

'Performance Measurement: Using a balanced scorecard approach'

QUALITY MATTERS! REPORT Q2 - July to September 2008

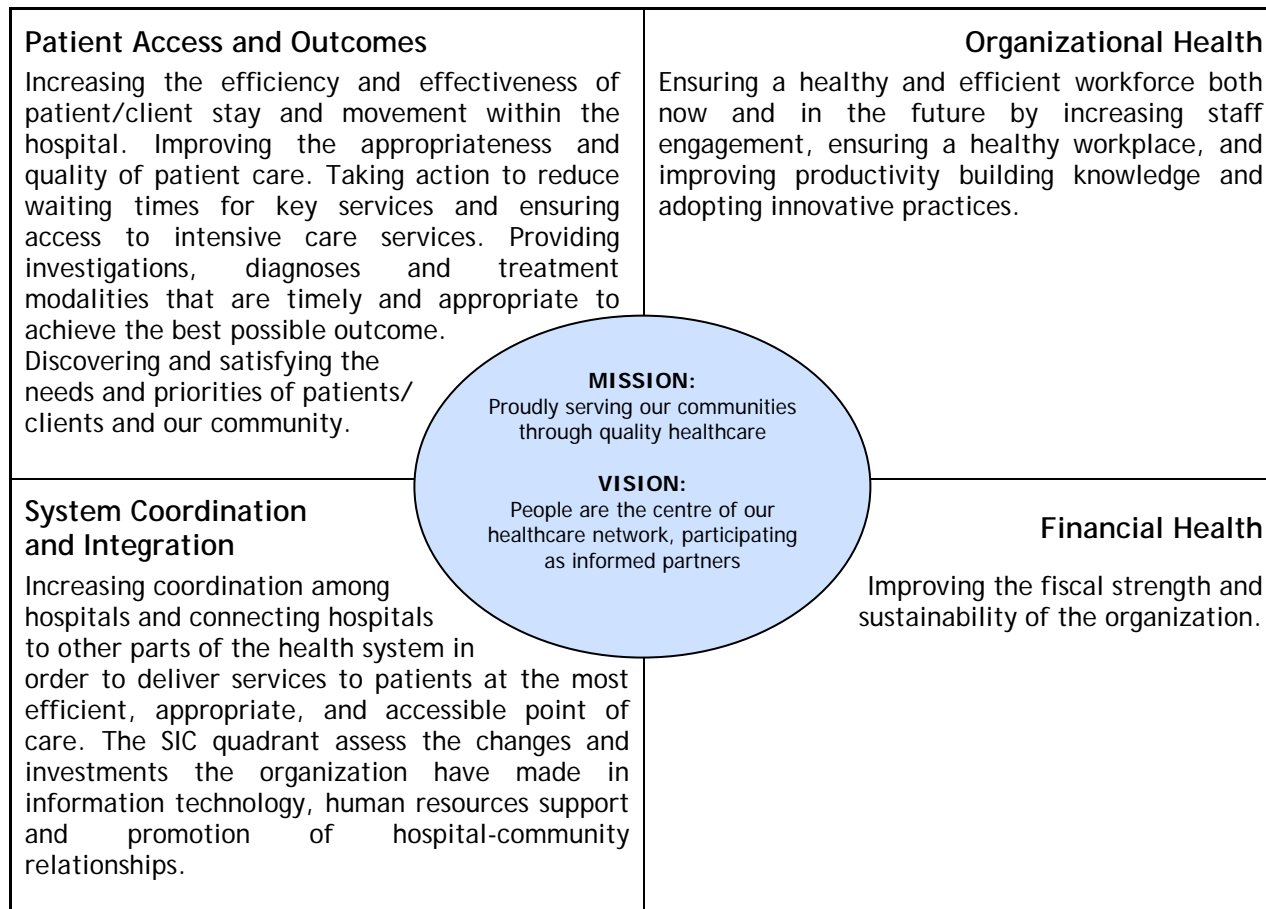
"We are what we repeatedly do, excellence then, is not an act, but a habit."
Aristotle

"Measure what is measurable and make measurable what is not."
Galileo (1564 - 1642)

Quality Council

Overview

Muskoka Algonquin Healthcare developed a Balanced Scorecard in 2006 as a performance measurement tool that monitors the performance of 43 different indicators, strategies and targets across the organization that have been grouped into the following four quadrants. The results are reported on a quarterly basis to the Board of Directors.



How Ratings are Applied to Measurements

Each indicator has a specific and defined target. The methodology of color ratings was established with the following parameters:

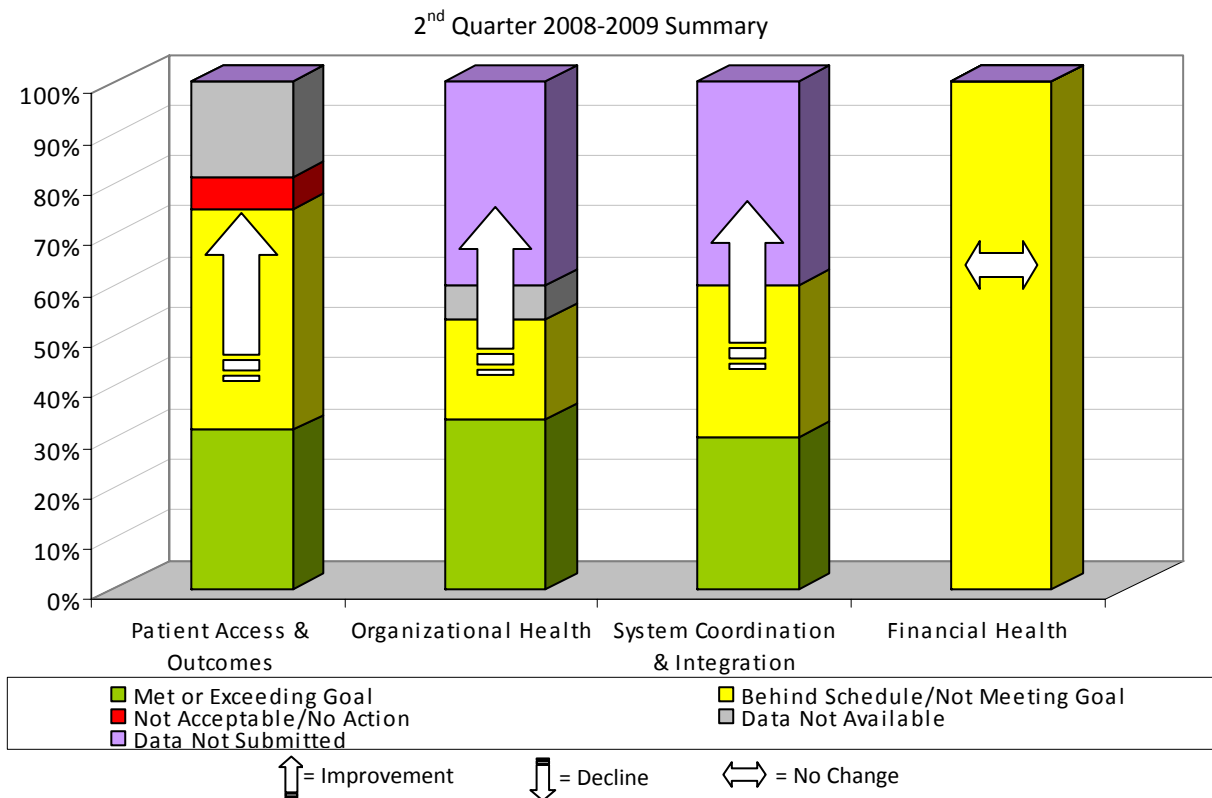
- ✓ **Green** indicates the performance for the indicator has met or exceeded the defined target;
- ✓ **Yellow** indicates the performance of the indicator is not meeting the defined goal or is behind schedule;
- ✓ **Red** is applied when the performance of the indicator is unacceptable or no action has been taken. These ratings are of a critical nature in need of attention.
- ✓ **Grey** is applied when data has not been submitted or is unavailable. Some indicators rely on external sources for data.
- ✓ **Purple** is applied when no indicator data has been received

In summary, each quadrant monitors a variety of indicators:

Patient Access and Outcomes	Organizational Health	System Coordination and Integration	Financial Health
<ul style="list-style-type: none"> Length of Stay, Risk of Re-admission, Percentage of FT Nurses, Wait-times - Cataracts, Door to Needle Time, HSMR, Volume (% occupancy), Patient Satisfaction Survey, Medication Adverse Incidents, Falls and Adverse Incidents, Incidents by Degree of Injury, Patients Leaving ER Unseen, Nosocomial Infection Rate 	<ul style="list-style-type: none"> Absenteeism Cost, Workplace injury – Lost Hours, Needlestick injuries, Student Placements – Medical and Allied Health, Recruit and retain quality people, Build effective teams, Lead by Example 	<ul style="list-style-type: none"> Maximize regionally compatible information technologies, Building relationships through effective communication, Strengthen and promote community partnerships, Use of standardized protocols 	<ul style="list-style-type: none"> Current Ratio, Total Margin

The following graphic provides an summary of the overall performance of each quadrant for the 2nd Quarter of 2008-2009 (July - September 2008).

The trend for that quadrant from the previous quarter is depicted in each bar with the corresponding arrow – please see the legend below. For detailed information on each quadrant and all of the indicators in the Quality Matters! Report, please visit our website at www.mahc.ca.



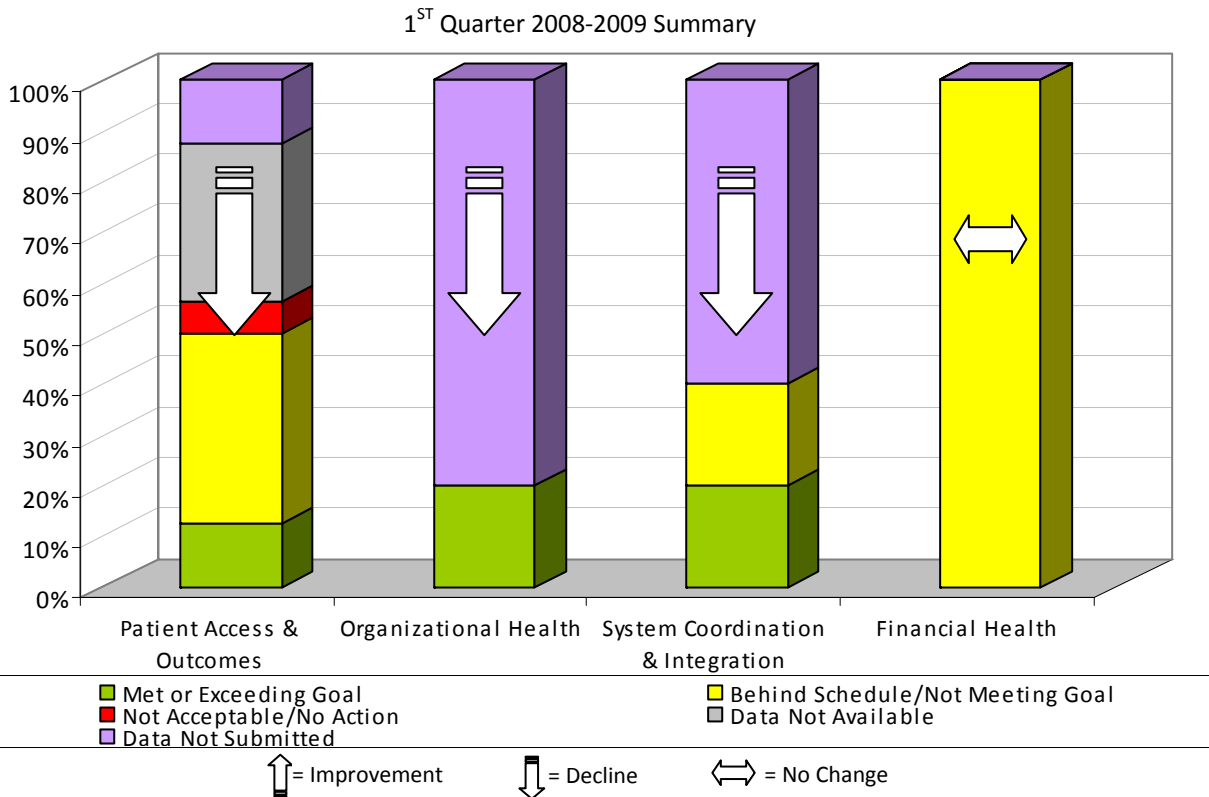
Printed copies of the full report can also be requested in person at any MAHC site, or requests can also be made via e-mail to info@mahc.ca, or by mail to: Muskoka Algonquin Healthcare, Huntsville District Memorial Hospital Site, 100 Frank Miller Drive, Huntsville, ON, P1H 1H7, Attention: Executive Assistant.

In summary, each quadrant monitors a variety of indicators:

Patient Access and Outcomes	Organizational Health	System Coordination and Integration	Financial Health
<ul style="list-style-type: none"> • Length of Stay, • Risk of Re-admission, • Percentage of FT Nurses, • Wait-times - Cataracts, • Door to Needle Time, • HSMR, • Volume (% occupancy), • Patient Satisfaction Survey, • Medication Adverse Incidents, • Falls and Adverse Incidents, • Incidents by Degree of Injury, • Patients Leaving ER Unseen, • Nosocomial Infection Rate 	<ul style="list-style-type: none"> • Absenteeism Cost, • Workplace injury – Lost Hours, • Needlestick injuries, • Student Placements – Medical and Allied Health, • Recruit and retain quality people, • Build effective teams, • Lead by Example 	<ul style="list-style-type: none"> • Maximize regionally compatible information technologies, • Building relationships through effective communication, Strengthen and promote community partnerships, • Use of standardized protocols 	<ul style="list-style-type: none"> • Current Ratio, • Total Margin

The following graphic provides an summary of the overall performance of each quadrant for the **1st Quarter of 2008-2009 (April - June 2008)**.

The trend for that quadrant from the previous quarter is depicted in each bar with the corresponding arrow – please see the legend below. For detailed information on each quadrant and all of the indicators in the Quality Matters! Report, please visit our website at www.mahc.ca.



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3	Not acceptable/no action to date
2 a.	Not meeting goal
2 b.	Behind schedule
1	Met or exceeded goal/on or ahead of schedule
DNS	Data Not Submitted
DNA	Data Not Available

Our Vision: People are the centre of our healthcare network, participating as informed partners
Our Mission: Proudly serving our communities through quality health care.

QUALITY MATTERS! BALANCED SCORECARD

2008-2009

STRATEGIC DIRECTION: Moving us towards people - centered healthcare, we will:

- Strategy #1: Recruit & retain quality people
- Strategy #2: Build an effective team
- Strategy #3: Lead by example

STRATEGIC DIRECTION: Moving us towards accessible, effective and collaborative services, we will:

- Strategy #4: Maximize regionally compatible information technologies
- Strategy #5: Build relationships through effective communication
- Strategy #6: Strengthen & promote community partnerships

DIMENSION	Page #s	MEASURES	Responsible	last fiscal	2008/09				Yr. End	COMMENT FOR MOST RECENT QUARTER (Action Taken)
					Q1	Q2	Q3	Q4		
Patient access and outcomes	1	4	Relative Acute and relative Total Length of Stay (HAA)	Frankie Dewsbury	1	1	DNA			Data not yet available (via CIHI) for Q2. Met established targets in fiscal 07/08 and in Q1
	2	5	Relative Risk of Readmission (HAA)	Frankie Dewsbury	1	1	DNA			Data not yet available (via CIHI) for Q2. Continued to meet established targets in fiscal 07/08 and in Q2
	3	6	Percentage of Full-Time Nurses (HAA)	Robert Hughes	1	2 a.	2 a.			
	4	7	Wait times- Cataracts (HAA)	Frankie Dewsbury	1	1	1			MAHC's average wait time for cataract surgery was 14 days and Onatrio's average was 125 days.
	5	8	'Door-to-needle' time	Bev McFarlane	1	DNS	2 a.			Thrombolytics are delivered in emergency and therefore the critical care door to needle times are much less frequent and therefore hard to monitor. With many of the times, there were co-morbidities that complicated the clinical picture, more diagnostics, etc.
	6	9	Hospital Standardized Mortality Ratio (HSMR)	Frankie Dewsbury	1	1	1			The HSMR for fiscal 07/08 for MAHC was 96 which is less than 100 which suggests MAHC's hospital mortality rate is lower than the national average. HSMR to date is acceptable.
	7	10	Volume (% occupancy)	Frankie Dewsbury	2a	3	3			Utilization of beds continue to be reviewed in an effort to reduce occupancy rates to operationally acceptable levels. MAHC combined site occupancy for Q2 was 106.9%
	8	11	Patient's Satisfaction Survey Results - MAHC	Frankie Dewsbury	1	1	1			Patient satisfaction survey results for April to June 2008 shows we met established targets 95% in Acute Care and 100% in Emergency Care
	9	15	Patient Safety - Medication Adverse Incidents	Harold Featherston	2 a.	2 a.	1			
	10	16	Patient Safety - Falls & Adverse Incidents	Bev McFarlane	2b.	2b.	2b.			
	11	17	Patient Safety - Incidents by Degree of Injury	a. Minor	Bev McFarlane	2 a.	2 a.	2b.		
	b. Moderate	2b.		2 a.	2b.			Root Cause Analysis was conducted on incidents involving diet order sheets. Improvements made.		
	c. Major/Near Miss	2b.		2b.	2b.					
	d. Major/Sentinel	1		2 a.	2 a.					

