td>At Least 1 FMEA per year</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

### BEST ORGANIZATION - Organizational Health

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>ANNUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance &lt; 10.3 Days OMA (2.6 Days Orthy)</td>
<td>2.19</td>
<td>2.30</td>
<td>2.35</td>
<td>2.35</td>
<td>2.30</td>
</tr>
<tr>
<td>Turnover Rate &lt;6% Community Hospital Rate (1.5% Orthy)</td>
<td>1.15%</td>
<td>2.0%</td>
<td>2.01%</td>
<td>1.01%</td>
<td>0.65%</td>
</tr>
<tr>
<td>Hard to Fill - Vacancy Rate - RN &lt;4% Ontario Community Nurse Rate</td>
<td>2.2%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>2.27%</td>
</tr>
<tr>
<td>Staff/Physician Survey Participation Rate &gt; 75%</td>
<td>Survey Participation Rate</td>
<td></td>
<td></td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>Lost Time 1.7% Industry Average (4235 Orthy)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0.36%</td>
</tr>
<tr>
<td>LEAN 100% of Leadership Team/yr</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Violence in the Workplace Investigations 0 episodes of violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Serious/Sentinel/Near Miss Reports 0.5% Internal Annual Benchmark</td>
<td></td>
<td></td>
<td></td>
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<td>0.59%</td>
</tr>
</tbody>
</table>

### BEST PATIENT CARE - Cause Patient's Patient Outcome

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>ANNUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Errors 4.2 per 100 admits/ino near miss 12/12</td>
<td>6.6</td>
<td>5.9</td>
<td>7.64</td>
<td>4.9</td>
<td>5.97</td>
</tr>
<tr>
<td>Patient Falls 7 pt/falls per 1000 pt days</td>
<td>7.74</td>
<td>8.83</td>
<td>11.69</td>
<td>8.63</td>
<td>8.55</td>
</tr>
<tr>
<td>Hospital Standard Mortality Ratio (HSMR) &lt; 100 (new calc Q3 2011/12)</td>
<td>91</td>
<td>87</td>
<td>74</td>
<td>87</td>
<td>74</td>
</tr>
<tr>
<td>Surgical Site Infections - Vag Hyst Class II 5-10% Internal</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>7.30%</td>
</tr>
<tr>
<td>Patient Satisfaction - ER &gt; 80% QIP Target</td>
<td>90.3%</td>
<td>92.8%</td>
<td>99.8%</td>
<td>95.1%</td>
<td>92.0%</td>
</tr>
<tr>
<td>Patient Satisfaction - Inpatient &gt; 80% QIP Target</td>
<td>89%</td>
<td>100%</td>
<td>90.2%</td>
<td>96.4%</td>
<td>95.15%</td>
</tr>
<tr>
<td>Clostridium Difficile Associated Disease (CDI) &lt; 0.4 per 1,000 patient days (DIP) Annual (0.10 Q1)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Methicillin Resistant Staphylococcus (MRSA) &lt; 0.4 per 1,000 patient days (DIP) Annual (0.10 Q1)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hand Hygiene &gt; 80% Before Patient Contact QIP Target</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>74%</td>
</tr>
<tr>
<td>Inpatient Occupancy Rate 85% budgeted patient days</td>
<td>75.8%</td>
<td>68.4%</td>
<td>89.9%</td>
<td>88.4%</td>
<td>80.9%</td>
</tr>
<tr>
<td>% ALC Occupancy 9.46% W/LHIN HSA &amp; QIP Target</td>
<td>6.7%</td>
<td>1.3%</td>
<td>13.7%</td>
<td>10.8%</td>
<td>5.99%</td>
</tr>
<tr>
<td>Average Acute Length of Stay 5 Days Internal Benchmark</td>
<td>6.8</td>
<td>6.3</td>
<td>6.3</td>
<td>6.4</td>
<td>6.3</td>
</tr>
<tr>
<td>90th Percentile LOS ER Visit Trig 1, 2 &amp; 3 90% LOS Non-Admitted Complex &lt; 6 hrs</td>
<td>5.7</td>
<td>5.7</td>
<td>6.3</td>
<td>6.1</td>
<td>6.0</td>
</tr>
<tr>
<td>90th Percentile LOS ER Visit Trig 4 &amp; 5 90% LOS Non-Admitted, Non-Complicated &gt; 4 hrs</td>
<td>3.6</td>
<td>3.9</td>
<td>3.9</td>
<td>3.5</td>
<td>3.7</td>
</tr>
<tr>
<td>90th Percentile LOS in ER for Admitted Patients 90% LOS &lt; 6 hrs</td>
<td>14.0</td>
<td>10.3</td>
<td>21.2</td>
<td>19.6</td>
<td>16.5</td>
</tr>
<tr>
<td>CTAS 4 &amp; 5 Percentage of Total Visits Indicator Be Developed</td>
<td>52.0%</td>
<td>55.0%</td>
<td>52.0%</td>
<td>50.0%</td>
<td>52.0%</td>
</tr>
<tr>
<td>Left Without Being Seen - ER &lt; 4.0% QIP Target</td>
<td>2.7%</td>
<td>2.5%</td>
<td>3.3%</td>
<td>3.8%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Surgical Checklist Compliance &gt;90% QIP Target</td>
<td>91%</td>
<td>93%</td>
<td>80.9%</td>
<td>90.0%</td>
<td>94.0%</td>
</tr>
</tbody>
</table>

### BEST FINANCIAL POSITION - Financial Health

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>ANNUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Ratio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.41:1</td>
</tr>
<tr>
<td>Total Margin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>48.09%</td>
</tr>
</tbody>
</table>

