MOHLTC - HSAPD
ER/ALC Quarterly Stocktake Report

DIRECTION · ACCOUNTABILITY · REPORTING

Purpose of this report

The Quarterly Stocktake Report demonstrates Ontario's progress towards the goals of the ER/ALC Strategy at the provincial and LHIN levels. It reports on measures that are reported to the public, as well as the system and supplementary measures outlined in agreements between each LHIN and the MOHLTC. It also provides supplementary data to provide more insight into current performance levels.

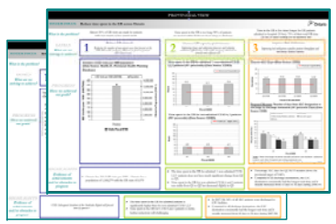
The Quarterly Stocktake Report is used to drive transparent performance discussions between the ADM of the HSAPD and LHIN CEOs at the quarterly MOHLTC-LHIN Results meetings.

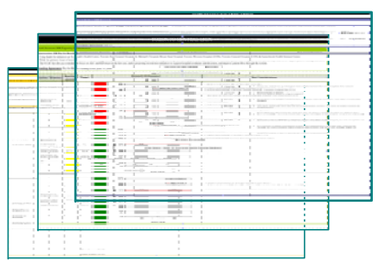
Populating this report

The LHIN CEOs are accountable for ensuring the Report for their respective LHIN is completed each quarter. Access to Care (ATC) will populate all standardized measures in the Report, however the ER/ALC LHIN Performance Lead in each LHIN is responsible for requesting/obtaining any supplementary performance information they feel should be included. This may be negotiated with ATC or other LHIN stakeholders as required. The LHIN Leads are also responsible for documenting explanations and interpretations of the populated information.

It is recognized that the timeliness of the data reported influences the meaningfulness of the Stocktake. The data used to populate the Stocktake will evolve to become more timely as initiatives under the ER/ALC Information Strategy are implemented. Specifically, enhancements to the WTIS and EDRS systems, which are scheduled for completion by summer 2010, will improve the currency of the data reported.

Components of the Report





PROVINCIAL VIEWS (pgs 2 & 3)

- Illustrates performance across Ontario as a whole as well as broken down by LHIN
- Consistently reports on the set system measures associated with the 3 goals of the ER/ALC strategy
- Highlights areas of significant progress and opportunities for improvements

LHIN VIEW (pg 5)

- Illustrates performance within the LHIN
- Consistently reports on the set system measures associated with the 3 goals of the ER/ALC strategy
- Highlights areas of significant progress and opportunities for improvement

DETAILED LHIN VIEWS (pgs 7-10)

- Illustrates performance within the LHIN against each of the 3 goals of the ER/ALC strategy by intervention/strategy
- Consistently reports on the set supplementary measures associated with each intervention/strategy (defined in accountabilities)
- Provides interpretations and explanations of performance associated with each intervention/strategy

Key Terms & Definitions

INTERVENTION

- A lever used to achieve an improvement in performance (e.g. funding)

MEASURES

- A calculation that illustrates progress in achieving a goal or objective; Synonym: indicator
- 2 types:

System Measures

- A limited set of highlevel measures directly linked to the goals of the strategy

Supplementary Measures

- A set of measures associated with a specific intervention/strategy that are indirectly linked to one or more overarching goals of the strategy

Ontario

PROVINCIAL VIEW

SYSTEM FOCUS: **Reduce time spent in the ER across Ontario**

Ontario

What is the problem?

Almost 50% of ER visits are made by patients with non-urgent or less urgent needs

Time spent in the ER is too long: 90% of patients are treated within 9.4 hours from triage to discharge

Time in the ER is five times longer for ER patients admitted to hospital (35 hrs); 75% of their total ER time (26 hrs) is spent waiting for an inpatient bed

GOALS

What are we striving to achieve?

1 Reduce ER demand

Reducing the number of non-urgent cases that present at the ER will enable emergency clinicians to focus on patients with critical needs

2 Increase ER capacity/performance

Improving triage and admission processes and reducing ambulance offload times will enable emergency clinicians to provide more efficient care

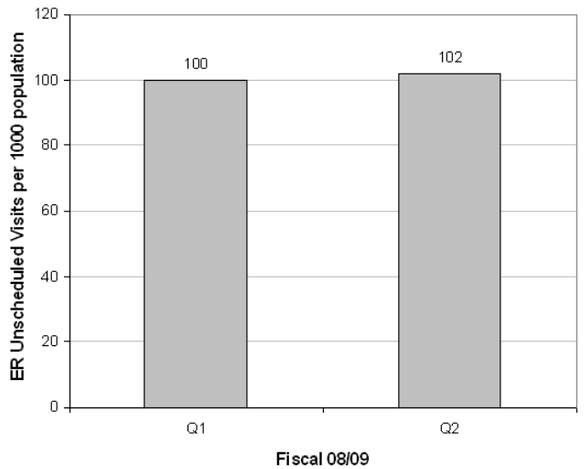
3 Improve Bed Utilization

Improving bed utilization expedites patient throughput and maximizes hospital capacity

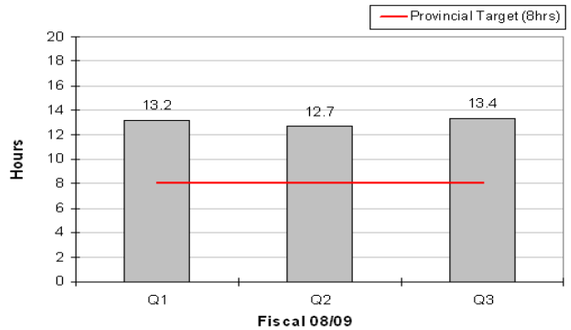
PROGRESS

Have we achieved our goals?

