Capital District Emergency Services Council "CDESC"

Quarterly Report

Quarter 2

With focus on Dartmouth General Hospital ED and Tri-Facilities ED

Capital Health
A different today. A better tomorrow.

IWK Health Centre

DALHOUSIE UNIVERSITY
Inspiring Minds

EHS
Emergency Health Services

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 <1>. 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.

Emergency Medicine	**Unforeseen** **Unscheduled**	**Predictable** **Schedulable**
CTAS 1, 2, 3	• Often described as "real" emergencies 97% of fixed costs of ED to meet population burden of acute illness and injury<4> • Does include exacerbations of chronic problems	• "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
CTAS 4, 5	• ***DO NOT*** cause ED overcrowding<2,3> • Very low marginal cost to see in ED<4,5> • 9/10 most common successful lawsuits in EM	• "inappropriate" ED visits (ED as gate keeper) - Medication refill - "sick note" for work or school - Queue jumping to see specialist

1. ACEP definition of Emergency Medicine: http://www.acep.org/Content.aspx?id=29164
2. MYTH: Emergency room overcrowding is caused by non-urgent cases - October 2009 Canadian Health Research Foundation Myth Buster of the year series
3. The Effect of Low-Complexity Patients on Emergency Department Waiting Times Schull MJ, Kiss A, Szalai JP. Ann Emerg Med. 2007 Mar;49(3):257-64, 264.e1. Acad Emerg
4. **THE COSTS OF VISITS TO EMERGENCY DEPARTMENTS** ROBERT M. W ILLIAMS , M.D., .PhD (N Engl J Med 1996;334:642-6.)
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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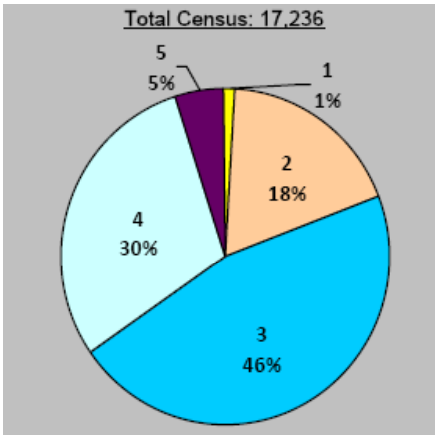
Demand

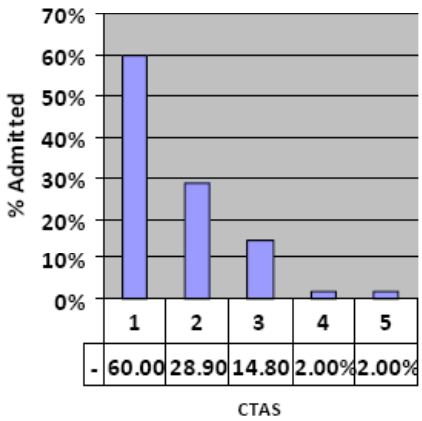
Census – Halifax Infirmary ED

Reporting Date: April 1 – June 30, 2013

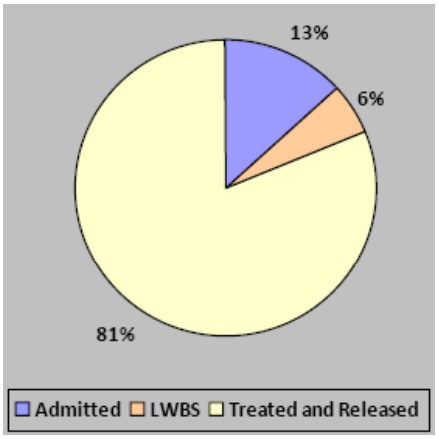
Context: Emergency Departments are designed to meet the unscheduled (from life threatening to relatively minor) health care needs of the population. The 5 level CTAS score is used to differentiate acuity (1 being severe and time dependent) though it is only a surrogate marker for the complexity of care. 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.



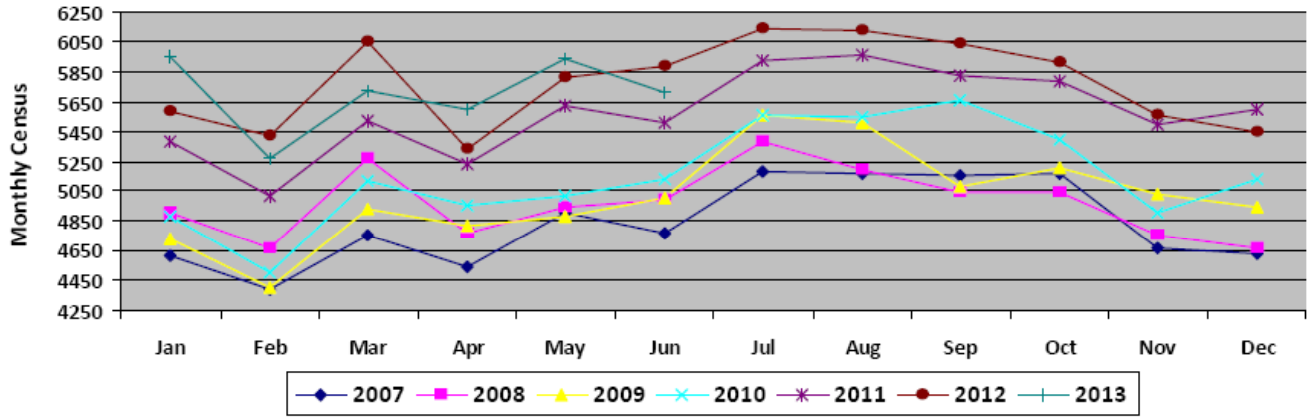
CTAS Distribution



Percentage Admits



Discharge Distribution



Analysis:

The daily census continues to be as high or higher than in previous years. CTAS 3 remains the largest category in terms of acuity. LWOBS remains at 6%. It remains to be seen whether new initiatives aimed at decreasing the length of stay of admitted patients decreases this number.

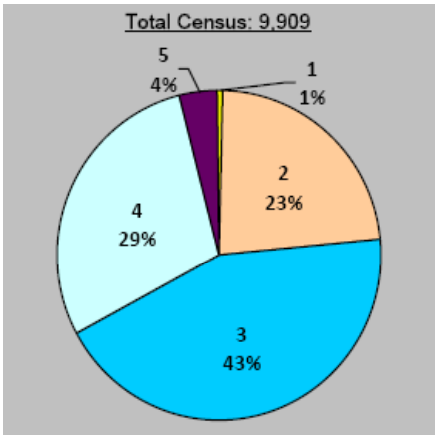
Sam Campbell, Site Chief, HI ED

Demand

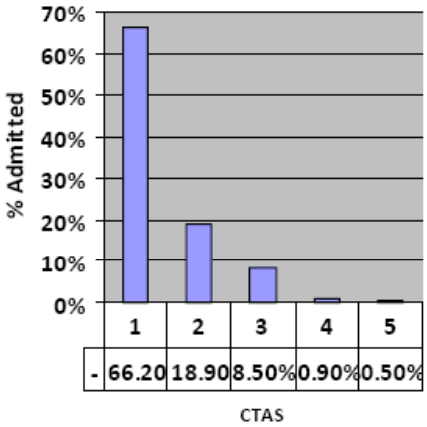
Census – Dartmouth General ED

Reporting Date: April 1 – June 30, 2013

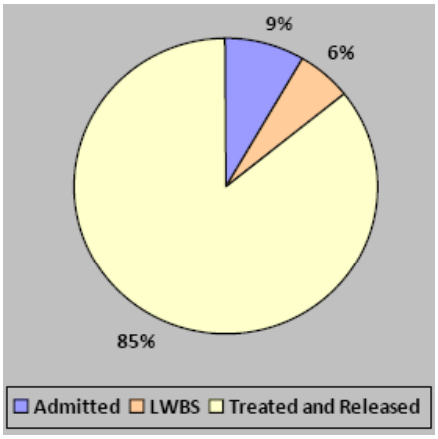
Context: Emergency Departments are designed to meet the unscheduled (from life threatening to relatively minor) health care needs of the population. The 5 level CTAS score is used to differentiate acuity (1 being severe and time dependent) though it is only a surrogate marker for the complexity of care. 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



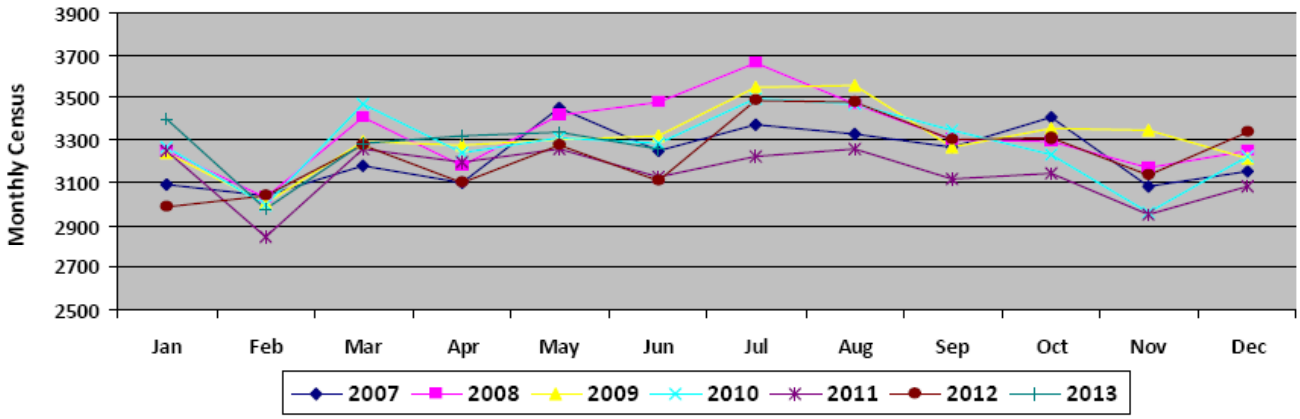
CTAS Distribution



Percentage Admits



Discharge Distribution



Analysis:

Increased volume when compared to the same quarter in 2012 and 2011.

