Capital District Emergency Services Council
“CDESC”

Quarterly Report
Quarter 4
With focus on CCHC and HCH EDs
Introduction

Emergency Medicine is the medical specialty dedicated to the diagnosis and treatment of unforeseen illness and injury. It includes the initial evaluation, diagnosis, treatment, and disposition of any patient requiring expeditious medical, surgical, or psychiatric care. Thus, the operationalization of “Integrated Networks of Emergency Care” is inherently interdisciplinary and interdependent upon multiple in-hospital and Health System wide structures and processes.

In alignment with the CDHA/IWK/EHSNS commitment to patient safety and with the Better Care Sooner standards (as well as with recommended national ED quality reporting guidelines) this quarterly report focuses on Key Process Indicators, and outcomes when available, to help drive the CQI imperative and to improve care to the patients and populations that we serve.

<table>
<thead>
<tr>
<th>Emergency Medicine</th>
<th>Unforeseen Unscheduled</th>
<th>Predictable Schedulable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CTAS 1, 2, 3</strong></td>
<td>• Often described as “real” emergencies 97% of fixed costs of ED to meet population burden of acute illness and injury&lt;4&gt; • Does include exacerbations of chronic problems</td>
<td>• “avoidable” CTAS 3 (ED as safety net) - frail elderly with no acute event or problem - partial diagnosis requiring further work up - chronic condition requiring follow up or has predictable clinical course</td>
</tr>
<tr>
<td><strong>CTAS 4, 5</strong></td>
<td>• <strong>DO NOT</strong> cause ED overcrowding&lt;2,3&gt; • Very low marginal cost to see in ED&lt;4,5&gt; • 9/10 most common successful lawsuits in EM</td>
<td>• “inappropriate” ED visits (ED as gate keeper) - Medication refill - “sick note” for work or school - Queue jumping to see specialist</td>
</tr>
</tbody>
</table>

2. **MYTH:** Emergency room overcrowding is caused by non-urgent cases - October 2009 Canadian Health Research Foundation Myth Buster of the year series
5. Emergency Medical Care: 3 Myths Debunked, Huffington Post. Leigh Vinocur, M.D. Director of Strategic Initiatives at the University of Maryland School Medicine.
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Demand

Census – Halifax Infirmary ED  Reporting Date:  Oct 1 – Dec 31, 2012

Context: Emergency Departments are designed to meet the unscheduled (from life threatening to relatively minor) health care needs of the population. The 5 level CTAS score is used to differentiate acuity (1 being severe and time dependent) though it is only a surrogate marker for the complexity of care. Left Without Being Seen (LWBS) is a reflection of decreased access secondary to wait times (target 2-3%). Percentage admitted national benchmark is 16-18% for CTAS 3s.

Analysis: We have seen a steady increase in our monthly census over the past 5 years. CTAS 2 and 3 patients continue to take up the largest portion of our patient load, with about 20% being subsequently admitted to hospital. These patient are more likely to need an ED bed for the duration of their ED stay, and are thus contribute to access block.

CTAS distribution is similar to other tertiary care hospitals across Canada.

The LWBS rates are still higher than what is considered a safe target through the rate has come down over the past year (despite rising volumes) because of multiple flow initiatives within the ED.

Sam Campbell, Site Chief, HI ED
**Demand**

**Census – Dartmouth General ED**

**Context:** Emergency Departments are designed to meet the unscheduled (from life threatening to relatively minor) health care needs of the population. The 5 level CTAS score is used to differentiate acuity (1 being severe and time dependent) though it is only a surrogate marker for the complexity of care. Left Without Being Seen (LWBS) is a reflection of decreased access secondary to wait times (target 2-3%). Percentage admitted national benchmark is 16-18% for CTAS 3s.

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**Analysis:** Monthly Registrations are up 8-10% since July 2012. Admission rates and CTAS distribution comparable with historical norms for DGH. Improvement in LWBS rate (4%) compared to previous (approx 8%) likely due to: 1) Liaison Nurse role started in June to expedite workup of CTAS 2/3 waiting to be brought into ED 2) Improved staffing levels for RNs and ACPs.

