Our Health Care Report Card

Sept 2016

This report card provides an update on Fraser Health's June 2014 Strategic and Operational Plan. The report card is issued quarterly to coordinate with progress reports provided to the Ministry of Health and tracks 30 indicators corresponding to priority action areas for quality and sustainable service delivery.

September 2016 highlights

Of the 30 indicators, nine are meeting the target; 17 are approaching the target (within 10 per cent) and four are off-target, requiring focused and sustained effort to achieve. We're pleased to see the number of indicators meeting or approaching target increasing. This reflects our continued focus on measuring our work and finding ways to continually improve.

Indicators fluctuate based upon season and demand. Every day, month, and quart

er tells a story of the work we perform. For instance, we are opening 403 residential care beds in 2016. In isolation, these openings hold little meaning, until you consider some of the other work taking place in our communities to allow seniors to live at home longer and healthier. One such example is our focus on frail seniors in the community. Working with divisions of Family Practice, we've created a Frail Seniors Care Team to address issues faced by frail seniors and ultimately keep them out of residential care and the hospital. We're investing in more community nurses and licensed practical nurses and, already this year, we've hired 14 full time equivalent positions in Abbotsford and Langley. When this work is done, there will be a total of 28.5 new full time equivalent positions caring for frail seniors in the communities of Abbotsford, Langley and Mission. What does this mean for our hospitals? These efforts – partnerships with Family Practice physicians, new residential care beds, focusing on frail seniors, and adding resources to the community – mean fewer trips to the emergency department and fewer admissions to hospital and that's better for patients and our health care system as whole.

Areas of focus

We look at a number of indicators to determine our capacity to care for people in our hospitals. Taken separately, they each tell a story. Taken together, you can begin to see a pattern reflecting the work we are doing and underpinned by the belief that people should receive the right level of care, at the right place, and the right time in their health care journey. We've seen a positive trend in areas like the average length of stay for patients in our hospitals, which helps us assess the quality of care patients receive. We believe by building community services and improving hospital processes, we can help people transition home sooner. Within our hospitals, we're also working to ensure people receive care in the best location. We're monitoring our transfer processes throughout the hospital and increasing our communication and collaboration to help move people from an Emergency bed to a hospital bed more quickly. The number of patients waiting for an inpatient bed across Fraser Health is moving closer to achieving our target in this area.

Success stories

- The rate of falls that result in an injury in residential care facilities continues to show improvement, down to 2.1 per 100 residents.
- The length of stay for patients from April to September has advanced consistently towards its target, decreasing nearly 3 percent when compared to the similar period two years ago.
- The average number of patients that have stayed more than 30 days has significantly improved, likely driven by the expansion of residential care capacity and other coordinated actions to improve their transitions to home.
- We are nearing our target for the percent of hip fractures surgeries completed within 48 hours.
- We continue to drive down the incidence rate of *C. difficile* in our hospitals.
- Our hand hygiene efforts continue to be well above our targets.

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Fraser Health

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No		Measure Name	Last Available Update	Target	Actual	Status	Preferred Direction	Trend
		MONTHLY						
		CAPACITY FOR CARE ACROSS ALL SECTORS						
1		Average In Hospital Length of Stay in Days	Apr-Aug 2016	7.8	8.09	▲	↓	
2		Long Stay Patients Staying Over 30 Days	Apr-Aug 2016	455	441.7	●	↓	
3	*	Alternate Level of Care Days	Apr-Jun 2016	10%	16.9%	◆	↓	
4	*	Emergency Patients Admitted to Hospital Within 10 Hours	Jan-Aug 2016	55%	37.1%	◆	↑	
5		Number of Admitted Patients Awaiting Inpatient Bed Placement (Including Emergency Admits)	Apr-Aug 2016	165	176.2	▲	↓	
		QUALITY AND SAFETY						
6	*	Care Sensitive Adverse Events Rate per 1,000 Hospitalizations (Age 55+)	Jan-May 2016	31.3	34.00	▲	↓	
7	*	Percent of Hip Fracture Fixations Completed Within 48 Hours	Apr-Aug 2016	90%	89.0%	▲	↑	
8		Facility-Associated Clostridium Difficile Infection (CDI) Incidence	Apr-Aug 2016	6.0	4.6	●	↓	
9		Facility-Associated Methicillin-Resistant Staphylococcus Aureus (MRSA) Incidence	Apr-Aug 2016	7.0	7.4	▲	↓	
10		Hand Hygiene Compliance (%)	Apr-Aug 2016	80.0%	86.0%	●	↑	
		STAFF						
11		Sick Time Rate	Apr-Aug 2016	5.0%	4.80%	●	↓	
12		Overtime Rate	Apr-Aug 2016	3.0%	2.52%	●	↓	
13		Difficult to Fill Vacancies	Apr-Aug 2016	1.6%	1.19%	●	↓	
		BUDGET ACCOUNTABILITY						
14		Budget Performance (Net Variance to Budgeted Expenditure Ratio)	Apr-Aug 2016	1.000	1.008	▲	↓	
15		Direct Care Hours Per Patient Day (Acute Nursing Inpatient)	Apr-Aug 2016	6.7	7.16	▲	↓	
16		Expenditures Per Separation (All Acute)	Apr-Aug 2016	$11,250	$11,905	▲	↓	
		QUARTERLY						
		CAPACITY FOR CARE ACROSS ALL SECTORS						
17	*	Average Length of Stay /Expected Length of Stay (ALOS/ELOS)	Apr-Sep 2015	0.95	1.01	▲	↓	
18	*	Readmission Rates Utilization (Emergent/Urgent), All Causes	Apr-Sep 2015	10%	10.5%	▲	↓	
19	*	Ambulatory Care Sensitive Conditions Hospital Admissions Rate (Age <75)	Apr-Dec 2015	234	246	▲	↓	
20		Ambulatory Care Sensitive Conditions Hospital Admissions Rate (Age 75+)	Apr-Dec 2015	3,048	3,322	▲	↓	
		QUALITY AND SAFETY						
21		Hospital Standardized Mortality Ratio	2015/2016	90	92	▲	↓	
22		Falls that Result in An Injury in Residential Care Facilities	2015/2016	3.0	2.1	●	↓	
23	*	Emergency Patient Experience	2014/2015	90.0%	78.4%	◆	↑	
		PUBLIC HEALTH MEASURES						
24		Percent of 2-Year Olds with Up-To-Date Immunizations	Jan-Jun 2016	80%	75.9%	▲	↑	
25		Percent of Drinking Water Systems Complying with Microbial Monitoring Requirements	Jan-Jun 2016	96%	93.5%	▲	↑	
		STAFF						
26	++	WorkSafeBC (WSBC) Claims Duration	Oct-Dec 2015	28	36.8	◆	↓	
27	++	WorkSafeBC (WSBC) Claims / 100 FTE	Oct-Dec 2015	7.0	6.8	●	↓	
		ANNUALLY						
		CAPACITY FOR CARE ACROSS ALL SECTORS						
28	*	Age-Standardized Hospitalization Rates for FH Residents (Age 70+)	2014/2015	253	261	▲	↓	
		PUBLIC HEALTH MEASURES						
29	*	Percent of Communities with Completed Healthy Living Strategic Plans	2015/2016	60%	80.0%	●	↑	
		STAFF						
30		Employee Engagement	2013/2014	3.75	3.52	▲	↑	

Status Legend:

- ● *Meeting Target*
- ▲ *Within 10% of Target*
- ◆ *Outside Target range by more than 10%*

All measures reported on YTD (Year-to-Date) basis

* Ministry of Health Measure

++ Measures Reported by Single Quarter

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Average In Hospital Length of Stay in Days

How long are our patients staying in the hospital per visit?

What are we measuring?

We are measuring the average number of days that patients stay in our hospitals. This measure includes Alternative Level of Care (ALC) days, when the patient could have been appropriately cared for in a non-hospital location.

Why?

Length of Stay (LOS) is an important metric for assessing the quality of care and planning capacity within a hospital. On the one hand, our patients need to stay in the hospital long enough to receive the proper treatment, and on the other, excessive stay would expose our patients to potential infections and occupy capacity that could be used for others in need.

How do we measure it?

Length of Stay (LOS) is defined as the number of days a patient spends in the hospital from the time of admission to time of discharge. We calculate the average LOS by summing the total length of stay for all patients in all our hospitals and dividing it by the total number of patients in all our hospitals.

How are we doing?

The year-to-date Average Length of Stay (ALOS) is 8.09 days. In a year-to-date comparison, our current performance is 0.14 day lower than our last year's performance of 8.23 days reported for April 2014 to August 2015. Frasers Health's overall length of stay has decreased from 8.85 to 8.09 for 2016/2017.

What are we doing?

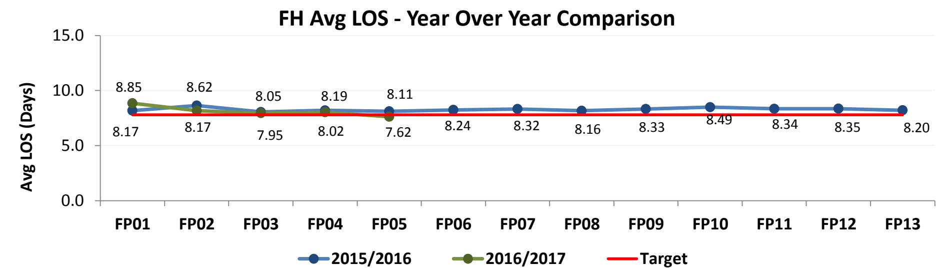
We are building community services to support patients at home. In hospitals, we are improving our care processes to decrease unnecessary delays in care and expedite steps that help people transition home sooner. We are working with patients and their families to begin planning for discharge early in a patient's stay to ensure patients have what they need for a smooth transition home. We have developed individual targets for all hospitals that are clear, concrete, intelligent, and we are rigorously perusing these performance targets keep us on track to deliver patient centered care.

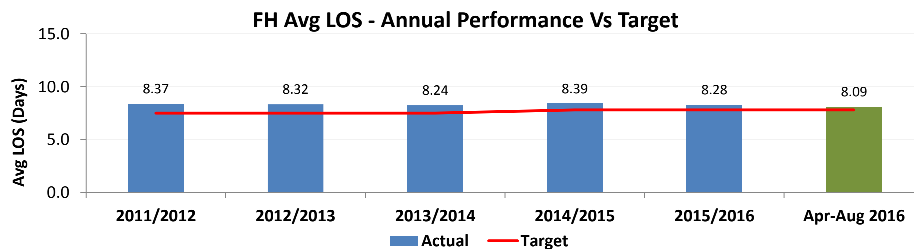
What can you do?