**Final September 6, 2013**
## CORPORATE SCORECARD

### FY 2012-13

### BEST SYSTEM - System innovation and Change

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>ANNUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2014 1</td>
</tr>
<tr>
<td>Ontario Laboratory Accreditation Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2015 1</td>
</tr>
<tr>
<td>Health Care Provider Learners</td>
<td>Students/Residents/Clinic/Nurse/Medical/Health/Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure Mode &amp; Effects Analysis (FMEA)/year</td>
<td>1 FMEA per year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BEST ORGANIZATION - Organisational Health

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>ANNUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance &lt;= 18.3 days OHA (26 days Quarterly)</td>
<td>1.27</td>
<td>1.23</td>
<td>1.13</td>
<td>1.11</td>
<td>1.52 2</td>
</tr>
<tr>
<td>Turnover Rate &lt;8% Annual Community Hospital Rate (1.5% Orth)</td>
<td>1.81%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>2.41% 2</td>
</tr>
<tr>
<td>Hand tie Fill - Vacancy Rate - RN &lt; 4% Ontario Community Hosp Rate</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0% 2</td>
</tr>
<tr>
<td>Staff/Physician Worklife Pulse Survey &gt; 75% Response Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2011 1</td>
</tr>
<tr>
<td>Lost Time 1.70% Industry Average (.423% Quarterly)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0.50% 3</td>
</tr>
<tr>
<td>LEAN 100% of Leadership Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2011 1</td>
</tr>
<tr>
<td>Violence in the Workplace Investigations 0 Episodes of Violence</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>4 3</td>
</tr>
<tr>
<td>Serious/Sentiment/Year Mis Reports 0.5% Internal Annual Benchmark</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2000 3</td>
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</table>

### BEST PRACTICE OF CARE - Preventable infectious and patient harm

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>ANNUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Errors 4.2 per 100 admits/no near miss 12/13</td>
<td>2.6</td>
<td>3.63</td>
<td>3.99</td>
<td>6.54</td>
<td>4.62 4</td>
</tr>
<tr>
<td>Patient Falls 7 Acute pte falls per 1000 pte days</td>
<td>6.85</td>
<td>5.83</td>
<td>7.83</td>
<td>6.74</td>
<td>7.81 4</td>
</tr>
<tr>
<td>Hospital Standard Mortality Ratio (HSMR) &lt; 10% (new rate 2012)</td>
<td>13%</td>
<td>14%</td>
<td>16%</td>
<td>70%</td>
<td>96% 4</td>
</tr>
<tr>
<td>Surgical Site Infections - Vag Hypt Class II 5-10%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0% 5</td>
</tr>
<tr>
<td>Patient Satisfaction - ER &gt; 80% QIP Target</td>
<td>*NA</td>
<td>93.1%</td>
<td>*NA</td>
<td>93.9%</td>
<td>91.6% 5</td>
</tr>
<tr>
<td>Patient Satisfaction - Inpatient &gt; 85% QIP Target</td>
<td>95.5%</td>
<td>94.7%</td>
<td>100%</td>
<td>100%</td>
<td>94.8% 5</td>
</tr>
<tr>
<td>Clostridium Difficile Associated Disease (CDI) &lt;0.4 per 1000 pte days (2011) Annual/0.3 Unity</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 6</td>
</tr>
<tr>
<td>Methicillin Resistant Staphylococcus (MRSA) &lt;0.4 per 1000 pte days (2011) Annual/0.3 Unity</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 6</td>
</tr>
<tr>
<td>Hand Hygiene &gt; 79% Before Patient Contact QIP Target</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2011 7</td>
</tr>
<tr>
<td>Inpatient Occupancy Rate &gt; 85% Budgeted Patient Days</td>
<td>53%</td>
<td>60%</td>
<td>63%</td>
<td>53%</td>
<td>58% 7</td>
</tr>
<tr>
<td>% ALC Occupancy &lt; 9.46% QIP / HSAA Target</td>
<td>8.5%</td>
<td>10.5%</td>
<td>12.5%</td>
<td>12.5%</td>
<td>14.7% 7</td>
</tr>
<tr>
<td>Average Acute Length of Stay 5 Days Internal Benchmark</td>
<td>3.8</td>
<td>4.1</td>
<td>4.5</td>
<td>3.9</td>
<td>4.1 8</td>
</tr>
<tr>
<td>90% Percentile LOS ER Vists Triage 1, 2 &amp; 3</td>
<td>90% LOS &lt; 6 hrs</td>
<td>5.3</td>
<td>4.7</td>
<td>5.1</td>
<td>5.2</td>
</tr>
<tr>
<td>90% Percentile LOS ER Vists Triage 4 &amp; 5</td>
<td>90% LOS &lt; 4 hrs</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>90% Percentile LOS in Emergency for Admitted Patients 90% LOS &lt; 6 hrs QIP Target (HSAA Bhs)</td>
<td>6.9</td>
<td>6.7</td>
<td>7.3</td>
<td>6.2</td>
<td>6.2 9</td>
</tr>
<tr>
<td>CTAS 4 &amp; 5 Percentage of Total Visits Indicator to be Developed</td>
<td>78%</td>
<td>78%</td>
<td>78%</td>
<td>78%</td>
<td>78% 9</td>
</tr>
<tr>
<td>Left Without Being Seen - ER &lt; 1.0% QIP Target</td>
<td>1.30%</td>
<td>1.97%</td>
<td>2.07%</td>
<td>0.90%</td>
<td>1.00% 9</td>
</tr>
<tr>
<td>Surgical Checklist Compliance &gt;95% QIP Target</td>
<td>95.7%</td>
<td>98.7%</td>
<td>98.4%</td>
<td>98.0%</td>
<td>98.7% 9</td>
</tr>
</tbody>
</table>