Target LWBS 2-3% achievable if successful with planned changes to MET (fasttrack).

Ravi Parkash, Site Chief, DGH ED
Demand

Census – Cobequid Community ED Reporting Date: Oct 1 – Dec 31, 2012

**Context:** Emergency Departments are designed to meet the unscheduled (from life threatening to relatively minor) health care needs of the population. The 5 level CTAS score is used to differentiate acuity (1 being severe and time dependent) though it is only a surrogate marker for the complexity of care. Left Without Being Seen (LWBS) is a reflection of decreased access secondary to wait times (target 2-3%). Percentage transferred is used as a surrogate for admits for CCHC.

**Analysis:** The census continues to rise in the department with a 6.3% increase in 2012 annual registrations versus 2011. Of note, operational hours were extended to 24:00 beginning in December. The December registrations reflected a 10% increase over 2011. Despite this continuing increase in volumes the LWBS rate, although above national benchmark, actually decreased from 7.4% in 2011 to 6.3% this year. This is a reflection of increased physician resource available (due to more responsive funding model with DHW) as well as departmental process improvements such as matching staffing to patient presentation times and implementation of chaircare.

Mike Clory, Site Chief, CCHC ED
Flow and Network Integration

ED Length of Stay for Admitted Patients

Context: ED LOS of admitted patients (i.e. “ED boarding”) has been recognized as the main – 75% of the variance - cause of overcrowding in the ED. Overcrowding is the term used to describe access block. Access block as manifested by increased patient wait times, increased ambulance offload times, and increased LWBS rates is associated with increased adverse outcomes, increased mortality (in a dose/response relationship), and increased costs to the system overall.

Analysis: The upper “90’tile performance” graph compares the ED LOS for admitted patients from the HI to DGH. The Better Care Sooner standard for this metric is 8 hours 90% of the time (in Ontario the 90th percentile standard is 6 hours). 45% of HI patients are admitted by 8 hours and 25% of DGH patients achieve this target. The 90th percentile performance for both hospitals is 30 hours (the comparison for Academic Health Science centers across Canada as measured by the Collaborative in Health Care Excellence is 16 hours).

The bottom graphic shows the trending of performance for this Key Process Indicator since 2007 at both the DGH and the HI.

David Petrie, District Chief, CDHA
Flow and Network Integration

Ambulance Offload / Transition

Context: Ambulance offload times are another Key Process Indicator which has implications both to the individual patient (i.e. wait times to see an MD), and to the community (i.e. turn around times for the ambulance to get back to the streets and available to the community for the next 911 emergency call.

Because of rising ambulance offload times in the past (due to ED access block) a transition team has been in place to assume the observation of care in the “ambulance hallway” prior to the placement of the patient in an ED bed (to allow the EHSNS crew to return to service).

Analysis: At the HI ED the mean time from ambulance arrival to placement in an ED bed has risen from 150 minutes to 250 minutes. This is essentially the same whether the transition team is on or not (which is to be expected). The metric that the transition team has improved on is the ambulance crew turn around times (which is not available at this time but will be available for the next quarterly report).

David Petrie, District Chief, CDHA
Flow and Network Integration

Matching Capacity with Demand:

**Context:** Ambulance smoothing has occurred in the central region for Quarter 4 2012 based on the relative surge capacity at each ED site. This table shows the percentage of time that the HI and DGH were on then escalating levels of capacity (Red being the highest surge level). CCHC is also part of this network. The surge levels are determined by 5 criteria and are measured real time so the status changes dynamically. If an ambulance patient does not meet exclusion criteria (CTAS ½ previously determined trip destination criteria for major trauma, stroke, STEMI, or have had recent admit to hospital) then patients may be rerouted from a Red ED to a Green ED.