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DIMENSION	Page #s	MEASURES	Responsible	last fiscal	2008/09				Yr. End	COMMENT FOR MOST RECENT QUARTER (Action Taken)	
					Q1	Q2	Q3	Q4			
	12	18	Patient Safety - Patients Leaving ER Unseen	Catherine Racine	3	3	DNA			An ad hoc team has been struck to look at causal factors of patients leaving the ER without being seen.	
	13	19	Patient Safety - Nosocomial Infection Rate	Dawn Major	1	1	1			Nosocomial infection rates are significantly less than established benchmarks. Specific Surgical, Systemic and Respiratory infection rate information is not available at this time	
Organizational Health	14	20	<u>Absenteeism Cost</u>	Robert Hughes	2 a.	2 a.	2 a.			New framework established to better benchmark with the OHA reporting. Q1 results to be input in new template. 06/07 Benchmarks have been received.	
	15	23	Lost Days due to Workplace Injuries	Carey Uyeda	2 a.	DNS	2 a.			Industry standard is being researched to establish if present benchmark is reasonable. All workplace injuries are investigated to understand causal factors in an effort to prevent future recurrence	
	16	24	<u>Needle stick Injuries</u>	Carey Uyeda	2 a.	DNS	2 a.			Injury occurred due to lack of adherence to established policies and procedures. Ongoing education required.	
	17 (a)	25	<u>Student Placements - Medical</u>	Kim Rose	1	1	1				
	17 (b)	25	<u>Student Placements - Allied Health</u>	Robert Hughes	1	1	1				
	18	26	<u>Recruit and Retain Quality People (Strategy 1)</u>	a. A comprehensive orientation and mentorship program	Mary	1	DNS	DNS			
				b. A community-wide recruitment and retention strategy	Mary	2 a.	DNS	DNS			
				c. reduce the % of unfilled nursing shifts per month.	Mary	2 a.	DNS	DNS			
	19	27	<u>Build Effective Teams (Strategy 2)</u>	c. Team Building Committee (TBC) to implement three new team building activities within the 12 months	Harold Featherston	1	1	1			Long Service awards and Staff appreciation held in this Quarter - Staff appreciation theme - Beach Party!
	20	28	<u>Lead By Example (Strategy 3)</u>	a. All staff members are aware of the strategic plan and know where they may obtain a copy.	Managers	2 a.	DNA	DNA			Managers were asked to post strategic plan in a visible area in their departments and to place the strategic plan as a standing agenda item at departmental meetings. The Staff Satisfaction Survey results show that 33% agreed to this question, 35% disagreed while 32% neither agreed nor disagreed. (126 respondents)
b. A leadership framework/model that supports and encourages .				Irene Murray	1	1	1			Leading By Example Code of Conduct and leadership framework completed. Presented to managers and senior admin. Broader communication and roll out/implementation plan pending.	
c. All managers identify their individual learning needs and goals annually.				Mary	1	DNS	DNS				
d. All managers annually engage in leadership training tailored to their learning needs.				Mary	1	DNS	DNS				
e. All managers have annual performance reviews.				Mary	2 a.	DNS	DNS				

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DIMENSION	Page #s	MEASURES	Responsible	last fiscal	2008/09				Yr. End	COMMENT FOR MOST RECENT QUARTER (Action Taken)
					Q1	Q2	Q3	Q4		
		f. Update strategic plan annually	Barry Lockhart	2 b	1	1			Board review process underway.	
System Coordination and Integration	21	29	<u>Maximize regionally compatible information technologies (Strategy 4)</u>	Brian Thomson	1	1	1		Consultant Reports from regional studys: Meditech Roadmap and Tri-LHIN Data Centre Consolidation are due shortly.	
	22	30	<u>Build relationships through effective communication (Strategy 5)</u>	a. MAHC staff newsletter	Tammy Tkachuk	1	1	2 b.		New lead to be established.
				b. Committee reports submitted for intranet posting, four per annum.	Tammy Tkachuk	DNS	1	1		Timeline for implementation established, list has been updated, Chair currently being contacted for explanation of process.
				c. Learning opportunities related to communication are made available for managers.	Mary	1	DNS	DNS		
				d. Develop and implement three new skill-development opportunities focusing on communication for all staff.	Mary	1	DNS	DNS		
				e. All staff members have regular opportunity to receive timely and meaningful information from their manager.	Managers/Mary	2 a.	DNS	DNS		
				f. Every signed OFI suggestion receives a response within eight working days of the received date.	Lori Treadwell	1	DNS	DNS		
	23	31	<u>Strengthen & promote community partnerships (Strategy 6)</u>	Partnering with NSM CCAC in the provincial Flo Collaborative to improve pt transition from acute care to community	Miriam Luddington	1	2b	2b		Moving forward with many initiatives and seeing some positive outcomes with increased collaborative EDD's, improved ITM mtgs, established community referral process, patient whiteboards, Patients in Motion program, etc.
				Successful partnership with NSM CCAC in provision of TCC role to maintain/promote optimal utilization and pt care coordination.	Miriam Luddington	1	2b	2b		Documentation duplication reduced. Staff coverage challenges with backlog of TCC referrals, and bed utilization challenges with expanding role expectations.
	24	32	<u>Use of Standardized Protocols</u>	MAC/Dr. Mathies/Bev McFarlane	1	1	1		3 protocols have been implemented; 31 protocols are currently in progress for approval at the Oct. 20th MAC meeting.	
Financial Health	25	34	<u>Current Ratio (HAA)</u>	John Frederick	2 a.	2 a.	2 a.		We are tracking significantly less than the HAA expected values. The current ratio will stay below '1' until we begin to pay off the debt that has been incurred over the past few years.	
	26	35	<u>Total Margin (HAA)</u>	John Frederick	2 a.	2 a.	2 a.		MAHC continues to show an operating deficit for the first three months of the 0809 fiscal year with the resulting negative margins.	

Further definition of the measures and interpretation of results is contained in Appendix A

LENGTH OF STAY (ELOS vs. ALOS)

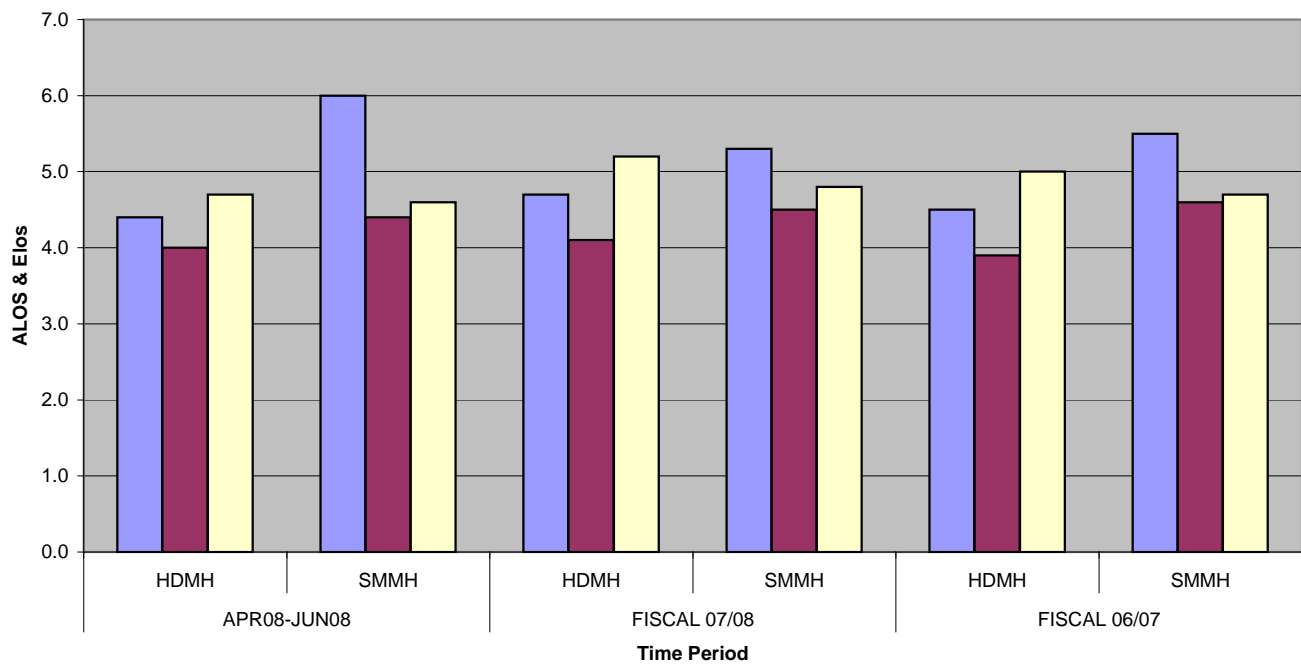
Leader: Health Information Services

Interpretation

Standard Met?- YES Action required?- NO

		Acute ALOS	Typical Acute Avg LOS	Avg ELOS	ELOS Over/Under	# Typ Cases	Total Cases
APR08-JUN08	HDMH	4.4	4.0	4.7	-292.3	460	577
	SMMH	6.0	4.4	4.6	-96.6	500	634
FISCAL 07/08	HDMH	4.7	4.1	5.2	-2070.2	1899	2348
	SMMH	5.3	4.5	4.8	-645.2	2175	2704
FISCAL 06/07	HDMH	4.5	3.9	5.0	-2146.7	1900	2413
	SMMH	5.5	4.6	4.7	-237.0	2260	2734

Average Length of Stay and Expected Length of Stay Comparison



RELEVANCE: The assignment/documentation of accurate diagnosis on the patient's chart ensures assignment of a proper Case Mix Group (CMG) and is therefore assigned the appropriate Expected Length of Stay. It is important that the hospital average length of stay compares favorably to the expected length of stay and that we are not keeping our patients in hospital longer than we should.

TARGET: '0'

FORMULA: Comparison of ALOS to ELOS

SOURCE: CIHI ELOS Report

QUADRANT: Patient Access and Outcomes

UNPLANNED READMISSIONS within ONE WEEK

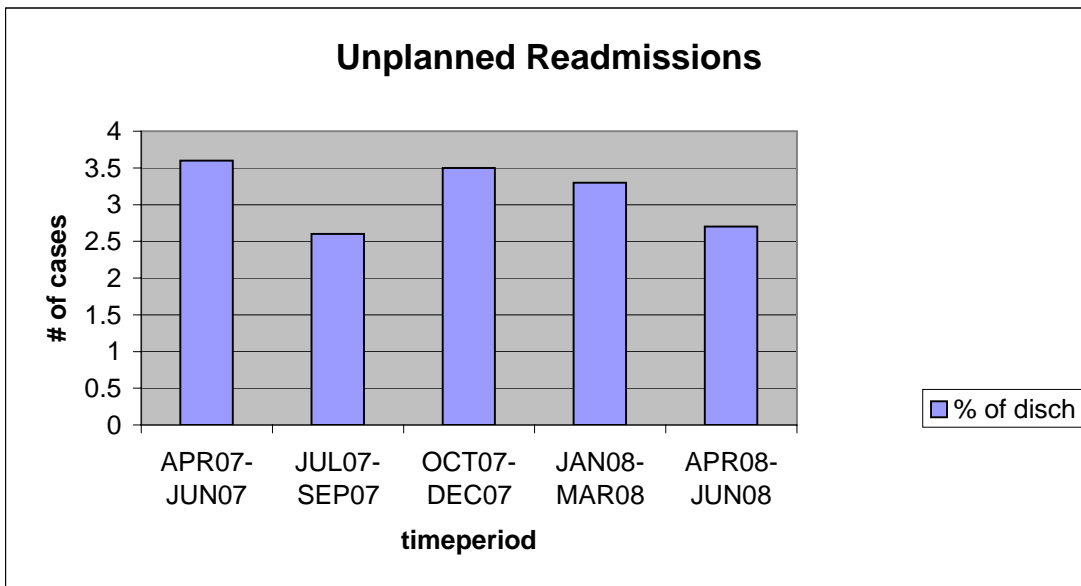
Leader: Health Information Services

Interpretation

Standard Met?- YES Action required?- NO

Unplanned Re-Admissions (< or = 7 days) Cases

	COMBINED		HDMH Site		SMMH Site	
	% of disch	<7 days	<7 days	% of disch	<7 days	% of disch
APR07-JUN07	3.6	42	22	4.3	20	3.1
JUL07-SEP07	2.6	33	20	3.5	13	1.9
OCT07-DEC07	3.5	40	14	2.6	26	4.3
JAN08-MAR08	3.3	39	25	4.3	14	2.4
APR08-JUN08	2.7	30	9	1.8	21	3.5



RELEVANCE: Readmission rates are performance indicators to assess the quality of care in the peri-discharge period and to ensure that shorter lengths of stay were not occurring at the expense of quality of care. Unplanned readmission with the same diagnosis within 7 days may be indicative of patient being discharged too soon, or, without appropriate support.

TARGET: < than or = 6% of discharges for the same period

FORMULA: Total acute hospital admissions (excluding newborns) that are re-admitted with the same diagnosis within 7 days.

SOURCE: CIHI

QUADRANT: Patient Access & Outcomes

% of FULL TIME NURSES

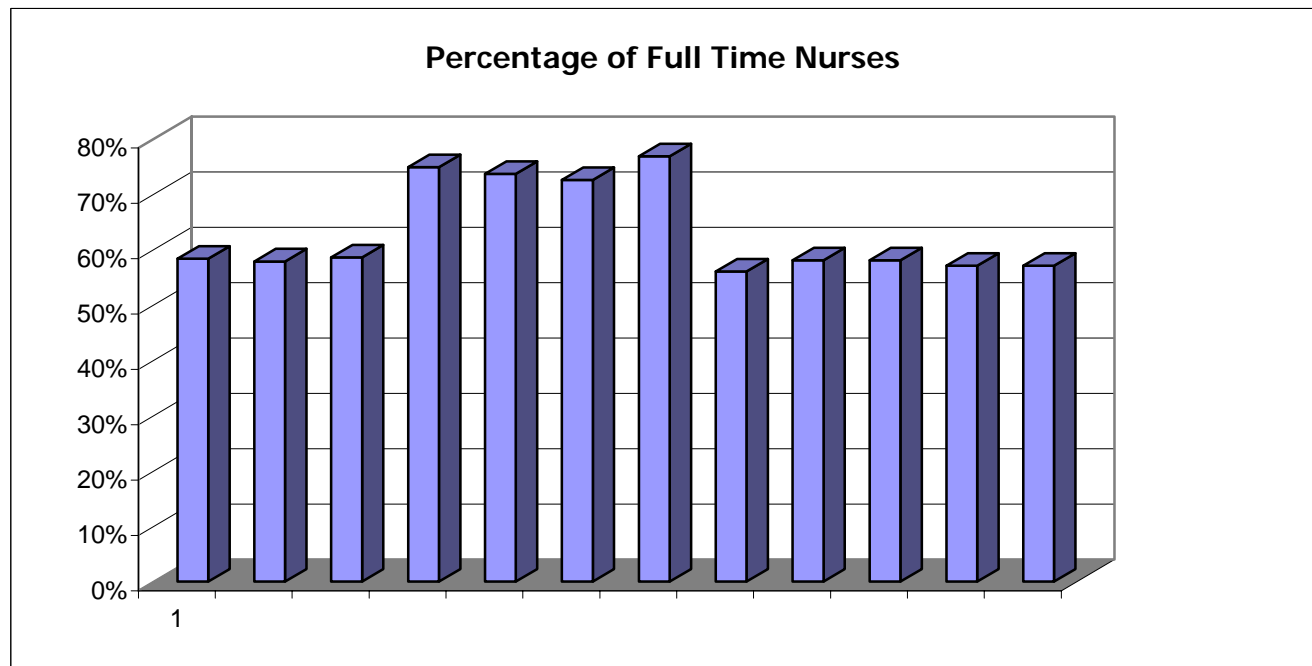
Leader: Human Resources

Interpretation

Standard Met?- No

Action required?- YES

	2008	2007	2006	
	MAHC	MAHC	SMMH	HDMH
APR	60%	58%	61%	50%
MAY	60%	58%	61%	50%
JUN	60%	59%	64%	50%
JUL	60%	75%	64%	50%
AUG	60%	74%	63%	50%
SEP	60%	73%	62%	50%
OCT		77%	62%	53%
NOV		56%	61%	55%
DEC		58%	58%	42%
JAN		58%	58%	42%
FEB		57%	58%	42%
MAR		57%	57%	43%



RELEVANCE: The Ministry, as part of its 'Healthy Work Environment" initiative, has focused on measuring the percentage of full-time nurses. The current target is to have at least 70% of the front line nursing being provided by FT nursing staff (RN's and RPN's). The rationale is that full-time nurses have been shown to have higher levels of work engagement and can also provide better continuity of care to patients. The 70% target takes into account the fact that for multiple reasons, a significant # of staff would, prefer to work part-time.