### BEST FINANCIAL POSITION (Financial Health)

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>ANNUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Ratio</td>
<td>HSAA Target = 1.36 - 1.662</td>
<td>1.67</td>
<td>1.83</td>
<td>1.83</td>
<td>2.11 10</td>
</tr>
<tr>
<td>Total Margin</td>
<td>Meet or better than HSA targets set at 1% QIP</td>
<td>153,514</td>
<td>178,642</td>
<td>160,816</td>
<td>111,897</td>
</tr>
</tbody>
</table>

*NA = Insufficient Data

Final as of September 6, 2013
APPENDIX B – Work Life Culture Survey Results for NWHC and GMCH, 2008 - 2012

<table>
<thead>
<tr>
<th>SURVEY QUESTION</th>
<th>2008</th>
<th>2010</th>
<th>2012</th>
<th>SURVEY QUESTION</th>
<th>NWHC Analyzed Survey Questions in 2012</th>
<th>RED FLAG</th>
<th>YELLOW FLAG</th>
<th>GREEN FLAG</th>
<th>RED FLAG</th>
<th>YELLOW FLAG</th>
<th>GREEN FLAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating one's stress levels at work</td>
<td></td>
<td></td>
<td></td>
<td>In the past 12 months, would you say that most days at work were: Not, somewhat, quite or extremely stressful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enough time to do job adequately</td>
<td></td>
<td></td>
<td></td>
<td>I am given enough time to do what is expected of me in my job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied with communications in work area</td>
<td></td>
<td></td>
<td></td>
<td>I am able to decide how to do my work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied with supervision</td>
<td></td>
<td></td>
<td></td>
<td>I am able to make improvements in how my work is done</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization supports learning and development</td>
<td></td>
<td></td>
<td></td>
<td>I have good opportunities to develop my career</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work environment is safe</td>
<td></td>
<td></td>
<td></td>
<td>My Workplace is Safe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating one's overall health</td>
<td></td>
<td></td>
<td></td>
<td>My job makes good use of my skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating one's physical health</td>
<td></td>
<td></td>
<td></td>
<td>Have the materials, supplies and equipment I need to do my work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating one's frequency of doing best work</td>
<td></td>
<td></td>
<td></td>
<td>Task recognition for good work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating one's overall satisfaction with organization</td>
<td></td>
<td></td>
<td></td>
<td>Task control the training I need to do my job well</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working conditions contribute to patient safety</td>
<td></td>
<td></td>
<td></td>
<td>The people I work with treat me with respect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with communications in organization</td>
<td></td>
<td></td>
<td></td>
<td>Senior Managers are committed to providing a safe and healthy workplace</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with amount of control over job activities</td>
<td></td>
<td></td>
<td></td>
<td>Senior Managers effectively communicate the organization's goals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with involvement in decision making processes in organization</td>
<td></td>
<td></td>
<td></td>
<td>The people I work with help each other out</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating one's trust level in organization</td>
<td></td>
<td></td>
<td></td>
<td>I feel like I belong to a team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job allows balance of work and personal life</td>
<td></td>
<td></td>
<td></td>
<td>My organization treats me fairly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>clarity of job expectations</td>
<td></td>
<td></td>
<td></td>
<td>I am able to balance my family and personal life with work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In past 12 months – Nurse Time</td>
<td></td>
<td></td>
<td></td>
<td>Understand what is expected of me in my job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In past 12 months – Working while ill</td>
<td></td>
<td></td>
<td></td>
<td>My organization provides feedback on how well I am doing my job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating one's satisfaction with job</td>
<td></td>
<td></td>
<td></td>
<td>I can count on my supervisor to help me with a difficult task</td>
<td></td>
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<tr>
<td>Overall, how satisfied are you with your job?</td>
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<td>Overall, how satisfied are you with your job?</td>
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</tbody>
</table>

Red Flag 2 columns representing the top 2 most indicative responses to this question and the sum of those 2 to 30%.

Yellow Flag 2 columns representing the top 2 most indicative responses to this question and added to the sum of those 2 to 10%.

Green Flag 2 columns representing the top 2 most indicative responses to this question and added to the sum of those 2 to 30%.

NRE:
- Green Flag 2 columns representing the top 2 most indicative responses to this question and added to the sum of those 2 to 30%.
- Yellow Flag 2 columns representing the top 2 most indicative responses to this question and added to the sum of those 2 to 10%.
- Red Flag 2 columns representing the top 2 most indicative responses to this question and added to the sum of those 2 to 30%.