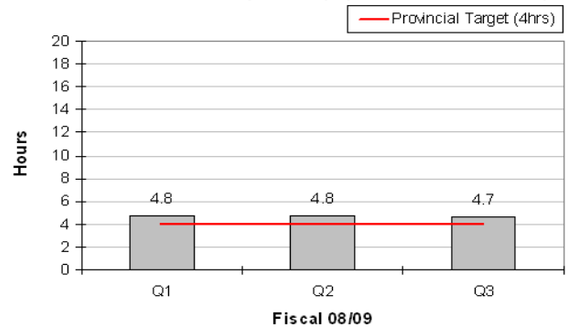
Number of ER Unscheduled Visits by quarter per 1000 population (Data Source: MoHLTC Provincial Health Planning Database & CIHI-NACRS)



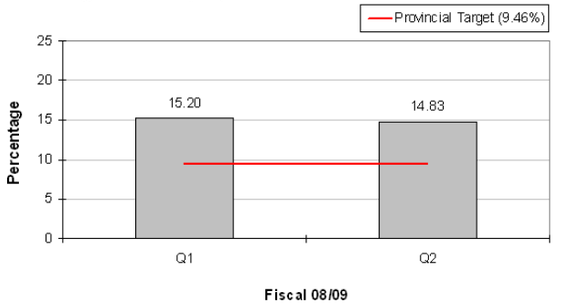
Time spent in the ER for high acuity patients (all admitted + non-admitted CTAS I, II, III patients). (Data Source: EDRS)



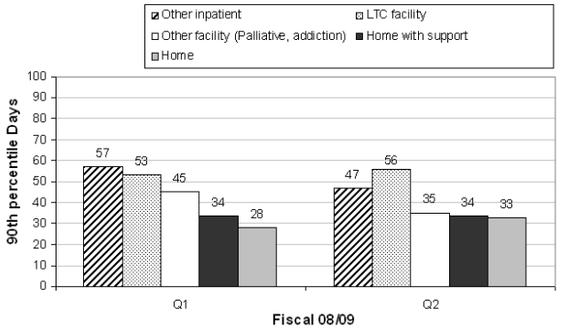
Time spent in the ER for low acuity patients (non-admitted CTAS IV & V patients). (Data Source: EDRS)



Percentage ALC Days (Data Source: CIHI-DAD)



<u>Proposed Measure</u>: Number of days from ALC designation to discharge by discharge disposition (90th percentile Days) (Data Source: CIHI-DAD)



<u>Note</u>: Patients discharged against medical advice and those who died are excluded from analysis. Q1 and Q2 08/09 has not been finalized by CIHI. Provincial target TBD.

HIGHLIGHTS

Evidence of achievements and/or obstacles to progress

- The number of ER unscheduled visits per 1000 population for Ontario has slightly increased in Q2 08/09 as compared to Q1. Estimated population for the Province of Ontario for 2008 was 12,919,572 and the estimated number of ER visits is approximately 5,100,000 for 08/09.

- The Provincial time spent in the ER for high acuity and low acuity patients has not significantly changed in Q3 from Q2 08/09. Pay for Results sites have seen more improvements than the rest of the EDRS sites.

- Percentage ALC days decreased slightly for Q2 08/09 but remains above the provincial target of 9.46%.
- Number of ALC days for patients waiting for Long Term Care has increased from 53 days in Q1 to 56 days in Q2 08/09.

PROVINCIAL VIEW BY LHIN

SYSTEM FOCUS: **Reduce time spent in the ER across Ontario**

Ontario

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PROGRESS
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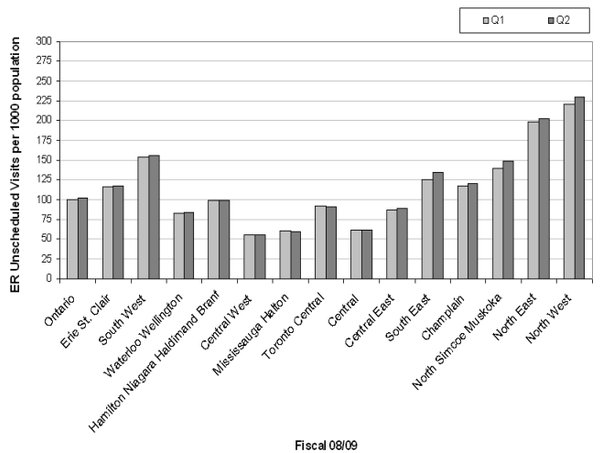

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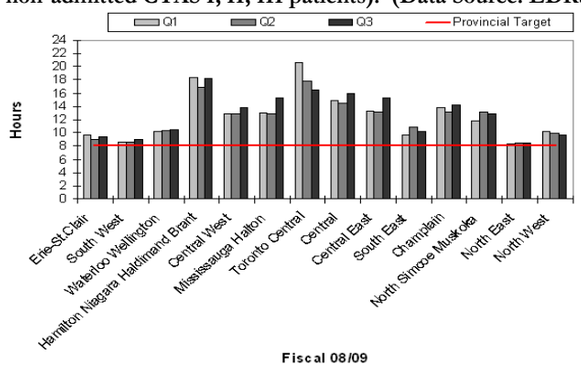
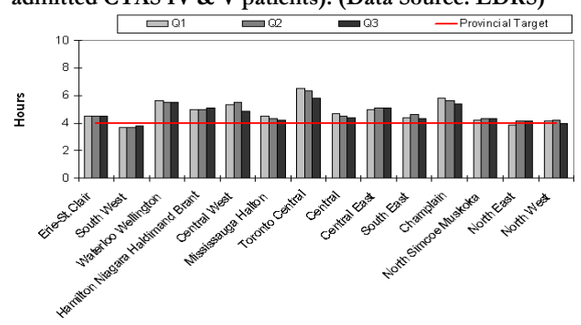
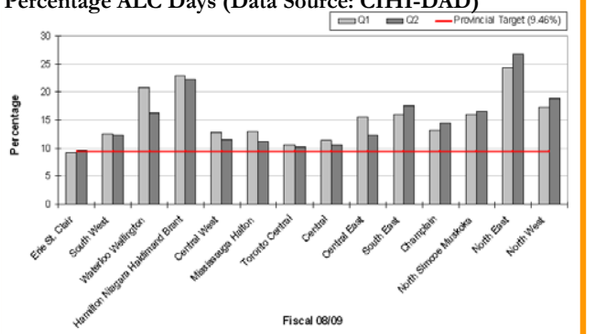