<table>
<thead>
<tr>
<th>QEII</th>
<th>DGH</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GREEN</td>
<td>GREEN</td>
<td>15.48%</td>
</tr>
<tr>
<td>YELLOW</td>
<td>GREEN</td>
<td>10.71%</td>
</tr>
<tr>
<td>GREEN</td>
<td>YELLOW</td>
<td>8.49%</td>
</tr>
<tr>
<td>YELLOW</td>
<td>YELLOW</td>
<td>5.84%</td>
</tr>
<tr>
<td>GREEN</td>
<td>ORANGE</td>
<td>4.05%</td>
</tr>
<tr>
<td>YELLOW</td>
<td>RED</td>
<td>3.73%</td>
</tr>
<tr>
<td>GREEN</td>
<td>RED</td>
<td>3.68%</td>
</tr>
<tr>
<td>YELLOW</td>
<td>ORANGE</td>
<td>3.08%</td>
</tr>
<tr>
<td>ORANGE</td>
<td>GREEN</td>
<td>2.67%</td>
</tr>
<tr>
<td>RED</td>
<td>GREEN</td>
<td>2.36%</td>
</tr>
<tr>
<td>ORANGE</td>
<td>RED</td>
<td>1.78%</td>
</tr>
<tr>
<td>ORANGE</td>
<td>YELLOW</td>
<td>1.72%</td>
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<tr>
<td>RED</td>
<td>YELLOW</td>
<td>1.62%</td>
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<tr>
<td>RED</td>
<td>ORANGE</td>
<td>1.44%</td>
</tr>
<tr>
<td>ORANGE</td>
<td>ORANGE</td>
<td>1.23%</td>
</tr>
<tr>
<td>RED</td>
<td>ORANGE</td>
<td>0.59%</td>
</tr>
</tbody>
</table>

**Analysis:** During Quarter 4 2012, DGH Red/HI Green occurred 3.68% of the time and HI Red/DGH Green occurred 2.36% of the time. Ambulance smoothing may occur during these times. CCHC also may receive CTAS 3/4/5 ambulance patients from both DGH and HI regions at 1 patient per hour before 16:00. Further Information will be available next quarter with regards to patient flow outcomes. 

David Petrie, District Chief, CDHA
Flow and Network Integration

Pod of Initial Destination at the HI ED / RAU

Context: Internal flow within an ED needs to optimize available space/capacity to meet the volume/CTAS demands of the presenting patients.

The HI ED has innovated (chair centric Pod 1, fast track/paramedic assisted pod 5) to meet the needs of this demand. The Rapid Assessment Unit is another aspect of the ED which has evolved to meet the needs of transferred patients and referred patients from our own ED. This allows expedited consultations to specific services and frees up bed time to see the next Emergency patient in the waiting room or ambulance hallway.

HI ED- POD Utilization

- Initial Location POD 1-2-3-4-5 or Psych
- Psych and Intake A part of Pod 1
- Intake B Part of Pod 5
- No LWBS Counted

RAU Patient Volume* by Origin

- Analysis: 74% of all patients are seen in Pod 1 (chair centric care) or Pod 5 (fast track). This is a reflection of the number of hours that our actual ED acute care beds in Pods 2, 3, and 4 are blocked by admitted in-patients. This ratio is likely too high and will be reduced with the reduction of ED boarding.

The RAU receives patients from many different sources with 16% being transferred from other hospitals from outside the district and 19% coming from within the district.

Interestingly 28% come from home (including post op rechecks / complications, etc) which potentially could be seen more efficiently in clinics. 

David Petrie, District Chief, CDHA
Flow and Network Integration

Clinical Decision Unit (CDU) Utilization

**Context:** The Clinical Decision Unit is a virtual unit embedded within the physical space of the ED which facilitates observation and rechecks by the Emergency Physician. The purpose is twofold; to improve the transfer of care with more explicit ordering and documentation clinical care pathways, and to try and reduce admissions for patients that potentially may “turn around” with 6 – 24 hours of treatment and observation.

