

Balanced Scorecard for Strategic Plan 2018-19
Definitions

Domain	Measure of Success	Rationale	Description	Source	Target Justification and Comment(s)	Units of Measure	Target	Baseline	Baseline Date	Frequency	Numerator	Denominator
Quality Patient Care	Enhance Patient Satisfaction in Inpatient Medicine/Surgery (Quality Improvement Plan - QIP)	Patient satisfaction effectively measures the success of hospitals and the staff who deliver care. This indicator is the voice of our patients and provides us with rich information on what we are doing well and what we need to improve on. The higher the score the better.	NRC Health provides results from Ontario Hospital Association (OHA) Recommended Patient Experience Surveys, CPES-IC: "Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate your care during this hospital stay?" for acute adult inpatient from Medicine and Surgery (add together % of those who responded 9 or 10).	NRC Health	Meet or exceed high performers	% of responses	>70%	56.70%	2017-18 Q1 (QIP)	Monthly Year-to-Date	Number of surveys returned for inpatient medicine/surgical care services that responded top box	Total number of inpatient medicine/ surgical care services surveys returned
	Enhance Patient Satisfaction in Emergency Care in Chatham and Wallaceburg (QIP)	Patient satisfaction effectively measures the success of hospitals and the staff who deliver care. This indicator is the voice of our patients and provides us with rich information on what we are doing well and what we need to improve on. The higher the score the better.	NRC Canada provides results from OHA Recommended Patient Experience Surveys, EDPEC. "Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate your care during this emergency room visit?" for ED at Chatham and Wallaceburg sites (add together % of those who responded 9 or 10).	NRC Health	Meet or exceed high performers	% of responses	> 63%	56.90%	2017-18 Q1 (QIP)	Monthly Year-to-Date	Number of surveys returned for emergency care services that responded top box	Total number of emergency care services surveys returned
	Infection Rate <i>Clostridium Difficile</i> (Hospital Service Accountability Agreement - H-SAA)	<i>Clostridium difficile</i> (C.difficile) is a hospital acquired infection which can be prevented. Eliminating these infections is the target.	<i>Clostridium Difficile</i> Infection (CDI) rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000	Internal - Infection Control	Meet or exceed Erie St. Clair (ESC) Local Health Integration Network (LHIN) H-SAA target	rate per 1,000 patient days	0.00	0.29	2017-2018	Monthly Year-to-Date	Number of patients newly diagnosed with hospital-acquired CDI	Total number of patient days in that month
	Hospital Standardized Mortality Ratio (HSMR)	HSMR measures how successful a hospital is at saving patients from unexpected life threatening injuries or illness. By measuring mortality trends the hospital can look for efficiencies in how care is provided to optimize patient outcomes.	This indicator measures the ratio of observed deaths to the number of expected deaths as measured by HSMR (multiplied by the Canadian average). This ratio is innately compared to all of Canada in its formula at 100.	Canadian Institute for Health Information (CIHI): Your Health System Insight	Meet or exceed high performers, National 25th percentile	% of expected deaths	≤72.3%	80.00%	2017-2018	Monthly Year-to-Date	Observed deaths as calculated by CIHI x 100	Expected Deaths as calculated by CIHI
	Quality-Based Procedures (QBP) Readmission Rate All Causes Chronic Obstructive Pulmonary Disease (QIP)	If a patient with COPD is readmitted to hospital within 30 days of discharge, it could indicate that treatment was not effective. A lower rate indicates that the patient received quality care and effective treatment.	Non-risk-adjusted 30-day all-cause readmission rate for patients with Chronic Obstructive Pulmonary Disease (COPD) (QBP cohort) among patients admitted to any acute care facility reported in Integrated Decision Support (IDS).	Using CIHI Data through IDS	Achieve 10% improvement to current performance and remain top performer in ESC LHIN	% of cases discharged to this cohort	< 12%	13.0%	2017-2018	Monthly Year-to-Date	The numerator is the sum of all readmissions for all index cases who had urgent /non-elective readmissions to any hospital in IDS within 30 days of discharge	The denominator is the sum of all index cases (discharges in the reporting period for COPD QBP)