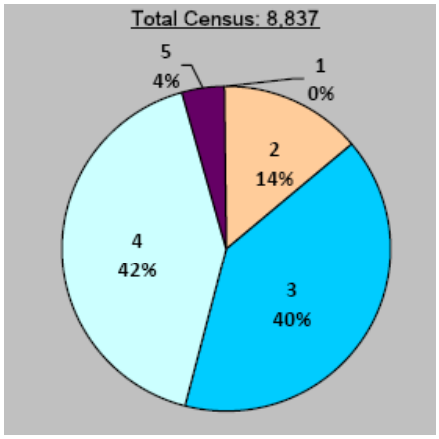
Ravi Parkash, Site Chief, DGH ED

Demand

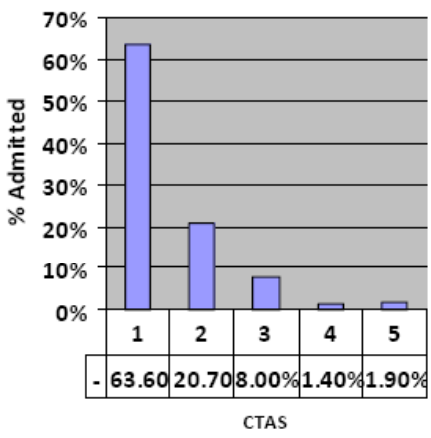
Census – Cobequid Community ED

Reporting Date: April 1 – June 31, 2013

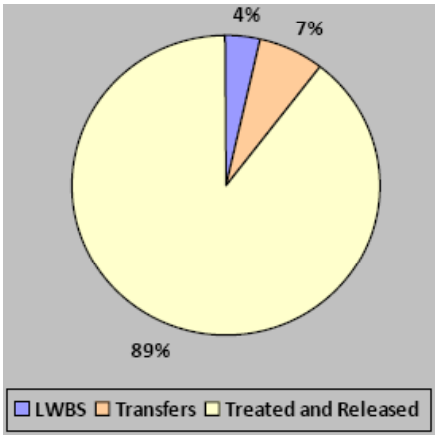
Context: Emergency Departments are designed to meet the unscheduled (from life threatening to relatively minor) health care needs of the population. The 5 level CTAS score is used to differentiate acuity (1 being severe and time dependent) though it is only a surrogate marker for the complexity of care. 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.



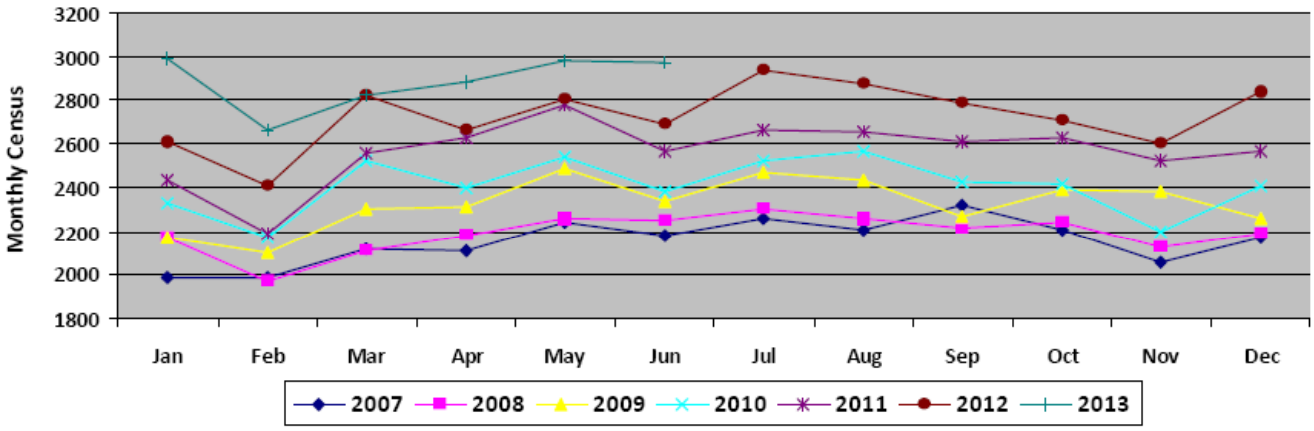
CTAS Distribution



Percentage Admits



Discharge Distribution



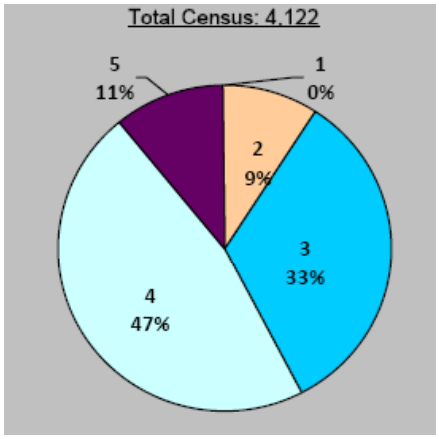
Analysis:

Demand

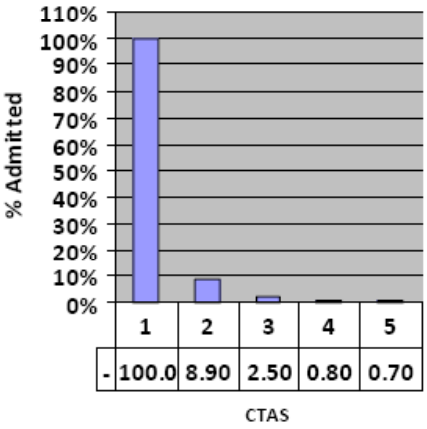
Census –Hants Community Hospital ED

Reporting Date: April 1 – June 31, 2013

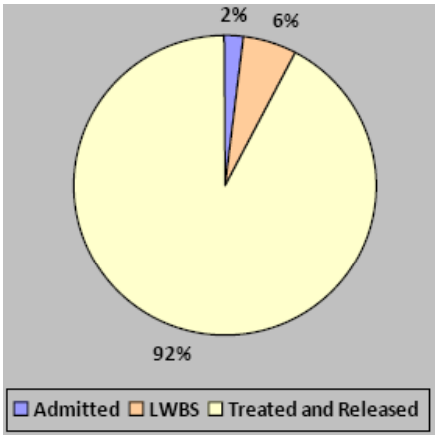
Context: Emergency Departments are designed to meet the unscheduled (from life threatening to relatively minor) health care needs of the population. The 5 level CTAS score is used to differentiate acuity (1 being severe and time dependent) though it is only a surrogate marker for the complexity of care. 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 HCH.



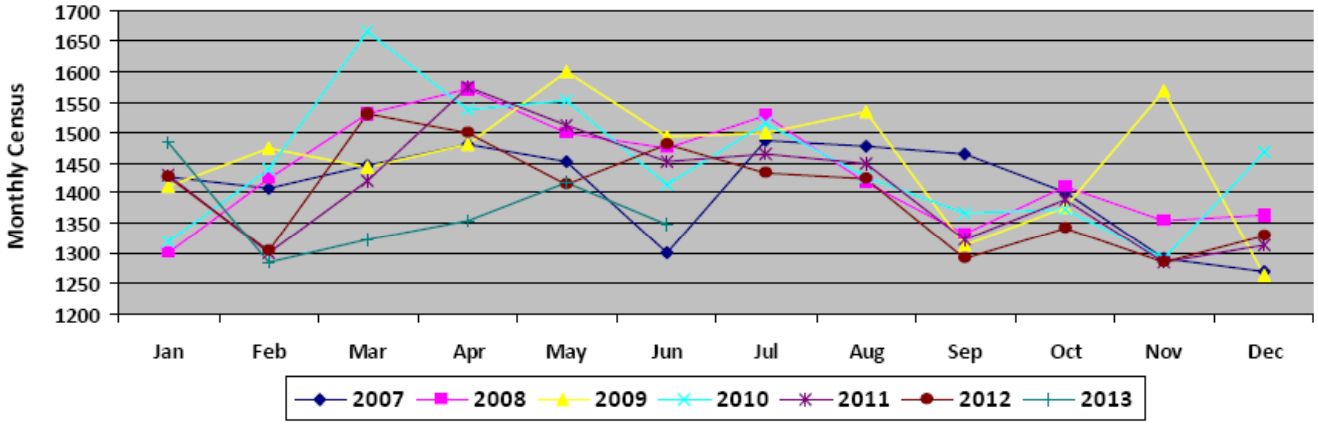
CTAS Distribution



Percentage Admits



Discharge Distribution



Analysis:

Hants' monthly census has remained relatively stable – with March 2013 registering 1600+. Large percentages of patients treated and released being CTAS 3 and 4 acuity. Transfers to the HI site for tertiary care account for 2%.

LWBS rates remain above standard – telephone data from this patient population is being gathered to determine causality.

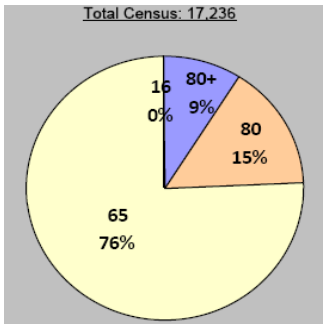
Tanya Penney, Health Services Manager, HCH ED

Demand

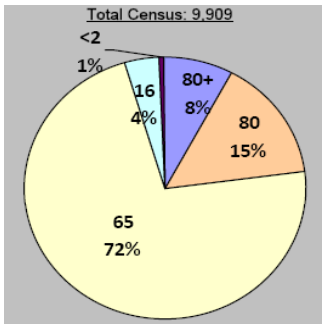
Demographics – HI ED / DGH ED / CCHC ED / HCH ED

Context:

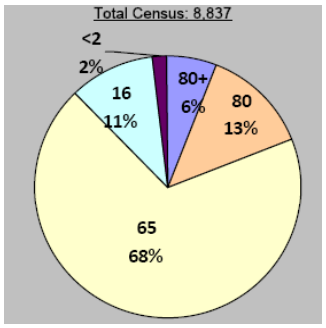
The complexity of patients presenting to the ED is a function of CTAS, age, presenting complaint, and many other factors. This data looks at the percentage of census in the following age groups (IWK excluded at this time): < 2 yrs, 2-16 yrs, 16-65 yrs, 65-80 yrs, and > 80 yrs.