<table>
<thead>
<tr>
<th>Site</th>
<th>CDU Patients</th>
<th>CDU Patient Admitted</th>
<th>Percentage CDU Admitted</th>
<th>Total Site Patient Volume</th>
<th>Percentage Total Patients CDU</th>
<th>Median Length of Stay CDU No Admitted Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>HI ED</td>
<td>201</td>
<td>37</td>
<td>18.4%</td>
<td>16922</td>
<td>1.2%</td>
<td>15</td>
</tr>
<tr>
<td>DGH ED</td>
<td>554</td>
<td>143</td>
<td>25.8%</td>
<td>9784</td>
<td>5.7%</td>
<td>14.5</td>
</tr>
<tr>
<td>CCHC ED</td>
<td>20</td>
<td>6</td>
<td>30.0%</td>
<td>8148</td>
<td>0.2%</td>
<td>6.9</td>
</tr>
</tbody>
</table>

**Analysis:** CDUs were only implemented in the past 6 months and the culture / operationalization of this process has not entirely caught on resulting in artificially low numbers (as compared to potential benefit). Approximately ¾ of the time the CDU is invoked an admission is avoided.

CDU Utilization is less than other sites at CCHC partly due to the fact that patients are often not observed and managed for as long a period as other EDs due to necessity of transfer to HI. In an Acad Emerg paper published this year the Ontario rates for a similar program is 4% and this resulted in reduced ED LOS, reduced admission rate, and no increase in ED revisit rate.

David Petrie, District Chief, CDHA
Patient Experience

Wait Times – HI ED

**Context:** One of the main ways ED access block manifests itself is in patient wait times (time from registration to time to see MD). Wait times have been shown to be associated with adverse outcomes in a dose response curve that suggests causation.

This data looks at the wait time performance curve for CTAS 2, 3, and 4s (assuming CTAS 1s get seen expeditiously and CTAS 5s have less of a time dependency).

The time targets are: CTAS 2 = 15 min, CTAS 3 = 30 min, CTAS 4 = 60 min.

**Analysis:**

- **CTAS 2:** 90th percentile performance time to MD is 1 hour 35 minutes.
- **CTAS 3:** 90th percentile performance time to MD is 3 hours 45 minutes.
- **CTAS 4:** 90th percentile performance time to MD is 4 hours 30 minutes.

While the recommendations are for 90% of patients with CTAS 3 to be seen within 30 minutes of their time of arrival, we are currently only manage this between 250 and 350 minutes – 10 times the recommended period. While CTAS 2 patients also wait about 10 times the recommended period, the proportion for CTAS 4 patients is less extreme (four times) partly because of initiatives to manage ambulatory patients more efficiently.

Sam Campbell, Site Chief, HI ED
Patient Experience

Wait Times – DGH ED

**Context:** One of the main ways ED access block manifests itself is in patient wait times (time from registration to time to see MD). Wait times have been shown to be associated with adverse outcomes in a dose response curve that suggests causation.

This data looks at the wait time performance curve for CTAS 2, 3, and 4s (assuming CTAS 1s get seen expeditiously and CTAS 5s have less of a time dependency).

The time targets are: CTAS 2 = 15 min, CTAS 3 = 30 min, CTAS 4 = 60 min.

**Analysis:**

<table>
<thead>
<tr>
<th>CTAS 2</th>
<th>90th percentile performance time to MD is 3 hours.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTAS 3</td>
<td>90th percentile performance time to MD is 4 hours.</td>
</tr>
<tr>
<td>CTAS 4</td>
<td>90th percentile performance time to MD is 4 hours 30 minutes.</td>
</tr>
</tbody>
</table>

Standards not being met however, improvement in wait times since Apr 2012. Improvement may be due to: 1) Liaison Nurse role 2) improved inpatient flow and coordination of inpatient discharges may be having positive effect. Wait times may further improve with: 1) planned changes to MET as of Feb 2013. 2) Clinical Leader (charge nurse) group now permanent and will continue to develop skills. 3) ongoing work by Flow Committee.

Ravi Parkash, Site Chief, DGH ED
Patient Experience

Wait Times – Cobequid ED

**Context:** One of the main ways ED access block manifests itself is in patient wait times (time from registration to time to see MD). Wait times have been shown to be associated with adverse outcomes in a dose response curve that suggests causation.