TARGET: Ministry Target: 70% or no significant variance in ratio for small community hospitals

FORMULA: SOURCE: HR

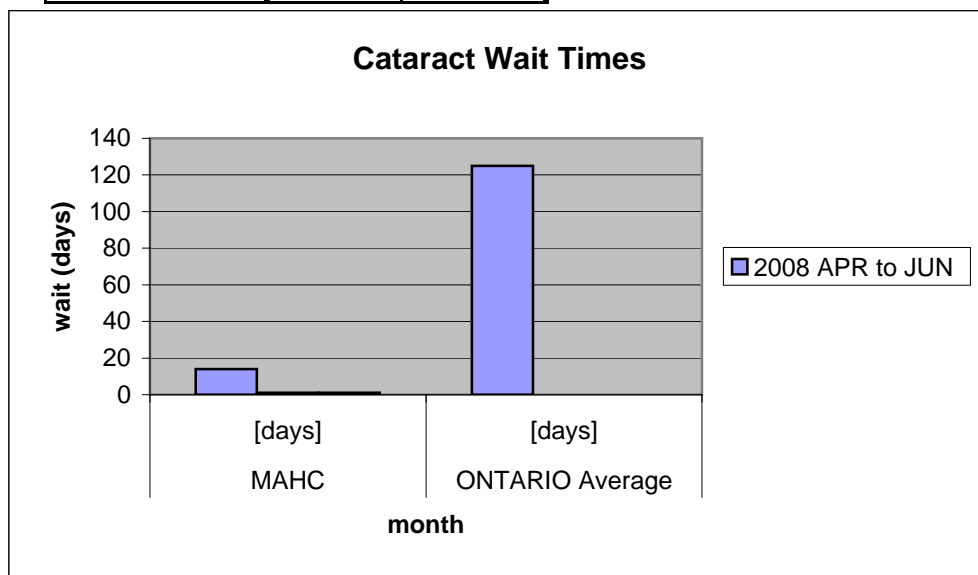
QUADRANT: Patient Access & Outcomes

WAIT TIMES- CATARACT SURGERY

INTERPRETATION:

Standard Met?- YES Action required?- NO
 MAHC's average wait time for cataract surgery was 14 days and the average days wait for Ontario was 125.

	MAHC	ONTARIO Average
	[days]	[days]
2008 APR to JUN	14	125



RELEVANCE: Reducing wait times for key health services is one of the Ontario government's top priorities. As part of this priority MAHC has agreed to participate in reporting Cataract wait time.

TARGET: < than or = to the database average (days)

FORMULA: # of days between decision to treat date and operative procedure date.

SOURCE: Health Record/Wait Time Strategy Database

'DOOR TO NEEDLE TIME'

INTERPRETATION:

Standard Met- YES Action required- NO
 Although the door to needle time of the reported case was below the national average, both sites must make improvements in reporting and audit to know 'door to needle time' performance.

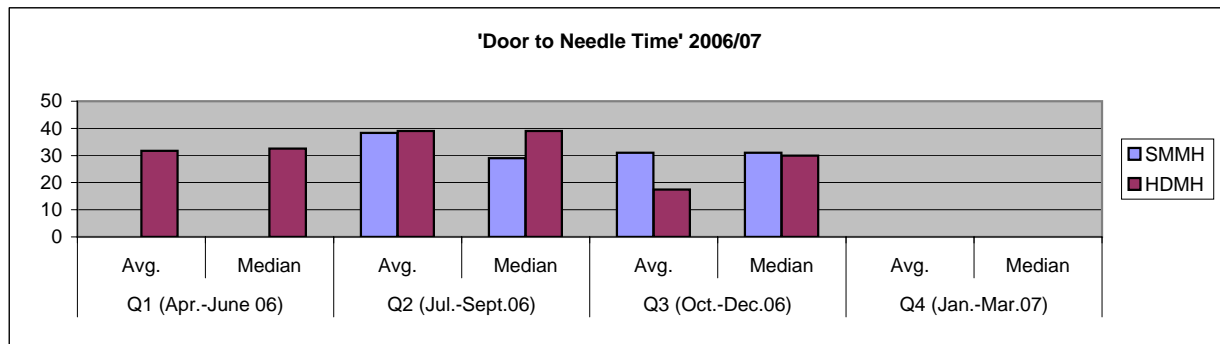
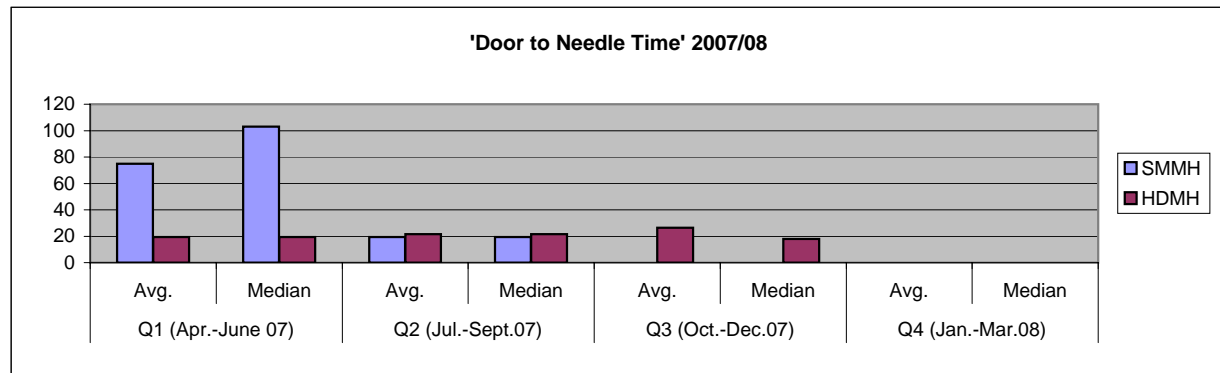
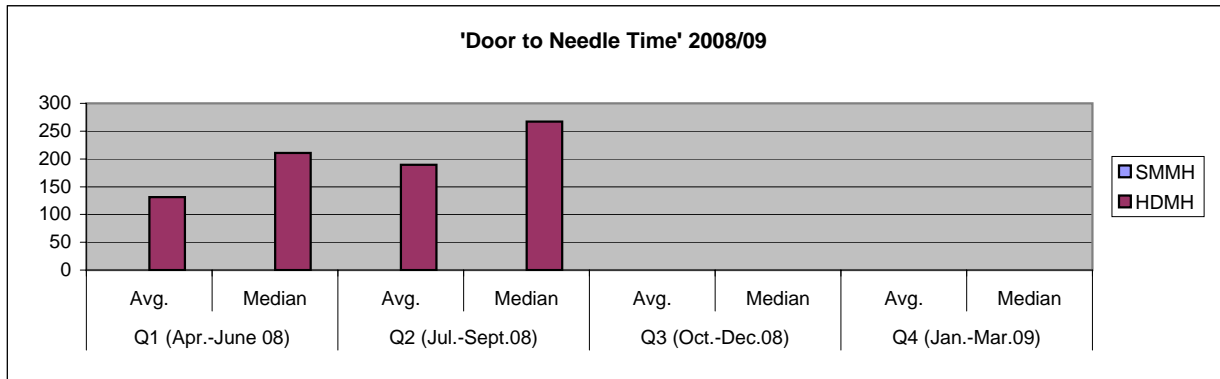
MACSTRAK CCU Activity Report

(In Minutes)

	Q1 (Apr.-June 06)		Q2 (Jul.-Sept.06)		Q3 (Oct.-Dec.06)		Q4 (Jan.-Mar.07)	
	Avg.	Median	Avg.	Median	Avg.	Median	Avg.	Median
SMMH			38.3	29	31	31		
HDMH	31.75	32.5	39	39	17.5	30		

	Q1 (Apr.-June 07)		Q2 (Jul.-Sept.07)		Q3 (Oct.-Dec.07)		Q4 (Jan.-Mar.08)	
	Avg.	Median	Avg.	Median	Avg.	Median	Avg.	Median
SMMH	75	103	19.5	19.5	ND	ND		
HDMH	19.5	19.5	21.5	21.5	26.5	18		

	Q1 (Apr.-June 08)		Q2 (Jul.-Sept.08)		Q3 (Oct.-Dec.08)		Q4 (Jan.-Mar.09)	
	Avg.	Median	Avg.	Median	Avg.	Median	Avg.	Median
SMMH								
HDMH	131	211	189.33	267				



Hospital Standardized Mortality Ratio (HSMR)

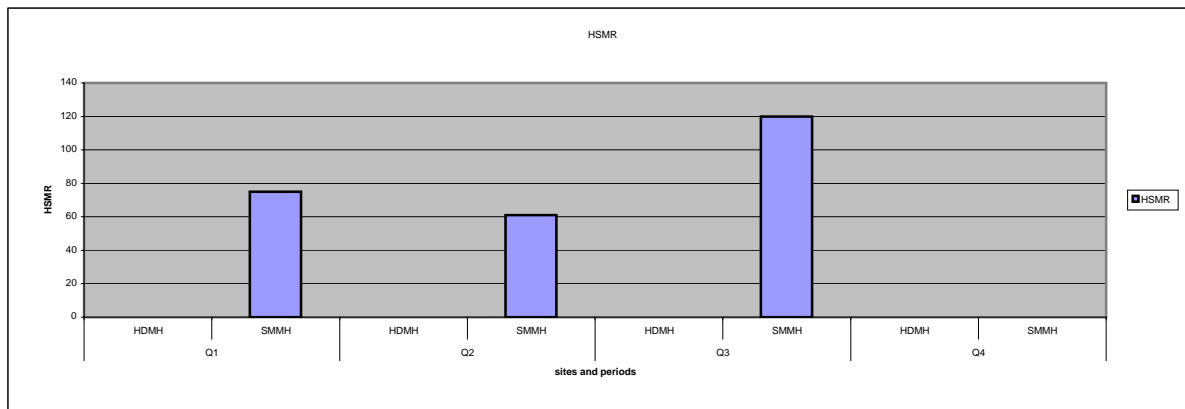
Interpretation

Standard Met?- YES Action required?- NO

The HSMR for fiscal 07/08 for MAHC was 96 which is less than 100 which suggests MAHC's hospital mortality rate is lower than the national average.

Fiscal 07/08		HSMR	peer range	#cases	# deaths
Q1	HDMH	89 !		225	17
	SMMH	75		243	17
Q2	HDMH	98 !		217	19
	SMMH	61		272	19
Q3	HDMH	111 !		176	21
	SMMH	120		260	33
Q4	HDMH	147 !			
	SMMH	111 !		255	21
YTD	MAHC	96	61-139	1852	146

These results with "!" should be interpreted with caution as sample size is small and unstable



RELEVANCE:The HSMR is used by hospitals worldwide to assess and analyze their mortality rates. The HSMR is a ratio of observed to expected deaths x100. A ratio equal to 100 suggests that there is no difference between MAHC's mortality rate than the average national rate, greater than 100 suggests that MAHC is higher than the national average and less than 100 suggest MAHC rates are lower than the national average.

TARGET: < than or = 100

FORMULA: Hospital Standardized Mortality Ratio (HSMR)

SOURCE: CIHI

QUADRANT: Patient Access & Outcomes

VOLUME-OCCUPANCY RATES

INTERPRETATION:

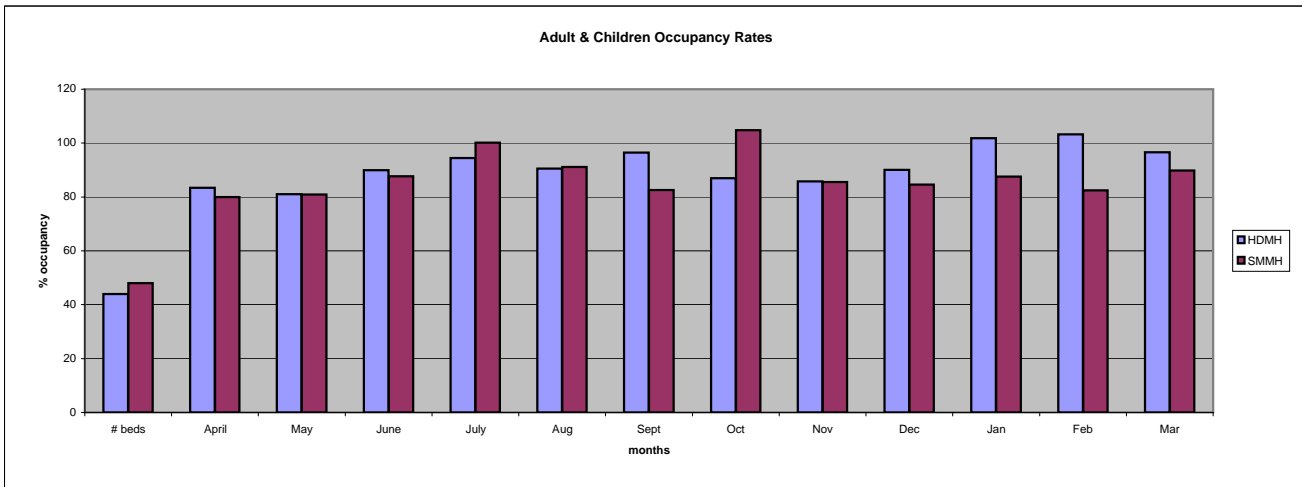
Standard Met? NO Action required?- YES

Utilization of beds continue to be reviewed in an effort to reduce occupancy rates to operationally acceptable levels.

MAHC combined site occupancy for Q2 was 106.9%

**Average % Occupancy:
Adults & Children**

# beds	08/09		07/08		06/07	
	HDMH	SMMH	HDMH	SMMH	HDMH	SMMH
# beds	44	48	44	48	44	49
April	92.5	97.6	83.4	80.0	89.0	85.3
May	90.6	102.4	81.0	80.9	92.4	86.2
June	95.0	98.3	89.9	87.7	96.2	82.3
July	95.2	100.3	94.4	100.1	98.9	84.5
Aug	110.9	104.0	90.5	91.1	105.9	91.4
Sept	103.0	112.5	96.5	82.6	106.5	89.7
Oct			87.0	104.8	107.0	93.5
Nov			85.8	85.6	105.2	98.2
Dec			90.1	84.6	106.7	83.5
Jan			101.8	87.6	108.9	90.0
Feb			103.3	82.4	106.4	95.3
Mar			96.6	89.8	106.5	87.6



RELEVANCE: According to publication of the OHA/JPPC, a hospital has difficulty maintaining quality standards when occupancy levels are > 85%.

TARGET: 85%

FORMULA: Med/Surg/ICU: Total Inpatient Service Days x 100 over the Total # of inpatient bed counts x the # days in the period.