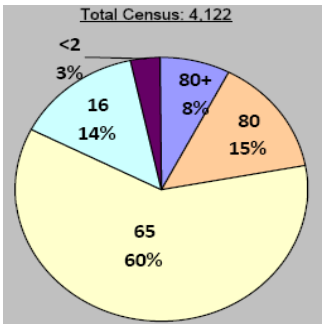
QEII ED Distribution



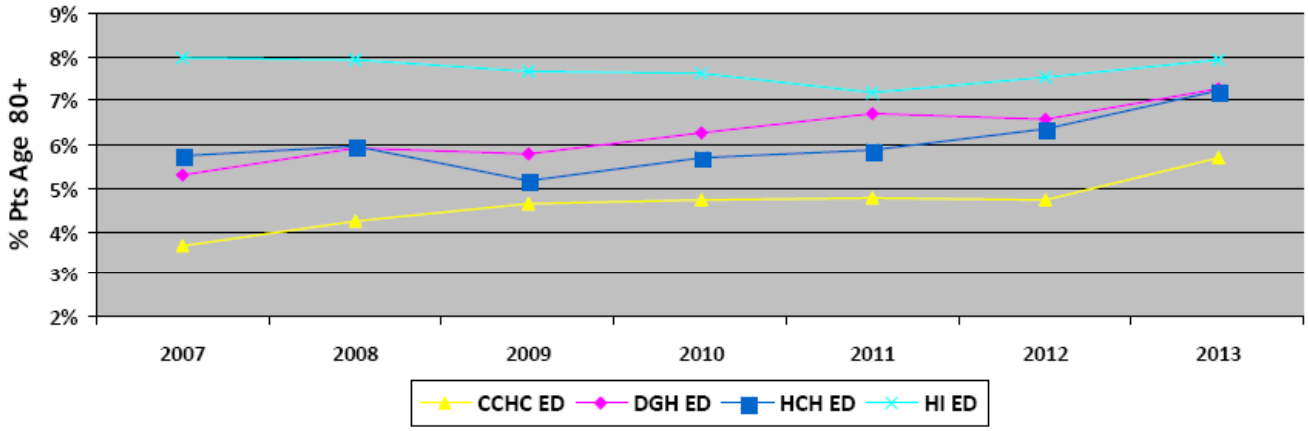
DGH ED Distribution



CCHC ED Distribution



HCH ED Distribution



Analysis:

The volumes of patients are up significantly in the district and the proportion presenting to the Emergency Department over 80 years of age has risen slowly. The differences between sites is likely reflects the geography of new families buying homes in the region and potentially the need for increasing levels of care for the elderly.

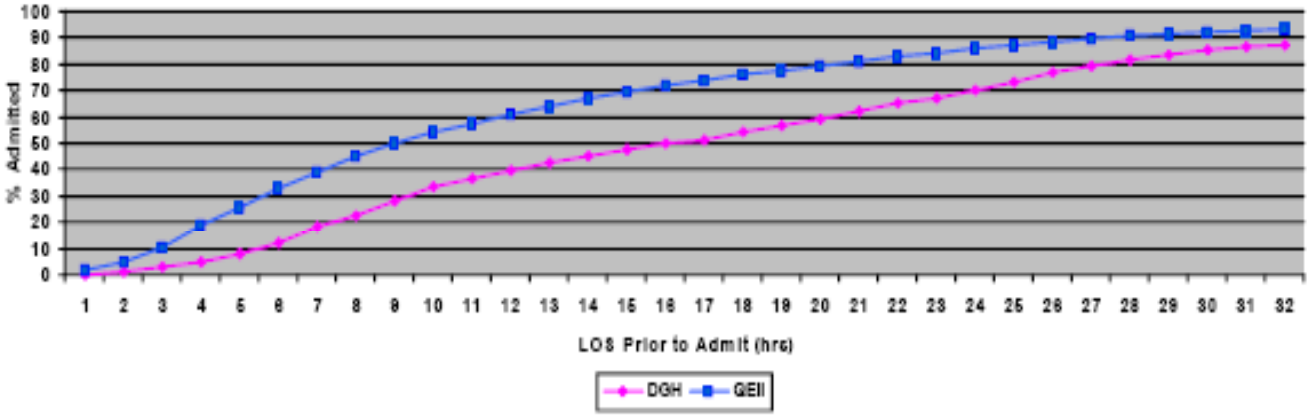
David Petrie, District Chief, CDHA

Flow and Network Integration

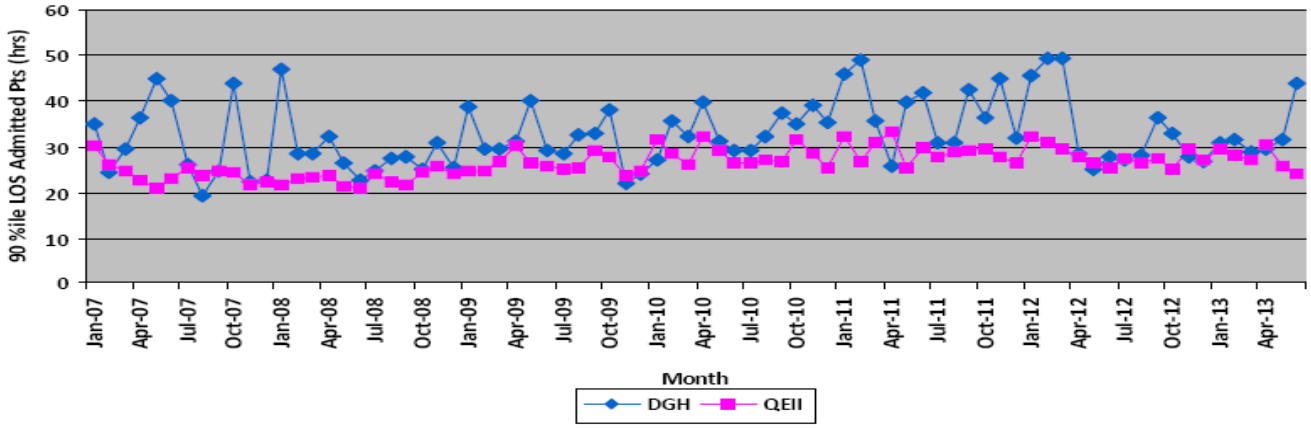
ED Length of Stay for Admitted Patients

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.

Percentile Length of Stay for Non CDU Admitted Patients



90th Percentile Length of Stay Admitted Patients



Analysis:

The upper "90 percentile 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 23 % of DGH patients achieve this target. The 90th percentile performance for the QEII is 32 hours and it is longer at the DGH (the comparison for Academic Health Science centres 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 DGH and the HI.

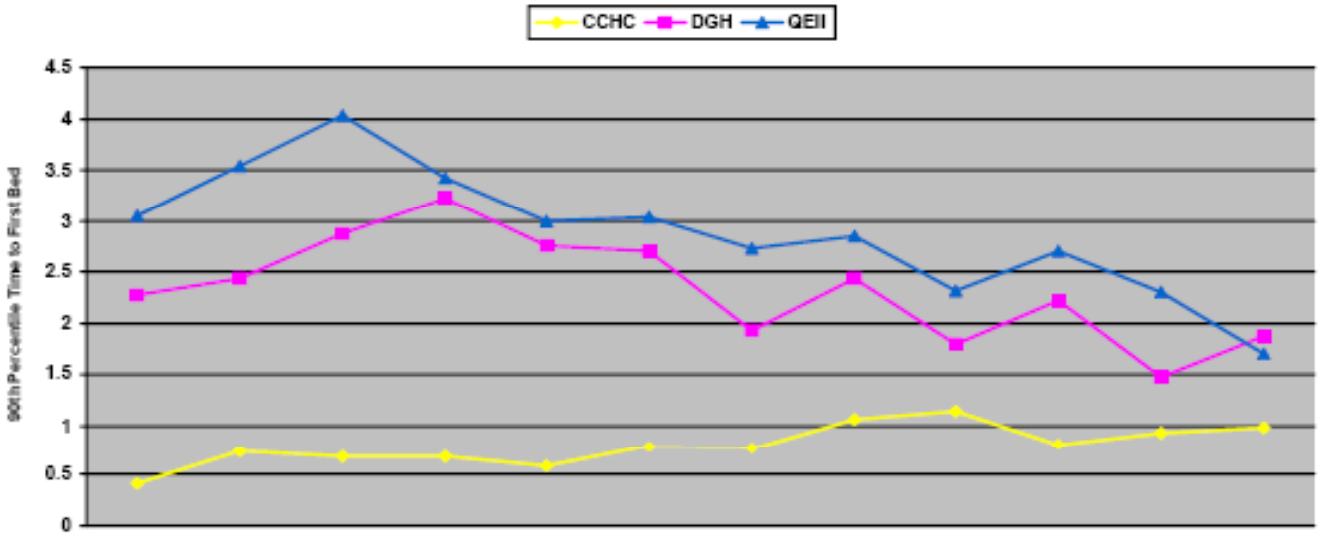
David Petrie, District Chief, CDHA

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).



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
CCHC	0.41	0.73	0.68	0.68	0.58	0.78	0.77	1.06	1.14	0.81	0.93	0.98
DGH	2.27	2.44	2.88	3.22	2.75	2.7	1.93	2.43	1.8	2.23	1.48	1.88
QEII	3.05	3.54	4.04	3.42	2.99	3.03	2.73	2.85	2.32	2.7	2.3	1.7

90th Percentile Time to Bed (hr)

CCHC	193	196	183	232	222	243	281	270	228	253	238	287
DGH	569	579	541	577	573	657	627	548	612	628	584	515
QEII	1229	1208	1180	1234	1177	1207	1295	1242	1191	1177	1284	1280

Ambulance Volume

Analysis:

There seems to be a downward trend in time to first bed at both the HI and DGH. This may possibly be due to the ambulance smoothing initiative which started in September 2012 within the district and an increased push on the efficiency of bed hours utilization in the ED. There has been a slight increase at the CCHC likely secondary to the increased volume of ambulances.