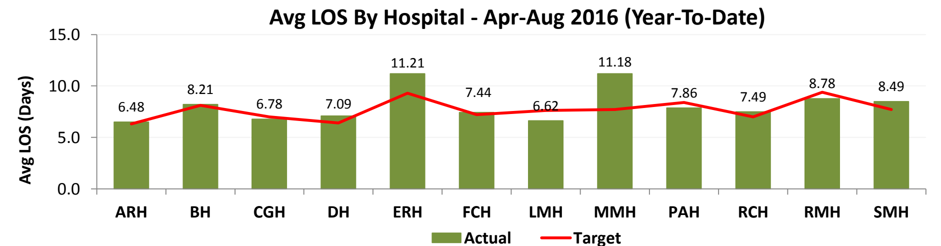
Talk with your care team about when you are likely to be discharged and what supports you might need to return home.

Our Performance	Target *
8.09	***<= 7.8***

Performance timeline:	Apr-Aug 2016 (Year-To-Date)
Data Source:	Meditech
* Target Source:	FHA Internal







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Long Stay Patients Staying Over 30 Days

How many patients are staying in hospital longer than 30 days?

What are we measuring?

The average number of patients per day staying in the hospital longer than 30 days.

Why?

Our goal is to provide the best quality of care for our patients. When patients have stayed longer than 30 days in the hospital, it is likely their care needs are better suited in a different setting, such as community, long term care, or a separate rehabilitation facility. Keeping patients in hospitals when they could be cared for elsewhere, is not an efficient use of our hospitals and contributes quality and safety risks.

How do we measure it?

A long stay patient is defined as a patient that stays in the hospital longer than 30 days. We track the daily number of long stay patients in our hospitals by performing a count of our patients at the end of each day. The average number of long stay patients per day is calculated by summing the daily counts of the measurement period and dividing it by the number of days in the period.

How are we doing?

At 441.7 the year-to-date average number of long-stay patients is lower than the Fraser Health internal target of 455. Fraser Health is pleased to report that our current number of long stay patients are the lowest that we have reported in four years at this point in time. This ensures that patients are receiving the right level of care at the right time in their health care journey.

What are we doing?

Fraser Health has patient care rounds that focus specifically on patients with complex needs to coordinate their care and identify resources that they might need. Health Care leaders are making adjustments to our community services to support patients who do not need to be in a hospital and can be cared for in the community. We continue focusing on strategies to improve our performance.

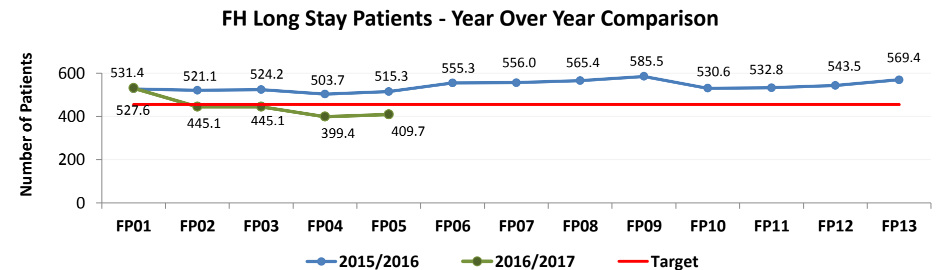
What can you do?

You are encouraged to talk with your health care team about when you are likely to be discharged and what supports you may need to return home.

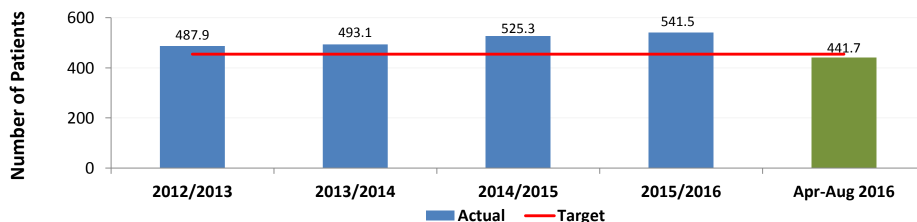
Our Performance	Target *
441.7	***<= 455***

Performance timeline:	Apr-Aug 2016 (Year-To-Date)
Data Source:	Meditech
* Target Source:	FHA Internal

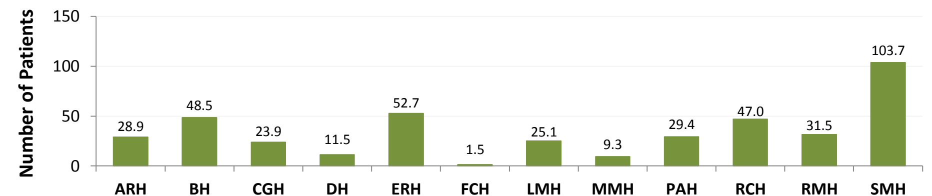
***Note** : Target is set based on an 8% improvement from FY2013/14*



FH Long Stay Patients - Annual Performance Trend Vs Target



Long Stay Patients By Hospital - Apr-Aug 2016 (Year-To-Date)



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Ministry of Health Measure

Report Generated: **September, 2016**

Alternate Level of Care Days

How many “extra” days do patients spend in hospital?

What are we measuring?

We track how many "extra" days patients spend in hospital when they no longer need hospital treatment. These patients are usually waiting to transfer to other care services such as residential care, home care, or specialized forms of housing and support. The ALC rate will never be zero due to lag between the time a patient finishes hospital treatment and moves to a new service

Why?

Timely access to the appropriate type of care is in the best interests of our patients and may increase their chances for a healthy recovery. It also means that hospital beds are available for the patients who truly need them. Within the organization, the time it takes to move a patient to an alternate level of care (ALC) may relate to how responsive our primary, community, residential care, mental health and addiction services are to patients, how closely the teams work together, a lack of capacity for the right type of care, or inefficient processes for transferring a patient.

How do we measure it?

We compare the actual date patients were discharged from hospital to the date they were expected to leave the hospital. The difference in the number of days reflects the “extra” ALC days. This is divided by the total number of patient days in hospital to give us an ALC percentage.

How are we doing?

Our year-to-date ALC rate is 16.9%, which does not meet our internal target of 10%. This is due to high demand for ALC services in all regions across Fraser Health.

What are we doing?

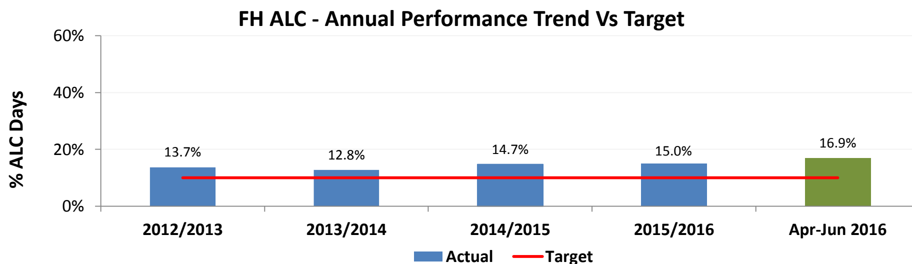
We prevent unnecessary admissions to hospital by providing access to appropriate community resources through our integrated community health networks. Daily meetings are held with clinical leadership and health care workers to focus on discharge planning. We ensure appropriate and sufficient community resources such as home support and residential care beds are available. To this end, in April 2015, 35 new residential care beds were added in Burnaby and in 2016, a total of 403 new residential care beds will be added across White Rock, Surrey and the TriCities. Multiple home health care intake lines have been consolidated into one centralized call center to provide user friendly access to community resources. We are identifying and facilitating safe discharge home plans for those individuals awaiting residential care through the Home First Initiative. Home Health nurses are contacting patients after hospital discharge to identify any unmet needs. Home Health has many initiatives underway to optimize capacity of resources to increase supports at home.

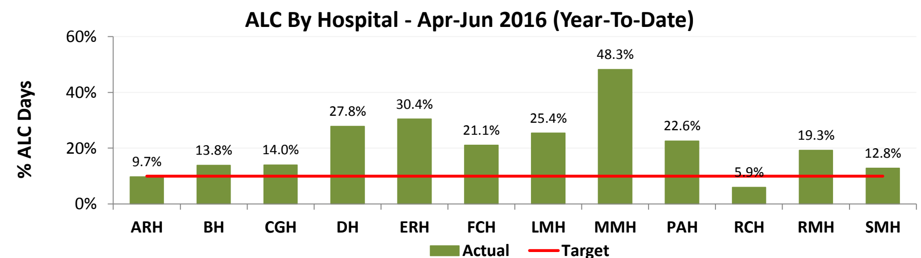
What can you do?

Collaborate with your health care team to establish a safe and appropriate discharge plan including access to appropriate community resources.

Our Performance	Target *
16.9%	<= *10.0%*

Performance timeline:	Apr-Jun 2016 (Year-To-Date)
Data Source:	Med2020 Abstracting and Coding System
* Target Source:	FHA Internal





Ministry of Health Measure

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Emergency Patients Admitted to Hospital Within 10 Hours

How quickly do patients who visit our emergency departments move to a hospital bed when needed?

What are we measuring?

We are measuring the percentage of emergency patients being admitted to the hospital who move from the Emergency Department(ED) to a hospital bed within 10 hours from the time they are registered or triaged (whichever is earlier).

Why?

Our Emergency Departments treat hundreds of people every day. In order to provide the best care for our patients, we want them to receive timely treatment and to move to a hospital bed for further care, if needed, within 10 hours. This frees up beds in the ED for other patients waiting for treatment and ensures proper care environment for our admitted patients.

How do we measure it?

We track from the time patients are triaged or registered (whichever is earlier) at the ED to the time they leave the ED to go to an inpatient bed. This gives us the number of patients who are admitted to hospital within 10 hours. We divide this number by the total number of patients being admitted to the hospital from the ED.

How are we doing?

Our 2016 year-to-date performance (37.1%) is not meeting our target (55.0%). We recognize the need to improve our performance continuously to achieve our target and to provide higher quality of care for our patients. Recent results at the site level show that most hospitals are still performing below the set targets. Each site is monitoring performance on this indicator and has developed a plan for improvement.