This data looks at the wait time performance curve for CTAS 2, 3, and 4s (assuming CTAS 1s get seen expeditiously and CTAS 5s have less of a time dependency).

The time targets are: CTAS 2 = 15 min, CTAS 3 = 30 min, CTAS 4 = 60 min.

**Analysis:**

- **CTAS 2:** 90th percentile performance time to MD is 1 hour 15 minutes.
- **CTAS 3:** 90th percentile performance time to MD is 3 hours 10 minutes.
- **CTAS 4:** 90th percentile performance time to MD is 3 hours 10 minutes.

The bottom graphic trends the wait time for CTAS 3 patients (compared to target) over the past 5 years.

Mike Clory, Site Chief, CCHC ED
Clinical Care

Diagnostic Imaging & Lab Reporting

**Context:** Through put of patients in the Emergency Department is impacted by the intensity of the work up (lab and diagnostic imaging required). Decision rules developed in the Emergency Department setting (Cat Scan Head, Cervical-Spine, Ottawa Ankle, Rule Out Deep Vein Thrombosis, Rule Out Pulmonary Emboli, etc) all impact the cost effectiveness of patient investigation.

Reporting Period from: Oct 01, 2012 to: Dec 31, 2012

<table>
<thead>
<tr>
<th>Site</th>
<th>Pt Volume</th>
<th>CT Orders (%Pt Volume)</th>
<th>US Orders (%Pt Volume)</th>
<th>MRI Orders (%Pt Volume)</th>
<th>XR Orders (% Pt Volume)</th>
<th>Total Di Orders (% Pt Volume)</th>
</tr>
</thead>
<tbody>
<tr>
<td>QEII</td>
<td>16920</td>
<td>2109 (12.5%)</td>
<td>663 (3.9%)</td>
<td>48 (0.3%)</td>
<td>7556 (44.7%)</td>
<td>10376 (61.3%)</td>
</tr>
<tr>
<td>DGH</td>
<td>9784</td>
<td>1352 (13.8%)</td>
<td>388 (4.0%)</td>
<td>0 (0.0%)</td>
<td>5273 (53.9%)</td>
<td>7013 (71.7%)</td>
</tr>
<tr>
<td>CCHC</td>
<td>8148</td>
<td>726 (8.9%)</td>
<td>189 (2.3%)</td>
<td>4 (0.0%)</td>
<td>4301 (52.8%)</td>
<td>5220 (64.1%)</td>
</tr>
<tr>
<td>HCH</td>
<td>3953</td>
<td>6 (0.2%)</td>
<td>52 (1.3%)</td>
<td>0 (0.0%)</td>
<td>1195 (30.2%)</td>
<td>1253 (31.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>38805</td>
<td>4193 (10.8%)</td>
<td>1292 (3.3%)</td>
<td>52 (0.1%)</td>
<td>18325 (47.2%)</td>
<td>23862 (61.5%)</td>
</tr>
</tbody>
</table>

**Labs Ordered**

<table>
<thead>
<tr>
<th>Site</th>
<th>Patients with Labs Ordered</th>
<th>%Pts with Labs</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>QEII</td>
<td>7142</td>
<td>42.2%</td>
<td>16920</td>
</tr>
<tr>
<td>DGH</td>
<td>4823</td>
<td>49.3%</td>
<td>9784</td>
</tr>
<tr>
<td>CCHC</td>
<td>3605</td>
<td>44.2%</td>
<td>8148</td>
</tr>
<tr>
<td>HCH</td>
<td>1297</td>
<td>32.8%</td>
<td>3953</td>
</tr>
<tr>
<td>Total</td>
<td>16867</td>
<td>43.47%</td>
<td>38805</td>
</tr>
</tbody>
</table>

**Analysis:** This is raw data looking at the percent of overall patients who receive a Cat Scan, Ultrasound, MRI (Magnetic Resonance Imaging), X-Ray or labs ordered during their assessments in the Emergency Department. This data is not adjusted to acuity, complexity, or presenting complaint / diagnosis. There are no national benchmarks for these indications but they will allow for some comparison within CDESC.