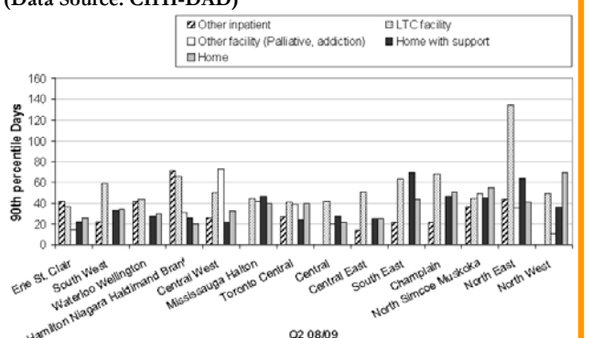
Time spent in the ER for low acuity patients (non-admitted CTAS IV & V patients). (Data Source: EDRS)



Percentage ALC Days (Data Source: CIHI-DAD)



<u>Proposed Measure</u>: Number of days from ALC designation to discharge by discharge disposition (90th percentile Days) (Data Source: CIHI-DAD)



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HIGHLIGHTS
Evidence of achievements and/or obstacles to progress

- In comparison to all the LHINs, NW LHIN has the highest number of ER visits per 1000 population, 221 visits per 1000 and 229 visits per 1000 in Q1 and Q2 08/09 respectively. CW LHIN has the lowest number of ER visits per 1000 population in comparison to all the LHINs, with 56 ER visits per 1000 in both Q1 and Q2 08/09.

- For high acuity patients, majority of the LHINs have not significantly changed in performance. The TC LHIN has seen the most improvement from 20.6 hours in Q1 to 16.5 hours in Q3 08/09. The MH LHIN's time spent in the ER for high acuity patients increased significantly from Q1 to Q3 08/09 (13 hours in Q1 to 15.3 hours in Q3).
- For low acuity patients, majority of LHINs have seen a decrease in the time spent in the ER. The SW LHIN has the shortest (3.8 hours) and the TC LHIN has the longest time spent in the ER for this category. However, the TC LHIN has seen the most improvement from 6.5 hours in Q1 to 5.8 hours in Q3.

- Percentage of ALC days remains relatively unchanged for majority of LHINs in Q2 2008/09.
- Number of ALC days for patients waiting for Long Term Care is consistently high for the majority of LHINs.

MOHLTC - HSAPD
ER/ALC Quarterly Stocktake Report

LHIN:	Erie St. Clair LHIN
Report Date:	April, 2009

Ontario

LHIN VIEW: ERIE ST. CLAIR LHIN

SYSTEM FOCUS: **Reduce time spent in the ER across Ontario**

Ontario

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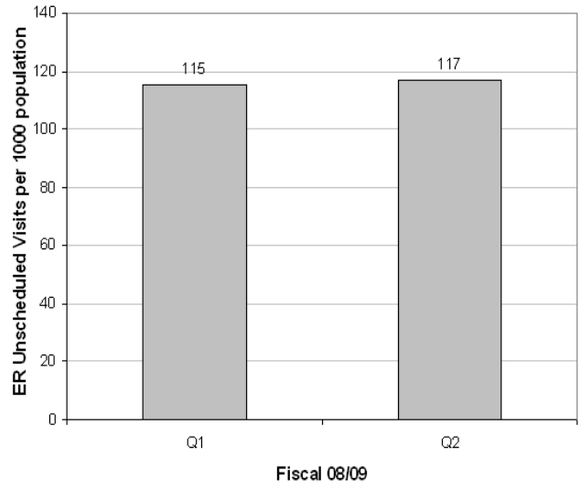

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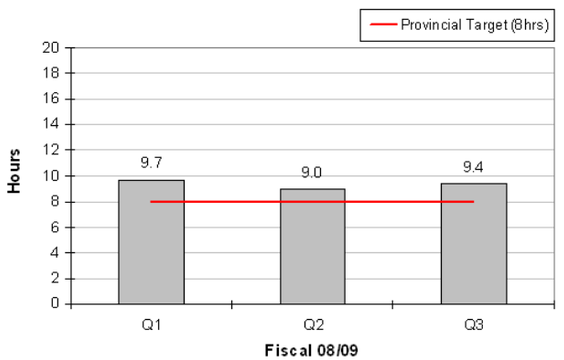

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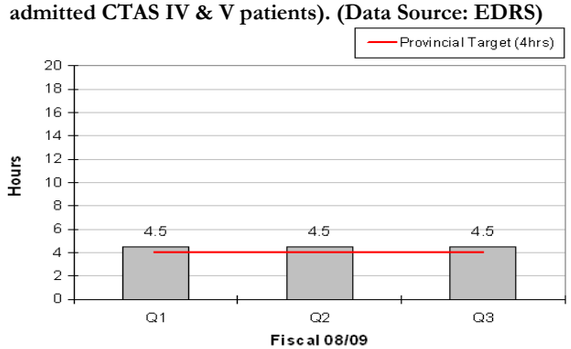