What are we doing?

Fraser Health wants to ensure that you receive your care in the right place at the right time. We are monitoring our transfer processes and have identified opportunities for improvement. These opportunities include increasing communication and collaboration as patients move through the hospital.

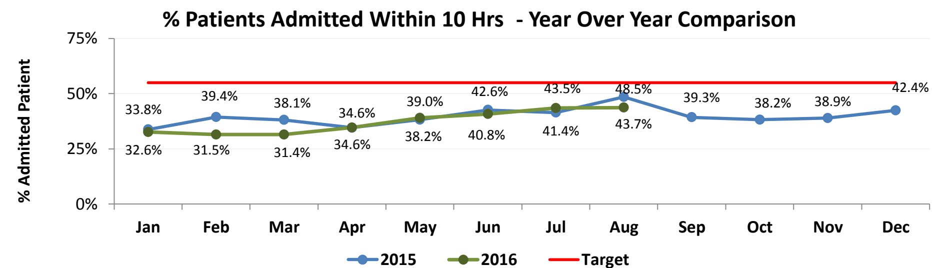
What can you do?

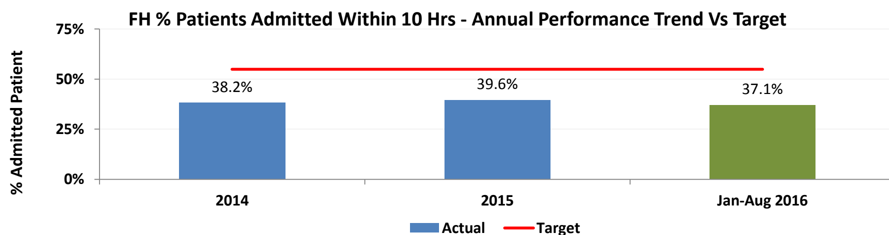
Fraser Health is committed to working with the communities that we serve to place more emphasis on the promotion of health and on preventing or delaying chronic diseases, disabilities, and injuries. Doing this will improve the quality of life while reducing disparities in health and the impact these conditions have on individuals, families, communities, the health-care system.

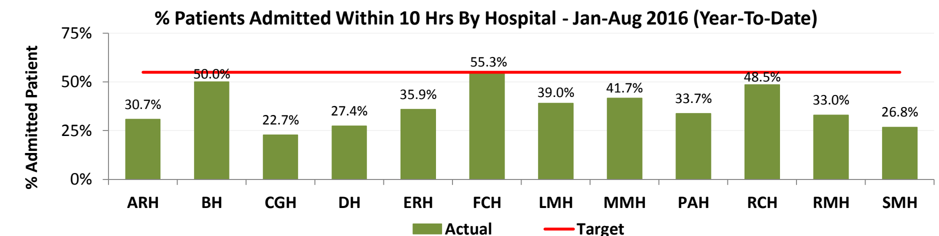
Our Performance	Target *
37.1%	***>= 55%***

Performance timeline:	Jan-Aug 2016 (Year-To-Date)
Data Source:	NACRS as measured by FHA
* Target Source:	BC Ministry of Health

***Note** : 1) Each site is equally weighted for the calculation of the average Fraser Health performance. This method matches the methodology used for the Pay for Performance evaluation criteria set by the BC Ministry of Health;*
2) Data source for this measure is from National Ambulatory Care Reporting System (NACRS). FHA started reporting data for all its acute hospitals officially from April 2014. Older data is available in NACRS since January 2014, but not prior to that date.







Number of Admitted Patients Awaiting Inpatient Bed Placement (Including Emergency Admits)

How many patients admitted to hospital are receiving care in locations typically not designated for inpatient clinical care?

What are we measuring?

Number of patients admitted to hospital receiving care in a location not typically designated for inpatient clinical care such as Emergency Department, hallway, lounge, or other spaces.

Why?

Patients who require inpatient hospital care receive the best care in locations designed specifically for that care. Patients who are waiting to move to an inpatient room have higher safety and quality of care risks. Moving admitted patients quickly out of the Emergency Department (ED) also allows our ED teams to respond to patients who require emergency care.

How do we measure it?

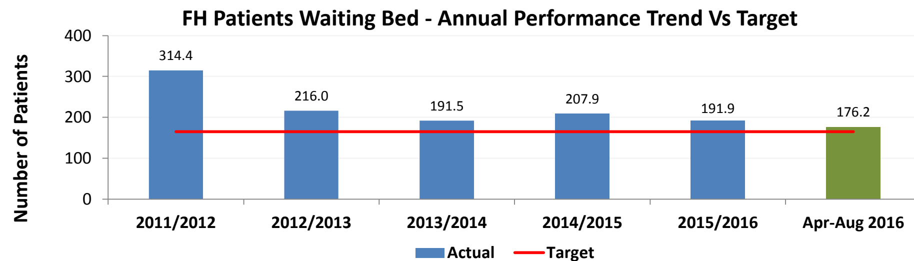
Every day at 2pm, we count the number of inpatients in our hospitals that are in locations that are not typically designated for clinical care (including Emergency Departments). We then take the average for all days for the reporting period. In future iterations of this measure, we will make a change to count at midnight instead of 2pm, to better reflect the overall status of the day.

Our Performance	Target *
176.2	***<= 165***

Performance timeline: Apr-Aug 2016 (Year-To-Date)

Data Source: Meditech Client Server (Admissions), Master Bed Map spreadsheet (Clinical Capacity Optimization and Finance)

* Target Source: FHA Internal



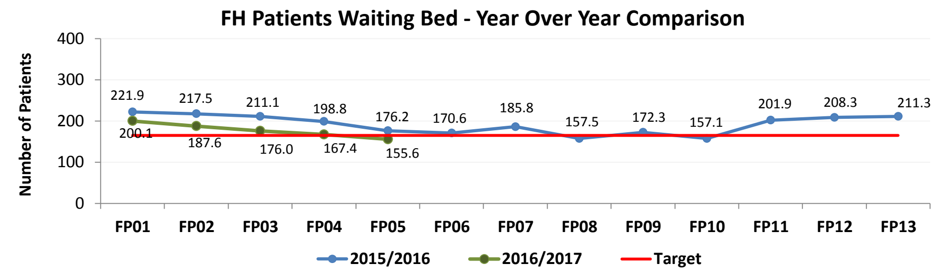
How are we doing?

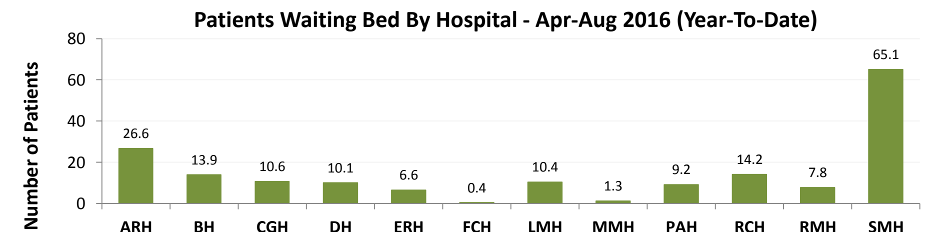
Fraser Health's year-to-date performance is 176.2. Although we achieved some progress towards our target, we had an increase in number of patients waiting for inpatient bed placement since the last quarter of 2014/15, driven by high demand for inpatient beds particularly in our regional hospitals. There has been a sustained downward trend in patients awaiting inpatient bed placement over the past five periods. The numbers that we have reported over the past five periods have been lower than our performance numbers from last year 2015/2016. Fraser Health's over all performance is the best we have had in the past five years and we are dedicated to enhancing our performance and achieving this target.

What are we doing?

Fraser Health is currently working with all of our care teams to improve care planning so that patients are moved to the right care location as quickly as possible. We have committed to patient centered care which is a broader change beyond caring for the sick and injured, focused concurrently on promoting wellness, prevention and safety for all patients, staff and the community at large. We continue our focused efforts to ensure that every available hospital bed is being used efficiently, so that patients can be cared for within appropriate care locations.

What can you do?





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Care Sensitive Adverse Events Rate per 1,000 Hospitalizations (Age 55+)

Are our patients receiving high quality of care provided by inter-professional care teams?

What are we measuring?

We are measuring the rate of Care Sensitive Adverse Events (CSAE) for all acute care inpatients (excluding Mental Health and Substance Use and Maternity) 55 years of age or older. An adverse event can occur when a patient is unintentionally harmed as a result of their care and treatment during their hospital stay. Care Sensitive Adverse Events include: urinary tract infections, pressure ulcers, in-hospital occurrence of fractures related to a fall and pneumonia.

Why?

Our goal is to provide the best care to our patients. Our patients will have optimal health outcomes and recovery, if there is a greater quality and preventative care provided by the inter-professional care team.

How do we measure it?

We take the number of patients 55 years or older who have acquired one or more (case) Care Sensitive Adverse Events while in hospital and divide it by the total number of discharged acute care inpatients (excluding Mental Health and Substance Use and Maternity) 55 years or older in that hospital. The rate we report is per 1,000 patient discharges.

Our Performance	Target *
34.00	<= *31.3*

Performance timeline: Jan-May 2016 (Year-To-Date)
Data Source: Med2020 Abstracting and Coding system
* Target Source: FHA Internal

***Note** : 1) Some previously reported data may change slightly due to system corrections and updates*
2) Based on FH staff feedback, we have now rebranded Nursing Sensitive Adverse Events to Care Sensitive Adverse Events

How are we doing?

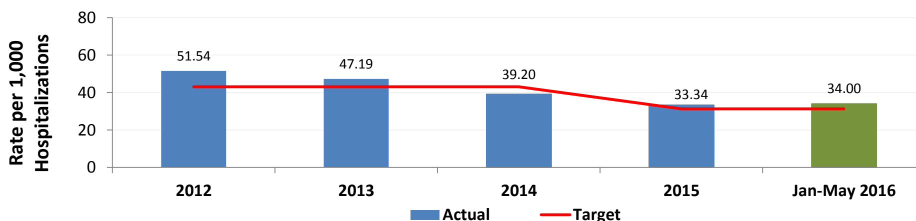
Overall, FHA CSAE year to date rate in 2016 is 34.00 for discharges of patients in the 55+ age group (excludes Mental Health and Substance Use and Maternity) This rate is below 3 of the 4 previous years, but does not meet our internal target of 31.3. Our two most common incidents of Care Sensitive Adverse Events, i.e. hospital-acquired pneumonia and urinary tract infections. Prevention of in-hospital acquired urinary tract infection and in-hospital acquired pneumonia is captured in the Fraser Health Patient Safety Priority Work Plan.