20
<table>
<thead>
<tr>
<th>SURVEY QUESTION</th>
<th>2008</th>
<th>2010</th>
<th>2011</th>
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<tbody>
<tr>
<td>1. Rating one's stress levels at work</td>
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<td>2. Enough time to do work adequately</td>
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<td>3. Satisfied with communications in work area</td>
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<td>4. Satisfied with supervisor</td>
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<td>5. Organization supports learning and development</td>
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<td>6. Work environment is safe</td>
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<td>7. Rating one's overall health</td>
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<td>8. Rating one's mental health</td>
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<td>9. Rating one's physical health</td>
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<td>10. Rating one's frequency of doing best quality work</td>
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<td>11. Rating one's overall satisfaction with organization</td>
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<td>12. Working conditions contribute to patient safety</td>
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<td>13. Satisfaction with communications in organization</td>
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<td>14. Satisfaction with amount of control over job activities</td>
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<td>15. Satisfaction with involvement in decision making processes in organization</td>
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<td>16. Rating one's trust level in organization</td>
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<td>17. Job allows balance of work and personal life</td>
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<td>18. Clarity of job expectations</td>
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<td>19. In past 12 months - Sick days</td>
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<td>20. In past 12 months - Working while ill</td>
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<tr>
<td>21. Rating one's satisfaction with job</td>
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</table>

**KEY:**

- **Green Flag:** Indicates that the organization is moving towards improvement or has already achieved the desired level.
- **Yellow Flag:** Indicates areas that require attention but are improving.
- **Red Flag:** Indicates significant areas of concern that need immediate attention.

**Notes:**
- Senior Managers are committed to providing high-quality care.
- Senior Managers act on staff feedback.
- My organization takes effective action to prevent violence in the workplace.
- My organization takes effective action to prevent abuse in the workplace.
- I am unsatisfied with changes affecting my job.
- How often does your work/unit provide top-quality patient care or other services?
- Would you recommend this organization to friends and family who require care?
- How frequently do you look forward to going to work?
- Overall, how would you rate your organization as a place to work?
APPENDIX C - WWLHIN Commitment to Integration

Groves Memorial Community Hospital, Board Approved Motion, June 12, 2012

Whereas the hospital has a fiduciary responsibility to serve our local community and such services can be improved from integration efforts, and specialty service leadership can also produce financial gains through consistency and economies of scale, while minimizing the need for travel, and, whereas principle #3 indicates the population served by each hospital includes all 800,000 residents of the WWLHIN and not just the residents of their individual local community or "catchment area", while the hospital sees the inclusion of all 800,000 residents as only appropriate for specialty services for the region,

MOVED by P. Smith and SECONDED by H. Dobson that the Board of Directors of Groves Memorial Community Hospital hereby direct our President and CEO to make the administrative and clinical integrations in the WWLHIN, consistent with the principles contained in the final version of the March 16, 2012 document titled: "WWLHIN Hospitals - Commitment to Integration", a priority in addition to integrations contemplated between the WHCA sites and the campus model advancements championed to date. This WWLHIN Hospitals - Commitment to Integration is to be a priority for areas of the hospital where it does not conflict with the WHCA and campus model advancements and that the resolution be communicated to internal and external hospital stakeholders in an appropriate manner. CARRIED.

North Wellington Health Care, Board Approved Motion, June 14, 2012

Whereas the hospital has a fiduciary duty to serve our local rural community and such service can be improved from integration efforts, and specialty service leadership can also produce financial gains through consistency and economies of scale, while minimizing the need for travel, and, Whereas principle #3 indicates the population served by each hospital includes all 800,000 residents of the WWLHIN and not just the residents of their individual local community or "catchment area" while the hospital sees the inclusion of all 800,000 residents as only appropriate for specialty services for the region,

"The Board of Directors of North Wellington Health Care Corporation hereby direct our President/CEO to make the administrative and clinical integrations in the WWLHIN, consistent with the principles contained in the final version of the March 16, 2012 document titled: ‘WWLHIN Hospitals – Commitment to Integration’, a priority in addition to integrations contemplated between WHCA sites and the campus model advancements championed to date. This WWLHIN Hospitals - Commitment to integration is to be a priority for areas of the hospital where it does not conflict with WHCA and campus model advancements, and that the resolution be communicated to internal and external hospital stakeholders in an appropriate manner.”
MEMORANDUM OF UNDERSTANDING ("MOU")

THIS MOU made as of the 26th day of June, 2013,

BETWEEN:

NORTH WELLINGTON HEALTH CARE CORPORATION ("NWHC")
- and -
GROVES MEMORIAL COMMUNITY HOSPITAL ("GMCH")
- and -
HOMEWOOD HEALTH CENTRE (HOMEWOOD)
- and -
EAST WELLINGTON FAMILY HEALTH TEAM ("EW FHT")
- and -
MOUNT FOREST FAMILY HEALTH TEAM ("MF FHT")
- and -
MINTO MAPLETON FAMILY HEALTH TEAM ("MM FHT")
- and -
UPPER GRAND FAMILY HEALTH TEAM ("UG FHT")
- and -
WATERLOO WELLINGTON COMMUNITY CARE ACCESS CENTRE ("WW CCAC")
- and –
CANADIAN MENTAL HEALTH ASSOCIATION WATERLOO
WELLINGTON DUFFERIN ("CMHA WWD")

WHEREAS each of the parties to this agreement provide various services to patients/clients and residents of the Rural Wellington and Rural North Wellington and South Grey WWLHIN planning areas. The aim of optimizing the health and well being of these individuals is our united purpose;

AND WHEREAS WW CCAC and CMHA WWD service patients/clients and residents in the entire WWLHIN area and beyond for select regional services;

AND WHEREAS the parties wish to provide appropriate services locally in order to enhance patient/client care in the communities served in Rural Wellington and to realize and optimize efficiencies, cost-savings and convergence of systems;

AND WHEREAS the parties are in favour of a more formal collaboration between the parties for the benefit of patients/clients and that we are stronger together than we could be independently;
AND WHEREAS the WWLHIN Rural Wellington Health Services Integration Report is a basis for planning, this MOU is to bring form and function to the ideals espoused through site, service and planning alignments;

NOW THEREFORE, FOR VALUE RECEIVED, the parties agree as follows:

1. **Goals.** By entering into this memorandum of understanding, the parties are committing to the following:
   
a. Supporting both executive leadership collaboration and broader collaboration between the parties;
   
b. Enhancing health and patient/client care in the communities served;
   
c. Improving the overall efficiency and effectiveness of the health care services at each of the organizations through collaboration, joint planning and sharing.
   
d. Leveraging the hospital sites and other health centres as established access points for rural health care to link other health care providers in physical locations where feasible and virtually where needed.