SOURCE: Census Summary/Utilization report

QUADRANT: Patient Access & Outcomes **REPORTING PERIOD:** Monthly

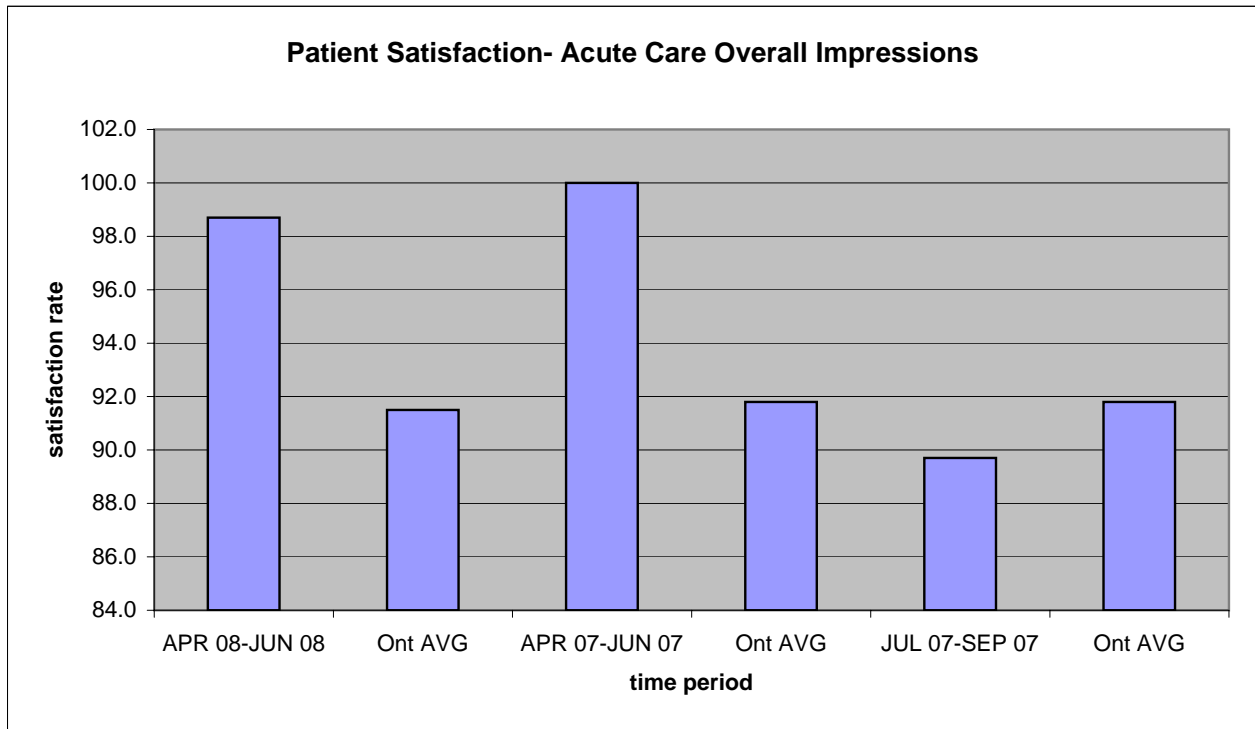
ACUTE CARE: PATIENT SATISFACTION RESULTS: ACUTE CARE

INTERPRETATION:

Standard Met? YES Action required?- NO

Overall Impressions

	APR 08- JUN 08	Ont AVG	APR 07- JUN 07	Ont AVG	JUL 07- SEP 07	Ont AVG
Acute Care	98.7	91.5	100.0	91.8	89.7	91.8



RELEVANCE: Patients will decide on the quality of care they receive by evaluating things they have basic knowledge about, such as, quality of care, conditions of the environment and good information regarding their treatment and care
TARGET: >or = to the Ontario Community Hospital's Average Score
FORMULA: Results of patient satisfaction survey provided by the OHA, via National Research Council
SOURCE: National Research Council/OHA
QUADRANT: Patient Access & Outcomes

PATIENT SATISFACTION RESULTS: ACUTE CARE

INTERPRETATION:

Standard Met? YES Action required?- NO

INPATIENT	APR 08- JUN 08		APR 07- JUN 07		JUL 07- SEP 07	
	MAHC	ONT AVG	MAHC	ONT AVG	MAHC	ONT AVG
Overall Care Received	98.7	91.5	100.0	91.8	89.7	91.8
Courtesy of nurses	97.3	92.7	97.2	93.1	95.4	93.1
Courtesy of physicians	97.3	94.7	94.7	94.0	96.6	94.8
Overall physician care	97.4	93.4	94.7	93.5	95.3	93.5
Confidence/trust in physicians	80.0	81.8	85.5	81.4	81.6	81.4
Confidence/trust in nurses	84.0	73.1	84.9	73.8	80.5	73.8
How well Drs/Nurses worked together	97.3	92.4	98.6	92.6	91.9	92.6
Courtesy during admission	100.0	94.5	98.7	94.5	95.3	94.5
Overall quality of food	77.5	61.7	58.3	60.2	60.7	60.2
Condition of room/hospital environment	88.0	83.3	90.7	83.2	84.7	83.2
Would recommend MAHC for Inpt Services	81.3	68.1	83.6	68.3	69.0	68.3
All Dimensions combined	78.4	73.0	78.7	73.2	75.2	73.2
1. Access	89.2	80.7	90.1	81.1	84.5	81.1
2. Continuity & Transition	69.5	64.8	68.6	64.9	66.7	64.9
3. Coordination of Care	78.0	74.7	82.2	74.5	73.6	74.5
4. Emotional Support	73.9	67.5	74.6	67.9	74.0	67.9
5. Information & Education	75.1	73.2	75.2	73.4	72.9	73.4
6. Involvement of Family	77.4	69.0	76.6	68.5	71.4	68.5
7. Physical Comfort	85.9	78.9	80.8	79.2	81.1	79.2
8. Respect for Patient Preferences	82.3	77.0	83.4	77.3	79.5	77.3
% of targets (20) met	95.0%		95.0%		85.0%	

= targets not met

RELEVANCE: Patients will decide on the quality of care they receive by evaluating things they have basic knowledge about, such as, quality of care, conditions of the environment and good information regarding their treatment and care

TARGET: >or = to the Ontario Community Hospital's Average Score

FORMULA: Results of patient satisfaction survey provided by the OHA, via National Research Council

SOURCE: National Research Council/OHA

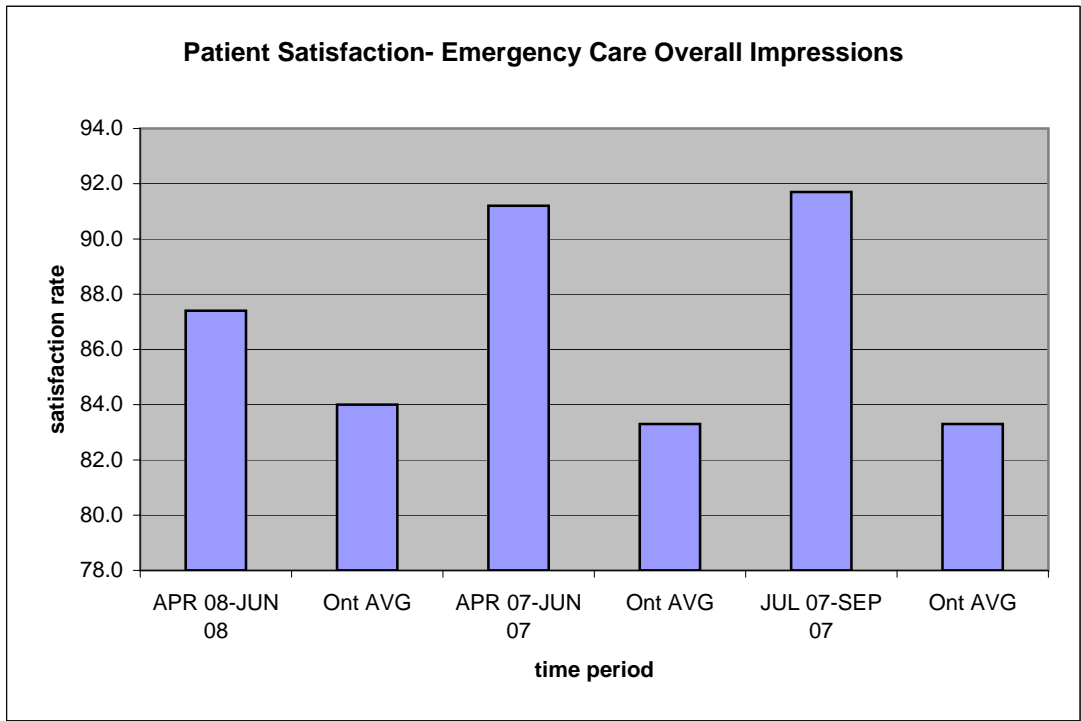
QUADRANT: Patient Access & Outcomes

PATIENT SATISFACTION RESULTS: EMERGENCY CARE

INTERPRETATION:
 Standard Met? YES Action required?- NO

Emergency Care- Overall Impressions

	APR 08- JUN 08	Ont AVG	APR 07- JUN 07	Ont AVG	JUL 07- SEP 07	Ont AVG
MAHC	87.4	84.0	91.2	83.3	91.7	83.3



RELEVANCE: Patients will decide on the quality of care they receive by evaluating things they have basic knowledge about, such as, quality of care, conditions of the environment and good information regarding their treatment and care
TARGET: >or = to the Ontario Community Hospital's Average Score
FORMULA: Results of patient satisfaction survey provided by the OHA, via National Research Council
SOURCE: National Research Council/OHA
QUADRANT: Patient Access & Outcomes

PATIENT SATISFACTION RESULTS: EMERGENCY CARE

TARGET: >or = to the Ontario Community Hospital's Average Score

INTERPRETATION:
Standard Met? YES Action required?- NO

EMERGENCY	APR 08- JUN 08		APR 07- JUN 07		JUL 07- SEP 07	
	MAHC	ONT AVG	MAHC	ONT AVG	MAHC	ONT AVG
Overall Quality of ED Care	87.4	84.0	91.2	83.3	91.7	83.3
Explanation of what ED did	92.8	86.6	93.3	86.1	89.8	86.1
Confidence/trust in ED nurses	76.8	70.7	86.1	70.4	80.2	70.4
Confidence/trust in ED physicians	76.2	71.0	83.5	70.4	76.4	70.4
How well ED Drs/Nurses worked together	91.1	89.0	94.1	88.7	92.1	88.7
Rate amount of time spent in ED	92.8	86.6	82.2	58.4	67.9	58.4
Cleanliness of ED	84.4	68.5	79.2	67.7	89.4	67.7
All Dimensions combined	73.3	66.5	78.4	66.1	74.7	66.1
1. Access and Coordination	74.3	66.1	76.8	65.9	73.4	65.9
2. Continuity and Transition	67.6	63.4	74.8	63.2	70.3	63.2
3. Emotional Support	69.4	62.9	78.8	62.3	72.1	62.3
4. Information and Education	71.1	62.8	75.2	62.1	71.2	62.1
5. Physical Comfort	67.0	62.1	77.8	60.9	75.6	60.9
6. Respect for Patient Preferences	82.2	77.1	87.1	76.5	85.2	76.5
% of targets met (14)	100%		100%		100%	

= targets not met

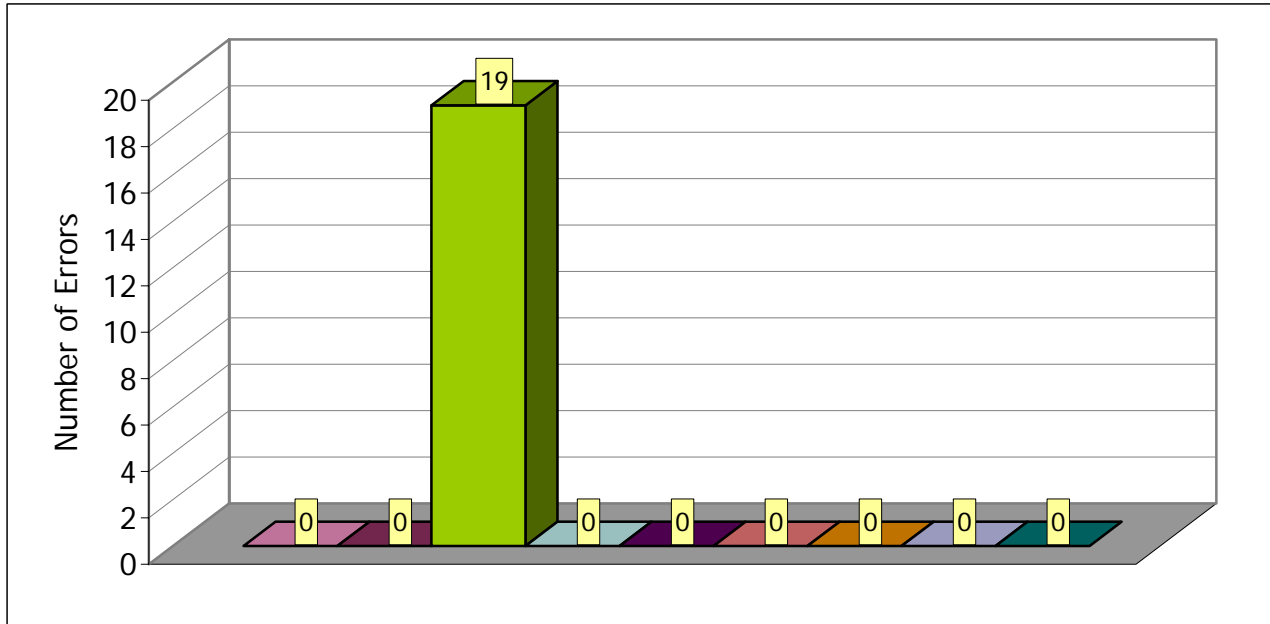
RELEVANCE: Patients will decide on the quality of care they receive by evaluating things they have basic knowledge about, such as, quality of care, conditions of the environment and good information regarding their treatment and care
 TARGET: >or = to the Ontario Community Hospital's Average Score
 FORMULA: Results of patient satisfaction survey provided by the OHA, via National Research Council
 SOURCE: National Research Council/OHA
 QUADRANT: Patient Access & Outcomes

Medication Errors

(% of Medication Errors which may have or resulted in harm)

July - Sept 2008

Standard Met?- yes	Action required?- NO
0 / 19	0%



	Q1	Q2	Q3	Q4
■ Circumstances or events that have the capacity to cause error	0	0		
■ An error occurred but the error did not reach the patient (An error of omission does reach the patient)	0	0		
■ Error Reached the patient but did not cause patient harm	31	19		
■ Error reached the patient requiring monitoring to confirm no harm and/or required intervention to prevent harm	1	0		
■ Error that may have contributed to or resulted in temporary harm to the patient and required intervention	1	0		
■ Error that may have contributed or resulted in temporary harm and required initial or prolonged hospitalization	0	0		
■ Error that may have contributed to or resulted in permanent patient harm.	0	0		
■ Error that required intervention necessary to sustain life	0	0		
■ Error that may have contributed to or resulted in the patient's death.	0	0		
Total Number of Errors	33	19		

RELEVANCE: A medication incident is defined as an event that involves the actual administration of a prescribed drug or omission of a prescribed drug to a patient. The following are examples of medication incidents:

- Dose Omission
- Improper Dose
- Wrong Strength/Concentration
- Wrong Drug
- Wrong Dosage Form
- Wrong Technique
- Wrong Route of Administration
- Wrong Rate/Frequency
- Wrong Duration
- Wrong Time
- Wrong Patient
- Monitoring Error
- Deteriorated Drug Error
- Other

TARGET: '0'

FORMULA: Total # of Medication Errors which may have or resulted in harm / Total # Med Errors

** Note*

SOURCE: Institute for Safe Medical Practice (ISMP) report

QUADRANT: Patient Access & Outcomes

FALLS AND ADVERSE EVENTS
(Type of Incident by Month)

INTERPRETATION:

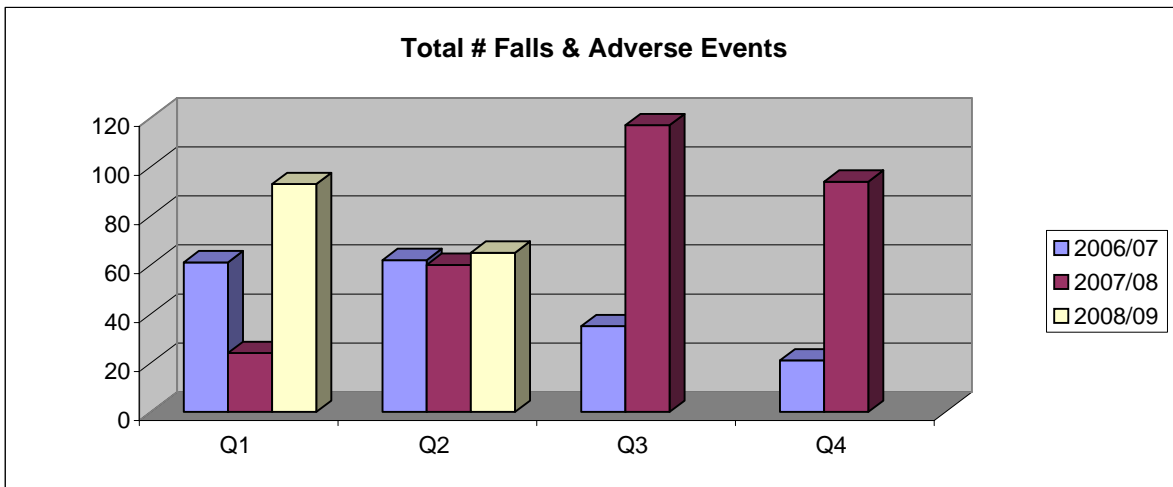
Standard Met?- NO Action required?- YES

August 21/07- The new format for incident reporting that is consistent across sites and disciplines commenced August 1/07. We have always had a lag between submission of the ENCON data (the system that was utilized at AHS) so the data for the Apr-June /07 quarter has not been returned to us yet for inclusion in the report. From August 1/07 forward there will be ability to populate the report with real time data.