David Petrie, District Chief, CDHA
Audit Date: Jan 23, 2013
Audit Type: Retrospective
Sample Size: CCHC 48
HCH 20

Department: Emergency Department
Audit Tools: EDIS Database/HPF
Audit Activity: Chart review of Asthma/COPD presentations to CCHC ED and HCH ED for the month of November 2012.

Standard Audited: Emergency Department care to patients presenting with Asthma/COPD

Criteria Audited: (What did you look at?)
HPF record of emergency visit for asthma/COPD presentations to CCHC. This included emergency charts and nursing notes.
(1) Time to MD by CTAS level
(2) Time to first treatment by CTAS level
(3) Concurrency with CH ED Asthma Care Pathway
(4) Appropriateness of care
(5) Quality of charting by MD and RN

Results:
Steroid treatment: CCHC ED 34 patients / HCH ED 10 patients
Discharge instructions: CCHC ED 34 patients / HCH ED 10 patients

<table>
<thead>
<tr>
<th></th>
<th>Cobequid Community Health Centre</th>
<th>Hants Community Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>CTAS 2</td>
<td>CTAS 3</td>
</tr>
<tr>
<td>Triage to MD (in minutes)</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>Triage to Treatment (in minutes)</td>
<td>52</td>
<td>99</td>
</tr>
<tr>
<td>Treatment time shorter than time to MD (number of charts)</td>
<td>37</td>
<td>117</td>
</tr>
<tr>
<td>Triage to MD within CTAS guidelines</td>
<td>0%</td>
<td>15%</td>
</tr>
<tr>
<td>Triage to treatment within CTAS guidelines</td>
<td>21%</td>
<td>15%</td>
</tr>
</tbody>
</table>

•Asthma care map not in use at either site.
•MDI instead of nebulizer was used in 4% of patients at CCHC and 15% of patients at HCH.
•Appropriate care provided to 45 of 48 patients (three cases did not provide indicated steroid treatment) for CCHC. Appropriate care provided to most patients at HCH.
•All antibiotic selections were deemed appropriate for respiratory infections at both sites.
•Discharge instructions were provided to 34 of 42 patients (not transferred to the QE II) at CCHC. Discharge instructions were provided to 50% of patients presenting to HCH.
•Steroids were given to 50% of patients who presented to HCH.

Issues:
•Appropriate asthma/COPD care being provided at both the CCHC and HCH EDs.
•Timeliness of patient care not meeting CTAS guidelines at either site.

Recommendations & follow up:
•Provide education to CCHC and HCH ED staff concerning the CH ED Asthma Care Pathway via Clinical Nursing Educator.
•Implement utilization of Asthma Care Pathway
•Perform follow up audit three to six months post implementation of Asthma Care Pathway.

Mike Clory, Site Chief, CCHC & HCH ED
# COBEQUID COMMUNITY HEALTH CENTRE ED
## Learners for Calendar Year 2012

<table>
<thead>
<tr>
<th>Month</th>
<th>Days</th>
<th>Med Students</th>
<th>Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1-31, 2012 (31 days)</td>
<td>31</td>
<td>30</td>
<td>37</td>
</tr>
<tr>
<td>February 1-28, 2012 (28 days)</td>
<td>28</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>March 1-31, 2012 (31 days)</td>
<td>31</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>April 1-30, 2012</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>May 1-31, 2012</td>
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<td>June 1-30, 2012</td>
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<td>July 1-31, 2012</td>
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<tr>
<td>Aug 1-31, 2012</td>
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<td>Sept 1-30, 2012</td>
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<td>Oct 1-31, 2012</td>
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<tr>
<td>Nov 1-30, 2012</td>
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</tr>
<tr>
<td>Dec 1-31, 2012</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Learner shifts</strong></td>
<td></td>
<td><strong>295</strong></td>
<td></td>
</tr>
</tbody>
</table>

Mike Clory, Site Chief, CCHC ED