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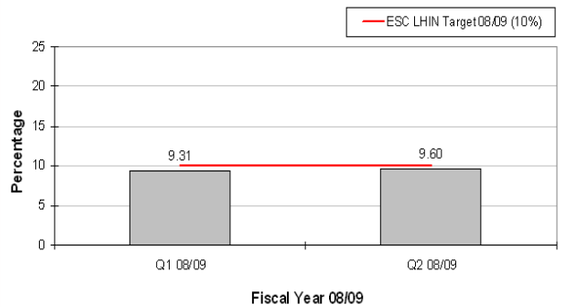

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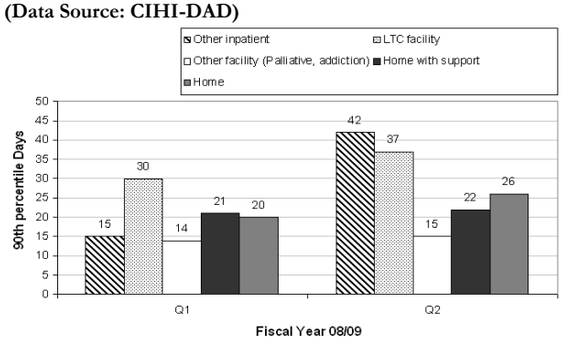

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HIGHLIGHTS
Evidence of achievements and/or obstacles to progress

- There is a wide variation in hospital use of Emergency Departments (EDs) for non-urgent Canadian Triage Acuity Scale (CTAS) 4 and 5 levels. The Erie St. Clair (ESC) LHIN small EDs show high volumes per 1,000 population.
- The ESC LHIN is currently undergoing a Small ED study, as well as pursuing a Family Health Team (FHT) expansion proposal and development of Community Health Centre (CHC) in Chatham-Kent (C-K)
- Our main concern is Leamington District Memorial Hospital (LDMH), as their wait times are the highest according to Q3 2007/08 EDRS data.

- There is a wide variation in wait times for CTAS 1, 2 and 3 in the ESC LHIN. Hôtel-Dieu Grace Hospital (HDGH) and LDMH have the highest wait times.
- Priority should be given to HDGH as they are our second highest in volumes for CTAS 1, 2 and 3.
- Given the occupancy and Alternate Level of Care (ALC) pressures at Sarnia's Bluewater Health (BWH) and LDMH, additional focus will be required in Sarnia and Leamington, respectively. Pay for Results (P4R) is already in place at Windsor Regional Hospital (WRH) and is being monitored for expected outcomes.

- Long-Term Care (LTC) median time to placement has increased in Q2 and Q3 with some relief seen in February 2008.
- The ESC Community Care Access Centre (CCAC) deficit has made it difficult for additional extenuating circumstances services to be offered to patients in the community. Without these services, patients feel less comfortable staying in the community and have requested to be placed on LTC wait lists. This is especially apparent in Windsor/Essex (W/E).
- In addition, the first available bed policy is not being utilized consistently across the ESC LHIN.

GUIDE: ER/ALC Interventions within ERIE ST. CLAIR LHIN

	Interventions	Page
Reduce ER demand	➢ Aging at Home (AAH) and Urgent Priorities Fund (UPF)	Page 7
Increase ER capacity/performance	➢ Pay-for-Results (P4R) Y1	Page 8
	➢ Pay-for-Results (P4R) Y2	Page 9
Improve Bed Utilization	➢ Aging at Home (AAH) and Urgent Priorities Fund (UPF)	Page 10

LEGEND: Interpreting intervention performance

Supplementary Measures	Baseline	Target	Quarterly Performance	Key Considerations
• A set of measures associated with a specific intervention/ strategy that are indirectly linked to one or more overarching goals of the strategy	The determined baseline will be inserted here and will remain the same each quarter	The determined target will be inserted here and will remain the same each quarter	Illustrates current performance with respect to the supplementary measure against defined targets. Graphs/charts are inserted by Access to Care. The red, amber and green color coding of performance results is a visual guide that allows users to easily identify their performance relative to the specified target for a particular indicator; there will be a selected target for each supplementary measure associated with an intervention. Indicators included in the MLAA will be coloured accordingly to the LHIN corridors. Doing Well – Below Corridors & LHIN Starting Point Improving – In Corridors & Equals or below LHIN Starting Point Monitor – In Corridors & above LHIN Starting Point Attention – Above Corridors, Reporting Required Additional indicators will be coloured according to the following corridors. Green: performance result meets or exceeds the specified target Amber: performance result is less than or equal to 10% from the specified target Red: performance result is more than 10% from the specified target	Explains current performance and what proposed changes could be put in place to improve performance. Information is inserted by LHIN. (These are guiding questions only)