January 2008 - There is a noticeable increase in the total number of incidents reported in the 3rd Quarter. We believe this is due to an increase in reporting as a result of implementing the new, user friendly reporting tool. The previous reporting tool used by the legacy AHS sites was difficult to use.

Nursing Leadership is presently reviewing restraint policies and products in use across the organization for standardization.

	Total	Falls		Treatment/Test/ Procedure		Other	
		SMMH	HDMH/ Burks	SMMH	HDMH/ Burks	SMMH	HDMH/ Burks
2006/07							
Q1	61	31	21	2	0	5	2
Q2	62	30	22	4	1	3	2
Q3	35	26	5	0	0	4	0
Q4	21	21		3		3	
2007/08							
Q1	24	24		3		3	
Q2	60	43	17	7	7	10	2
Q3	117	46	43	11	9	20	9
Q4	94	26	42	7	6	15	11
2008/09							
Q1	93	37	20	7	2	22	14
Q2	65	31	12	3	4	12	10
Q3							
Q4							



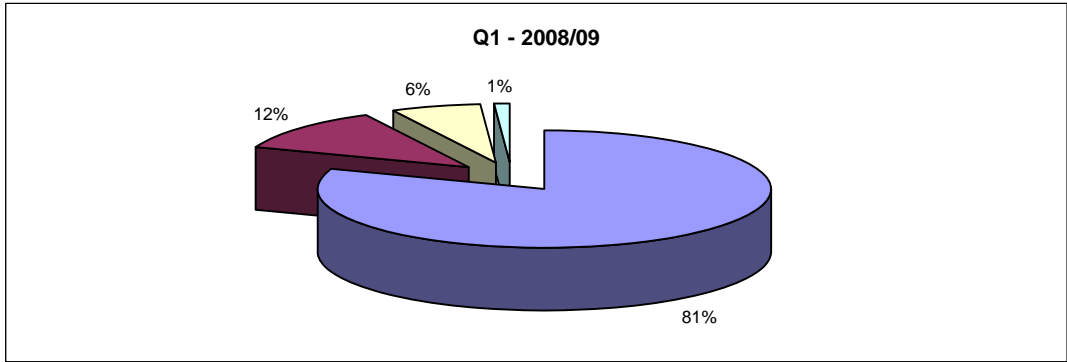
INCIDENTS BY DEGREE OF INJURY

INTERPRETATION:
 Standard Met?- NO Action required?- YES

August 21/07- The new format for incident reporting that is consistent across sites and disciplines commenced August 1/07. We have always had a lag between submission of the ENCON data (the system that was utilized at AHS) so the data for the Apr-June /07 quarter has not been returned to us yet for inclusion in the report. From August 1/07 forward there will be ability to populate the report with real time data.

Incidents by Degree of Injury

2008	Total #	Minor				Moderate				Major				Major/Sentinel			
		S	H&B	Tot#	%	S	H&B	Tot#	%	S	H&B	Tot#	%	S	H&B	Tot#	%
Q1	93	47	28	75	80.6	8	3	11	11.8	3	3	6	6.5	1	0	1	1.1
Q2	65	37	18	55	84.6	3	4	7	10.8	2	0	2	3.1	1	0	1	1.5
Q3				0	#DIV/0!			0	#DIV/0!			0	#DIV/0!			0	#DIV/0!
Q4				0	#DIV/0!			0	#DIV/0!			0	#DIV/0!			0	#DIV/0!



2007	Total #	Minor				Moderate				Major				Major/Sentinel			
		S	H&B	Tot#	%	S	H&B	Tot#	%	S	H&B	Tot#	%	S	H&B	Tot#	%
Q1	22	21		21	95.5	1		1	4.5	0		0	0.0	0		0	0.0
Q2	76	44	15	59	77.6	6	4	10	13.2	2	4	6	7.9	1		1	1.3
Q3	118	54	49	104	88.1	8	3	11	9.3	4	0	4	4.5	0		0	0.0
Q4	94	34	48	82	87.2	5	3	8	8.5	2	2	4	4.3	0	0	0	0.0
Total	310			266	85.8			30	9.7			14	4.5			1	0.3
2006																	
Q1	74	26	21	47	63.5	14	11	25	33.8	0	1	1	1.4	0	1	1	1.4
Q2	69	26	26	52	75.4	10	5	15	21.7	0	2	2	2.9	0	0	0	0.0
Q3	36	19	5	24	66.7	11	1	12	33.3	0	0	0	0.0	0	0	0	0.0
Q4	74	26	21	47	63.5	14	11	25	33.8	0	1	1	1.4	0	1	1	1.4
Total	253			170	67.2			77	30.4			4	1.6			2	0.8

Note: 2007 Q1 Data is for SMMH Only.

RELEVANCE: # of patient incidents of falls may indicate causative factors that require improvement.
FORMULA: Count of falls as noted in incident reports, which are generated in all areas of the hospital. Categorization of outcome of falls as noted in incident reports, which are generated in all areas of the hospital.
TARGET: All adverse events will have a "minor" severity rating.
SOURCE: Incident Reports
QUADRANT: Patient Access & Outcomes

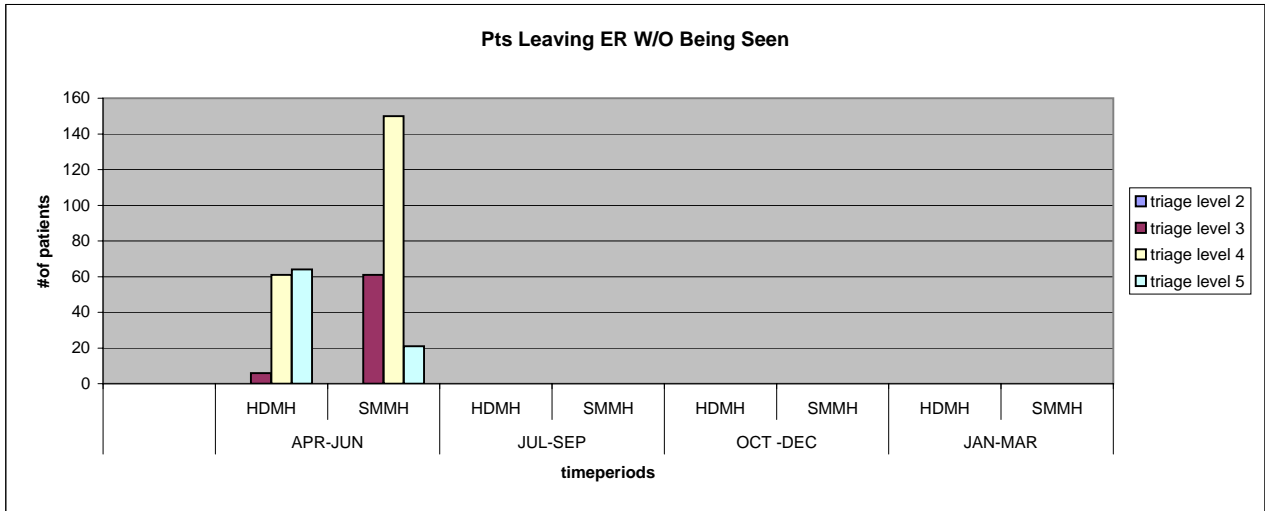
ER- Patients Who Left ER Without Being Seen by a Physician (Triage Level 2,3,4,5)

INTERPRETATION:
 Standard Met?- NO Action required?- YES
 An ad hoc team has been struck to look at causal factors of patients leaving ER without being seen.

Patients Who Left ER Without Being Seen by a Physician

FY 08/09		totals	triage level 2	triage level 3	triage level 4	triage level 5
APR-JUN	HDMH	131	0	6	61	64
	SMMH	232	0	61	150	21
JUL-SEP	HDMH					
	SMMH					
OCT -DEC	HDMH					
	SMMH					
JAN-MAR	HDMH					
	SMMH					

Triage Legend:
 Resuscitation (1)
 Emergent (2)
 Urgent (3)
 Less Urgent (4)
 Non Urgent (5)



RELEVANCE: It is important that all patients triaged are seen by a physician. If a patient leaves without being seen, there must be appropriate follow-up.
TARGET: 0
FORMULA: # of patients who left ER without being seen
SOURCE: Coding Abstracting System- Cactus
REPORTING PERIOD: Monthly
QUADRANT: Patient Access & Outcomes

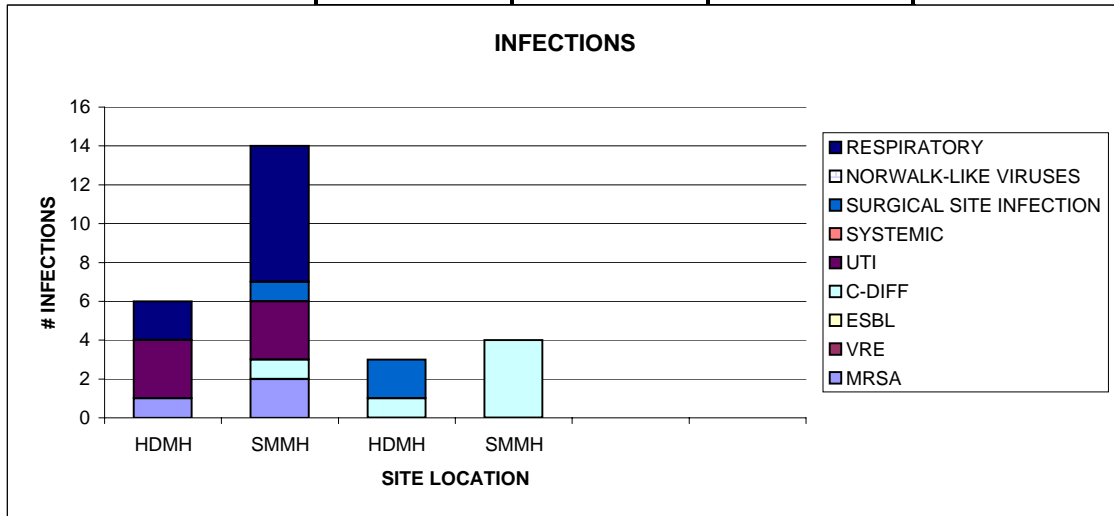
NOSOCOMIAL INFECTION RATE

INTERPRETATION:

Standard Met?-YES Action required?- NO
Surgical site, Systemic and Respiratory infection information not available at this time.

ALL Infections:

Infection	JUL 08- SEP 08		APR 08- JUN08		JAN08-MAR08		APR07-JUN07	
	HDMH	SMMH	HDMH	SMMH	HDMH	SMMH	HDMH	SMMH
MRSA	0	0	1	1	1	2		
VRE	0	0	0	0				
ESBL	1	0	2	0				
C-DIFF	1	0	3	2		1	1	4
UTI			2	3	3	3		
SYSTEMIC								
SURGICAL SITE INFECTION (other than ARO related)						1	2	
NORWALK-LIKE VIRUSES								
RESPIRATORY					2	7		
TOTAL # Infections	2	0	8	6	6	14	3	4
Number of patient days	6307	6923	5836	6679	4841	5990	5552	5845
Infection Rate	0.32%	0.00%	1.37%	0.90%	1.24%	2.34%	0.54%	0.68%



RELEVANCE: Nosocomial infections are acquired after admission to hospital

TARGET: Literature indicates 3%-6% is a reasonable infection rate depending on the type of patients cared for in the organization.

(Infection Control Guidelines for LTC Facilities: Publisher- Laboratory for Disease Control for National Health & Welfare of Canada)

FORMULA: Acute Care: number of infections/number of resident days x1000

SOURCE: Infection Control monthly statistics

QUADRANT: Quality/Risk

ABSENTEEISM COST

INTERPRETATION:

Standard Met? Action required?

ABSENTEEISM COST

<i>fiscal 05/06</i>	Cost (\$) of Absenteeism			# Hours Paid Sick Leave		# Hours Unpaid Sick Leave		Total Absenteeism Hours	
	SMMH	HDMH	TOTAL	SMMH	HDMH	SMMH	HDMH	SMMH	HDMH
APR-JUN 05	\$ 68,801.52	\$ 125,583.59	\$ 194,385.11	2,618.8	4,639.9	1,481.00	1,244.0	4,099.75	5,883.9
JUL-SEPT 05	\$ 85,068.18	\$ 89,642.19	\$ 174,710.37	3,233.5	3,249.0	2,064.25	1,452.8	5,297.75	4,701.8
OCT-DEC 05	\$ 88,574.63	\$ 124,236.94	\$ 212,811.57	3,346.5	4,287.0	2,459.25	1,570.8	5,805.75	5,857.8
JAN-MAR 06	\$ 93,545.49	\$ 87,924.72	\$ 181,470.21	3032.0	3210.0		1815.5		5025.5
TOTAL	\$ 335,989.82	\$ 427,387.44	\$ 763,377.26	12,230.8	15385.92	6,004.5	6,083.0	15,203.3	21,469.0
<i>fiscal 06/07</i>	SMMH	HDMH	TOTAL						
APR-JUN 06	\$ 58,016.35	\$ 123,066.56	\$ 181,082.91	2,069.8	4,049.3	1,035.00	1,349.0	3,104.75	5,398.3
JUL-SEPT 06	\$ 28,362.64	\$ 98,801.47	\$ 127,164.11	1,081.0	3,488.3	718.50	919.5	1,799.50	4,407.8
OCT-DEC 06	\$ 60,940.00	\$ 96,712.42	\$ 157,652.42	2,005.8	3,298.3		874.5		4,172.8
JAN-MAR 07	\$ 65,378.00	\$ 104,062.30	\$ 169,440.30	2556.3	3682.3		994.5		7233.0
TOTAL YTD	\$ 212,696.99	\$ 422,642.75	\$ 635,339.74	7,712.8	14,518.0	1,753.5	4,137.5	4,904.3	21,211.8

OHA Grouping	SMMH					HDMH			
	Hours	Dollars	Number of Full Time Employees	Average # Days	Fiscal 05/06 Average # Days	Hours	Dollars	Number of Full Time Employees	Average # Days
<i>fiscal 06/07</i>									
Nurse	3,543.25	\$ 118,310.15	45	10.5	15.96	6,938.00	\$ 232,789.40	89	10.4
Service	1,777.50	\$ 33,862.52	39	6.1	7.76	3,229.25	\$ 67,567.61	43	10.0
Clerical	716.75	\$ 14,814.96	20	4.8	9.04	1,838.75	\$ 42,357.07	35	7.0
Paramedical	1,073.25	\$ 36,534.92	30	4.8	11.66	1,753.25	\$ 54,069.31	32	7.3
Administration	513.50	\$ 18,833.97	11	6.2	7.11	673.00	\$ 22,749.48	29	3.1
	7,624.25	\$ 222,356.52	145	7.0	10.3	14,432.25	\$ 419,532.87	228	8.4