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.

QEII	DGH	%
GREEN	GREEN	18.15%
YELLOW	GREEN	13.18%
YELLOW	YELLOW	9.61%
GREEN	YELLOW	8.84%
YELLOW	RED	8.70%
GREEN	RED	6.40%
ORANGE	GREEN	5.03%
YELLOW	ORANGE	4.86%
ORANGE	RED	3.79%
GREEN	ORANGE	3.76%
RED	YELLOW	3.66%
RED	RED	3.32%
RED	GREEN	3.07%
ORANGE	ORANGE	2.66%
ORANGE	YELLOW	2.50%
RED	ORANGE	2.47%

Analysis:

During Quarter 1, 2013, DGH Red/HI Green occurred 6.40% of the time and HI Red/DGH Green occurred 3.07% 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.

David Petrie, District Chief, CDHA

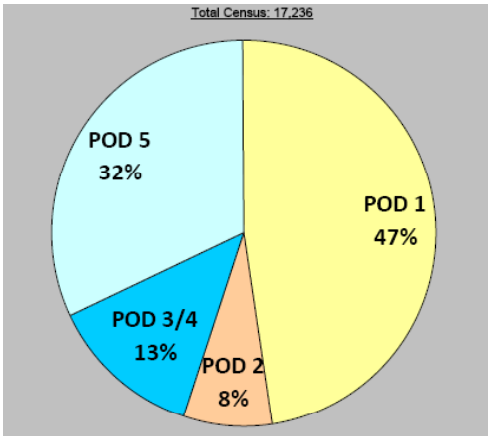
Flow and Network Integration

Pod of Initial Destination at the HI ED / RAU

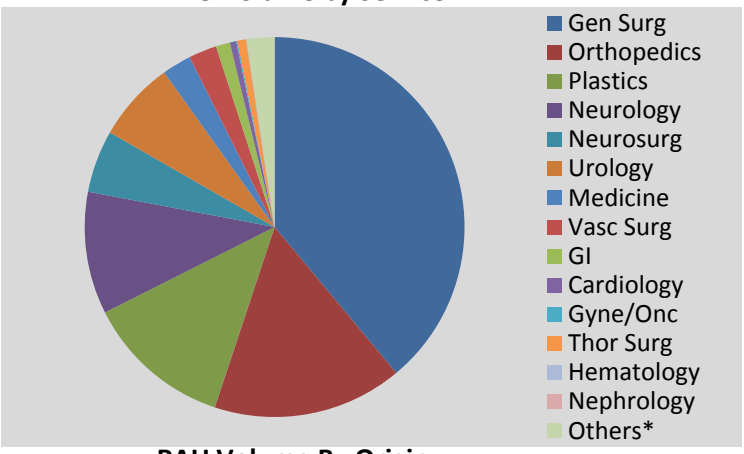
Context: Internal flow within an ED needs to optimize available space/capacity to meet the volume/CTAS demands of the presenting patients**.**

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

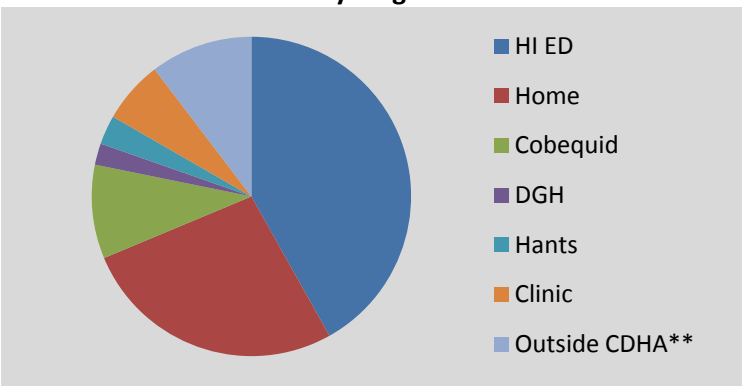


RAU Volume by Service



- 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 Volume By Origin



Analysis:

79% of all patients are seen in Pod 1 (chair centric care) or Pod 5 (fast track) – up from 74% in Quarter 4, 2012. This is a reflection of the number of hours that our actual ED acute care beds in Pods 2, 3, and 4 are blocked with admitted in-patients. This ratio is likely too high and will be decreased 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. This significantly reduces the load on the main ED beds.

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.

Site	CDU patients	CDU Patients Admitted	Percentage CDU Admitted	Total Site Patient Volume	Percentage Total Patients CDU	Median Length of Stay CDU Non Admitted patients (hr)
HI ED	178	33	18.5%	17236	1.0%	18.47
DGH ED	501	126	25.1%	9909	5.1%	15.62
CCHC ED	12	2	16.7%	8837	0.1%	7.73

Analysis:

The benchmark for CDU use in the province of Ontario is 4 – 5%. Unfortunately documentation of its use has not bee very good at the HI or CCHC but is approximately at the expected rate at the DGH.

CDU has been shown to reduce EDLOS, reduce admission rates with no increase in ED revisit rates in a recent Academic Emergency Paper.

David Petrie, District Chief, CDHA

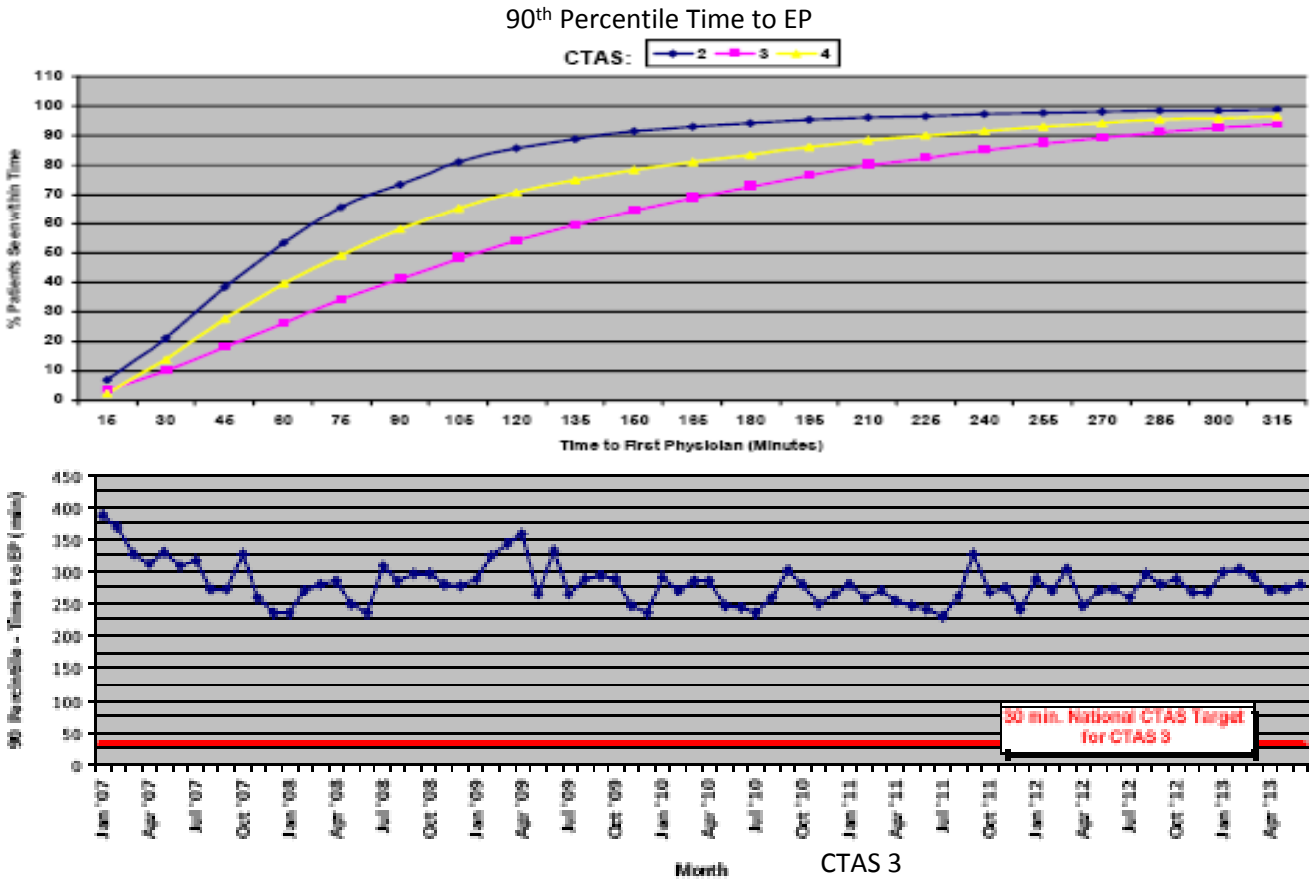
Patient Experience

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:

Our patients continue to wait an unacceptably long time for their emergency care, with CTAS 3 patients being most affected.

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.