	QBP Readmission Rate All Causes Congestive Heart Failure (CHF) (QIP)	If a patient with CHF is readmitted to hospital within 30 days of discharge, it could indicate that treatment was not effective. A lower rate indicates that the patient received quality care and effective treatment.	Non-risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) among patients admitted to any acute facility reported in IDS.	Using CIHI Data through IDS	Achieve 30% improvement over current performance	% of cases discharged to this cohort	<15%	21.3%	2017-2018	Monthly Year-to-Date	The numerator is the sum of all readmissions for all index cases who had urgent /non-elective readmissions to any hospital in IDS within 30 days of discharge	The denominator is the sum of all index cases (discharges in the reporting period for CHF QBP)
	Readmission within 30 days by Patient Groups using Selected Health Based Allocation Model Inpatient Grouping Methodology (HIGs) Site Specific (H-SAA)	If a patient with select conditions is readmitted to hospital within 30 days of discharge it could indicate that treatment was not effective. A lower rate indicates that the patient received quality and effective treatment.	Risk-adjusted readmission to hospital ratio for patients with an acute inpatient hospital stay for: •Acute myocardial infarction; •Cardiac conditions (excluding heart attack); •Congestive heart failure; •Chronic obstructive pulmonary disease; •Pneumonia; •Diabetes; •Stroke; and •Gastrointestinal disease, who, after discharge, may have a subsequent non-elective readmission within 30 days to the same hospital where the index visit occurred.	Using CIHI Data through IDS	Meet or exceed LHIN H-SAA target	% of cases discharged to this cohort	15.50%	15.10%	2017-2018	Monthly Year-to-Date	The numerator is the sum of all readmissions for all index cases who had urgent/non-elective readmissions to any hospital in IDS within 30 days of discharge	The denominator is the sum of all index cases (discharges in the reporting period for selected HIG)
	Wait Times for Emergency Department Length Of Stay (ED LOS) for Complex Patients (H-SAA)	Access to care is important for patients and quality care. Evidence indicates that getting a patient into the right care environment (unit) and bed sooner has a positive impact on outcome. CKHA strives to assess and treat complex patients within 6.7 hours or less of coming to the ED.	The total ED LOS where 9 out of 10 complex patients completed their visits. ED LOS defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED.	HSA, using CCO iPort	Achieve 5% improvement to current performance and exceed LHIN H-SAA target	hours	≤ 6.2 hrs	6.5 hrs	2017-2018	Monthly Year-to-Date	Admitted patients – Disposition Codes 06 and 07 Non-Admitted Patients – Disposition Codes 01, 04 – 05, 08 – 17, 30, 40, 62, 64 and 90 with assigned CTAS I, II, or III	The 90th percentile is the case where 9 out of 10 complex patients have completed their visits
	Wait Times for Emergency Department Length Of Stay for Minor/Uncomplicated Patients (H-SAA)	Access to care is important for patients and quality care. Minor or uncomplicated cases are given a standardized acuity level based on the Canadian Triage and Acuity Scale (CTAS) of 4 or 5. These patients are non-admitted (sent home or to destinations other than admission). This indicator reflects when 9 out of 10 patients leave the ED within the reported hours. The shorter this amount of time the better.	The total ED LOS where 9 out of 10 complex patients completed their visits in less than 3.7 hours. ED LOS defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED.	HSA, using CCO iPort	Meet or exceed LHIN H-SAA target	hours	≤4.0 hrs	4.1 hrs	2017-2018	Monthly Year-to-Date	Non-Admitted Patients – Disposition Codes 01, 04 – 05, 08 – 17, 30, 40, 62, 64 and 90 with assigned CTAS IV and V.	The 90th percentile is the case where 9 out of 10 minor/uncomplicated patients have completed their visits