OHA Grouping	SMMH					HDMH			
	Hours	Dollars	Number of Full Time Employees	Average # Days	Fiscal 06/07 Average # Days	Hours	Dollars	Number of Full Time Employees	Average # Days
April/June 2007									
Nurse	1,382.75	49,942.22	47.00	3.92	10.50	1,550.33	55,071.74	68.00	3.04
Service	732.00	14,338.07	40.00	2.44	6.10	781.00	17,263.10	42.00	2.48
Clerical	100.50	3,170.99	21.00	0.64	4.80	795.50	20,115.86	47.00	2.26
Paramedical	150.00	5,431.50	38.00	0.53	4.80	270.50	8,065.96	32.00	1.13
Administration	59.75	1,304.75	12.00	0.66	6.20	227.50	7,405.31	34.00	0.89
	2,425.00	\$ 74,187.53	158	2.0	7.0	3,624.83	\$ 107,921.97	223	2.2

July/September 2007										
Nurse	1,078.00	38,582.52	45.00	3.19	10.50	1,295.25	47,007.97	72.00	2.40	
Service	773.50	13,952.91	40.00	2.58	6.10	978.50	19,641.03	42.00	3.11	
Clerical	47.00	873.26	14.00	0.45	4.80	291.75	6,299.72	28.00	1.39	
Paramedical	223.00	8,129.51	25.00	1.19	4.80	244.75	8,311.48	31.00	1.05	
Administration	135.00	4,809.40	7.00	2.57	6.20	41.00	1,465.48	34.00	0.16	
	2,256.50	66,347.60	131.00	2.30	7.0	2,851.25	82,725.68	207.00	1.84	

October/December 2007										
Nurse	1,337.75	48,415.18	45.00	3.96	10.50	1,706.75	62,181.70	66.00	3.45	
Service	1,605.50	32,998.72	39.00	5.49	6.10	1,066.08	23,633.19	44.00	3.23	
Clerical	173.50	3,186.51	14.00	1.65	4.80	192.17	4,467.57	28.00	0.92	
Paramedical	323.00	11,361.56	25.00	1.72	4.80	592.75	20,144.72	32.00	2.47	
Administration	176.25	6,771.03	7.00	3.36	6.20	546.50	16,769.96	34.00	2.14	
	3,616.00	102,733.00	130.00	3.71	7.0	4,104.25	127,197.14	204.00	2.68	

January/March 2008										
Nurse	1,466.50	34,343.55	42.00	4.66	10.50	1,819.75	50,941.15	63.00	3.85	
Service	1,720.25	19,213.94	42.00	5.46	6.10	1,228.50	17,077.90	46.00	3.56	
Clerical	206.50	2,202.83	14.00	1.97	4.80	426.25	7,101.27	15.00	3.79	
Paramedical	349.00	9,507.76	25.00	1.86	4.80	397.00	12,042.62	32.00	1.65	
Administration	168.75	7,245.43	7.00	3.21	6.20	280.75	9,291.13	36.00	1.04	
	3,911.00	72,513.51	130.00	4.01	7.0	4,152.25	96,454.07	192.00	2.88	

OHA Grouping	SMMH					HDMH				
	Hours	Dollars	Number of Full Time Employees	Average # Days	Fiscal 07/08 Average # Days	Hours	Dollars	Number of Full Time Employees	Average # Days	
April/June 2008										
ONA	826.75	21,638.42	45.00	2.45	10.50	1,652.75	62,608.24	70.00	3.15	
Service	2,988.25	41,794.66	42.00	9.49	6.10	1,279.75	28,501.16	49.00	3.48	
Clerical	116.75	1,907.94	14.00	1.11	4.80	349.00	8,042.58	15.00	3.10	
Paramedical	429.25	11,825.27	25.00	2.29	4.80	212.75	6,873.54	32.00	0.89	
Administration	145.00	4,455.29	6.00	3.22	6.20	210.00	8,171.34	25.00	1.12	
	4,506.00	81,621.58	132.00	4.55	7.0	3,704.25	114,196.86	191.00	2.59	

July/September 2008										
ONA	1,063.50	33,194.45	45.00	3.15	10.50	1,749.92	67,313.95	70.00	3.33	
Service	2,128.25	24,149.08	42.00	6.76	6.10	981.75	23,016.78	49.00	2.67	

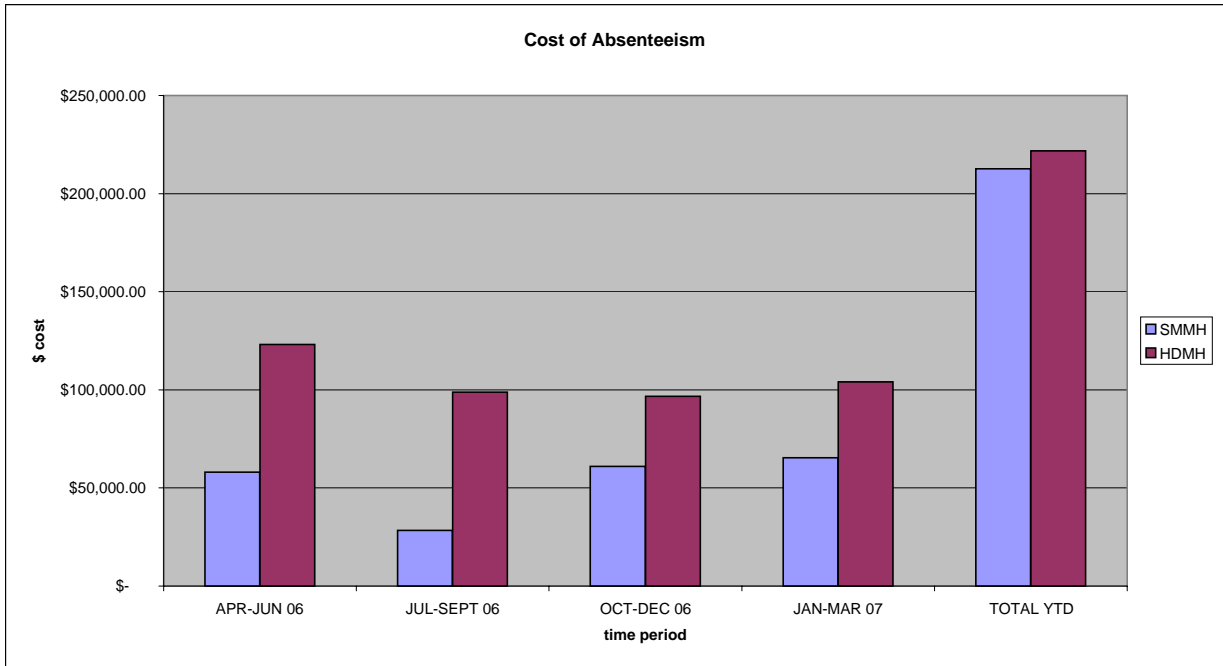
ABSENTEEISM COST

INTERPRETATION:

Standard Met?- ? Action required - NO

ABSENTEEISM COSTS

	Cost (\$) of Absenteeism			Total Cost of Payroll		% of total payroll	
	SMMH	HDMH	TOTAL	SMMH	HDMH	SMMH	HDMH
<i>fiscal 04/05</i>							
APR-JUN 04	\$ 42,819.00	\$ 118,072.51	\$ 160,891.51				
JUL-SEPT 04	\$ 40,526.00	\$ 103,354.65	\$ 143,880.65				
OCT-DEC 04	\$ 79,251.00	\$ 108,059.22	\$ 187,310.22				
JAN-MAR 05	\$ 51,429.01	\$ 155,488.60	\$ 206,917.61				
TOTAL	\$ 214,025.01	\$ 484,974.98	\$ 698,999.99	\$ 13,660,323.00	\$ 18,932,179.00	5.1	2.6
<i>fiscal 05/06</i>							
APR-JUN 05	\$ 68,801.52	\$ 125,583.59	\$ 194,385.11				
JUL-SEPT 05	\$ 85,068.18	\$ 89,642.19	\$ 174,710.37				
OCT-DEC 05	\$ 88,574.63	\$ 124,236.94	\$ 212,811.57				
JAN-MAR 06	\$ 89,836.00	\$ 87,924.72	\$ 177,760.72				
TOTAL	\$ 332,280.33	\$ 427,387.44	\$ 759,667.77	\$ 13,787,069.00	\$ 18,629,793.43	5.5	2.3
<i>fiscal 06/07</i>							
APR-JUN 06	\$ 58,016.35	\$ 123,066.56	\$ 181,082.91	\$ 3,706,707.00	\$ 4,968,312.00	4.9	2.5
JUL-SEPT 06	\$ 28,362.64	\$ 98,801.47	\$ 127,164.11	\$ 3,571,906.00	\$ 5,515,211.00	3.6	1.8
OCT-DEC 06	\$ 60,940.00	\$ 96,718.42	\$ 157,658.42	\$ 3,791,480.00	\$ 5,365,365.00	4.2	1.8
JAN-MAR 07	\$ 65,378.00	\$ 104,062.30	\$ 169,440.30	\$ 3,446,457.00	\$ 5,080,839.00	4.9	2.0
TOTAL YTD	\$ 212,696.99	\$ 221,868.03	\$ 434,565.02	\$ 14,516,550.00	\$ 20,929,727.00	3.0	2.1
<i>fiscal 07/08</i>							
APR-JUN 07	\$ 73,348.06	\$ 107,921.97	\$ 181,270.03	\$ 3,768,294.00	\$ 5,478,354.00	4.8	2.0
JUL-SEPT 07	\$ 66,347.60	\$ 82,725.68	\$ 149,073.28	\$ 3,833,379.00	\$ 5,078,281.00	3.9	1.6
OCT-DEC 07	\$ 107,732.98	\$ 127,197.14	\$ 234,930.12	\$ 3,922,812.00	\$ 4,878,633.00	6.0	2.6
JAN-MAR 08	\$ 72,513.50	\$ 96,454.07	\$ 168,967.57	\$ 3,779,703.00	\$ 4,784,572.00	4.5	2.0
TOTAL YTD	\$ 319,942.14	\$ 414,298.86	\$ 734,241.00	\$ 15,304,188.00	\$ 20,219,840.00	4.8	3.6
<i>fiscal 08/09</i>							
APR-JUN 08	\$ 81,621.58	\$ 114,196.61	\$ 195,818.19	\$ 3,768,294.00	\$ 5,478,354.00	5.2	2.1
JUL-SEPT 08	\$ 81,093.01	\$ 102,061.55	\$ 183,154.56	\$ 3,833,379.00	\$ 5,078,281.00	4.8	2.0
OCT-DEC 08	\$ -	\$ -	\$ -	\$ -	\$ -	#DIV/0!	#DIV/0!
JAN-MAR 09	\$ -	\$ -	\$ -	\$ -	\$ -	#DIV/0!	#DIV/0!
TOTAL YTD	\$ 162,714.59	\$ 216,258.16	\$ 378,972.75	\$ 7,601,673.00	\$ 10,556,635.00	5.0	3.6



RELEVANCE: High absenteeism can be indicative of problems associated with quality of work life. Financial costs associated with sick time increase the budget pressures as we try to preserve service delivery.

TARGET: the OHA benchmarks. is 10.31 days per year, per eligible employee. An eligible employee is one entitled to sick leave benefits.

FORMULA: Count of number of sick hours paid and unpaid.

SOURCE: Human Resources, payroll system, Occupational Health

QUADRANT: People Learning & Growth

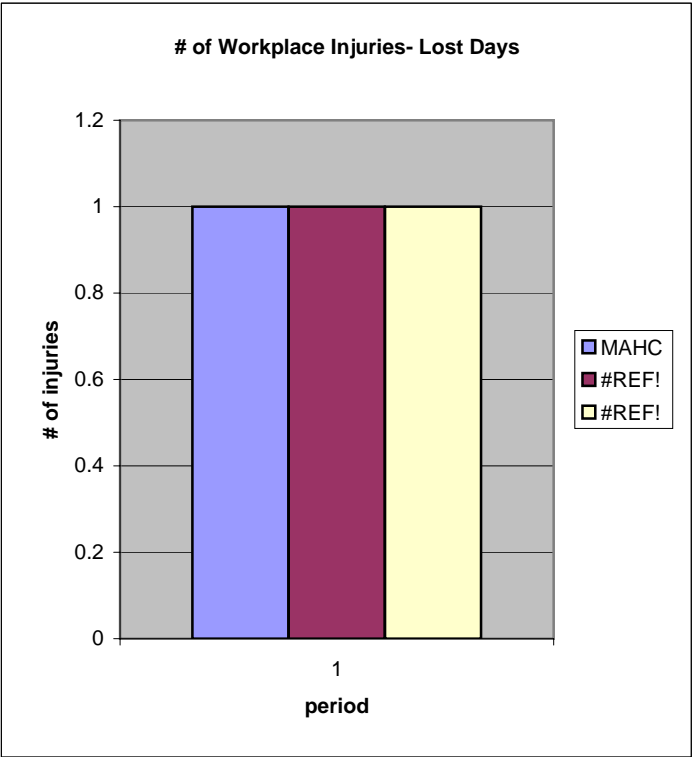
REPORTING PERIOD: Quarterly

WORKPLACE INJURY

INTERPRETATION:
 Standard Met?- NO
 Action required?- YES

of Workplace Injuries

	MAHC	Totals
08/09		
Q1 2008	20	20
Q2 2008	13	13
Q3 2008		0
Q4 2008		0
Total 2006	33	33



RELEVANCE: Workplace injuries, which result in lost days, provide an associated heavy financial burden on the hospital
TARGET: 5 or less, per quarter
FORMULA: Count of number of workplace injuries
SOURCE: Occupational Health
QUADRANT: Organizational Health

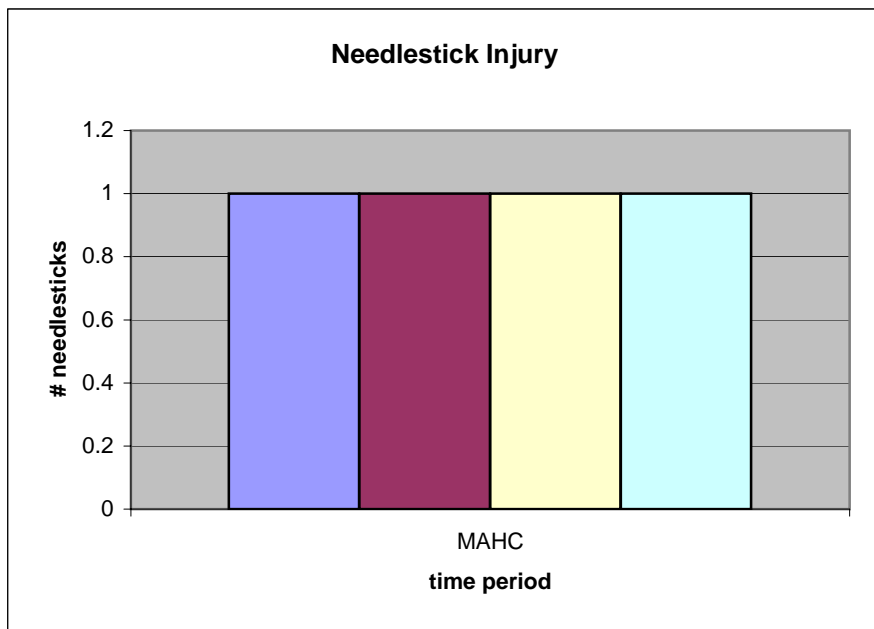
OCCUPATIONAL HEALTH: NEEDLESTICK INJURIES

INTERPRETATION:

Standard Met?- NO Action required?- YES

Needlestick Injuries-

	MAHC	Totals
08/09		
Q1	2	2
Q2	2	2
Q3		0
Q4		0



RELEVANCE: Needle stick injuries can cause HepB,C and HIV Aids. It is imperative that all chances of needlestick injury are eradicated

TARGET: 0

SOURCE: Incident Reports

FORMULA: # of needlestick injuries

QUADRANT: Organizational Health

STUDENT PLACEMENTS

	Medical Learners		Allied Health		Organization Wide	
	Total Learners	Total Learner Days	Total Learners	Total Learner Days	Total Learners	Total Learner Days
Apr - June '06	17	427	11	295	28	722
July - Sept '06	18	497	12	555	30	1052
Oct - Dec '06	10	334	5	285	15	619
Jan - Mar '07	9	317	7	312	16	629

SMMH Site	Medical Learners		Allied Health		SMMH Totals	
	Total Learners	Total Learner Days	Total Learners	Total Learner Days	Total Learners	Total Learner Days
Apr - June '07	4	159	2	128	6	287
July - Sept '07	10	75	2	128	12	203
Oct - Dec '07	3	94	2	130	5	224
Jan - Mar '08*	0	182	2	132	2	314
Apr - June '08	7	289	2	42	9	331
July - Sept '08	12	363	2	132	14	495

HDMH Site	Medical Learners		Allied Health		HDMH Totals	
	Total Learners	Total Learner Days	Total Learners	Total Learner Days	Total Learners	Total Learner Days
Apr - June '07	8	395	5	185	13	580
July - Sept '07	19	105	3	139	22	244
Oct - Dec '07	9	304	0	0	9	304
Jan - Mar '08*	10	738	3	183	13	921
Apr - June '08	11	684	3	195	14	879
July - Sept '08	17	482	3	198	20	680

* Full-time medical students: headcount reflected in quarter reported; actual learner days reflected in each quarterly period

RELEVANCE: It is important for an organization to mentor students who are pursuing education in the healthcare field. This indicator will measure # of Learner days and outcome of placement satisfaction survey
TARGET: TBD
FORMULA: Count of number of placements
SOURCE: HR and Medical Advisory Committee
QUADRANT: Organizational Health

BUILD AN EFFECTIVE TEAM (STRATEGY #2)

Strategy Leader: Harold Featherston

Strategy Detail

As an organization created through amalgamation, we will work together to: build relationships, help each other succeed, and promote collegiality. This is our concept of 'team'.