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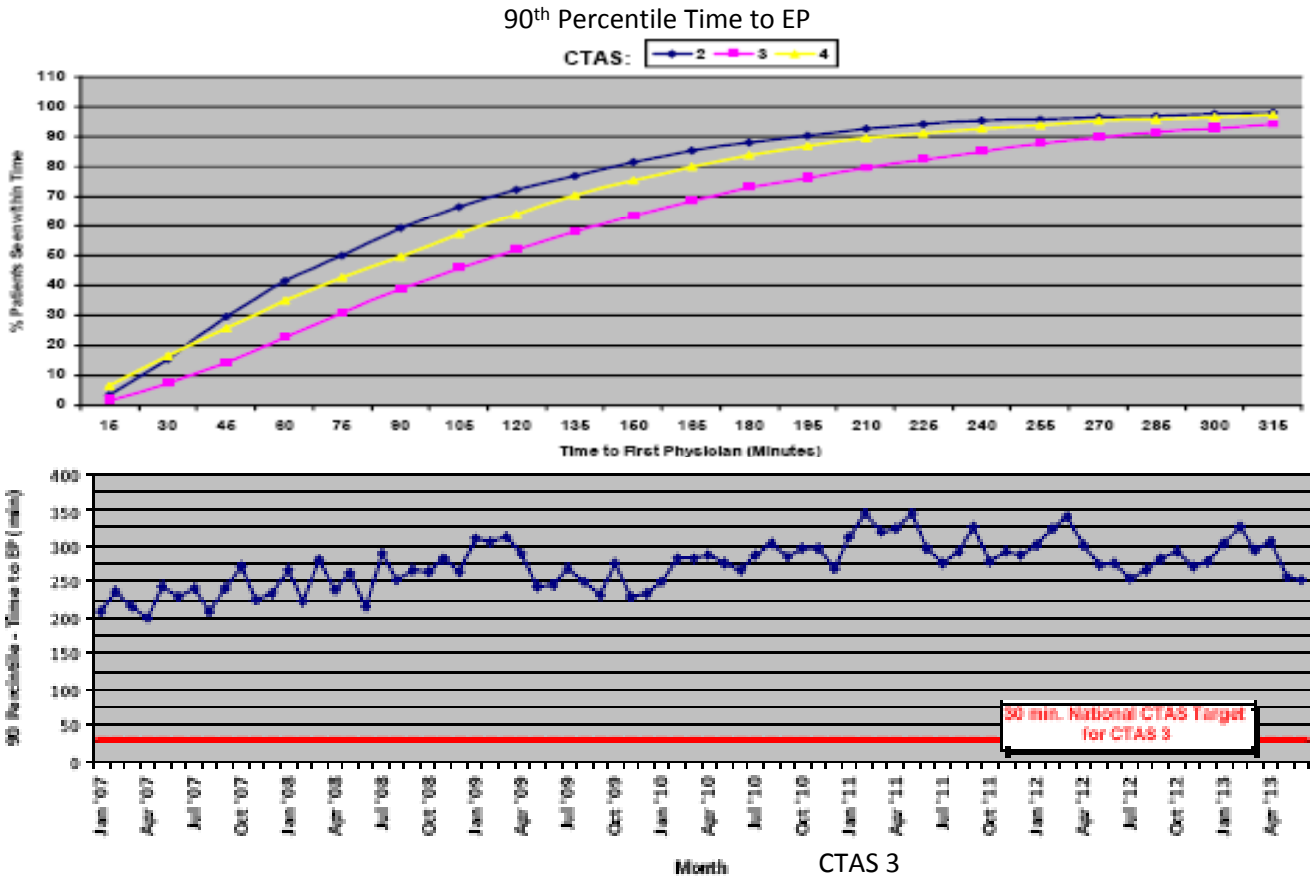

Analysis:

Since January 2013 the 90th percentile time to Emergency Physician is improving with aid from the new Emergency Department process implemented in January 2013 and additional physician coverage in April 2013.

Although there has been some recent improvement, since 2007 wait times have steadily increased. Lack of inpatient capacity at DGH continues to be the number one issue.

Ravi Parkash, Site Chief, and Lori Sanderson, Health Services Manager, DGH ED

Patient Experience

Wait Times – Cobequid ED

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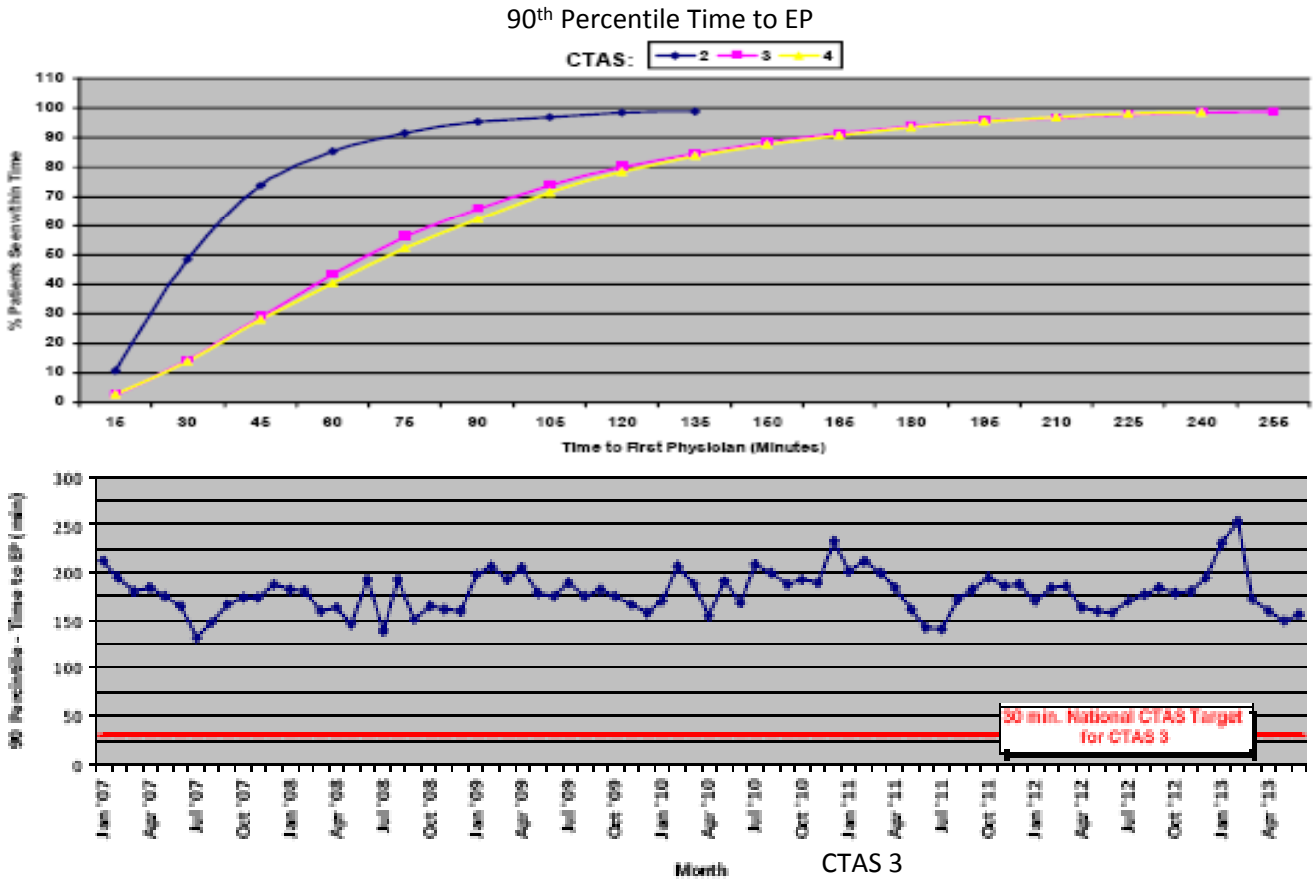


Analysis:

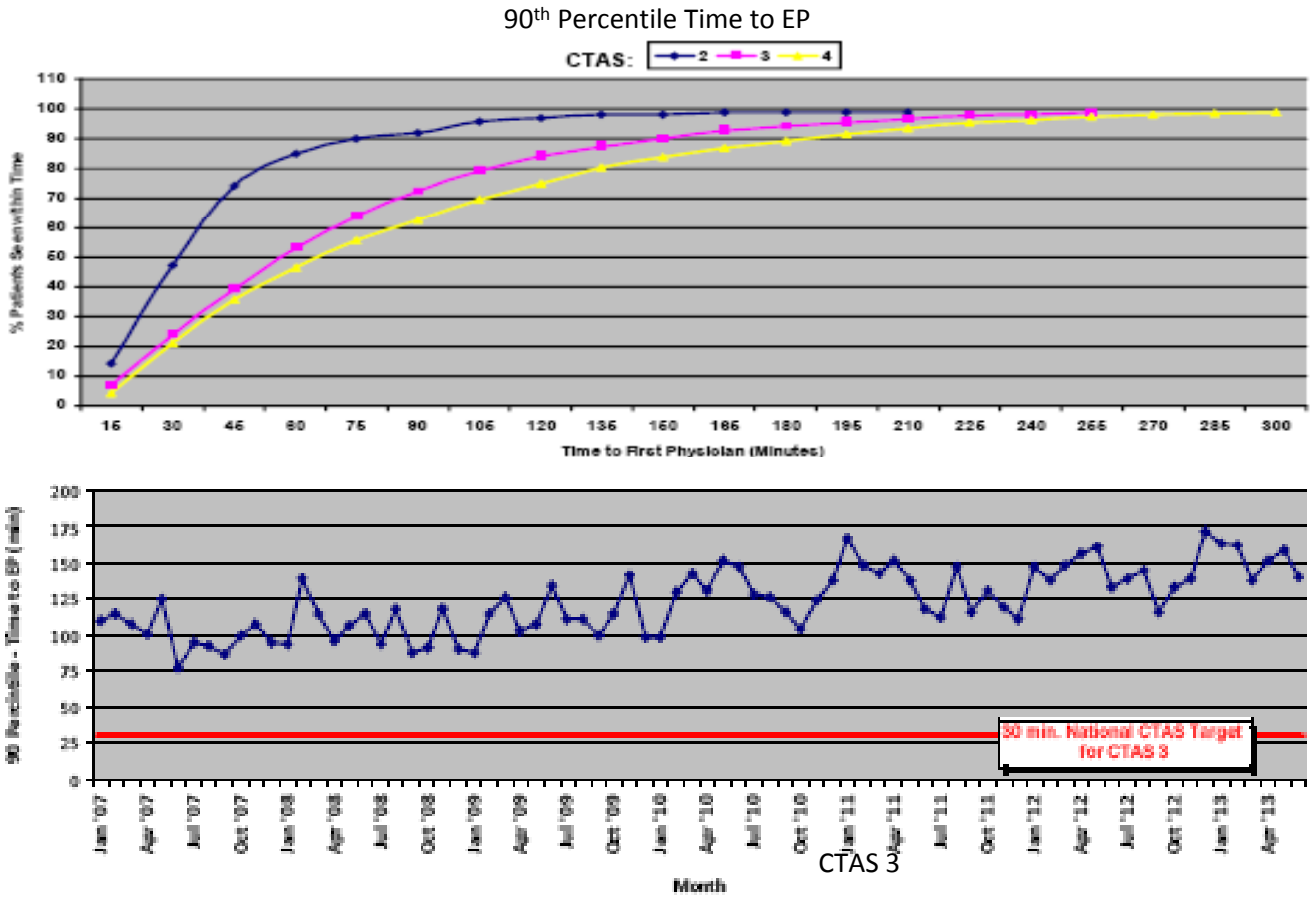
Patient Experience

Wait Times – Hants 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.