Percentage of Closed Cases Within Provincial Targets for Orthopedic Surgeries Wait Times Total Hip Replacement (H-SAA)	Access to care is important for patients and quality care. The Provincial Wait Time targets for priority 2 to 4 hip replacements vary between 6 and 26 weeks. This indicator measures the percent of closed cases that met the provincial targets compared to all of the closed hip replacement cases. Evidence indicates that getting a patient to the right care environment sooner has a positive impact on outcomes and patient satisfaction.	The percent of closed cases that met the target is measured against all closed cases, based on the provincial access targets: Priority Level 2 Access Target within 6 weeks: •Severe pain that actively affects role and independence; •High probability of disease progression and morbidity affecting function Priority Level 3 Access Target within 12 weeks : •Moderate pain; •Disability is a threat to role and independence; •Disease progression is moderate Priority Level 4 Access Target within 26 weeks: •Minimal pain; disability does not threaten role and independence; and •Disease progression is minimal	HSA, using CCO iPort	Be a high performer and exceed LHIN H-SAA target	% of discharged cases	≥96.1 %	94.50%	2017-18	Monthly Year-to-Date	Number of closed cases where wait list entries with procedure dates within date range submitted by hospitals through the Wait Time Information System (WTIS) for Priority 2, 3, or 4 and where wait times are less than or equal to the provincial targets. Patient age greater than or equal to 18 years old on the day the procedure was completed.	Total number of cases completed for the reporting period for priority 2, 3, and 4	

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Quality Patient Care	Percentage of Closed Cases Within Provincial Targets for Orthopedic Surgeries Wait Times Total Knee Replacement (H-SAA)	Access to care is important for patients and quality care. The Provincial Wait Time targets for priority 2 to 4 knee replacements vary between 6 and 26 weeks. This indicator measures the percent of closed cases that met the provincial targets compared to all of the closed knee replacement cases. Evidence indicates that getting a patient to the right care environment sooner has a positive impact on outcomes and patient satisfaction.	The percent of closed cases that met the target is measured against all closed cases, based on the provincial access targets: Priority Level 2 Access Target within 6 weeks: •Severe pain that actively affects role and independence; •High probability of disease progression and morbidity affecting function Priority Level 3 Access Target within 12 weeks : •Moderate pain; •Disability is a threat to role and independence; •Disease progression is moderate Priority Level 4 Access Target within 26 weeks: •Minimal pain; disability does not threaten role and independence; and •Disease progression is minimal	HSA, using CCO iPort	Meet or exceed LHIN H-SAA target	% of discharged cases	≥ 90 %	41.70%	2017-2018	Monthly Year-to-Date	Number of closed cases where wait list entries with procedure dates within date range submitted by hospitals through the WTIS for Priority 2, 3, and 4 and where wait times are less than or equal to the provincial targets. Patient age greater than or equal to 18 years old on the day the procedure was completed.	Total number of cases completed for the reporting period by priority level (Priority 2, 3 and 4)
	Percentage of Closed Cases Within Provincial Targets for Diagnostic Imaging Wait Times CT Scan (H-SAA)	Access to care is important for patients and quality care. The Provincial Wait Time targets for priority 2-4 CT scans vary between 48 hours and 4 weeks (from time of ordering exam to exam completion). This indicator measures the percent of closed cases that met the provincial targets compared to all of the closed CT imaging cases.	The percent of closed cases that met the target is measured against all closed cases based on the Provincial Access Targets •Priority 2: 48 hours •Priority 3: 2 - 10 days •Priority 4: 4 weeks	HSA, using CCO iPort	Meet or exceed LHIN H-SAA target	% of completed exams	≥ 90 %	61.5%	2017-2018	Monthly Year-to-Date	Number of closed cases where wait list entries with procedure dates within date range submitted by hospitals through the WTIS for Priority 2, 3, and 4 and where wait times are less than or equal to the provincial targets. Patient age greater than or equal to 18 years old on the day the procedure was completed.	Total number of cases completed for the reporting period by priority level (Priority 2, 3 and 4)