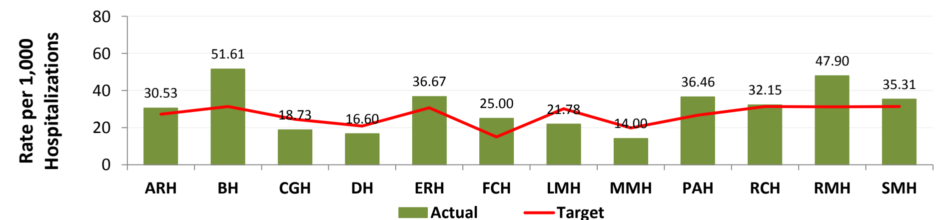
What are we doing?

Our Care Sensitive Adverse Event rates are monitored closely by clinical leaders at all 12 acute care sites. Site leadership continue to develop quality and safety focused action plans that incorporate best practices to prevent care sensitive adverse events both at the patient care unit level and at an overall site perspective, focusing on patient flow and transition. CSAE data is published on a monthly basis on the CSAE dashboard of the current performance of the site as a whole and individual in-patient acute care units. The Fraser Helath Patient Safety Priority Work Plan includes focused activities at all levels from executive and operational leadership, Physicians, consultants, frontline leaders and direct care staff. Improvements are focused on behavioural changes, diagnostics, identification of risk, issue escalation/mitigation, education, and reinforcement re: basic care principles

What can you do?

Please ask your health care providers if you need assistance mobilizing. It is important that you move as much as you are able, e.g. sit in a chair to have your meals, sit up in bed or at the side of your bed, or you can go for walks. You are also encouraged to take deep breaths and cough every hour to reduce the risk of acquiring pneumonia It is also important to empty your bladder every few hours, to reduce the risk of acquiring a urinary tract infection. If you have an indwelling urinary catheter, clarify with your health care provider when it can be removed. Clean your hands frequently as well as cleaning your teeth in the morning, after each meal and at bedtime. Together we can help you to reduce the risk of acquiring an infection or injury during your hospital stay.





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Percent of Hip Fracture Fixations Completed Within 48 Hours

How fast do patients get surgery to fix a hip fracture?

What are we measuring?

We are measuring the percentage of hip fracture patients who have surgery within 48 hours from the time they are first admitted to hospital

Why?

Our goal is to ensure we provide the best care for our patients. Research shows that patients who wait less than 48 hours for surgery have fewer pressure ulcers, urinary tract infections and a lower mortality rate.

How do we measure it?

We record the time and date patients were admitted to hospital, and the time and date patients entered the operating room, to find out how many patients had hip fracture surgery within 48 hours. Then, we divide that number by the total number of patients who had hip fracture surgery.

Our Performance	Target *
89.0%	***>= 90%***

Performance timeline:	Apr-Aug 2016 (Year-To-Date)
Data Source:	Meditech
* Target Source:	BC Ministry of Health

How are we doing?

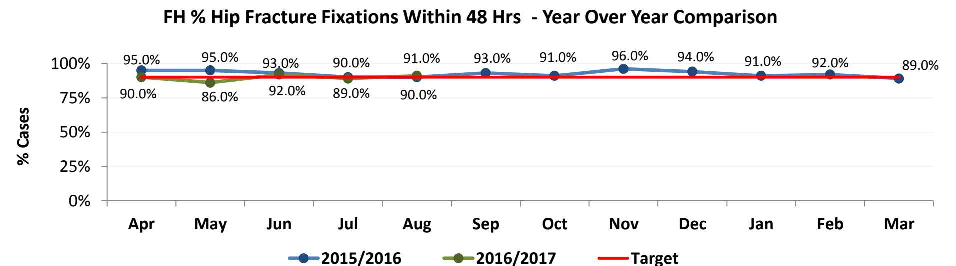
Fraser Health continues to meet the Ministry of Health target (90% of hip fracture patients having surgery within 48 hours of admission). Continuous oversight is still required to consistently achieve or exceed this target at all Fraser Health sites. Monthly Leadership meetings are held to review progress, identify barriers, and develop mitigation strategies.

What are we doing?

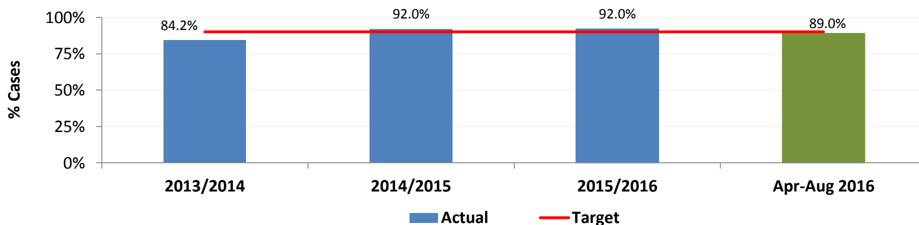
Surgical Services at all sites have implemented multi modal strategies to build capacity, define and disseminate best practices and engage teams to uphold standards. Clinical Leaders closely monitor all patients admitted with hip fractures. Dedicated time has been made more available in our Operating Rooms. A Hip Fracture Escalation Protocol has been implemented at all sites to reduce and eliminate barriers to surgery. Clinical Leaders have worked to increase the awareness amongst all care givers, from pre-hospital care to discharge, of the need for specialized care and timely surgery. Care is focused on quality pain management, enhanced nutrition and early/frequent mobility. Additional focus is now on discharge planning and secondary prevention. This process is referred to as "Fresh Start"

What can you do?

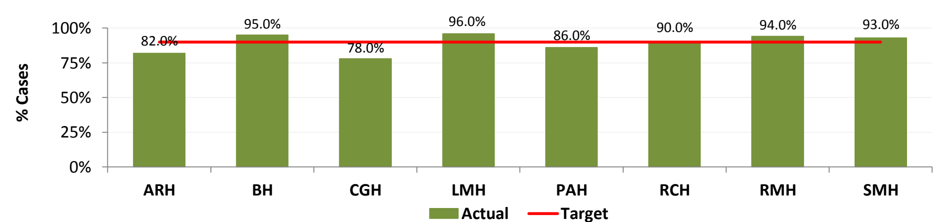
If you are over age 50 and had a fracture with a fall from a standing height, speak to your doctor about your bone health. Begin a regular exercise program
Have a Health Care Provider review your medicines
Have your vision checked
Make your home safer (avoid slips and trips)
Consider a referral to our Mobile Falls Clinic
http://www.fraserhealth.ca/your_health/seniors/falls_and_injury_prevention/



FH % Hip Fracture Fixations Within 48 Hrs - Annual Performance Trend Vs Target



% Hip Fracture Fixations Within 48 Hrs By Hospital - Apr-Aug 2016 (Year-To-Date)



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Report Generated: **September, 2016**

Facility-Associated Clostridium Difficile Infection (CDI) Incidence

What is the rate of patients who acquire a Clostridium difficile infection during their hospital stay?

What are we measuring?

Number of new healthcare-associated CDI cases at the FH acute care site where CDI was most likely acquired and confirmed or diagnosed per 10,000 patient days, within a specified time frame e.g. fiscal period, year-to-date, fiscal year (Note: does not account for cases that are transferred between sites)

Why?

C. difficile is the most common cause of hospital-acquired infectious diarrhea. C.difficile infection happens when antibiotics kill the good bacteria in the gut and allow the C. difficile bacterium to grow and produce toxins that can damage the bowel. It most commonly causes diarrhea but can sometimes cause more serious intestinal conditions.

How do we measure it?

([Number of new healthcare-associated CDI cases attributed to the same FH acute care site where CDI was most likely acquired and confirmed or diagnosed] / [Total number of patient days for a particular site or FH overall] * 10,000) for a specified reporting period

How are we doing?

The Fraser Health CDI incidence rate for fiscal year-to-date 2016/17 is 4.6 cases per 10,000 patient days. The CDI rate for fiscal period 05 2016/17 was 2.9 cases per 10,000 patient days, which is lower than the rate in period 05 (4.3 cases per 10,000 patient days) last fiscal year 2015/16.

What are we doing?

We aggressively monitor, report and address our CDI rates by providing units and acute care sites with regular reports that show the number of cases acquired on units. This helps staff consider issues and focus on improvement efforts to reduce CDI transmissions. Select units with an increase in the number of CDI are required to implement action plans and address issues affecting infection control best practices. Our infection control team works with units to identify opportunities for improvement. We work with the hospital pharmacy and physicians to promote appropriate antibiotic treatment. We provide additional cleaning of hospital isolation rooms and equipment. All rooms with patients known or suspected of having C. difficile are cleaned twice a day with bleach. We conduct detailed review of each healthcare-associated CDI case to understand the factors that may have contributed to the infection. We monitor hand hygiene compliance across our organization.

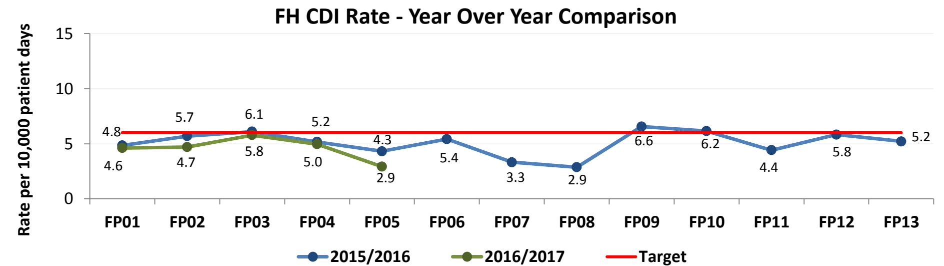
What can you do?

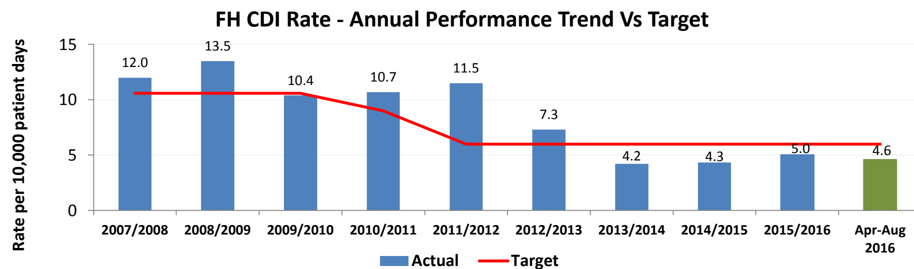
One of the key things you can do is to clean your hands and remind others to do the same. Clean your own hands thoroughly and often especially before and after eating and after going to the washroom.