CTAS 3

Analysis:

Wait times within HCH exist due to:
1. Admitted bed shortages – creates limited space.
2. Increases time to consult/tertiary care.
3. Physician dependent (1 ERP) – limited flux.

Throughput initiative – increase initiation and use of nurse initiated protocols.

Tanya Penney, Health Services Manager, HCH 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: Apr 01, 2013 to: Jun 30, 2013

DI Ordered						
Site	Pt Volume	CT Orders (%Pt Volume)	US Orders (%Pt Volume)	MRI Orders (% Pt Volume)	XR Orders (%Pt Volume)	Total Di Orders (% Pt Volume)
QEII	17236	2207 (12.8%)	835 (4.8%)	36 (0.2%)	7445 (43.2%)	10523 (61.1%)
DGH	9909	1473 (14.9%)	466 (4.7%)	0 (0.0%)	5288 (53.4%)	7227 (72.9%)
HCH	4122	1 (0.0%)	65 (1.6%)	0 (0.0%)	1209 (29.3%)	1275 (30.9%)
CCHC	8837	649 (7.3%)	179 (2.0%)	0 (0.0%)	4413 (49.9%)	5241 (59.3%)
Total	40104	4330 (10.8%)	1545 (3.9%)	36 (0.1%)	18355 (45.8%)	24266 (60.5%)

Labs Ordered			
Site	Patients with Labs Ordered	% Patients with Labs	Patient Volume
QEII	7477	43.4%	17236
DGH	4920	49.7%	9909
HCH	1257	30.5%	4122
CCHC	3778	42.8%	8837
total	17432	43.47%	40104

Analysis:

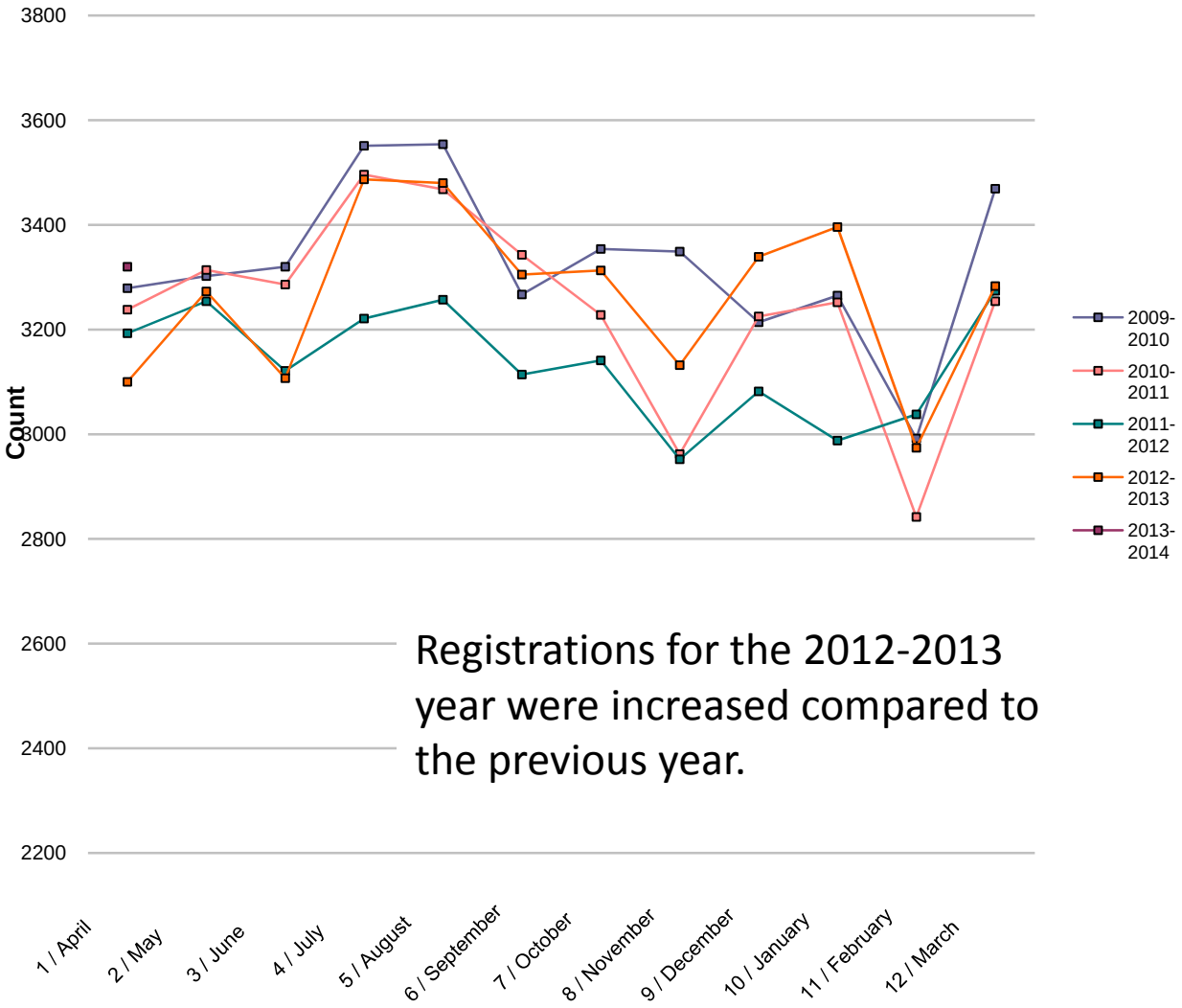
This is raw data looking at the percent of overall patients who receive a Cat Scan, Ultrasound, MRI (Magnetic Resonance Imaging), X-Ray or labs ordered during their assessments in the Emergency Department. This data is not adjusted to acuity, complexity, or presenting complaint / diagnosis. There are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

David Petrie, District Chief, CDHA

Capital Health - DGH ED

Emergency Department Registrations

	1	2	3	4	5	6	7	8	9	10	11	12	
	April	May	June	July	August	September	October	November	December	January	February	March	Fiscal Total
2009-2010	3279	3302	3320	3551	3554	3267	3354	3349	3214	3265	2992	3469	39916
2010-2011	3238	3314	3286	3496	3468	3343	3228	2962	3225	3252	2842	3254	38908
2011-2012	3193	3254	3121	3221	3257	3114	3141	2952	3082	2988	3038	3274	37635
2012-2013	3100	3273	3107	3487	3480	3305	3313	3132	3339	3396	2974	3283	39189
2013-2014	3320												3320

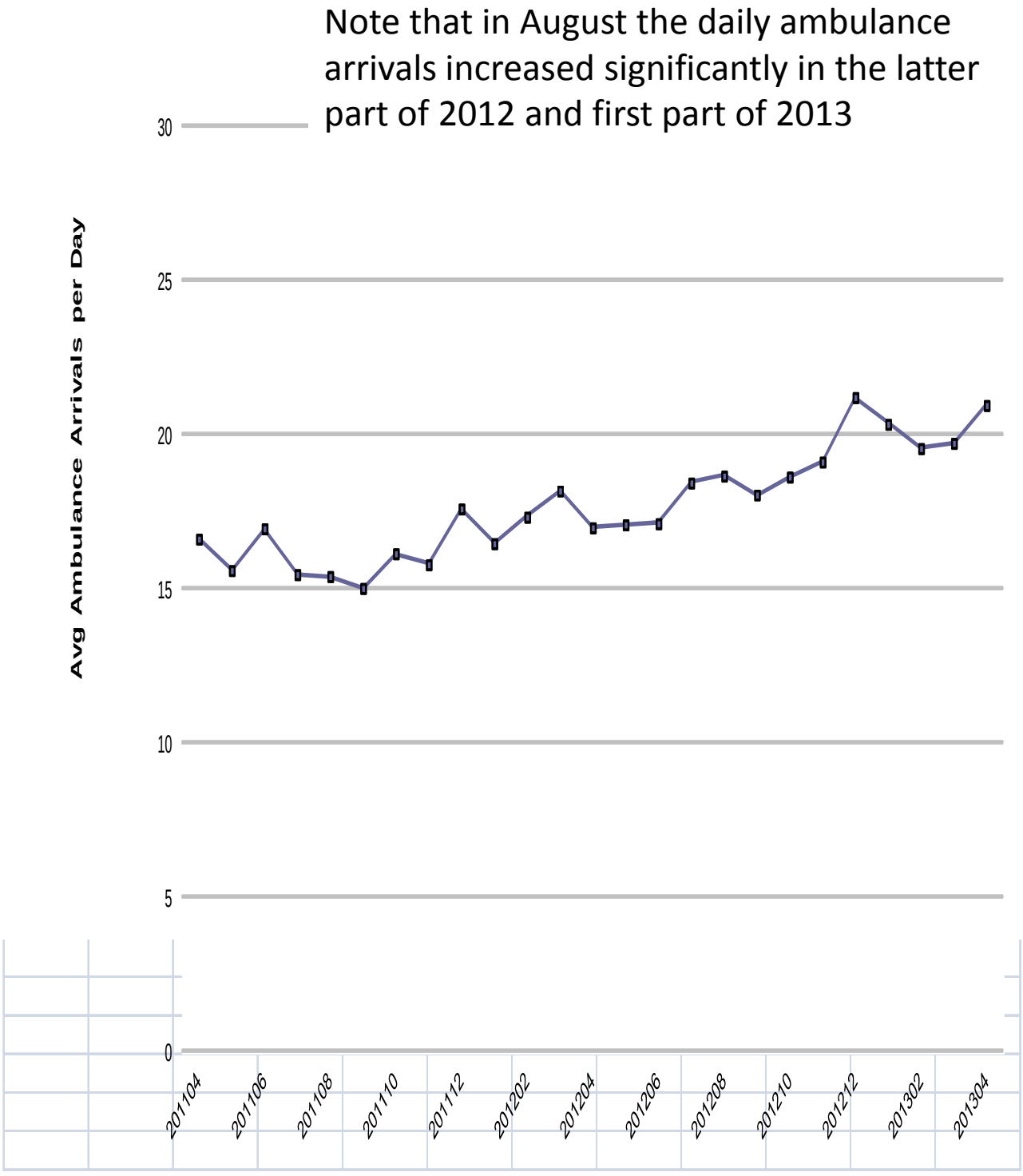


Registrations for the 2012-2013 year were increased compared to the previous year.