2. **Guiding Principles/ Beliefs.** The parties agree to abide by the following guiding principles and beliefs:
   
a. We value trust, honesty, commitment, best practice, and innovation
   
b. The right thing is to maximize the benefit to patients/clients/individuals with the resources available
   
c. If we do more of the same, we will get more of the same. This is no longer acceptable for the residents in our community
   
d. The parties acknowledge that those who live in rural areas have a strong identification with and loyalty to their local health care providers. Accordingly, all parties will work together to enhance the current level of health care available to the communities served as well as to strategically evolve their existing capabilities and service roles
   
e. The parties will work together to ensure that where critical mass exists and quality can be maintained, the services will be provided by people located in the rural area and those services
   
f. The parties are committed to developing appropriate, viable and functional linkages with each other and with other regional partners to enable the delivery of specialized services to the rural communities served in an appropriate manner;
g. The parties are dedicated to the common cause of achieving and ensuring excellence in patient/client care in the most appropriate setting. In pursuit of this, the parties mutually agree to act in good faith at all times and in accordance with professional and clinical service standards, use their resources wisely and efficiently, share information deemed vital and relevant to the collective purpose of the parties, and measure and report on their performance to key stakeholder groups. Furthermore, the parties will ensure that all who are affected by this joint undertaking, including patients, their families, professional practitioners, staff and volunteers, are treated in a considerate and respectful manner.

h. The parties will work in co-operation to leverage potential sources of funding to improve service.

i. The parties will also align efforts for non health improvements like transportation and housing which are recognized as having an impact on health status.

j. The parties acknowledge the need to respect the unique interests, cultures and responsibilities of all parties for consistent, equitable, fair and reliable dealings. Accordingly, the parties will recognize the roles, competencies, diversity, worth and contributions of all practitioners and staff who will or who may be affected by this MOU.

k. The mission vision and value statements of each organization are found in appendices to this agreement to evidence commitment to support the aims of the parties to this MOU.

3. Chief Executive Officers (CEO). The Chief Executive Officer (or equivalent) of each party is responsible to proactively identify, evaluate and work to implement opportunities on an ongoing basis that will be beneficial to all parties. Each CEO will notify the others preferably in writing of a potential collaborative opportunity and arrange to meet to discuss the opportunity as soon as practical. The meeting may include any other appropriate resource (e.g. management or professional staff) that may contribute to the discussion.

CEO or designates, shall act as the members of the Rural Wellington Health Advisory (WHA) Operations Committee which shall report to the Rural Wellington Health Advisory (WHA)Steering Committee.

4. Joint Board Interaction. The members of the respective boards will be the full Advisory Council. They may meet annually for reports on progress of the integration of the Rural Wellington Health System. This Advisory Council does not require full participation of all board members and is to provide guidance and feedback to the Governance Steering Committee.

5. Examples of Collaboration. Types of collaboration to be explored under this MOU include:
a. Sharing of staff members to supplement skill sets

b. Movement of staff and resources from one organization to another to provide local care to the residents of Rural Wellington

c. Facilitation of system navigation by patients/clients through one stop access point

d. Leveraging and co-locating Information Systems, plant, maintenance, security, communication, and other back office functions and duties for a given location

e. Provision of back-up for service access when providers unavailable

f. Involving partners in joint planning of space to the mutual benefit of others

g. Providing a united rural voice for needs in a given area

h. Cross-credentialing of professional staff;

i. Strategically planning to provide complementary health care services in specialized areas, where appropriate; and

j. Integrating non-clinical services where efficient and appropriate.

6. In order to accomplish the above goals and beliefs, the parties agree to:
   a. Appoint a Board representative to a Rural WHA Steering Committee
   b. The Rural WHA Steering Committee enable to be hired a Change Agent to guide and assist the organizations in the implementation of the Rural Wellington Health Services Integration Strategy.
   c. Commit resources to support the project implementation as agreed upon by the Rural WHA Steering Committee and as approved by each MOU partners’ Board of Directors where appropriate.

7. Semi-annual deliverables. On a semi-annual basis the Rural WHA Steering Committee will establish a schedule A of expected deliverables (plans and objectives) for the half year. These will serve as the basis for planning joint efforts while remaining open to new opportunities where parties see it of value to pursue.

8. Sharing of costs and gains. Where joint efforts are established each party is responsible for ensuring an equitable division of costs and responsibility with a view of aligning costs
to funded programs wherever practical. No party should seek to gain financial advantage at the expense of another party to this agreement or intentionally cause added unfunded costs to another party without joint agreement to do so. Documentation of initiative agreements and cost sharing arrangements will be done where appropriate.

9. Dispute Resolution. Where any party has a conflict or dispute with another party, reasonable effort to find a mutually agreeable alternative approach will be made. If a single item of dispute is unresolved, this would not be a basis for termination, and rather a joint effort of all parties to help address the issue(s) will be considered to help facilitate resolution for the benefit of all organizations and most of all the patients/clients.

10. Ability to Bind Other Party. Nothing in this MOU permits any party to incur liabilities on behalf of the other parties or to hold itself out as an agent of the other parties.