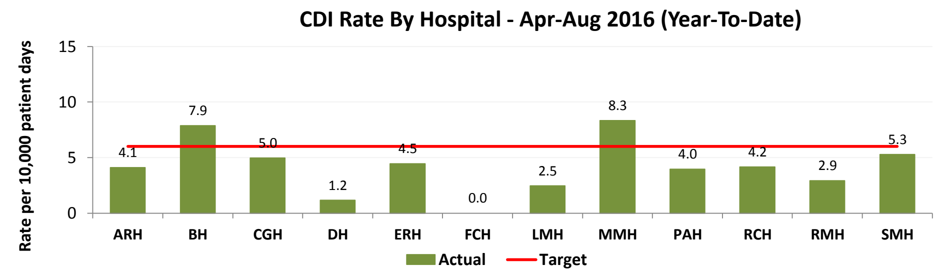
Our Performance	Target *
4.6	***<= 6.0***

Performance timeline: Apr-Aug 2016 (Year-To-Date)
Data source: FH Infection Prevention and Control Database
* Target Source: FHA Internal

Note *: 1) Data are examined and updated on a regular basis, therefore numbers may change slightly based on adjustments*
2) Starting Apr 1, 2015, MSA acute care data are combined with ARH data
3) Starting Apr 1, 2015, YR acute care data are combined with SMH data







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Facility-Associated Methicillin-Resistant Staphylococcus Aureus (MRSA) Incidence

What is the rate of patients who acquire MRSA during their hospital stay?

What are we measuring?

Number of new healthcare-associated MRSA cases at the FH acute care site where MRSA was most likely acquired and confirmed or diagnosed per 10,000 patient days, within a specified time frame e.g. fiscal period, year-to-date, fiscal year (Note: does not account for cases that are transferred between sites)

Why?

Staphylococcus aureus is a bacterium that normally lives on skin and noses. Many people are carriers of Staphylococcus aureus and never have symptoms. Others may develop an infection, usually involving the skin. Sometimes it can cause more serious problems such as bloodstream or respiratory infections. MRSA is a strain of Staphylococcus aureus that is resistant to a number of antibiotics. Infections with MRSA can be more difficult to treat.

How do we measure it?

([Number of new healthcare-associated MRSA cases attributed to the same FH acute care site where MRSA was most likely acquired and confirmed or diagnosed] / [Total number of patient days for a particular site or FH overall] * 10,000) for a specified reporting period

How are we doing?

The Fraser Health MRSA incidence rate for fiscal year-to-date 2016/17 is 7.4 cases per 10,000 patient days. The MRSA rate for fiscal period 05 2016/17 was 7.8 cases per 10,000 patient days, which is higher than the rate in period 05 (6.7 cases per 10,000 patient days) last fiscal year 2015/16.

What are we doing?

Many of the initiatives to reduce C.difficile infections are also used to reduce MRSA infection in hospitals - particularly hand cleaning with alcohol based hand rub and closely following infection prevention and control best practices. We aggressively monitor, report and address our MRSA rates by providing units and acute care sites with regular reports that show the number of cases acquired on units which helps staff consider issues and focus on improvement efforts to reduce MRSA transmissions. Our infection control team works with units to identify opportunities for improvement. Investigation of facilities with higher rates of MRSA is taking place and actions are underway to mitigate the increase in MRSA.

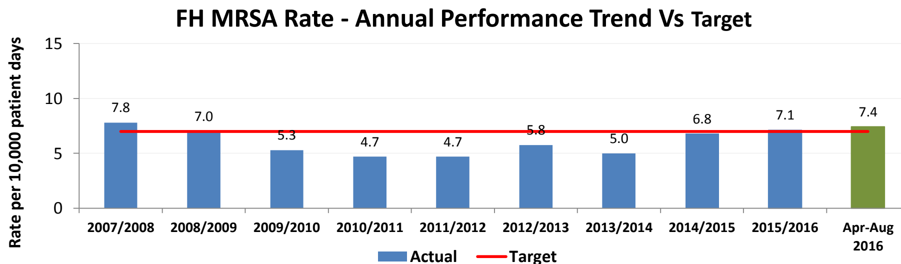
What can you do?

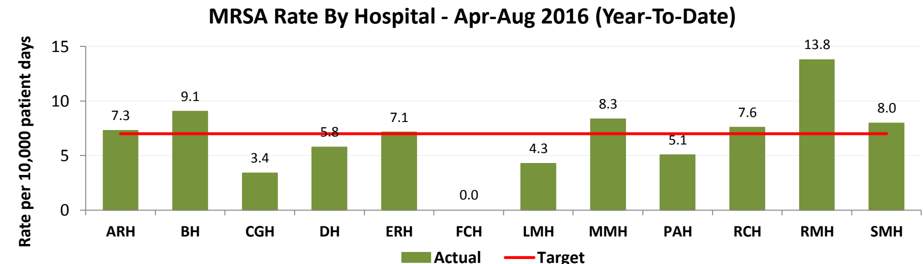
One of the key things you can do is to clean your hands thoroughly and often, and remind others to do the same. It is also important to practice good personal hygiene.

Our Performance	Target *
7.4	<= *7.0*

Performance timeline: Apr-Aug 2016 (Year-To-Date)
Data Source: FH Infection Prevention and Control Database
* Target Source: FHA Internal

Note: *1) Data are examined and updated on a regular basis, therefore numbers may change slightly based on adjustments*
2) Starting Apr 1, 2015, MSA acute care data are combined with ARH data
3) Starting Apr 1, 2015, YR acute care data are combined with SMH data





Hand Hygiene Compliance (%)

What percentage of healthcare workers and physicians perform hand hygiene according to FH protocols/policy in

What are we measuring?

The number of employees observed to be following Fraser Health's hand-hygiene policy as a percentage of all employees audited during a specified time frame e.g. fiscal period, year-to-date, fiscal year. Observations for hand hygiene compliance include before-and-after opportunities based on the 4 moments for hand hygiene. Use of either soap and water; or alcohol-based hand rub (ABHR) is acceptable. Missed opportunities represent moments when hand hygiene did not occur.

Why?

Hand hygiene is a critical patient safety initiative and one of the most effective, well-known measures to reduce the transmission of healthcare associated infection worldwide. Hand hygiene education and training is being provided across FH through new employee orientation sessions along with on-the-job training and education provided by Infection Prevention and Control Practitioners. Through monitoring hand hygiene compliance and using continuous observational audits and on-going improvement activities, FH is continuing to align with the Canadian Patient Safety Institute's Safer Healthcare Now! Initiative, and with Accreditation Canada's Required Organizational Practices, as well as the provincial auditing and reporting of hand hygiene compliance.

How do we measure it?

([Number of employees observed to be following Fraser Health's hand-hygiene policy] / [Total number of hand hygiene observations collected among staff] * 100) for a specified reporting period

How are we doing?

The FH hand hygiene compliance for fiscal year-to-date 2016/17 is 86.0%, which exceeds the provincial target (80%). Hand hygiene compliance was 86.0% in fiscal period 05, 2016/17. Hand hygiene compliance is consistently lower before patient contact than after patient contact.

What are we doing?

We have installed new hand sanitizer dispensers in convenient locations. We conduct compliance audits each fiscal period at a minimum to reinforce that hand cleaning is important and to determine if units are getting better at cleaning their hands. We provide educational support for staff groups and sites and help them develop action plans. We post hand hygiene cleaning compliance rates on each unit and around the site so staff, families and visitors know how well hand cleaning is done.

What can you do?

Continue to clean your hands and support hand cleaning actions around you. Clean your own hands thoroughly and often, especially before and after eating and after going to the washroom. Politely ask health care workers if they cleaned their hands before they examine or treat you, and encourage your family and loved ones to wash their hands.

Our Performance	Target *
86.0%	>= ***80%***

Performance timeline: Apr-Aug 2016 (Year-To-Date)

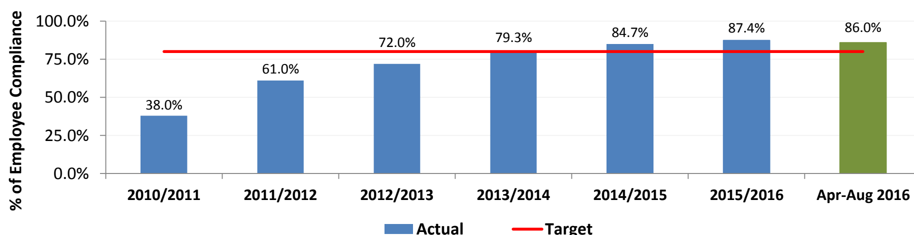
Data Source: FH Infection Prevention and Control Program Hand Hygiene System (FormAudit)

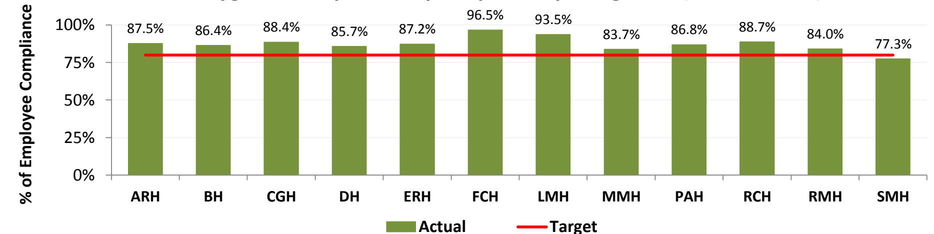
* Target Source: Provincial Target

Note: *1) Data are examined and updated on a regular basis, therefore numbers may change slightly based on adjustments*

2) Starting Apr 1, 2015, MSA acute care data are combined with ARH data

3) Starting Apr 1, 2015, YR acute care data are combined with SMH data





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Sick Time Rate

How often are staff away from work due to an illness or non-occupational injury?

What are we measuring?

Paid sick leave hours as a percent of total productive hours

How are we doing?

Our current performance for financial period 5 YTD is 4.80% which is less than our performance target 5.0%.

Why?