Capital Health - DGH Emergency Department

Average Daily Ambulance Arrivals (EHS Ground)

April 2011 to April 2013

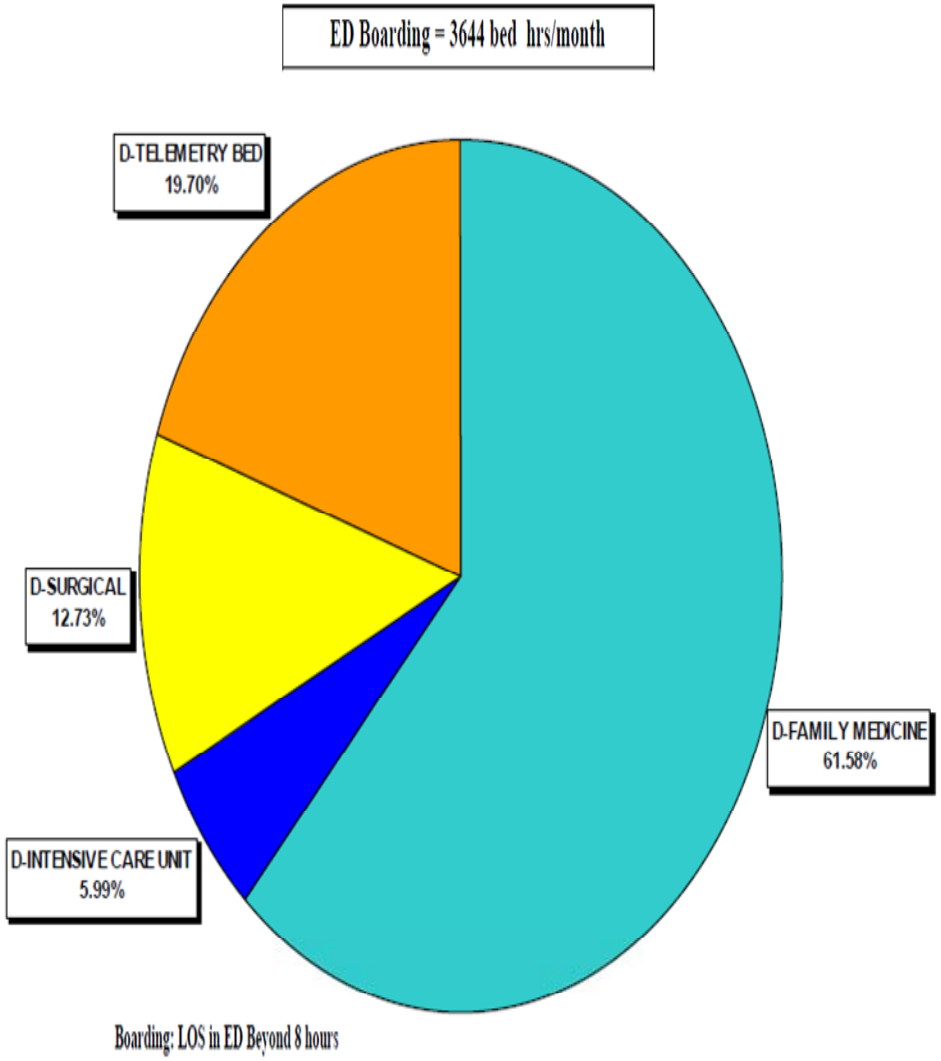


Dartmouth General Emergency Department Information System (EDIS)

Admitted Patient LOS Summary (Time Triaged to Time Depart ED for Inpatient Bed)

Reporting Period from: Apr 01, 2013 to: Apr 30, 2013

Service	Total Admits	LOS > 8 Hrs	LOS > 24 Hrs	Avg LOS in ED	90%ile LOS in ED
FAMILY MEDICINE	190	170 (89.5%)	55 (28.9%)	19.0	30.6
INTENSIVE CARE UNIT	40	15 (37.5%)	1 (2.5%)	8.5	22.3
SURGICAL	64	43 (67.2%)	2 (3.1%)	12.6	21.8
TELEMETRY BED	39	35 (89.7%)	24 (61.5%)	25.6	43.7



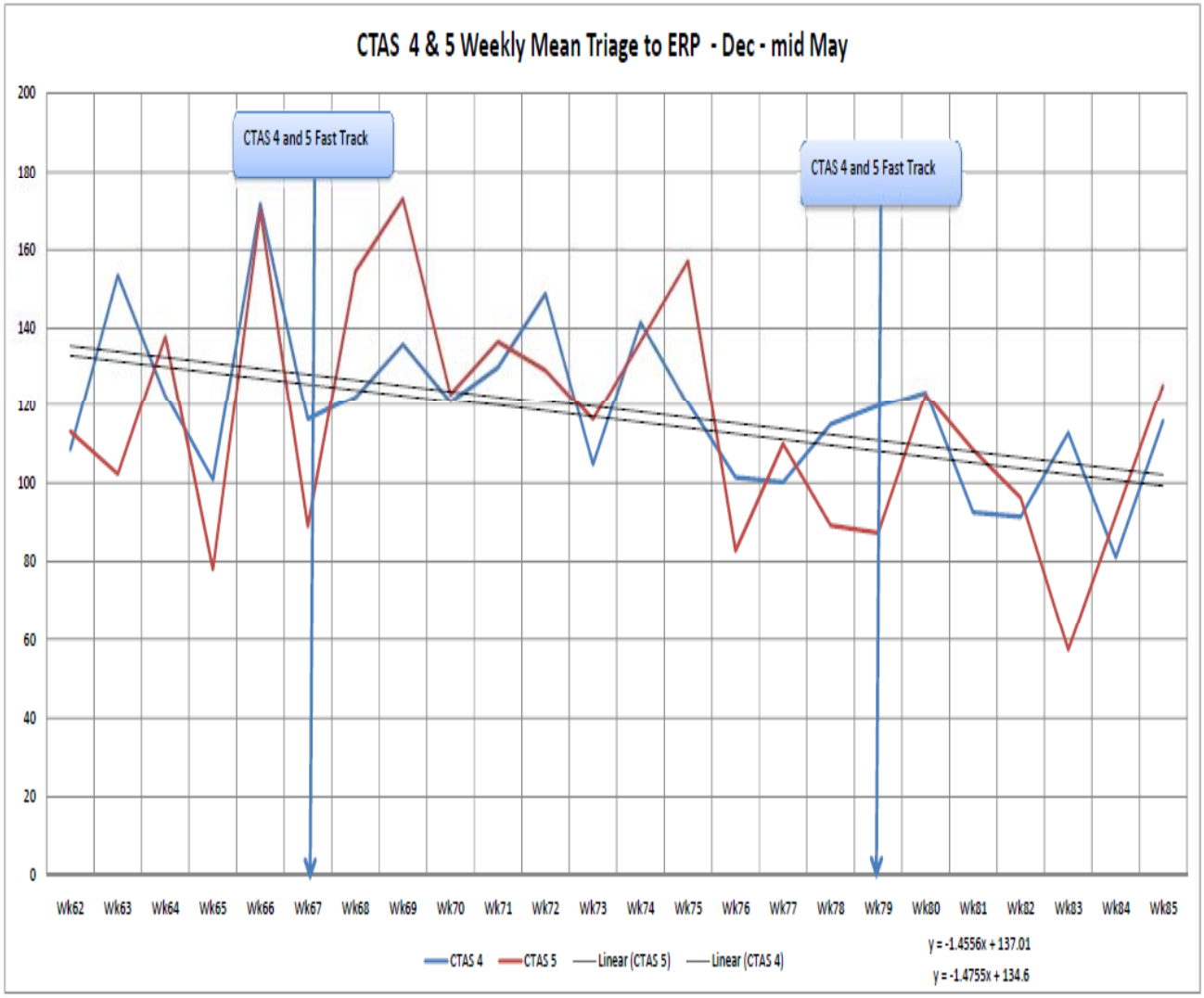
When admitted patients are held in the Emergency Department, space end nursing resources which would otherwise be used to treat incoming patients is limited. This “access block” is the main obstacle in providing timely care to Emergency Department patients. Emergency Department boarding of inpatients averaged 3644 bed hours/month (or approximately 120 bed hours/day) for April 2013.

The focus of Dartmouth General ED…

Ensuring the most rapid possible contact with a Physician satisfies the desires of the ED patients, promotes efficiency of care and shortens length of stay”

“Leading Practices in Emergency Department Patient Experience”, Ontario Hospital Association (2010/2011)

Triage to ERP Times CTAS 4 - 5



In January 2013, changes to the Fast Track area at Dartmouth General Hospital for lower acuity patients were made. Since then, wait-times have decreased significantly by approximately 40 minutes. Week 67 represents implementation. At week 79, additional physician coverage was added. We are encouraged that the trend towards reduced wait times will continue at Dartmouth General Hospital Emergency Department.