11. Assignment. No party will be entitled to assign this MOU without the prior written consent of the other parties.

12. Termination. Where any party wishes to terminate participation in this MOU it should be communicated in writing to the other parties and with reasonable notice of no less than 30 days the parties shall convene a meeting of the CEO’s to discuss the concerns prior to termination. There is no fixed term on this MOU, and it will be evaluated and updated on an annual basis by the executives as noted in number 4 above.

13. Governing Law. This MOU will be governed by and interpreted in accordance with the laws of the Province of Ontario.

This MOU was agreed to amongst the nine partner organizations and signed in June 2013.
Outline:
Through the summer 2013, the CEO met with many staff as well as a few volunteers and others to discuss progress on strategic plans, building project updates Waterloo Wellington Health Integration Network (WWHIN) directions and the continued emphasis of campus models of care.

Results:
20 sessions with 139 staff (32% of staff) and a handful of volunteers and one physician participated from across the three sites. Detailed notes were taken by CEO during sessions and the full summary will be shared with senior team and will be discussed at an upcoming leadership team meeting.

Themes:

Best Patient Care and Best System:
Everyone who attended expressed support for the concept that to improve patient care we should plan to – increase safe medication administration, support LEAN tools, implement best practices support a senior friendly environment, enhance IT services and programs.

When asked about barriers to care the repeated messages from staff included:
- **Process improvements are needed**- in medication administration, communication, and supply distribution. Many identified a willingness to help solve these issues over time. Staff also acknowledged our need to develop better change management supports.
- **Challenges with the Information systems** regarding integration, support and functionality including WiFi for patients
- **Physical Environmental challenges** – with older facilities including climate control issues and accessibility
- **Training needs** – to support better care delivery, while appreciating investments to date, more is desired.

Few issues were mentioned regarding partner alignment or communication other than access to case management (CCAC) and mental health staff for support at specific times, and an appreciation when they are available.

Best Organization:
A large focus of discussion with staff was about further developing a “workplace of choice” as well as further defining how to make people feel valued at work. Many comments were shared that we already are a workplace of choice, and this is shown by seniority of many staff, successful recruitment and general mood/attitude amongst staff. Suggestions for ongoing improvement included:
• **Appropriate acknowledgement** – a simple thank you for most staff was noted as very valued, whether from peer, manager, senior team or physicians. It encourages the heart to know they make a difference

• **Education supports.** Added money needed at GMCH while NWHC education fund was often commended as a valued investment. These investments were for hospital specific initiatives like LEAN, and professional advancement including developing specific work related skills. By far the LEAN training positives were the most talked about in the sessions, with notation of understanding better impacts on others as well as appreciating the ideas of staff in solving everyday problems

• **Staffing levels** – workload varies greatly in some areas, and concerns with being less effective when short staffed. Some concerns with lack of night supports as well, given the reliance on hospitals by the community. It is especially important to acknowledge and address the effort while resolving the concern of staffing levels in a timely way

• **Competitive wages and Full Time/Regular Part Time work**- it was noted that some problems in recruitment are as a result of less competitive wages and the number of casual positions as opposed to more regular or full time positions. Most staff acknowledged as well the challenge of solving these issues. Even the scheduling aspect of some areas raised concerns with some variance in desire for 12hour shifts, fixed rotations and self-scheduling

• **Tangible acknowledgements**- staff genuinely appreciated the occasional ice cream day, pizza lunch and pot luck gathering to improve spirits and celebrate as a team. An often mentioned noted change was the lack of free dinners on Christmas Day (removed 3 years ago).

• **Open Communication**- was underlined as a strength overall, while having some areas for improvement when it came to change management. Understanding the why things change as opposed to just what is changing came through a few times
APPENDIX F – WWLHIN Dashboard for Resident-Focused Performance Monitoring

Waterloo Wellington LHIN: Our Local Areas for Improvement
We are focused on improving the following areas to provide better health for our residents

<table>
<thead>
<tr>
<th>Enhancing Your Access To Primary Care</th>
<th>Results for North Wellington Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Plans for High Need Residents</strong></td>
<td>Produced on: November 15, 2013</td>
</tr>
<tr>
<td><strong>Percentage Individuals Referred to a Health Care Provider</strong></td>
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<tr>
<td><strong>Emergency Visits Best Seen Elsewhere</strong></td>
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<tr>
<td><strong>New Users of Clinical Connect</strong></td>
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<tr>
<td><strong>Hospital Report Delivery System</strong></td>
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</table>