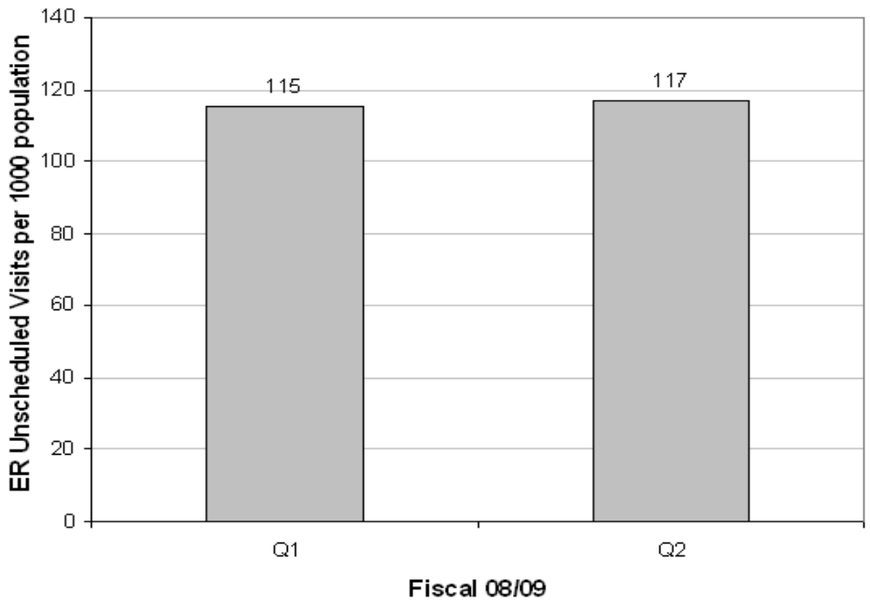
ERIE ST. CLAIR LHIN

Goal: Reduce ER Demand

ED Reduction Strategies

- Aging at Home
- Psycho-Geriatric Outreach Teams in Chatham-Kent Health Alliance (CKHA) and BWH plus the WRH expansion of Psycho-Geriatric Resource Consultant (PRC) Teams
- Ten Geriatric Emergency Nurses (GEM RNs) in ESC LHIN EDs (6 for Windsor/Essex, 2 for Chatham-Kent and 2 for Sarnia/Lambton)
- Friendly Visits/Security Check linked to GEM RNs – Identify high risk seniors requiring on-going safety check and reduce isolation
- Rapid Response Teams – (Rehab, Geriatric and End Of Life)
- Crisis Intervention – Target "hard to serve" seniors and ED links to Community Support Services (CSS) and provide a means of addressing elder abuse
- Transitional Care – Target "well" LTC resident's transition back to the community to free up needed LTC beds
- Ambulation Team – HDGH and WRH

Ontario

Supplementary Measures	Quarterly Performance	Key Considerations
Number of ER Unscheduled Visits by quarter per 1000 population	 (Data Source: MoHLTC Provincial Health Planning Database & CIHI-NACRS)	• The ESC LHIN is the second highest under serviced area in the province for family Physicians therefore, ED visits that could be managed elsewhere are significantly higher. Chatham-Kent and Sarnia/Lambton do not have Walk-in Clinics or Urgent Care Centres. Coupled with this fact, ESC LHIN has a lower proportion of Family Health Teams and Community Health Centres. • Low acuity patient management by Nurse Practitioners in WRH ED. • Current strategies include the following: - Expanding Family Health Teams via Wave Four; supporting the development of new Community Health Centres in Chatham-Kent and the new Nurse Practitioner (NP) Led Clinic in Belle River. - Linking Schedule 1 discharged unattached patients to CHC (specializing in Seriously Mentally ill). Through identification of unattached ED frequent visitor postal code information, the patient will be coordinated with the nearest Family Health Team and CHC in ESC LHIN thus, addressing this indicator and care closer to home.

ERIE ST. CLAIR LHIN

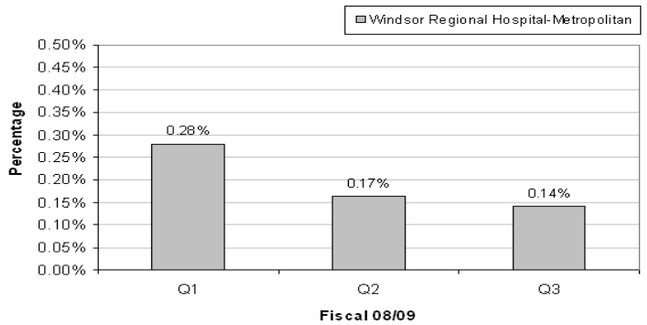
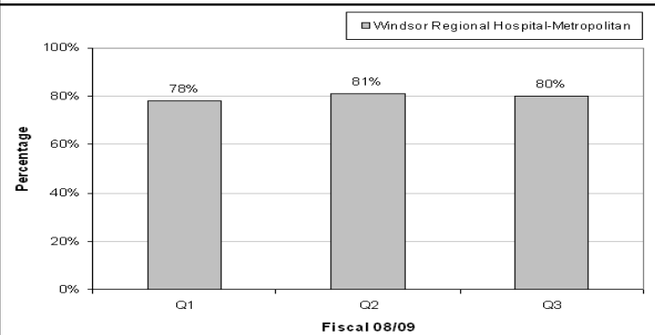
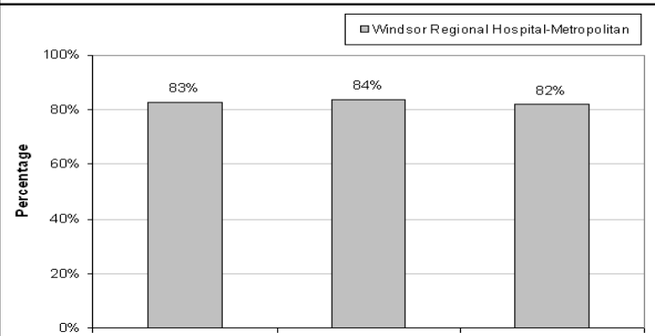
Goal: Increase ER Capacity/Performance

- Lean/six sigma process improvement techniques to evaluate and streamline service delivery procedures
- Implementation of appropriate patient placement within the ED for specified assessment and treatments
- Redeployment of physicians within the department including Physician Triage, also aligned with RN redeployment
- Increased access to Computerized Tomography (CT) scanning services beyond base funded hours
- Implementation of ambulance to offload nursing position
- Access to physician clinical services/management of admitted patients and utilization of inpatient beds
- ED patient flow redesign/elimination of external waiting room
- Installation of computerized ED information systems "Tracking Boards & Isis Pro"
- Additional Nurse Practitioners for CTAS 4 and 5
- Increased coverage/access to diagnostic and therapeutic services
- Ten GEMs in July 2009 will help streamline ED visits for 65+
- The following are needed and are currently in the planning stages:

** 24/7 Psychiatric Assessment Nurses

** Urgent Care/next day Mental Health (MH) clinics to divert ED MH patients from EDs

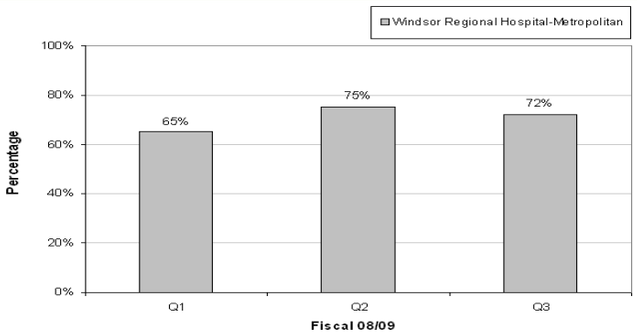
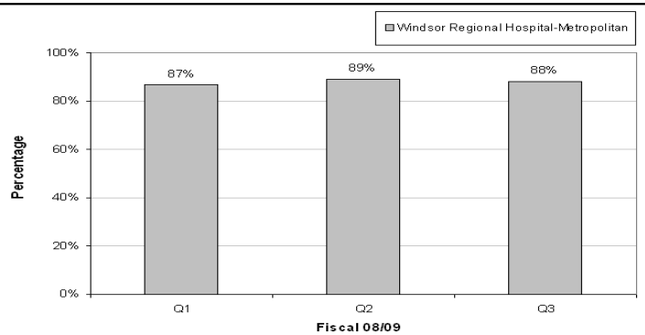
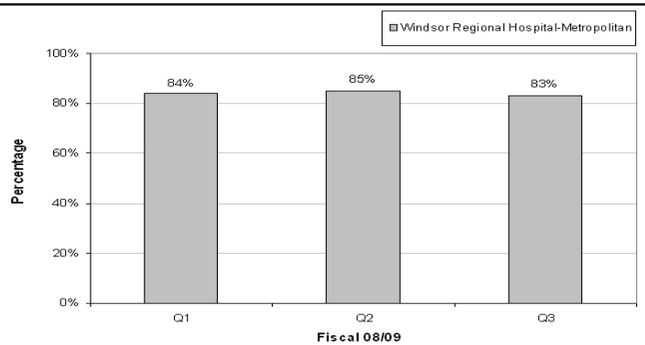
Ontario

Supplementary Measures	Baseline (Q3/Q4 07/08)	Target	Current Performance	Quarterly Performance (Data Source: EDRS)	Key Considerations
Proportion of ED-LOS exceeding 24 hrs	0.58%	No more than 2% of total volume by end of FY 08/09	0.14%		• Utilization RNs are using tracking boards and liaising with physicians, admitting, housekeeping and units to expedite the flow of patient through the department, resulting in a decreasing Length of Stay (LOS). • ESC LHIN is ten fold better than the province for % > 24 hrs, and while the province has been stable, WRH continues to improve. • The ESC LHIN has engaged with the CCAC, CHCs, FHTs, Canadian Mental Health Associations (CMHAs) and all five hospitals to discuss the following: - Prevention of admission - NP Outreach Teams to LTC – Support – Education (WRH and HDGH) - Linking unattached patients via postal codes FHT/CHC.
Proportion of CTAS I & II patients treated within ≤8 hours and within ≤6 hours for CTAS III	78%	5% Improvement in Q3/Q4 07/08	80%		• Compared to the province, ESC LHIN has 27% more patients seen within target wait times in ED for CTAS 1, 2 and 3 • Access to additional CT support on weekends has proved to decrease LOS in the ED for CTAS 1, 2 and 3 patients by 2.5%. This decrease in LOS is predicted to continue. Expand the Emergency Medical Service (EMS) offload nursing coverage to 12hrs X 7 days. Decrease the LOS for CTAS 1, 2 and 3. Charge nurses now freed up to take responsibility for patient flow through the ED. • WRH has improved 6% from baseline; however, BWH is our top performer for CTAS 1, 2 and 3 at 8.4 hours. In contrast, HDGH and LDMH are at approximately 12.7 hours for CTAS 1, 2 and 3. • One of the poor performer sites that have not seen improvement is HDGH. Discussions are underway with HDGH regarding the Mental Health Strategy for unattached patients to be connected to FHTs and CHCs.
Proportion of CTAS IV and V patients treated within ≤4 hours	75%	Stable or increasing by end of FY 08/09	82%		• WRH has shown a tremendous improvement of 7.5% while the province has improved 4.6%. • All sites, with the exception of HDGH, have improved on this measure 3 to 6 % from baseline. HDGH has unfortunately been impacted by increasing CTAS 4 and 5's for Mental Health that have in turn been admitted. • Introduction of Nurse Practitioners to assess and treat CTAS 4 and 5 in ambulatory hallway. Introductions of ambulatory waiting area for diagnostics and lab to free up hallway to improve utilization and flow. • Geriatric Emergency Nurses working in partnership with ESC CCAC Case Manager's to link high needs seniors who are unattached and then link them to FHTs, CHCs and Aging at Home programs. • Further strategies being considered include: Medworxx, Expansion of Psychiatric Assessment Nurse (PAN MH), ED diversion of CTAS 4 and 5 to Community Support Services, also secure bed units within LTC Homes and enhancing the skill mix within FHT and CHC (MH). • The ESC LHIN has developed the following forums to address strategies: 1) ED/Medicine Advisory Network 2) P4R Performance Group, 3) Regional ALC Strategy Group, and 4) Monthly ED/ALC performance Management Committee.