Patient Satisfaction Results

Pre and Post implementation	Pre Implementation	Post Implementation
	% Agree or Strongly Agree	% Agree or Strongly Agree
1. I was seen in triage (first assessment) in a reasonable amount of time	88%	95%
2. I was seen by a Doctor in a reasonable amount of time	15%	55%
3. I received care, and treatment in a reasonable amount of time	15%	29%
4. Throughout my visit, I (or family /friends/care giver) was kept informed about delays and wait times	13%	55%
5. I (or family/friends/care giver) was kept informed about tests and treatments	37%	63%
6. I (or family/friends/care giver) felt understood and cared about by the Emergency Department staff	54%	82%
7. Throughout my Emergency Department visit (triage, registration, tests and treatment), my pain level was managed in a timely manner	57%	58%
8. Staff kept me (or family/friends/care giver) informed about the next steps in care	26%	60%

Since introducing changes to the Fast Track area for lower acuity patients, patient satisfaction results have improved significantly. The changes were centered around ensuring the most rapid possible contact with a physician. Further changes will be coming in the next several months and a follow up survey done.



Tri Facilities Update

A major shift in the delivery of care has occurred in the tri- facilities over the past year. The Twin Oaks Memorial Hospital, (TOMH), and the Musquodoboit Valley Memorial Hospital, (MVMH), opened Collaborative Emergency Centres, (CEC), as part of the Department of Health and Wellness Better Care Sooner plan. As has been well publicized, these centres provide primary care, as well as urgent care on a same or next day basis to patients in the catchment areas and beyond. Care is delivered in a variety of settings including doctor's offices, hospital primary care clinical areas and hospital emergency rooms. Patient's self select the care most appropriate to their needs. Physicians provide the service for the most part during the hours of 8am to 8 pm and paramedics in the community provide urgent care after 8 pm in the catchment of MVMH, and in the hospital emergency room in collaboration with a RN at TOMH.

The proposed advantages of the CEC included a greater availability of primary care in the community, better allocation of limited physician resource to the hours it is most needed, and possible reduction in emergency room usage to care being delivered in a more appropriate setting. Concerns included the withdrawal of 24/7 in community physician availability to the emergency room with possible adverse heath consequences, possible increased referral to regional hospitals due to the lack of 24 hour physician coverage and demand for same day services overwhelming the available resource.

Attached is some early data comparing clinical activity in the two community CEC's. In the case or TOMH, we compared activity in the 6 months leading up to the opening of the CEC and the first 6 months after opening. At MVMH, with only 2 months of data, we compared the same months in the year previous.

Of interest, in both CEC's the visit to the ER's significantly declined. At TOMH, ER visits declined by 39% and at MVMH, the decline was 44%. Total number of transfers at both institutions increased slightly from 122 to 132 at TOMH and from 25 to 27 at MVMH. The transfer rate at TOMH increased from 6 % prior to the CEC to 11% after the CEC. At MVMH the transfer rate increased from 4% prior to the CEC to 8% in its first two months.

We have also attached the Emergency Room Activity at Eastern Shore Memorial Hospital in Sheet Harbour. Due to geographic isolation, the CEC model was not seen as a safe fit for the community and it continues to maintain a 24 hour emergency service.

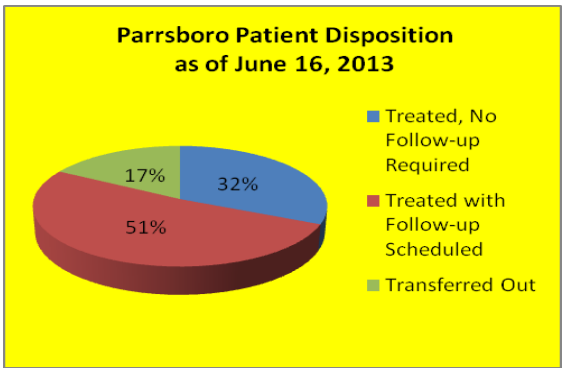
ED Visits and Transfers
Eastern Shore Memorial Hospital,
Twin Oaks Memorial Hospital, and
Musquodoboit Valley Memorial Hospital

1.	ESMH – total number of ED *visits* for the past six months (November 1, 2012 to April 30, 2013) (no time of day restrictions)	**726**
2.	ESMH – total number of *transfers from ED to another facility* for the past six months (November 1, 2012 to April 30, 2013) (no time of day restrictions)	**54**
3.	ESMH – total number of visits between 2000 hr and 0800 hr in the past six months (November 1, 2012 to April 30, 2013)	**175**
1.	TOMH – total number of patients seen in the ED between 2000 hr and 0800 hr for the six months *prior* to the CEC transition (May 1, 2012 to October 31, 2012)	**383**
2.	TOMH – total number of patients seen in the ED between 2000 hr and 0800 hr for the six months *after* the CEC transition (November 1, 2012 to April 30, 2013)	**243**
3.	TOMH – total number of patients seen in the ED (no time of day restrictions) for the six months *prior* to the CEC transition (May 1, 2012 to October 31, 2012)	**1,941**
4.	TOMH – total number of patients seen in the ED (no time of day restrictions) for the six months *after* the CEC transition (November 1, 2012 to April 30, 2013)	**1,190**
5.	TOMH – total number of transfers from the ED to another facility (no time of day restrictions) for the six months *prior* to the CEC transition (May 1, 2012 to October 31, 2012)	**122**
6.	TOMH – total number of transfers from the ED to another facility (no time of day restrictions) for the six months *after* the CEC transition (November 1, 2012 to April 30, 2013)	**132**
1.	MVMH – total number of patients seen in the ED (no time of day restrictions) about one year *prior* to the CEC transition (March and April 2012)	**584**
2.	MVMH – total number of patients seen in the ED (no time of day restrictions) *after* the CEC transition (March and April 2013)	**331**
3.	MVMH – total number of transfers from the ED to another facility (no time of day restrictions) about one year *prior* to the CEC transition (March and April 2012)	**25**
4.	MVMH – total number of transfers from the ED to another facility (no time of day restrictions) *after* the CEC transition (March and April 2013)	**27**

Collaborative Emergency Centres Dashboard

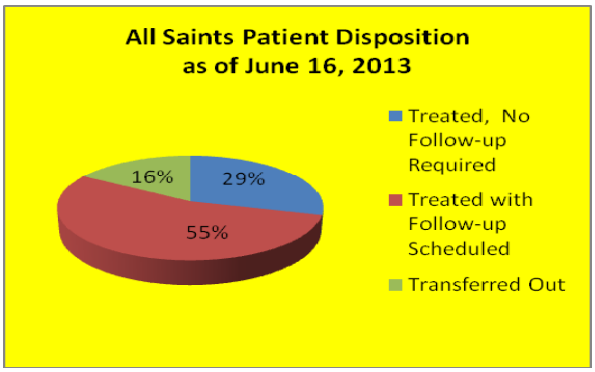
Parrsboro

Days in Program – 690
Total Patients – 528
Overall Incidence Rate – 0.77
Adjusted Incidence Rate – 1.50
Non-Utilization Rate – 49%



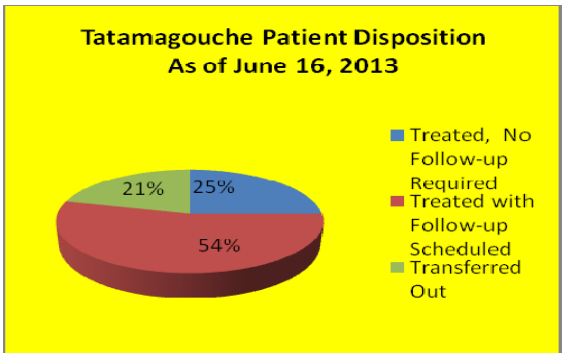
All Saints

Days in Program – 445
Total Patients – 707
Overall Incidence Rate – 1.59
Adjusted Incidence Rate – 2.09
Non-Utilization Rate – 24%



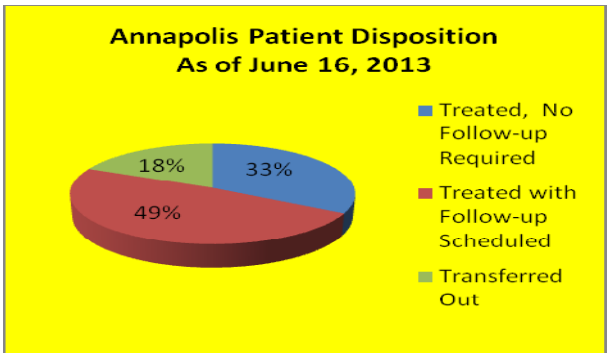
Tatamagouche

Days in Program – 342
Total Patients – 428
Overall Incidence Rate – 1.25
Adjusted Incidence Rate – 1.93
Non-Utilization Rate – 35%



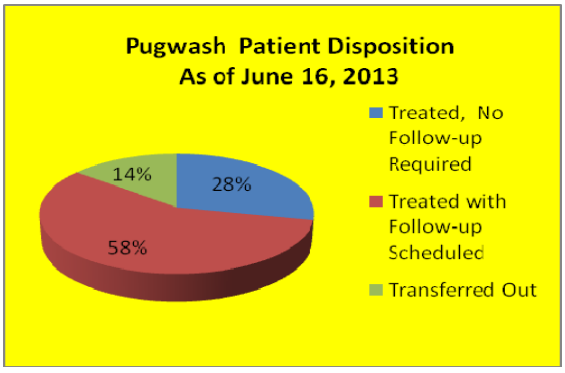
Annapolis

Days in Program – 273
Total Patients – 266
Overall Incidence Rate – 0.97
Adjusted Incidence Rate - 1.57
Non-Utilization Rate – 38%



Pugwash

Days in Program – 271
Total Patients – 289
Overall Incidence Rate – 1.07
Adjusted Incidence Rate – 1.75
Non-Utilization Rate – 39%



Musquodoboit

Days in Program – 209
Total Patients – 248
Overall Incidence Rate – 1.19
Adjusted Incidence Rate – 1.70
Non-Utilization Rate – 30%