<table>
<thead>
<tr>
<th><strong>Most Recent Performance by Patient</strong></th>
<th><strong>Improvement from Starting Point</strong></th>
<th><strong>Local System Target</strong></th>
<th><strong>LHIN Rank</strong></th>
<th><strong>Most Recent Reporting Period</strong></th>
</tr>
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<tbody>
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<td>NOH</td>
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<td>13.0%</td>
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<td>3</td>
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</tr>
<tr>
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<td>2012</td>
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<td>10.3%</td>
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<td>0</td>
<td>Sep 2013</td>
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<td>1</td>
<td></td>
</tr>
<tr>
<td>No</td>
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<td>1</td>
<td>Apr-Jul 2013</td>
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<thead>
<tr>
<th>Creating a More Seamless &amp; Coordinated Healthcare Experience</th>
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<tbody>
<tr>
<td><strong>Acute ALC Days Best Cared For In Another Setting</strong></td>
<td>7.5%</td>
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<tr>
<td><strong>Readmissions to Hospital for Certain Medical Conditions</strong></td>
<td>15.0%</td>
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<tr>
<td><strong>Readmissions to Emergency for Mental Health Conditions</strong></td>
<td>14.0%</td>
</tr>
<tr>
<td><strong>Readmissions to Emergency for Substance Abuse</strong></td>
<td>23.5%</td>
</tr>
<tr>
<td><strong>Wait Time for Community Residents - CCAC App to First Assmt</strong></td>
<td>3.0%</td>
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<tr>
<td><strong>Wait Time for Community Residents - CCAC First Assmt to First Service</strong></td>
<td>12.7%</td>
</tr>
<tr>
<td><strong>Wait Time for Hospital Patients - From Discharge to CCAC First Service</strong></td>
<td>14.0%</td>
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<th><strong>Most Recent Performance by Patient</strong></th>
<th><strong>Improvement from Starting Point</strong></th>
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<td>Apr-Jul 2013</td>
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<td>9.1%</td>
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<tr>
<th>Leading a Quality Healthcare System Using Evidence-based Practice</th>
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<tbody>
<tr>
<td><strong>Emergency Room Stay for Admitted Patients</strong></td>
<td>7.5%</td>
</tr>
<tr>
<td><strong>Emergency Room Stay for Complicated Conditions</strong></td>
<td>15.0%</td>
</tr>
<tr>
<td><strong>Emergency Room Stay for Uncomplicated Conditions</strong></td>
<td>23.5%</td>
</tr>
<tr>
<td><strong>Wait Times for MRI (non-emergent)</strong></td>
<td>3.0%</td>
</tr>
<tr>
<td><strong>Wait Times for CT Scan (non-emergent)</strong></td>
<td>12.7%</td>
</tr>
<tr>
<td><strong>Wait Times for Hip Replacement (non-emergent)</strong></td>
<td>14.0%</td>
</tr>
<tr>
<td><strong>Wait Times for Knee Replacement (non-emergent)</strong></td>
<td>23.5%</td>
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<tr>
<td><strong>Wait Times for Cancer Surgery (non-emergent)</strong></td>
<td>14.0%</td>
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<tr>
<td><strong>Wait Times for Cataract Surgery (non-emergent)</strong></td>
<td>23.5%</td>
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<tr>
<td><strong>Wait Times for Cardiac BYPass Surgery (non-emergent)</strong></td>
<td>14.0%</td>
</tr>
<tr>
<td><strong>Readmissions to Hospital for Stroke Patients (per 100 patients)</strong></td>
<td>14.0%</td>
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<th><strong>Most Recent Performance by Patient</strong></th>
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<th><strong>LHIN Rank</strong></th>
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<td>14</td>
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</tr>
<tr>
<td>Note 1</td>
</tr>
<tr>
<td>Note 2</td>
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</table>
|Note 3| Indicators of emergency Room Stay and Wait Times represent the experience of the ith person out of 10 people tracked. In other words, if other people had lower wait times than this number and one had a higher wait time.
APPENDIX G – WWLHIN: Our Local Areas for Improvement

Waterloo Wellington LHIN: Our Local Areas for Improvement

Guided by achieving the best outcomes for residents, the WWLHIN has established performance targets based on the provincial target or clinical evidence, whichever is better.

Produced on: February 5, 2013

### Enhancing Your Access To Primary Care

<table>
<thead>
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<th>Local System Target</th>
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### Creating a More Seamless & Coordinated Healthcare Experience

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<td>19.9%</td>
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<td>15.6%</td>
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<td>9.0%</td>
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<td>14.5%</td>
<td>13.3%</td>
<td>11.1%</td>
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### Leading a Quality Healthcare System Using Evidence-based Practice

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<th>Improvement from Starting Point</th>
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<td>-</td>
<td>-</td>
<td>5.6%</td>
<td>6.5%</td>
<td>1.5%</td>
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</table>

**Legend**
- **1** Starting Point: Performance prior to LHIN or first available data point after creation of LHIN
- **2** A positive number represents an improvement from the starting point
- **3** ND stands for North Dumfries
- **4** KW stands for Kitchener, Waterloo, Wellesley, Woolwich and Wilmot

**Note**
1. These values are year-to-date starting April of a fiscal year.
2. These values are cumulative since beginning of program.
3. Indicators of Emergency Room Stay and Wait Times represent the experience of the 9th person out of 10 people tracked. In other words, 8 other people had lower wait times than this number and one had a higher wait time.

For more information, please contact the WWLHIN at waterlowellington@lhin.on.ca
EMERGENCY VISITS BEST SEEN ELSEWHERE - WWLHIN

Control Chart Type: P

Emergency Visits Best Seen Elsewhere Quarterly Process

Order of LHIN Performance - Q2 FY 2013-14

Definitions: The percentage of visits to Emergency Rooms where patients were seeking care for conditions (such as eye infections, bladder infections, sore throats, or common colds) that could be treated in alternative primary care settings. The values being reported on the Dashboard are quarterly fiscal year-to-date values, while those reported on the detailed drill-down layers are for discrete quarters.