	Percentage of Closed Cases Within Provincial Targets for Diagnostic Imaging Wait Times MRI (H-SAA)	Access to care is important for patients and quality care. The Provincial Wait Time targets for priority 2-4 MRI scans vary between 48 hours and 4 weeks (from time of ordering exam to exam completion). This indicator measures the percent of closed cases that met the provincial targets compared to all of the closed MRI imaging cases.	The percent closed cases that met the target is measured against all closed cases based on the Provincial Access Targets •Priority 2: 48 hours •Priority 3: 2 - 10 days •Priority 4: 4 weeks	HSA, using CCO iPort	Meet or exceed LHIN H-SAA target	% of completed exams	≥ 90 %	31.7%	2017-2018	Monthly Year-to-Date	Number of closed cases where wait list entries with procedure dates within date range submitted by hospitals through the WTIS for Priority 2, 3, and 4 and where wait times are less than or equal to the provincial targets. Patient age greater than or equal to 18 years old on the day the procedure was completed.	Total number of cases completed for the reporting period by priority level (Priority 2, 3 and 4)
	Hospital Harm Indicator	The purpose of measuring quality and safety is to improve patient care and optimize patient outcomes. It is a priority to prevent unintended harm during a hospital stay by implementing known evidence-informed practices.	This indicator is defined as the rate of acute care hospitalizations with at least one occurrence of unintended harm during a hospital stay that could have been potentially prevented by implementing known evidence-informed practices. It also classifies harm into actionable clinical groups; therefore, improvement efforts in patient safety can be tracked at the facility level overall and for each specific clinical group. While not all instances of harm captured by this indicator can be prevented, adoption of evidence-informed practices can help to reduce the rate of harm. Harm is captured only when it is identified as having occurred after admission and within the same hospital stay; requires treatment, alters treatment or prolongs the hospital stay; and, is one of the conditions from the 31 clinical groups in the Hospital Harm Framework. Near misses or incidents that did not reach the patient; and reportable incidents or events that reached the patient and could potentially have caused harm or injury but did not are not reported.	CIHI: Your Health System Insight	Achieve a 5 % improvement over baseline	% of acute care discharges	≤ 5.8%	6.10%	2016-17 CIHI Data Preview	Annually	A subset of the denominator: discharges with at least one occurrence of harm identified during the hospital stay. Inclusions: Harm is identified based on the International Statistical Classification of Diseases and Related Health Problems (ICD 10-CA)/Canadian Classification of Health Interventions (CCI) and the Canadian Coding Standards and is classified into 31 clinical groups under 4 categories of harm.	Number of discharges from an acute care institution in a fiscal year
People and Culture	Enhance Physician Engagement (QIP)	Engaged physicians are committed to the organization, satisfied with their work, and willing to give extra effort to achieve the organization's goals. Research suggests that engaged physicians achieve better outcomes for their organization and for their patients.	NRC Health looks at 5 Employee Engagement questions on the employee survey: 1) Proud to tell others I am part of organization, 2) Values similar to organization's values, 3) Organization inspires the best job performance, 4) Look forward to going to work, 5) Satisfaction with current job. A value is calculated based on the percentage of positive responses per worker.	NRC Health	Meet or exceed Ontario Hospital Association (OHA) average	% of responses	> 74%	62.90%	2017-18 Q3 (QIP)	Aligns with survey schedule	Number of positive responses to the specified questions	Number of responses to survey
	Enhance Employee Engagement (QIP)	Engaged employees are committed to their employer, satisfied with their work, and willing to give extra effort to achieve the organization's goals. Research suggests that organizations with top quartile engagement scores achieve a 17% improvement in productivity and over 40% less absenteeism.	NRC Health looks at 5 Employee Engagement questions on the employee survey: 1) Proud to tell others I am part of organization, 2) Values similar to organization's values, 3) Organization inspires the best job performance, 4) Look forward to going to work, 5) Satisfaction with current job. A value is calculated based on the percentage of positive responses per worker.	NRC Health	Meet or exceed OHA average	% of responses	> 74%	62.90%	2017-18 Q3 (QIP)	Aligns with survey schedule	Number of positive responses to the specified questions	Number of responses to survey