We want to help our staff be well and productive at work so they can provide the best care to our patients, clients and residents. Reducing sick time improves our services, reduces the workload stress and overtime costs of staff covering for ill or injured coworkers, and allows us to reinvest in patient care.

What are we doing?

The APP team is working with Managers to address employees that have higher than average sick time as well as address employees that have not improved their sick time while in APP. Ensure supports are offered to help reduce the sick time.

How do we measure it?

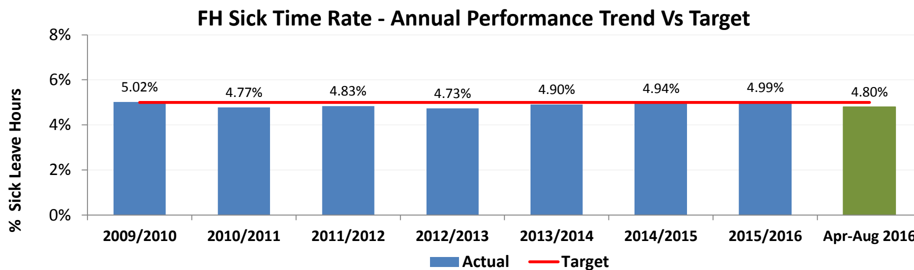
We track the number of hours lost (paid sick leave) to illness or non-occupational injury and divide it by the total number of productive (working) hours. This gives us the percentage of productivity lost to sickness.

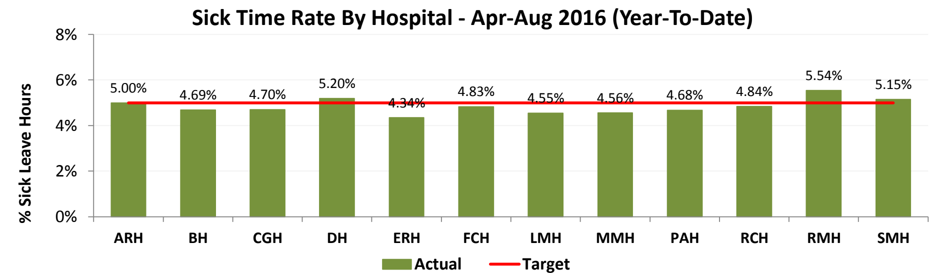
What can you do?

Ensure Optimum Health by creating a Healthy Balance of Rest and Relaxation. Evaluate your physical, mental and emotional health and how your work and home environments are contributing to your state of wellness. Maximize your happiness by increasing your hobbies, enjoying a holiday and reconnecting with your friends and family.

Our Performance	Target *
4.80%	<= ***5.0%***

Performance timeline:	Apr-Aug 2016 (Year-To-Date)
Data Source:	Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server
* Target Source:	FHA Internal





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Overtime Rate

How often do our staff work overtime?

What are we measuring?

Total overtime hours as a percent of total productive hours

Why?

As we are accountable for the funds we receive through B.C. taxpayers, we want to deliver the highest quality patient care at the lowest possible cost. Providing care at overtime rates is often more expensive than providing the same care at regular wage rates. Overtime also puts workload stress on individual employees.

How do we measure it?

We take the total overtime hours and divide by total productive (working) hours.

How are we doing?

Overall, the FHA overtime rate has been trending fairly steady. For all clinical units that are above their target, Managers not meeting the stated targets are asked, with the help of the corporate support teams, to develop action plans on how they will mitigate their OT. Ongoing education sessions to discuss OT reduction strategies and best practices for reducing high OT are being provided.

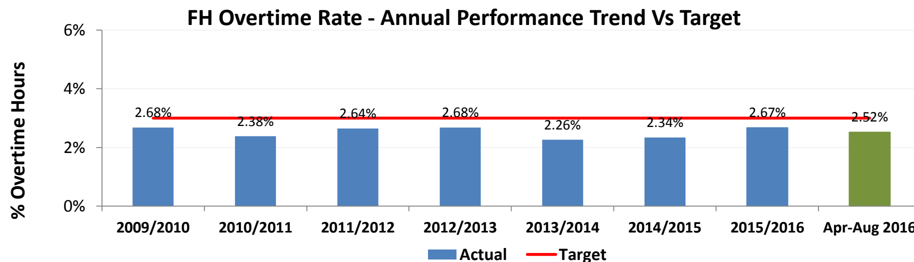
What are we doing?

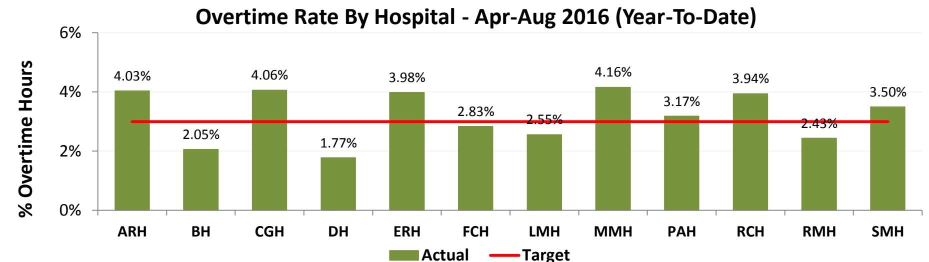
Managers are accountable for approving all overtime. Overtime logs are kept and reviewed monthly and overtime audits are run on a regular basis. Overtime mitigation tools and resources are readily available. A re-education plan on overtime reduction strategies and best practices has recently been delivered. A Workforce Planning Team that will proactively work with units and sites to develop and implement strategies to help mitigate overtime is in development.

What can you do?

Our Performance	Target *
2.52%	<= ***3.0%***

Performance timeline: Apr-Aug 2016 (Year-To-Date)
Data Source: Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server
* Target Source: FHA Internal





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Difficult to Fill Vacancies

What are we measuring?
Vacancy rate of jobs which remain unfilled for more than 90 days as a percentage of total number of regular employees

Why?
Timely access to appropriate health services is affected by the supply of appropriate personnel in the appropriate setting. Difficult to Fill vacancy rate is an effective measure of supply.

How do we measure it?
We take the number of full-time and part-time active external vacancies older than 90 days, divided by the active number of full-time and part-time employees added to the number of over 90 day active vacancies. Vacancies older than 90 days are considered difficult to fill vacancies

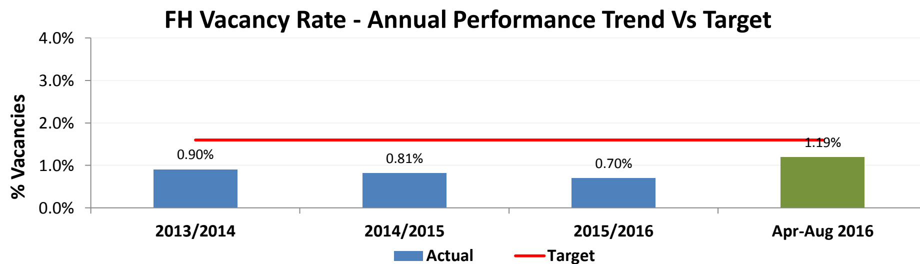
Our Performance	Target *
1.19%	*<= 1.6%*

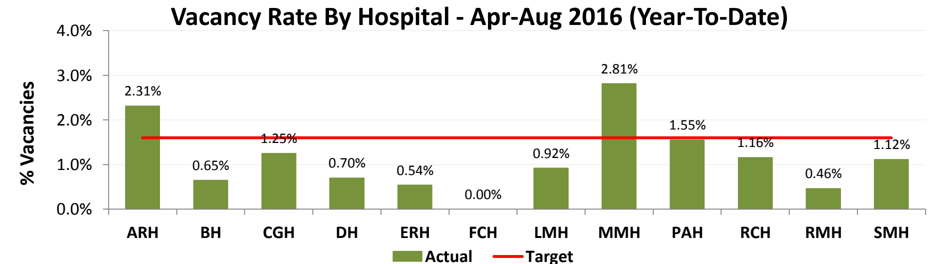
Performance timeline: Apr-Aug 2016 (Year-To-Date)
Data Source: FHA People Services
* Target Source: BC Ministry of Health

How are we doing?
The overall Difficult to Fill Vacancy Rate is 1.2% with 206 Difficult to Fill Vacancies and 17081 regular active employees.
Excluded and Paramedicals have the highest Difficult Vacancy Rate with 1.8%. But Nurses continue to have the highest number of Vacancies with 104; 50% of the total Vacancies. Community, Facilities and Nurses (LPN) have the lowest Vacancies Rate of the 6 groups.
The Difficult to Fill Vacancy Rate by Site shows 'VC, PHA, PHSA', MMH, and ARHCC as having the highest Vacancy Rate with 3.4%, 2.8% and 2.3% respectively. They are the only three sites that have over 2% Vacancy Rate. 'VC, PHA, PHSA' and ARHCC both have 26 Vacancies, but 'VC, PHA, PHSA' only has 747 employees where ARHCC has 1098 – 47% more employees. MMH has the lowest of the three employee counts with 242 employees. 12 sites out of 20 Sites have less than 1.2% Vacancy Rate, FHA overall rate this month.

What are we doing?
We continue to look for further opportunities to fill these vacancies by utilizing social media, attending conferences specifically for Nurse Practioners, Physiotherapists Pharmacists, and Respiratory Therapists, Nursing and for other difficult fill professions. We also utilized certified candidates through Fraser Health's specialty education program, attended Career Fairs, posted electronic and print advertisements in professional journals/website and presented to University graduates across Canada to attract further interest in Fraser Health career opportunities.
June 14, 2016 FHA new Posting system, eRecruit, went live. The posting process is further streamlined and support is put in place to assist with this transition. Support is put in place to support this transition

What can you do?





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Budget Performance (Net Variance to Budgeted Expenditure Ratio)

How well are we performing to plan?

What are we measuring?

This is a measure of how programs are performing against their Board approved budget.

Why?

To measure and monitor financial performance to help ensure that no program is running a deficit.

How do we measure it?

Budgeted expenditures less net variance to budget over budgeted expenditures.

How are we doing?

The fifth fiscal period closed with a deficit of $10.0 million which primarily reflected the timing of resource reduction associated with the Increasing Quality and Capacity for Care (IQCC) plan. Acute hospital demand continues to decrease as community programs are implemented and resource usage is expected to follow. There are a number of ongoing mitigation strategies, including the IQCC plan, which will continue to improve productivity and transition care to the appropriate level.