Data Source: IntelliHealth Ontario, MOHLTC

Target Source: Established by the WWLHIN

Notes:
### Enhancing Your Access To Primary Care

<table>
<thead>
<tr>
<th>Category</th>
<th>Current</th>
<th>Target</th>
<th>Status</th>
<th>Baseline</th>
<th>Last Update</th>
<th>Rank</th>
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<td>Percentage Individually Referred to a Health Care Provider</td>
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<td>13.2 %</td>
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### Creating a More Seamless & Coordinated Healthcare Experience

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<th>Status</th>
<th>Baseline</th>
<th>Last Update</th>
<th>Rank</th>
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<tr>
<td>Acute ALC Days Best Cared For In Another Setting</td>
<td>12.7 %</td>
<td>9.5</td>
<td>14.1</td>
<td>10.2</td>
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<td>Readmissions to Hospital for Certain Medical Conditions</td>
<td>16.9 %</td>
<td>14.0</td>
<td>14.0</td>
<td>18.3</td>
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<td>16.0</td>
<td>18.3</td>
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<tr>
<td>Readmissions to Emergency for Substance Abuse</td>
<td>34.3 %</td>
<td>18.1</td>
<td>19.1</td>
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### Leading a Quality Healthcare System Using Evidence-based Practice

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<td>4.0</td>
<td>4.4</td>
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<td>0.0</td>
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Note 1: Performance Status: Green – meets or exceeds target; Yellow – does not meet target but has improved from baseline; Red – does not meet target and has not improved from baseline.

Note 2: Baseline value is based on the most recent full Fiscal Year available.
## Enhancing Your Access To Primary Care

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## Creating a More Seamless & Coordinated Healthcare Experience

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## Lending a Quality Healthcare System Using Evidence-based Practice

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**Notes:**

1. Performance Status: Green = meets or exceeds target; Yellow = does not meet target but has improved from baseline; Red = does not meet target and has not improved from baseline.

2. Baseline value is based on the most recent full Fiscal Year available.
### Enhancing Your Access To Primary Care

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<th>Rank</th>
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<td><strong>Hospital Repeat Delivery System</strong></td>
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### Creating a More Seamless & Coordinated Healthcare Experience

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<td>%</td>
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<td>16.0%</td>
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### Leading a Quality Healthcare System Using Evidence-based Practice

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<td><strong>Emergency Room Stay for Uncomplicated Conditions</strong></td>
<td>hours</td>
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<td><strong>Wait Times for MRI (non-emergent)</strong></td>
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<tr>
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<td>days</td>
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<td>days</td>
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<td>days</td>
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<td><strong>Wait Times for Cataract Surgery (non-emergent)</strong></td>
<td>days</td>
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<td><strong>Hospital Standardized Mortality Ratio</strong></td>
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<td><strong>Readmissions to Hospital for Stroke Patients (per 100 patients)</strong></td>
<td>%</td>
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</tbody>
</table>

**Note 1:** Performance Status: Green – meets or exceeds target; Yellow – does not meet target but has improved from baseline; Red – does not meet target and has not improved from baseline

**Note 2:** Baseline value is based on the most recent full Fiscal Year available
APPENDIX G – Clinical Connect Deployment

### ClinicalConnect - Today

#### ClinicalConnect Health Care Information Sources
November 2013

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<td>Niagara Health System (7 sites)</td>
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<td>Hotel Dius Shaer Rehab Centre (St. Catharines)</td>
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Demographics, Contacts, Placements & Service Lists
### APPENDIX H:
Waterloo Wellington Local Health Integration Network Dashboard Selected Indicator Definitions

**Waterloo Wellington LHIN Dashboard Indicator Definitions – 2013-14 (Strategic Priority: Enhancing Access to Primary Care)**

<table>
<thead>
<tr>
<th>Strategic Priorities</th>
<th>Performance Measure (Technical Name)</th>
<th>Performance Measure (Name for Summary Level)</th>
<th>Indicator Definition</th>
<th>Data Source</th>
<th>Metric type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhancing Your Access to Primary Care</td>
<td>Number of Individualized Care Plans</td>
<td>Care Plans for High Need Residents*</td>
<td>The number of completed Care Plans for high-needs residents, as reported by the Health Links. High-needs residents are individuals who use a high proportion of health care resources.</td>
<td>Health Link</td>
<td>YTD Quarterly Value</td>
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<td>Enhancing Your Access to Primary Care</td>
<td>Increased number of residents who are attached to a primary care provider</td>
<td>Percentage Individuals Referred to a Primary Care Provider</td>
<td>The percentage of eligible individuals registered with the Health Care Connect program who have been referred to a Primary Care Provider since the beginning of the program.</td>
<td>Health Care Connect</td>
<td>Cumulative Percent from 2009</td>
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<td>Enhancing Your Access to Primary Care</td>
<td>Reduced ED Visits for non-urgent cases that could have been seen in a primary care setting (ED Visits Best Managed Elsewhere)</td>
<td>Emergency Visits Best Seen Elsewhere**</td>
<td>The percentage of visits to Emergency Rooms where patients were seeking care for conditions (such eye infections, bladder infections, ear infections or common colds) that could be treated in alternative primary care settings.</td>
<td>Intellihealth (Discharge Abstract Database)</td>
<td>Quarterly Percentage</td>
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<td>Enhancing Your Access to Primary Care</td>
<td>Clinicians Using Clinical Connect to Access Patient Health Records</td>
<td>New Users of Clinical Connect</td>
<td>The number of primary care providers who have signed up to use the Clinical Connect program to access their patients’ Electronic Medical Records.</td>
<td>Number obtained from the WWLHIN E-health physician lead.</td>
<td>YTD Quarterly Value</td>
</tr>
<tr>
<td>Enhancing Your Access to Primary Care</td>
<td>Hospital Report Manager Available to Primary Care Providers</td>
<td>Hospital Report Delivery System</td>
<td>HRM is an enabling technology for system integration that allows clinicians to securely receive patient reports electronically from participating sending facilities.</td>
<td>Number obtained from the WWLHIN E-health lead</td>
<td>Current Status</td>
</tr>
</tbody>
</table>

*Created Feb 24, 2014 (from WWHSS DSC Indicator template)*