	Patient Experience Advisors Meaningfully Engaged in Programs and Services	The Patient and Family Centered Care (PFCC) model promotes Patient Advisors to represent the patient and family perspective in partnership with CKHA employees. The goal is to have all 24 council positions filled with engaged Patient Advisors.	Quota of Patient Advisors sitting on councils and other committees.	Internal - Patient Relations	Fill all 24 Patient Advisor positions on Councils	% of positions on Program Councils filled	100%	54%	2017-2018	Monthly Year-to-Date	Number of Patient Advisors	Total number required to fill all positions
	Reduce Lost Time Due to Injury and Workplace Violence	Staff safety is an organizational priority. Reduction in the number of lost days due to injury or workplace violence is a direct measure of success for the organization's goal of providing a safe environment.	This indicator measures the amount of time in days employees lose due to violence or workplace injury.	Internal - Occupational Health and Safety	Achieve a 5% improvement over baseline.	Cumulative number of days	≤ 94 days	99 days	Average prior 3 years	Monthly Year-to-Date	Number of work days employees lose due to violence or workplace injury	As compared to target maximum for the year
	Improve the Percent of Departments with Reductions in Sick Hours Compared to Target	Staff are a key resource; their health and wellness is an important factor in overall organizational performance. Each department has a budgeted amount of sick time. This indicator measures the departments operating within that budgeted time as a proportion of all the departments. A higher rate is better.	Percentage of all department whose sick time, when measured against budgeted sick time, is below budget.	ESM	Maintain or exceed OHA recommended target.	% of departments	≥59%	56%	2017-2018	Monthly Year-to-Date	Number of departments below budget for sick time	Total number of departments
Percentage of Family Medicine Residents Who Train in Chatham-Kent Choose to Practice in Rural Settings	This indicator measures the percentage of medical residents who trained in Chatham-Kent (Family Medicine Residency Program) and have committed to or are now practicing in a rural setting. Residents who choose to practice in rural settings are aiding in filling the gap of healthcare access in rural communities.	This indicator measures the percentage of medical residents who trained in Chatham-Kent (Family Medicine Residency Program) and have committed to or are now practicing in a rural setting.	Internal - Medical Affairs	Residents committed to practicing in a rural community after completing residency.	% of residents	100%	33%	2017-2018	Annually	Number of medical residents who trained through the CKHA Family Medicine Residency Program in the given period and following their training have committed to practice or are practicing in a rural setting	Total number of medical residents trained at CKHA in the given period	

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Internal Business Processes	Percentage of Revenue for Capital Allocation	The capital allocation for equipment shows how the organization is reinvesting resource funds back towards high priority equipment needs. The organization's ability to reinvest in capital equipment is another key measure of fiscal health.	This indicator measures the capital allocation as a percentage of the revenue.	Internal - Finance	Sustain investment in capital equipment.	% of revenue dollars	2%	N/A	N/A	Quarterly	Total capital equipment spending excluding building and renovation projects	Total revenue
	Percent of Secondary Care of Chatham-Kent Residents Delivered in Chatham-Kent	Access to care is a tenant of CKHA's mandate. This indicator supports the CKHA strategic direction of providing exceptional quality and safe care within a comprehensive community hospital. A higher rate is better.	This indicator measures the percentage of patients who were C-K residents who received secondary care at CKHA of all the CK residents who received secondary care in the same time period in or out of the CK region.	IDS	Achieve a 5% improvement over baseline.	% of stays CK residents have in acute hospitals	≥70.6%	67.2%	2017-2018	Monthly Year-to-Date	Number of patients at CKHA receiving acute secondary care who are CK Residents (based on Residence Codes within CK)	Total number of patients who are CK Residents (based on Residence Codes within CK) who received secondary care in an Ontario Hospital (IDS participating hospital) in a given period of time