<i>Action</i>	<i>Targets</i>	<i>Progress/Results</i>
<p>A fully functioning MAHC Team Building Committee with clear terms of reference. The committee will implement three (3) new team building activities within the next 12 months.</p> <p align="right">Chris Maurer, Chair of TBC</p>	July - Sept 08	Long service awards / Beach party theme Staff appreciation week

LEAD BY EXAMPLE (STRATEGY #3)

Strategy Leader: Irene Murray

Strategy Detail		
We will focus on continuous leadership development because our team members expect and deserve proactive and effective leadership.		
<i>Action</i>	<i>Targets</i>	<i>Progress/Results</i>
a. All staff members are aware of the strategic plan and know where they may obtain a copy. (Managers)	March 31, 2007 100% of MAHC staff members (as measured in annual staff satisfaction survey) are aware of the strategic plan and know where they may obtain a copy.	The Staff Satisfaction Survey results show that 33% agreed to this question, 35% disagreed while 32% neither agreed nor disagreed.
b. A leadership framework/model that supports and encourages effective leadership throughout the organization with measurable positive impacts on patient/client and staff satisfaction. (Irene Murray)	March 31, 2007 Based on the organizational vision, develop a leadership framework/model that encourages collegial thinking; creative, proactive planning and resilience; initiative and effectiveness; staff retention; unity; increased capacity to deliver; improved access; and service quality and commitment. This will be done through holding brainstorming sessions/focus groups to define good leadership. Information will then be prioritized and used as a baseline for evaluation by all team members. A standards of service and care document will be developed to reflect and guide leadership at all levels of the organization. All managers will increase their accessibility and familiarity with the team by engaging quarterly in "A Day in My Shoes".	Brainstorming sessions are scheduled and invitations distributed. The literature review and input to 'Standards of Service and Care' document are ongoing. "A Day In My Shoes" program will be introduced at the April Managers' meeting.
	June 30, 2007	Day In My Shoes Event completed. Draft framework document in progress incorporating results from staff focus groups and aligning with organization's values. 54% participation from mgt. group in this initiative
	September 30, 2007	Leading By Example Code of Conduct and leadership framework completed. Presented to managers and senior admin. Broader communication and roll out/implementation plan pending.
c. Managers identify their individual learning needs and goals annually. (Julie Smith)	March 30, 2007 100% of management staff identify learning goals annually.	completed and ongoing
d.. All managers annually engage in leadership training tailored to their learning needs. (Julie Smith)	March 31, 2008 100% of managers have completed a minimum of 2 leadership learning activities	Communications Skills training session scheduled for November 2nd for managers.
e. All managers have annual performance reviews . (Julie Smith)	March 31, 2007 Review of existing performance review materials for consistency and usefulness	completed and ongoing
	June 30, 2007 100% of managers have had a performance review within 30 days of their anniversary date of hire (as applicable within the quarter)	Managers' review date to be reflective of fiscal year and to occur in April/May timeframe each year (same model as CEO and Sr. Team)
	September 30, 2007 100% of managers have had a performance review within 30 days of their anniversary date of hire (as applicable within the quarter)	Sr. managers distributed materials for reviews to get up to date for the 2007/2008 fiscal year. None received by HR to date.
f. Update the Strategic Plan annually. (Barry Lockhart)	December 2008 The Organization's Strategic Plan will be reviewed and revised as necessary and reviewed at least annually.	The Board is in the process of reviewing the current plan. It is anticipated that the review will be complete by December 2008. Review timeline currently on target.

Maximize Regionally Compatible Information Technologies (STRATEGY #4)

Strategy Leader: Brian Thomson

Strategy Detail
We will allocate resources (time and money) to work with our LHIN partners to create regionally compatible information systems.

<i>Action</i>	<i>Targets</i>	<i>Progress/Results</i>
Develop MAHC focused IT Strategy	September 30, 2008 Need to develop alternate MAHC IT Strategy in light of short to medium term obstacles with regional initiatives (governance, operational, funding). i) focus on PACS implementation ii) common ADT for all MAHC sites iii) standarization of HR systems (common payroll system, staff scheduling system) for all MAHC sites iv) LIS planning and implementation v) eliminate Novell network at SMMH site	
Development of Regional IT Strategy	June 30, 2008 Hire business analyst/project manager - this position is needed to provide resources for MAHC continuous improvement initiatives and strategic projects.	- see comments below for regional eHealth strategy - business analyst/project manager position has been filled.
	March 31, 2008 Participate in Regional e-Health studies: i) Meditech Roadmap ii) Tri-LHIN Data Centre Consolidation Study	9/22/08 Significant effort went into MAHC participation in these two regional initiatives during Q1 and Q2. Effort included support for data collection, providing input to study authors, attending and actively participating in discussions.. Data collection and analysis phase of both regional studies is complete. Final Conclusions and recommendations to be presented to CEOs/CFOs or participating hospitals during first part of Q3
MAHC I.T. Project Listing ranked by priority.	December 31, 2007 Departmental listing of top three IT priorities	04/12/06 Department managers asked for their input 08/01/07 Completed: Manager's input collated into spreadsheets
	March 31, 2007 IT Priorities:	16/01/07 Present preliminary findings to CEO and direct reports 1/3/07 Project Profile sheets created
	i) Summarized	7/3/07 Team meeting to prioritize projects
	ii) Costed	10/3/07 Team meeting to prioritize projects
	iii) Staff Time Costed iv) Implementation Timeframe	17/3/07 Team meeting to sequence high priority projects
June 30, 2007 i.) Communications materials for IT project priorities ii) Proposal for MAHC IT governance model (how are priorities set and projects selected in the long term. iii) Proposal for IT Project Management Methodology	10/4/07 Completed IT Project Priority presentation 1/6/07 Reconstituted cross-functional ICT Steering Committee 1/8/07 Actively participating in newly formed Regional IT Council 1/9/07 Developing project tracking and status reporting process based on the new Helpdesk Application 30/9/07 Documented MAHC IT Governance Model Proposal is not started. 30/9/07 IT Project Management Methodology is in progress.	
September 30, 2007		

Build Relationships Through Effective Communication (STRATEGY #5)

Strategy Leader:

Strategy Detail

We will increase the frequency and quality of our communication with staff, physicians, volunteers, our partners and communities.

<i>Action</i>	<i>Targets</i>	<i>Progress/Results</i>
a. MAHC Staff Newsletter - printed and electronic versions	November 15, 2008	Establish new process and circulation dates. Ownership has been established; circulation dates yet to be confirmed.
b. All committees to have at least four brief reports on our intranet site and/or newsletter annually.	November 15, 2008 All Committee Chairs to be contacted and time scheduled for training.	List has been updated. Process yet to be developed for posting of information.
c. Facilitate/make available learning opportunities to assist managers in meeting their learning needs related to communication .	March 30, 2008 100% of managers engage in at least one learning activity annually related to their communication learning goals.	Communication Skills workshop scheduled for November 9, 2007.
d. Develop and implement three new skill development opportunities focusing on communication for all staff .	December 31, 2007 Three new skill development opportunities related to communication have been made available for employees.	Various sessions available to employees via our Learning calendar which is posted quarterly. Conflict resolution, non-violent crisis intervention are offered October - December.
e. All staff members have a regular opportunity (e.g. staff meeting, meeting minutes) to receive timely and meaningful information from their manager .	June 30, 2007 100% of staff report that they have regular opportunity (e.g. staff meeting, meeting minutes) to receive timely and meaningful information from their manager (as measured in annual staff survey planned for June).	Staff survey questioned employees re 'My manager keeps me in the loop so that I know what is happening in the Organization that impacts my work.' Out of 126 respondents 51% agreed, 27% disagreed and 22% neither agreed nor disagreed.
f. Every signed " Opportunity for Improvement (OFI) " suggestion received a response within 8 working days of the date it is received.	March 31, 2007 100% of responses to OFIs are sent within 8 working days of the date of receipt.	Target met.
	June 30, 2007 100% of responses to OFIs are sent within 8 working days of the date of receipt.	Target met.
	September 30, 2007 100% of responses to OFIs are sent within 8 working days of the date of receipt.	Target met.

STRENGTHEN AND PROMOTE COMMUNITY PARTNERSHIPS (STRATEGY #6)

Strategy Leader: Miriam Luddington

Strategy Detail		
We will promote collegial relationships with our partners, working together to find creative solutions for meeting people's needs.		
<i>Action</i>	<i>Targets</i>	<i>Progress/Results</i>
a) MAHC is a partner with NSM CCAC in the provincial Flo Collaborative to improve the timelines and effectiveness of transitions of care from admission to an acute care unit to subsequent care destinations. (Partnering with CCAC regionally, and with Collingwood General and Marine Hospital who are also doing the Flo Collaborative; and partnering provincially with other LHIN's doing Flo by sharing data, processes, and successes. Local community partners also involved with Improvement Team mtgs and planning. (Miriam Luddington)	March 31, 2008 1. Collaborative EDD 2. Interdisciplinary team mtgs 3. Community partners shared referral. 4. Staff whiteboard with pt d/c status	1. TCC/pysician collaboration for EDD increasing. 2. ITM increased efficiency/productivity 3. developing referral process with community partners to increase info sharing. 4. staff whiteboard challenges and reviewing process.
	June 30, 2008 1. Patient whiteboards 2. Discharge Posters 3. Pt Info brochure 4. Patients in Motion 5. D/C notification 24-48 hr in advance 6. Streamline LTCH transfer documentation	1. Positive feedback for pt whiteboards and increase trial size. 2. Discharge Posters not visible enough and revising. 3. Pt info brochure - adding pt safety hand hygiene 4. PIM - trialing with pts, recruiting volunteers. 5. Increased d/c notification by some physicians 6. mtg with LTCH re processes
	September 30, 2008 1. ALC Flow Map 2. ALC Kardex/care plan 3. D/C Matrix decision tool 4. Staff education re ALC care planning. 5. Streamline d/c med reconciliation	
b) Successful partnership with NSM CCAC in the provision of the TCC role(discharge planning & CCAC case management) to maintain/promote optimal bed utilization and best practice patient care coordination for transition to community. (Miriam Luddington)	June 30, 2008 Mtg with CCAC senior mgr: review documentation process, identify efficiencies; discuss increased case mgmt role responsibility- staff coverage	Documentation duplication reduced. Relief and full time staff coverage challenges at SMMH site, with backlog of TCC referrals. Utilization focus for EDD and ALC status challenges at SMMH site.
	September 30, 2008 Mtg with CCAC senior mgrs: discuss staffing challenges and changing TCC role responsibilities.	

PREVALENCE, DEVELOPMENT & USE OF CLINICAL PATHWAYS

Interpretation

The development and use of standardized protocols for the diagnosis and treatment of a broad range of relatively common clinical conditions and procedures. This indicator measures the extent to which the organization demonstrates use of an evidence-based approach.

2008-2009

<i>Quarter</i>	<i>Protocol</i>	<i>Committee</i>	<i>Progress/Action</i>	<i>Expected MAC Approval Date</i>	
Q1 Jul to Sep '08	Standard Post Partum Orders for Obstetrical Patients	Obstetrics Committee	In progress	20-Oct-08	
	Newborn Eye Prophylaxis Policy	Obstetrics Committee	In progress	20-Oct-08	
	Protocol for Forceps Delivery	Obstetrics Committee	In progress	20-Oct-08	
	Protocol for Vacuum Delivery	Obstetrics Committee	In progress	20-Oct-08	
	Protocol for Examination of Placenta	Obstetrics Committee	In progress	20-Oct-08	
	Protocol for Physician Attendance at Delivery	Obstetrics Committee	In progress	20-Oct-08	
	<u>Emergency Department Medical Directives:</u>				
	Administration of Acetaminophen and Ibuprofen (Paediatrics)	Emergency Dept. Committee	In progress	20-Oct-08	
	Administration of ASA (Adult)	Emergency Dept. Committee	In progress	20-Oct-08	
	Administration of Fentanyl for Pain	Emergency Dept. Committee	In progress	20-Oct-08	
	Administration of Inhalations (Paediatrics)	Emergency Dept. Committee	In progress	20-Oct-08	
	Administration of Oral Ondansetron for Nausea and Vomiting (Paediatrics)	Emergency Dept. Committee	In progress	20-Oct-08	
	Administration of Oxygen (Paediatrics)	Emergency Dept. Committee	In progress	20-Oct-08	
	Administration of Salbutamol & Atrovent (Adult)	Emergency Dept. Committee	In progress	20-Oct-08	
	Administration of Tetanus & Diphtheria Toxoid (TD)	Emergency Dept. Committee	In progress	20-Oct-08	
	Administration of Topical Anaesthetics	Emergency Dept. Committee	In progress	20-Oct-08	
	Application of EMLA (Paediatrics)	Emergency Dept. Committee	In progress	20-Oct-08	
	CTAS 5 Directive	Emergency Dept. Committee	In progress	20-Oct-08	
	Diagnostic Imaging - Xray (Ankle)	Emergency Dept. Committee	In progress	20-Oct-08	
	Diagnostic Imaging - Xray (Foot)	Emergency Dept. Committee	In progress	20-Oct-08	
	Diagnostic Imaging - Xray (Knee)	Emergency Dept. Committee	In progress	20-Oct-08	
	Eye Irrigation	Emergency Dept. Committee	In progress	20-Oct-08	
	IV Insertion	Emergency Dept. Committee	In progress	20-Oct-08	
	Lab - 12 Lead ECG	Emergency Dept. Committee	In progress	20-Oct-08	
	Lab - Capillary Blood Glucose	Emergency Dept. Committee	In progress	20-Oct-08	
Lab - Cardiac Markers	Emergency Dept. Committee	In progress	20-Oct-08		
Lab - Coagulopathy	Emergency Dept. Committee	In progress	20-Oct-08		
Lab - POCT Urine	Emergency Dept. Committee	In progress	20-Oct-08		
Lab - Pregnancy Testing	Emergency Dept. Committee	In progress	20-Oct-08		
Oxygen Administration (Adult)	Emergency Dept. Committee	In progress	20-Oct-08		
Paediatric Catheterization	Emergency Dept. Committee	In progress	20-Oct-08		
Protocol for Oral Rehydration - Paediatrics	Emergency Dept. Committee	In progress	20-Oct-08		
Time Limited Emergency Department Admission Orders	ED, QC and P&T Committees	Complete	15-Sep-08		
Proton Pump Inhibitors Automatic Substitution Policy	Pharmacy & Therapeutics Committee	Complete	15-Sep-08		
Nitroglycerin Administration Guidelines	Pharmacy & Therapeutics Committee	Complete	15-Sep-08		
Q1 Apr-Jun '08	Standard Post Partum Orders for Obstetrical Patients	Obstetrics Committee	In progress	19-Oct-08	
	Newborn Eye Prophylaxis Policy	Obstetrics Committee	In progress	19-Oct-08	
	Standard Orders for Post-Operative Epidural / Spinal	Obstetrics Committee	In progress	19-Oct-08	
	Epidural Removal Policy	Obstetrics Committee	Complete	16-Jun-08	
	Total Parenteral Nutrition Pre-printed Orders	Pharmacy & Therapeutics Committee	Complete	16-Jun-08	
	Laxative Protocol	Pharmacy & Therapeutics Committee	In progress	-	
	Routine Coronary Care Orders	Pharmacy & Therapeutics Committee	Complete	21-Apr-08	
	Full Dose Heparin Order Sheet	Pharmacy & Therapeutics Committee	Complete	21-Apr-08	
	Clinical Pathway Ischemic Stroke Routine Physician's Orders	Stroke Best Practice Implementation Council	Complete	21-Apr-08	
	Weight Monitoring Policy & Procedure	Food & Nutrition Services	Complete	26-May-08	
	Nutrition & Hydration Policy & Procedure	Food & Nutrition Services	Complete	26-May-08	
	Food & Fluid Intake Policy & Procedure	Food & Nutrition Services	Complete	26-May-08	
	Referral to Dietitian Policy & Procedure	Food & Nutrition Services	Complete	26-May-08	
	Time Limited Admission Orders	ED, QC and P&T Committees	In progress	15-Sep-08	
	Asthma Care Map	Emergency Department Committee	In progress	-	
	Medical Directive: Ultrasound Technologist Impressions	Emergency Department Committee	In progress	15-Sep-08	
	Acute Coronary Syndrome	Emergency Department Committee	On Hold	-	
	Ectopic Pregnancy	Emergency Department Committee	On Hold	-	
	Spontaneous Abortions	Emergency Department Committee	On Hold	-	
	Emergency Department Directives	Emergency Department Committee	In progress	-	
	Pressure Related Wound Care Guidelines	Nursing	Complete	16-Jun-08	
	Pressure Related Wound Care Chart – Assessment and Treatment	Nursing	Complete	16-Jun-08	
	Wound Assessment Documentation Tool	Nursing	Complete	16-Jun-08	
	2007-2008				
	Q4 Jan-Mar'08	Standard Post Partum Orders for Obstetrical Patients	Obstetrics Committee	In progress	-
Standard Orders for Post-Op Caesarean Sections		Obstetrics Committee	Complete	17-Mar-08	
Standard Orders for Post-Operative Epidural / Spinal					
Analgesic		Obstetrics Committee	In progress	-	