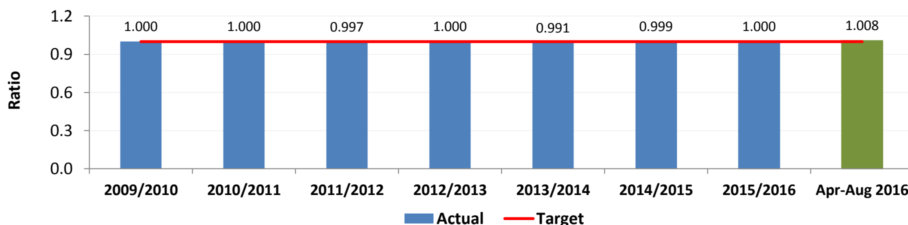
What are we doing?

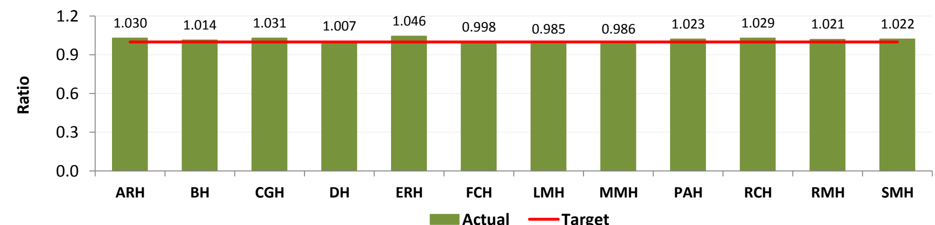
Fraser Health has a comprehensive financial control framework that is embedded in the budgeting, reporting and operational processes across the organization and is inherent in both the internal control and financial management processes. Management continues to enforce stringent protocols when VP's, ED's and managers exceed budget variance thresholds across both sites and portfolios.

What can you do?

Our Performance	Target *
1.008	<= *1.000*

Performance timeline: Apr-Aug 2016 (Year-To-Date)
Data Source: Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server
* Target Source: FHA Internal





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Direct Care Hours Per Patient Day (Acute Nursing Inpatient)

How many direct hours of care are provided each day a patient is in the hospital?

What are we measuring?

Productive hours worked (regular, relief, overtime, workload) by direct care nursing staff in nursing inpatient units over patient days in acute nursing inpatient units.

How are we doing?

Our current performance for this indicators is 7.16. Our performance is trending away from our performance target.

Why?

To measure and monitor the productive or care hours provided per acute inpatient day. Measuring productivity levels helps us understand patients needs while balancing resources to take care of those needs. Several different care providers are utilized to provide quality patient care. It is important to ensure we utilize the best care provider for the best role. Also, some patients in the hospital, as in the intensive care unit, require 24 hours of nursing care per day. Other patients do not need as many direct nursing hours to receive quality patient care and a full recovery. It's about using our staff resources (labour) in the most efficient and effective way possible. This measure divides the total number of nursing hours paid (labour) by the number of patient days (volume). As per the Ministry of Health definition, this measure includes Medical, Surgical, Med/Surg, ICU, Obstetrics, Pediatrics, MHSU, Physical Rehab, and Palliative Nursing Units.

What are we doing?

We need to be cost effective with our resources but also ensure that patient care is the priority. We try to match our nursing hours to the patients needs and adjust staffing as needed. We have shifted administrative responsibilities of leaders to ensure a more visible presence in care areas to support staff caring for patients. We continuously allocate resources to match patient needs. Approximately 13% of all days were for patients in alternate level of care (ALC) status. The relatively high number of these patients has reduced the need for daily care hours. We measure the productivity of nursing staff who provide direct patient care, including registered nurses, licensed practical nurses and health care assistants.

How do we measure it?

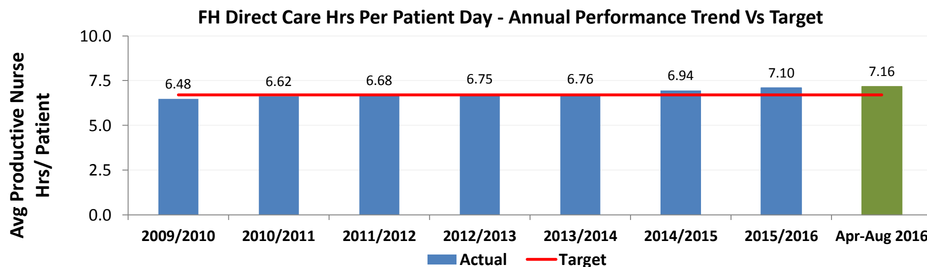
The number of productive hours worked by direct care staff in nursing inpatient units is divided by the number of patient days in nursing inpatient units. The patient days are based on the average number of patients in a unit during a 24 hour period.

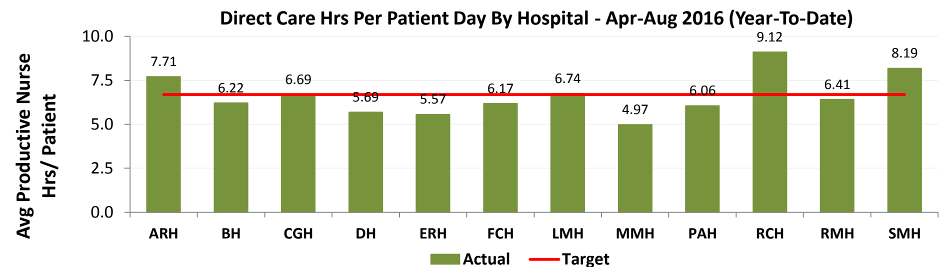
What can you do?

You can be an active participant in your care (or your family/friends care). Work with the care team for effective hospital to home discharge. Smooth and efficient transitions help reduce over utilization of nursing hours.

Our Performance	Target *
7.16	<= ***6.7***

Performance timeline:	Apr-Aug 2016 (Year-To-Date)
Data Source:	Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server
* Target Source:	FHA Internal





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Expenditures Per Separation (All Acute)

What is the cost of providing health services to a patient that is admitted in a hospital?

What are we measuring?

All acute general hospital expenditures (before amortization) over inpatient separations.

Why?

To measure and monitor financial performance on the average cost per stay in acute care.

How do we measure it?

The total expenses before amortization at an acute site for both direct nursing inpatient units (units with separations) and indirect clinical and corporate support costs (such as Administration, Lab, Medical Imaging, Housekeeping, etc.) are divided by the number of patient separations for that site. Included in the total expenses are the clinical and corporate support costs for any residential beds that are located at the site.

How are we doing?

Our current performance for this indicator is $11,905. Performance on this measure will improve as acute capacity and resourcing are adjusted to reflect the appropriate level of care and Average Length of Stay is lowered.

What are we doing?

Priority action plans, primarily the Increasing Quality and Capacity for Care plan, are focused on reducing Average Length of Stay and alleviating demand in acute sites by ensuring that patients are receiving the appropriate level of care. Acute sites that are meeting target will be used as benchmarks for other sites.

What can you do?

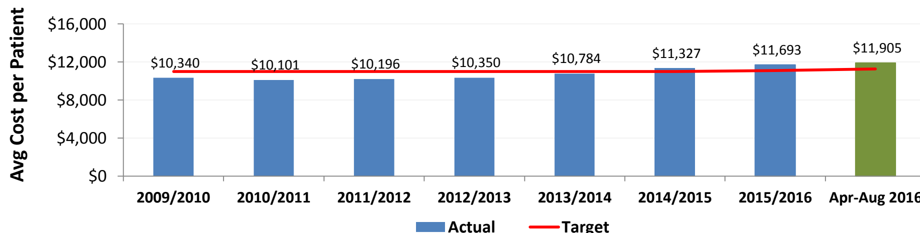
Our Performance	Target *
$11,905	<= ***$11,250***

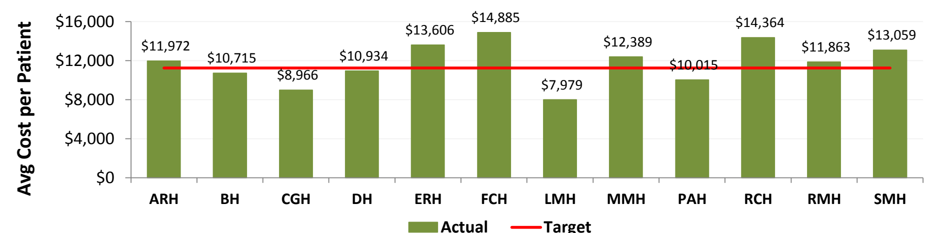
Performance timeline: Apr-Aug 2016 (Year-To-Date)

Data Source: Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server

* Target Source: FHA Internal

***Note** : Target is adjusted based on the FY2015/16 budget*





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Ministry of Health Measure

Report Generated: **September, 2016**

Average length of stay /Expected length of stay (ALOS/ELOS)

Are our patients having longer hospital stay compared to the national average?

What are we measuring?

Ratio of inpatient Average Acute Length of Stay (ALOS) for medical cases to the average Expected Length of Stay (ELOS). This measure focuses only on typical patients to be comparable to the national benchmark.

How are we doing?

Our current performance (1.01) is not meeting our target (0.95). Fraser Health recognize the need to improve our performance for efficient and effective acute care operations.

Why?

Length of stay (LOS) is influenced by many factors but safe and effective patient care should result in a shorter hospital stay. Measurement of LOS is important in evaluating efficiency and optimal use of resources, and comparing against a national average (ELOS) benchmark would take into consideration the effect of changes in mix of patients across different hospitals and time periods.

What are we doing?

We are developing standardized care planning tools for specific patient groups, to improve communication between all team members, our patients and their families. This will ensure that every patient receives the best quality of care for their medical condition as well as their personal situation.

How do we measure it?

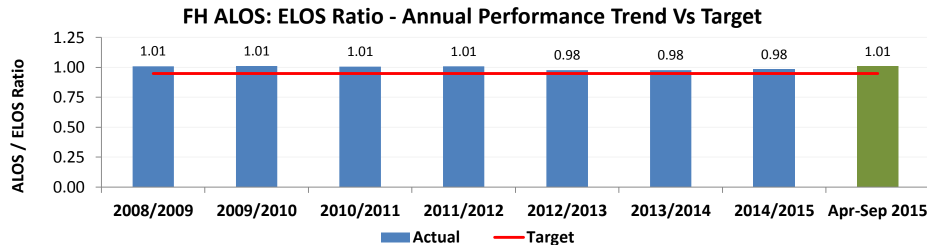
This measure is calculated by taking the actual average acute length of stay (ALOS) for typical patient discharges and dividing by the expected length of stay (ELOS) for the same group of patients. The ELOS for each hospital visit is calculated by the Canadian Institute of Health Information on the basis of actual stays across Canadian hospitals for every cluster of diagnoses, interventions, age, sex, and complexity.