	Goals and Objectives for the 2018-2021 Strategic Plan	The Strategic Plan includes numerous process outcomes. This indicator measures the extent of the objectives that are complete within the set out timeframe.	This indicator measures the successful completion of the goals and objectives detailed in the 2018-2021 strategic plan based on timeframes or time period.	Internal - PMO Office	Goals and objectives should be achieved within timeframes or time period	% of goals or objectives completed on target	≥90%	N/A	N/A	Monthly Year-to-Date	Number of completed goals/objectives outlined in the strategic plan due to be completed in that timeframe or time period.	Total number of goals and objectives on the strategic plan due in that timeframe or time period
	Medication Reconciliation Completed on Discharge (QIP)	Medication reconciliation can prevent harmful medication errors or adverse drug events. When used effectively it can intercept these errors before they lead to an adverse event. Misses and errors will be viewed as a collaborative learning opportunity rather than a failure.	Medication reconciliation at discharge: total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion to the total number of patients discharged.	Internal - Pharmacy as reported to QIP	Increase by 15 percentage points over baseline (60% improvement)	% of discharges from hospital	> 40.0%	25.10%	2017-18 Q3	Monthly	Number of discharged patients for whom a Best Possible Medication Discharge Plan was created. Excludes hospital discharge that is death, newborn or stillborn.	Number of patients discharged from the hospital. Excludes hospital discharge that is death, newborn or stillborn
	Workplace Violence Prevention as Seen in Increase in Number of Incidents Reported by Hospital Workers (QIP)	It is critical to develop a culture of reporting, preventing and addressing violent incidents that extend beyond the most serious incidents already reported to the Ministry of Labour. This indicator measures CKHA's success in promoting reporting incidences of violence into RL6 system (RL6 is the Risk Management software for safer healthcare). This indicator is part of the QIP as mandated by the Minister of Health and Long-Term Care.	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	Internal - Workplace Violence Committee Report	Collecting baseline	% of full time equivalent staff	N/A	N/A	N/A	Monthly Year-to-Date	Cumulative number of reported incidents	CKHA FTE = 967 (budgeted--at time QIP work plan was submitted)
Utilization and Fiscal Health	Balanced Financials Total Margin (H-SAA)	Total Margin is a measurement of an organization's fiscal health. It is calculated using financial information from the hospital's Statement of Revenue and Expense (also known as the Income Statement). A negative or low positive value signifies that expenditures exceed revenues and that cost containment measures (and/or additional revenue generation measures) are required to bring this measure back on target.	This indicator measures the total margin per generally accepted accounting principles. When calculated this indicator depicts the margin (+/-) where revenues exceed or fall short of expenses in a given year.	H-SAA-Finance	LHIN H-SAA target	% of total revenue dollars	> 0%	3.31%	2017-2018	Monthly Year-to-Date	Revenue minus expenses (excluding interdepartmental revenue and expenses and facility deferred revenue and amortization expenses)	Revenue (excluding interdepartmental revenue and facility deferred revenue)
	Balanced Financials Current Ratio (H-SAA)	This ratio measures the amount of current assets to the amount of current liabilities. A higher current ratio means that the organization has a greater capability of paying it's obligations.	Number of times a hospital's short-term obligations can be paid using the hospital's short-term asset. A current ratio within 0.8 - 2.0 corridor signifies CKHA's ability to meet short-term payment obligations. Calculated by dividing the current assets by the current liabilities.	H-SAA -Finance	LHIN H-SAA target	Ratio of assets to liabilities	≥ 0.44	0.712	2017-2018	Monthly Year-to-Date	Current assets	Current Liabilities