ERIE ST. CLAIR LHIN

Goal: Increase ER Capacity/Performance

Intervention: ER Pay for Results Year 2 –

Supplementary Measures	Baseline	Target	Current Performance	Quarterly Performance (Data Source: EDRS)	Key Considerations
Proportion of admitted patients treated within the LOS target of ≤ 8 hours	Fiscal 08/09	10 point improvement in percentage	72%		• This section will not be completed during the first round of Stocktake
Proportion of non-admitted high acuity patients treated within their respective targets of ≤ 8 hours for CTAS I-II and ≤ 6 hours for CTAS III	Fiscal 08/09	10 point improvement in percentage	88%		• This section will not be completed during the first round of Stocktake
Proportion of non-admitted low acuity patients treated within the LOS target of ≤ 4 hours	Fiscal 08/09	10 point improvement in percentage	83%		• This section will not be completed during the first round of Stocktake

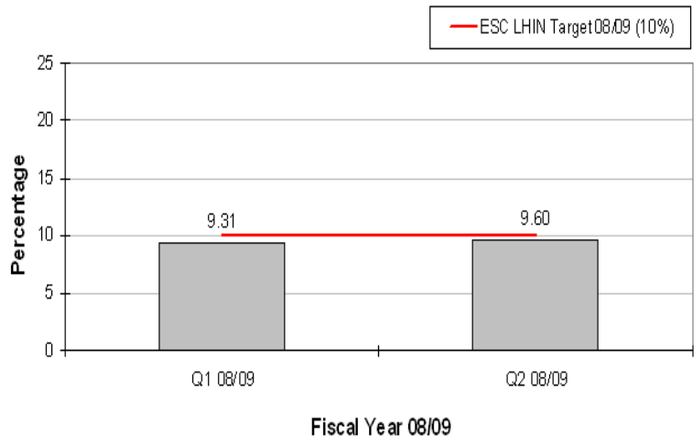
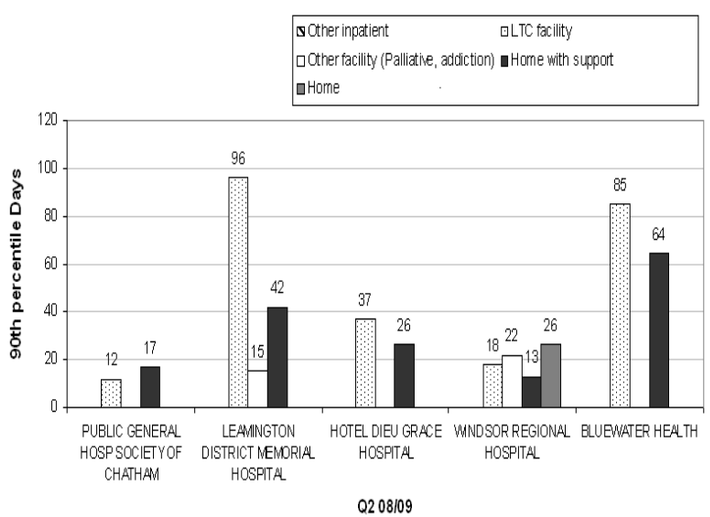
ERIE ST. CLAIR LHIN

Goal: Improved Bed Utilization

Aging at Home – Year One
- None

Urgent Priority Funding – Year One
- Chronic care transitional beds at BWH and Charlotte Eleanor Englehart Hospital (CEEH) sites
- Windsor/Essex transitional beds

Ontario

Supplementary Measures	Baseline	Target	Current Performance	Quarterly Performance	Key Considerations
Percentage ALC Days	10.90%	10.00%	9.60%	 Data Source: CIHI-DAD	• Prior to Year One funding becoming available in (2008/09), ESC CCAC provided additional exceptional circumstances services to keep people at home. Subsequently, ESC LHIN's funding provided support for chronic care beds at CEEH site of BWH in petrolia. In addition, transitional care beds were established in both Windsor/ Essex and Sarnia in retirement homes. • In 2008/09, ESC CCAC began decreasing their provision of exceptional circumstance additional home services. This decrease was transitioned over time causing a lagging impact. • ESC LHIN's current performance of 9.60% is below the ESC LHIN target of 10% and is 35% lower than the province's performance. • BWH and LDMH have shown increases over the year while others have shown improvement. However, there is a statistical trend in Schedule 1 for admits at HDGH for Psycho-Geriatric issues. The preliminary stages of planning to expand the Psychiatric Assessment Nursing (PAN) Model are currently in place as well as examining alternative settings for the Psycho-Geriatric patients. Planning for all three areas is in process. • ESC CCAC's placement time to LTC Homes has increased substantially for Windsor/Essex and Sarnia/Lambton resulting in a significant backlog in the acute care sector. The ESC CCAC community placement to LTC and demand to supply ratio has also increased in Sarnia/Lambton and Windsor/Essex, creating more pressure on the system. To summarize, the LTC wait list, lack of first available bed policy implementation, slow start up of Aging at Home initiatives and increasing lack of access to tertiary mental health services for Psycho-Geriatric patients have resulted in the ESC LHIN's ALC situation. CKHA routinely reports ALC patients in acute care awaiting regional MH service in London. • Some dialogue has occurred with community service providers during Aging at Home planning to improve bed utilization. The ESC LHIN's ALC situation is treated as a process and improvements are not anticipated to occur immediately. • Further strategies being considered include: Medworxx, Expansion of PAN Nurse (MH), ED diversion of CTAS 4 and % of admitted patients, secure bed units within LTC Homes and enhancing the Skill Mix within FHT and CHC (MH). • The ESC LHIN has developed the following forums to address strategies: 1) ED/Medicine Advisory Network, 2) P4R Performance Group, 3) Regional ALC Strategy Group, and 4) Monthly ED/ALC performance Management Committee.
Number of days from ALC designation to discharge by discharge disposition	TBD	TBD	31 Days	 Data Source: CIHI-DAD	