	Epidural Removal Policy	Obstetrics Committee	In progress	-	
	Laxative Protocol	Pharmacy & Therapeutics Committee	In progress	-	
	Routine Coronary Care Orders	Pharmacy & Therapeutics Committee	In progress	21-Apr-08	
	Full Dose Heparin Order Sheet	Pharmacy & Therapeutics Committee	In progress	21-Apr-08	
	Reduced Dose Heparin Order Sheet	Pharmacy & Therapeutics Committee	Complete	21-Jan-08	
	Thrombolytic Therapy for STEMI	Pharmacy & Therapeutics Committee	Complete	21-Jan-08	
	Eptifibatide (Integrillin)	Pharmacy & Therapeutics Committee	Complete	21-Jan-08	
	Acute Coronary Syndrome	Emergency Medicine Committee	In progress	-	
	Ectopic Pregnancy	Emergency Medicine Committee	In progress	-	
	Spontaneous Abortions	Emergency Medicine Committee	In progress	-	
	Emergency Department Directives	Emergency Medicine Committee	in progress	-	
	Professional Staff Rules and Regulations	Medical Advisory Committee	Complete	17-Mar-08	
Q3	Oct-Dec '07	Magnesium Sulphate Infusion Protocol	Obstetrics Committee	Complete	15-Oct-07
		Standard Admission Orders for Obstetrical Patients	Obstetrics Committee	Complete	15-Oct-07
		Standard Orders for Oxytocin Induction Protocols #1 & 2	Obstetrics Committee	Complete	15-Oct-07
		Standard Post Partum Orders for Obstetrical Patients	Obstetrics Committee	In progress	-
		Standard Orders for Post-Op Caesarean Sections	Obstetrics Committee	In progress	-
		Standard Orders for Misoprostol Induction of Labour	Obstetrics Committee	Complete	17-Dec-07
		Standard Orders - Neonatal	Obstetrics Committee	Complete	17-Dec-07
		Standard Orders: Scheduled/Emergency C-Section Pre-Anaesthetic Procedure	Obstetrics Committee	Complete	17-Dec-07
		Laxative Protocol	Pharmacy & Therapeutics Committee	In progress	-
		Routine Coronary Care Orders	Pharmacy & Therapeutics Committee	In progress	21-Jan-08
		Full Dose Heparin Order Sheet	Pharmacy & Therapeutics Committee	In progress	21-Jan-08
		Reduced Dose Heparin Order Sheet	Pharmacy & Therapeutics Committee	In progress	21-Jan-08
		Thrombolytic Therapy for STEMI	Pharmacy & Therapeutics Committee	In progress	21-Jan-08
		Eptifibatide (Integrillin)	Pharmacy & Therapeutics Committee	In progress	21-Jan-08
		Diet Orders	Dysphagia Management Team	Complete	17-Dec-07
		Acute Coronary Syndrome	Emergency Medicine Committee	In progress	-
		Ectopic Pregnancy	Emergency Medicine Committee	In progress	-
		Spontaneous Abortions	Emergency Medicine Committee	In progress	-
		Emergency Department Directives	Emergency Medicine Committee	in progress	-
Q2	Jul-Sept '07	Magnesium Sulphate Infusion Protocol	Obstetrics Committee	In progress	15-Oct-07
		Standard Admission Orders for Obstetrical Patients	Obstetrics Committee	In progress	15-Oct-07
		Standing Orders for Oxytocin Induction Protocols #1 & 2	Obstetrics Committee	In progress	15-Oct-07
		Standing Post Partum Orders for Obstetrical Patients	Obstetrics Committee	In progress	-
		Standing Orders for Post-Op Caesarean Sections	Obstetrics Committee	In progress	-
		Clinical Pathway for Managing Still Birth	Obstetrics Committee	In progress	-
		Laxative Protocol	Pharmacy & Therapeutics Committee	In progress	15-Oct-07
		Acute Coronary Syndrome	Emergency Medicine Committee	In progress	-
		Ectopic Pregnancy	Emergency Medicine Committee	In progress	-
		Spontaneous Abortions	Emergency Medicine Committee	In progress	-
		Emergency Department Directives	Emergency Medicine Committee	in progress	-
Q1	Apr-June '07	LHIN 12 Pre-printed Orders – Palliative Care	Pharmacy & Therapeutics Committee	Complete	28-May-07
		MRSA De-Colonization Standing Orders	Pharmacy & Therapeutics Committee	Complete	28-May-07
		MAHC Potassium Chloride Policy	Pharmacy & Therapeutics Committee	Complete	28-May-07
		Magnesium Sulphate Infusion Protocol	Obstetrics Committee	In progress	-
		Standing Post Partum Orders for Post-Op Caesarean Sections	Obstetrics Committee	In progress	-
		Cord Blood Gas Collection Protocol	Obstetrics Committee	In progress	-
		Clinical Pathway for Managing Still Birth	Obstetrics Committee	In progress	-
		Acute Coronary Syndrome	Emergency Medicine Committee	In progress	-
		Ectopic Pregnancy	Emergency Medicine Committee	In progress	-
		Spontaneous Abortions	Emergency Medicine Committee	In progress	-
		Emergency Department Directives	Emergency Medicine Committee	in progress	-
2006-2007					
Q4	Jan-Mar'07	Emergency Department Directives	Emergency Medicine Committee	In progress	
Q3	Oct-Dec'06	Emergency Department Directives	Emergency Medicine Committee	In progress	
Q1	Apr-June '06	Fentanyl Analgesia Protocol	Emergency Medicine Committee	Complete	Apr-06
		Pediatric Urethral Catheterization Protocol	Emergency Medicine Committee	Complete	Apr-06

RELEVANCE: The development and use of clinical pathways provides consistent excellence in quality of care by standardizing care practices which reflect best practice.

TARGET:

SOURCE: Senior Management

QUADRANT: System Coordination and Integration

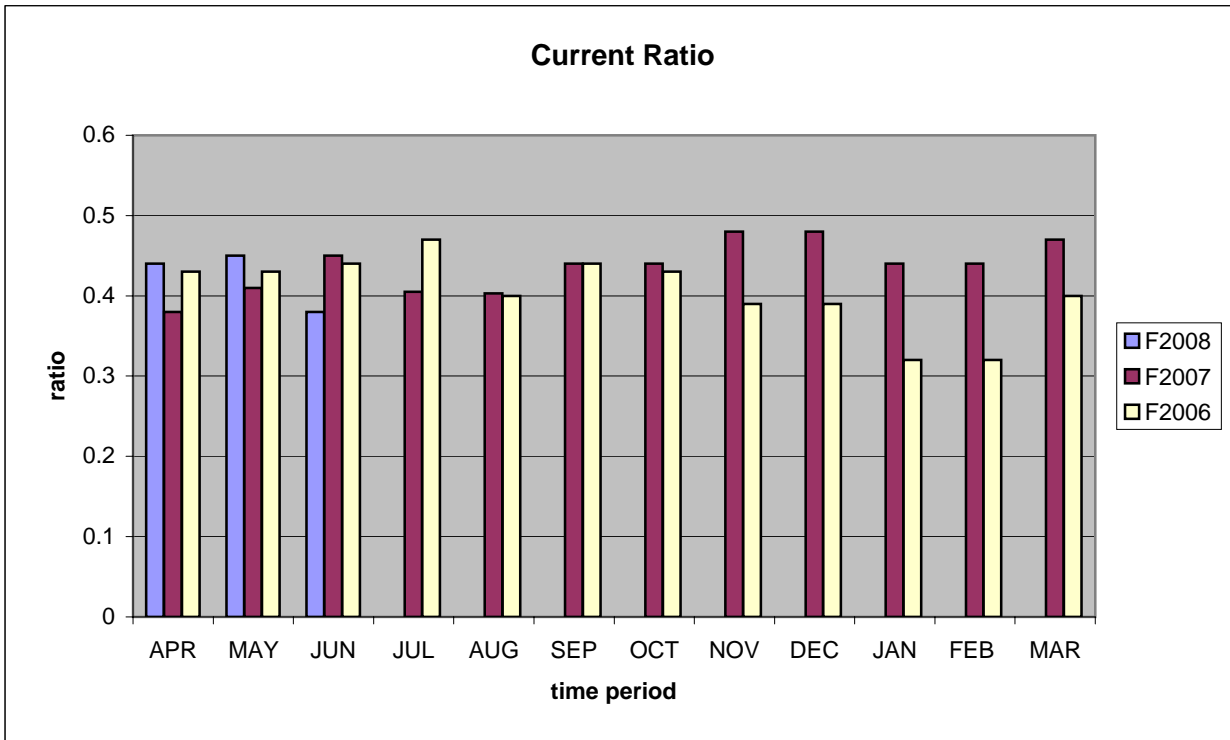
CURRENT RATIO

INTERPRETATION:

Standard Met?- NO Action required?- YES

We are tracking significantly less than the HAA expected values. The current ratio will stay below '1' until we begin to pay off the debt that has been incurred over the past few years.

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
F2008	0.44	0.45	0.38									
F2007	0.38	0.41	0.45	0.405	0.403	0.44	0.44	0.48	0.48	0.44	0.44	0.47
F2006	0.43	0.43	0.44	0.47	0.4	0.44	0.43	0.39	0.39	0.32	0.32	0.4



RELEVANCE: Current Ratio is a liquidity indicator. Liquidity indicators measure how well the hospital is managing its current assets (those that could be converted to cash within a year) and current liabilities (wages, supplier's bills, and other expenses which must be paid within a year). Hospital's with greater liquidity have more financial flexibility, particularly with respect to buying equipment. Current Ratio represents the number of times its short-term obligations can be paid using the hospitals short-term assets. A current ratio of one or greater means that current liquid assets are greater than the current liabilities that exist.

A higher value indicates greater liquidity, a lower value indicates lesser liquidity. If the Current Ratio is less than 1, the hospital has insufficient current assets to cover its current liabilities.

TARGET: a current ratio of 1 or greater; Ontario average for 2001-2002 was .95

FORMULA:

SOURCE: CFO

QUADRANT: Financial Health

TOTAL MARGIN

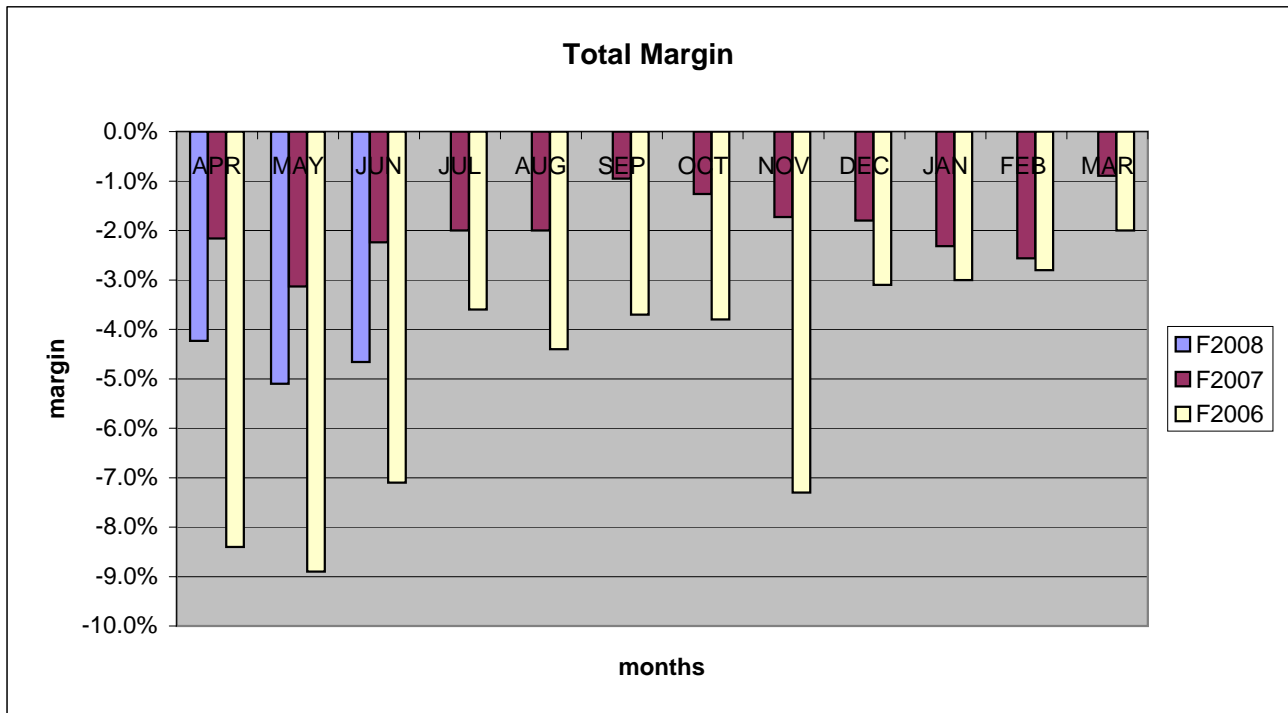
INTERPRETATION:

Standard Met? No Action Required? Yes

MAHC continues to show an operating deficit for the first three months of the 0809 fiscal year with the resulting negative margins.

Data Table

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
F2008	-4.2%	-5.1%	-4.7%									
F2007	-2.16%	-3.13%	-2.24%	-2.00%	-2.00%	-0.95%	-1.26%	-1.73%	-1.80%	-2.32%	-2.56%	-0.89%
F2006	-8.4%	-8.9%	-7.1%	-3.6%	-4.4%	-3.7%	-3.8%	-7.3%	-3.1%	-3.0%	-2.8%	-2.0%



RELEVANCE: This Total Margin indicator measures the financial viability of the hospital. Financial viability refers to the hospital's ability to fund growth, new programs, working capital needs and new equipment through an excess of revenues over expenses. A positive value indicates that revenues exceed expenses; a negative indicates that expenses exceed revenue. Since MAHC is a not-for-profit organization, total revenues should be slightly more than total expenses.

TARGET: 0%

FORMULA: Total Revenues - (Total Expenses - facility Amortization) x 100 divided by Total Revenues (excluding Other Votes), OHIP Revenue, Grants, Donations, Interdepartmental Recoveries

SOURCE: CFO

QUADRANT: Financial Health