	ALC Rate Corporate for Acute and Post Acute (H-SAA)		Percentage of patient days in acute and post-acute units, of patients designated as no longer requiring acute or post-acute level of care but have not been discharged as a proportion of all patient days in acute and post-acute care.	WTIS Cancer Care Ontario (CCO) iPort	Meet or exceed high performers	% of patient days for that period	≤ 11.5 %	17.1%	2017-2018	Monthly Year-to-Date	Total number of ALC days in a given time period (WTIS)	Total number of patient days in the same time period (Bed Census Summary -BCS)
	ALC Rate Acute for Chatham and Wallaceburg (H-SAA)	Having patients who are designated as needing an alternate level of care (ALC) can have a negative impact on the efficiency and resource use of hospitals; an example would be long waits in the emergency department pending the availability of an inpatient bed. This indicator identifies barriers to alternative placement and monitors the prevalence of cases in hospital with ALC status.	Percentage of patient days in acute care of patients designated as no longer requiring an acute level of care, but have not been discharged as a proportion of all patient days in acute care.	WTIS CCO iPort	Meet or exceed high performers	% of patient days for that period	≤ 12.5 %	11.7%	2017-2018	Monthly Year-to-Date	Total number of ALC days in a given time period (WTIS)	Total number of patient days in the same time period (BCS)
	ALC Rate Post Acute (H-SAA)		Percentage of patient days in post-acute units for patients designated as no longer requiring an acute level of care, but have not been discharged as a proportion of all patient days in acute care.	WTIS CCO iPort	Meet or exceed high performers	% of patient days for that period	≤ 6.1 %	24.5%	2017-2018	Monthly Year-to-Date	Total number of ALC days in a given time period (WTIS)	Total number of patient days in the same time period (BCS)
	Occupancy in Acute Care	The occupancy rate shows the percentage of a hospital's acute care beds that are in use, on average, in a given period of time. While there is no clear benchmark, the occupancy rate should be in a range that minimizes unused capacity while still providing flexibility for the hospital to respond to unpredictable healthcare needs of the patients it serves.	Occupied beds as a percentage of total bed capacity in acute care	Internal - Finance	Maintain occupancy at 95% or greater	% of occupancy	≥ 95%	80%	2017-2018	Monthly Year-to-Date	Number of patient days at midnight for acute care (excluding newborns and same-day admits)	Total bed capacity in acute care based beds staffed and in operation
	Cost of a Standard Hospital Stay	Cost of a standard hospital stay is an indicator that measures the relative cost-efficiency of a hospital's ability to provide acute inpatient care. A high cost of a standard hospital stay indicates a relatively high cost of treating the average acute inpatient; a low cost of a standard hospital stay indicates that the cost of treating the average acute inpatient is relatively low.	This indicator measures the ratio of a hospital's total acute inpatient care expenses to the number of acute inpatient weighted cases related to the inpatients for which the hospital provided care (obtained from the Discharge Abstract Database, excluding day procedures).	Internal - Ontario Hospital Cost Distribution Methodology	Meet or exceed high performers	\$	≤ \$ 4,811	\$5,520	2016-2017	Quarterly, available 1 month after quarter end	The numerator is the total inpatient cost for the facility	Denominator includes total acute inpatient weighted cases (obtained from the Discharge Abstract Database), excluding day procedures
	Access to Ambulatory Care with Reduction of Ambulatory Sensitive Admissions	Managing bed capacity begins before admissions and post-discharge. This indicator is an acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital. This indicator supports the shift from bedded to ambulatory care for patients.	Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital, per acute hospital admissions younger than age 75. CIHI includes the following chronic conditions in this indicator: angina, asthma, COPD, diabetes, epilepsy, heart failure, and hypertension.	IDS	Achieve a 5 % improvement over baseline	% of discharged cases from acute care	≤ 4.7 %	4.90%	2017-2018	Monthly Year-to-Date	Total number of acute care hospitalizations for ambulatory care sensitive conditions in patients younger than age 75	Total acute care admissions younger than age 75