APPENDIX A

Summary of System Measures

Measure	Definition	Report Breakdown*	Data Source
Number of ER Unscheduled Visits by quarter per 1000 population	The Rate of ER visits for every 1,000 population: Total number of unscheduled ER visits per quarter divided by the 2008 population estimate, multiplied by 1,000. The data includes all ER visits submitted to NACRS excluding scheduled visits and volume for Urgent Care Centres.	- Provincial View, By Quarter (pg. 2) - Provincial View, By LHIN, By Quarter (pg. 3)	MoHLTC Provincial Health Planning Database & CIHI-NACRS
Time spent in the ER for high acuity patients (all admitted + non-admitted CTAS I, II, III patients)	The ER LOS (90th percentile) for all admitted and non-admitted CTAS I, II, III patients (ER LOS = time from triage or registration, whichever comes first, to the time the patient leaves the ER). *This measure applies to all sites submitting data to EDRS.*	- Provincial View, By Quarter (pg. 2) - Provincial View, By LHIN, By Quarter (pg. 3)	EDRS
Time spent in the ER for low acuity patients (non-admitted CTAS IV & V patients)	The ER LOS (90th percentile) for non-admitted CTAS IV & V patients (ER LOS = time from triage or registration, whichever comes first, to the time the patient leaves the ER). *This measure applies to all sites submitting data to EDRS.*	- Provincial View, By Quarter (pg. 2) - Provincial View, By LHIN, By Quarter (pg. 3)	EDRS
Percentage of ALC days	Number of inpatient days a physician (or designated other) has indicated a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment divided by the total number of inpatients days multiplied by 100. *This measure applies to all facilities submitting ALC data to CIHI-DAD.*	- Provincial View, By Quarter (pg. 2) - Provincial View, By LHIN, By Quarter (pg. 3)	CIHI-DAD
Number of days from ALC designation to discharge by discharge disposition (90th percentile Days)	Total ALC days represented as number of days from ALC designation to discharge from an acute care facility. The point at which 9 out of 10 ALC patients have been discharged. *This measure applies to all facilities submitting ALC data to CIHI-DAD.*	- Provincial View, By Quarter (pg. 2) - Provincial View, By LHIN, By Quarter (pg. 3)	CIHI-DAD

**** Please note: Where volume of visits or cases is less than 6, no value is displayed.***

APPENDIX B

Summary of Supplementary Measures

	Measure	Definition	Report Breakdown*	Data Source
AAH & UPF	Number of ER Unscheduled Visits by quarter per 1000 population	The Rate of ER visits for every 1,000 population: Total number of unscheduled ER visits per quarter divided by the 2008 population estimate, multiplied by 1,000. The data includes all ER visits submitted to NACRS excluding scheduled visits and volume for Urgent Care Centres.	- LHIN View, By Quarter (pg. 7)	MoHLTC Provincial Health Planning Database & CIHI-NACRS
P4R – Y1	Proportion of ER LOS exceeding 24 hours	The proportion of all emergency room patients who have an ER length of stay is greater than 24 hours (ER LOS = time from triage or registration, which ever comes first, to time the patient leaves the ER). *This measure applies to Year 1 P4R sites only.*	- LHIN View, By Quarter (pg. 8)	EDRS
	Proportion of CTAS I & II patients treated within ≤8 hours and within ≤6 hours for CTAS III	The proportion of CTAS I & II patients that meet the defined ER length of stay target of 8 hours and the proportion of CTAS III patients that meet the defined ER length of stay target of 6 hours (ER LOS = time from triage or registration, which ever comes first, to time the patient leaves the ER). *This measure applies to Year 1 P4R sites only.*	- LHIN View, By Quarter (pg. 8)	EDRS
	Proportion of CTAS IV & V patients treated within ≤4 hours	The proportion of CTAS IV & V patients that meet the defined ER length of stay target of 4 hours (ER LOS = time from triage or registration, which ever comes first, to time the patient leaves the ER). *This measure applies to Year 1 P4R sites only.*	- LHIN View, By Quarter (pg. 8)	EDRS
P4R – Y2	Proportion of admitted patients treated within the LOS target of ≤ 8 hours	The proportion of admitted patients that meet the defined ER length of stay target of 8 hours or less (ER LOS = time from triage or registration, which ever comes first, to the time the patient leaves the ER). *This measure applies to Year 2 P4R sites only.*	- LHIN View, By Quarter (pg. 9)	EDRS
	Proportion of non-admitted high acuity patients treated within their respective targets of ≤ 8 hours for CTAS I-II and ≤ 6 hours for CTAS III	The proportion of CTAS I & II patients that meet the defined ER length of stay target of 8 hours or less and the proportion of CTAS III visits that meet the defined ER length of stay target of 6 hours or less (ER LOS = time from triage or registration, which ever comes first, to the time the patient leaves the ER). *This measure applies to Year 2 P4R sites only.*	- LHIN View, By Quarter (pg. 9)	EDRS
	Proportion of non-admitted low acuity patients treated within the LOS target of ≤ 4 hours	The proportion of CTAS IV & V patients that meet the defined ER length of stay target of 4 hours or less (ER LOS = time from triage or registration, which ever comes first, to the time the patient leaves the ER). *This measure applies to Year 2 P4R sites only.*	- LHIN View, By Quarter (pg. 9)	EDRS
AAH & UPF	Percentage of ALC days	Number of inpatient days a physician (or designated other) has indicated a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment divided by the total number of inpatients days multiplied by 100. *This measure applies to all facilities submitting ALC data to CIHI-DAD.*	- LHIN View, By Quarter (pg. 10)	CIHI-DAD
	Number of days from ALC designation to discharge by discharge disposition (90th percentile Days)	Total ALC days represented as number of days from ALC designation to discharge from an acute care facility. The point at which 9 out of 10 ALC patients have been discharged. Discharge disposition information available through CIHI. *This measure applies to all facilities submitting ALC data to CIHI-DAD.*	- LHIN View, By Quarter (pg. 10)	CIHI-DAD

**** Please note: Where volume of visits or cases is less than 6, no value is displayed.***