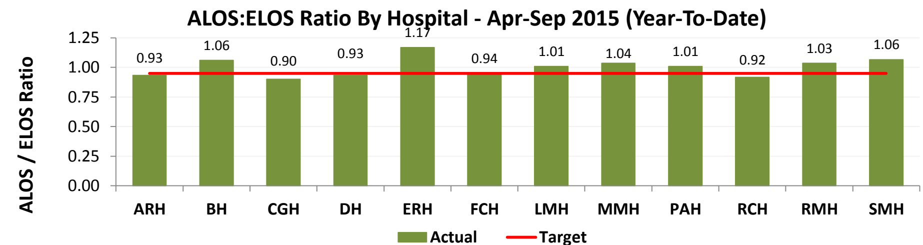
What can you do?

Take an active role in planning your care. Ask questions about your medical condition and participate in setting your goals for care. Inform your care providers about what you need to feel supported to leave the hospital.

Our Performance	Target *
1.01	< *0.95*

Performance timeline:	Apr-Sep 2015 (Year-To-Date)
Data Source	MoH Measurement SharePoint
* Target Source:	FHA Internal





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Ministry of Health Measure

Report Generated: **September, 2016**

Readmission Rates Utilization (Emergent/Urgent), All Causes

How many FHA residents return to a acute care hospital within 30 days?

What are we measuring?

Rate of FHA residents who are unexpectedly readmitted to an acute care hospital within 30 days of an inpatient episode of care. Readmission may or may not be related to the previous episode of care. This is based on the place of residence of the patient, not the location of the hospital.

Why?

Urgent returns to hospital are difficult for patients and costly for the health system. While not all readmissions can be prevented, the rate can often be reduced through better follow-up and coordination of care for patients after discharge. Tracking the readmission rate helps us understand the effectiveness of hospital care, and how well we support patients after they leave the hospital.

How do we measure it?

We take the number of FHA residents who are unexpectedly admitted to an acute care hospital within 30 days of an inpatient episode of care, and divide it by the total number of all inpatient episodes of care between April 1 and March 1 of the fiscal year.

How are we doing?

Our current performance at 10.5% does not meet our target of 10%. Comparing our year to date results for April-September 2015/16 (10.5%) versus results of same reporting period in last year, April- September 2014/15 (10.6% not shown below) indicates a maintained, slightly improved performance. Overall, the annual FHA performance trend has been increasing since 2008/2009 against the desirable direction.

What are we doing?

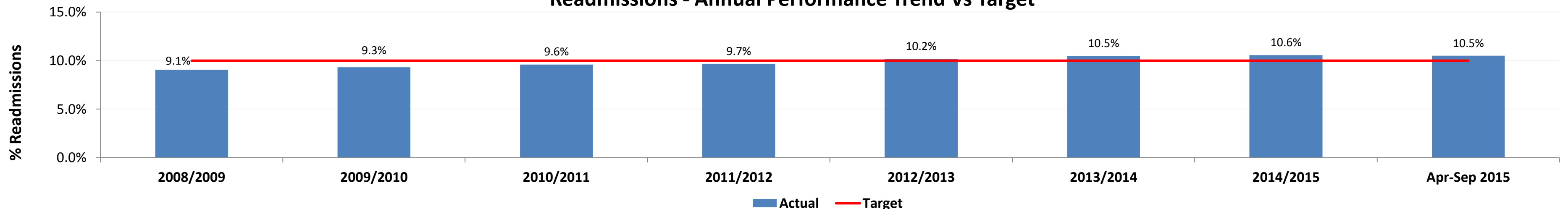
We have established a Transitions Working Group that is focusing on initiatives supporting seamless transitions between Hospital and Community. We are enhancing our discharge planning processes that will include improved communications with our patients and community providers to ensure they have the information they need for continuity of care. We are developing and enhancing programs and services to support follow up and monitoring of patients post discharge from hospital. We are identifying additional indicators that will give us a more detailed understanding of our readmission rate performance.

What can you do?

If you or your loved one needs to stay in one of our hospitals, discuss with our healthcare providers the discharge plan before going home. The plan could include information about the type of care required, activities that will help with the recovery, medications, diet and/or equipment. Let your healthcare provider know as soon as possible if you have any questions. Familiarize yourself with the discharge instructions and contact information provided. Connect with the suggested community provider for any concerns about your recovery.

Our Performance	Target *
10.5%	*<= 10%*

Performance timeline:	Apr-Sep 2015 (Year-To-Date)
Data Source:	MoH Measurement SharePoint
* Target Source:	FHA Internal



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Report Generated: **September, 2016**

Ambulatory Care Sensitive Conditions Hospital Admissions Rate (Age <75)

How many hospital stays could be avoided by using GP, outpatient clinics and community health resources instead?

What are we measuring?

Number of people with a chronic disease admitted to hospital per 100,000 people aged less than 75 years (Ambulatory Care Sensitive Conditions admissions rate). Hospitalization for Ambulatory Care Sensitive Conditions (ACSC) is an indirect measure of access to primary care and the capacity of the system to manage chronic conditions such as diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), and asthma. ACSC hospitalizations are often referred to as avoidable and are an indirect measure of the effectiveness of the health care system in the community.

Why?

The rate of admissions to hospital for ACSC's is used as a measure of patient access to appropriate health care in the community. A very low rate of ACSC admissions could indicate that there is good access to appropriate primary care and other outpatient care. However, we still expect some ACSC admissions because not all hospital admissions with these conditions are avoidable.

How do we measure it?

The "ACSC hospital admission rate (Age<75) is the number of people with specific "ACSC" conditions (typically chronic diseases) in every 100,000 people of this age group who are admitted to hospital in a given time period. Definition of ACSC is based on 2011 CIHI Health Indicator technical notes.

How are we doing?

Our current performance (246) is not meeting our target (234). However, our ACSC rate has consistently been declining since 2012/13, indicating improved performance over time. We will continue with our efforts described below.

What are we doing?

We are in the midst of an overall systematic change in how we deliver health care in partnership with our family physicians and are working in Partnership with the Divisions of Family Practice in each of our communities. We have implemented a Fraser Health wide service (BreatheWell/COPD) which is designed to provide patient respiratory assessment, diagnostic testing, patient education on COPD self-management, and patient health promotion to patients with complex COPD needs. BreatheWell is now available at all communities across Fraser Health and is in the process of expanding to all Residential Care homes in Fraser Health as well. We are continuously partnering with the division partners to support recruitment/ retention of primary care providers (Nurse Practitioners and GPs) to better support patients in the community. Finally, we are identifying and implementing structural, performance and outcome measures for Primary Health Care. This will help monitor and drive program direction and will help better target this population.

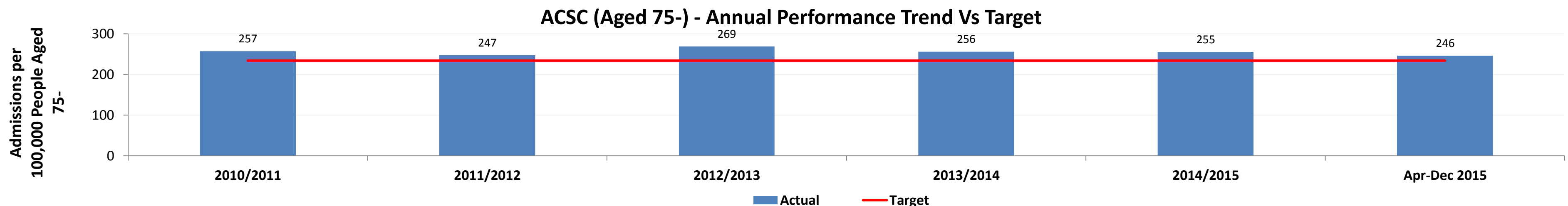
What can you do?

Seek alternative treatment before going to the Emergency such as going to your family doctor, or using other community resources. Ask your family physician, nurse practitioner, or other healthcare providers to help you learn how to manage your chronic condition to avoid a deterioration of your health. Know what to do in the event of emergency. Build a relationship with your GP, and partner with your doctor in keeping yourself well. Exercise if you can. Eat a healthy diet, and try to maintain a healthy weight.

Our Performance	Target *
246	<= ***234***

Performance timeline:	Apr-Dec 2015 (Year-To-Date)
Data Source:	MoH Measurement SharePoint
* Target Source:	BC Ministry of Health

Note *: 1) Service Plan target for 2014/15 – 2016/17*
2) Population data provided by BC STATS (P.E.O.P.L.E. 40), previously reported data were adjusted accordingly



Report Generated: **September, 2016**

Ambulatory Care Sensitive Conditions Hospital Admissions Rate (Age 75+)

How many hospital stays could be avoided by using GP, outpatient clinics and community health resources instead?

What are we measuring?

Number of people with a chronic disease admitted to hospital per 100,000 people aged 75 years or greater (Ambulatory Care Sensitive Conditions admissions rate). Hospitalization for Ambulatory Care Sensitive Conditions (ACSC) is an indirect measure of access to primary care and the capacity of the system to manage chronic conditions such as diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), and asthma. ACSC hospitalizations are often referred to as avoidable and are an indirect measure of the effectiveness of the health care system in the community.

Why?

The rate of admissions to hospital for ACSC's is used as a measure of patient access to appropriate health care in the community. A very low rate of ACSC admissions could indicate that there is good access to appropriate primary care and other outpatient care. However, we still expect some ACSC admissions because not all hospital admissions with these conditions are avoidable.

How do we measure it?

The "ACSC hospital admission rate (Age>75) is the number of people with specific "ACSC" conditions (typically chronic diseases) in every 100,000 people of this age group who are admitted to hospital in a given time period. Definition of ACSC is based on 2011 CIHI Health Indicator technical notes.

How are we doing?

Our current performance has remained relatively stable the past 4 years and is not meeting our target of 3048. We are currently taking actions as described below to drive the measure towards the target.

What are we doing?

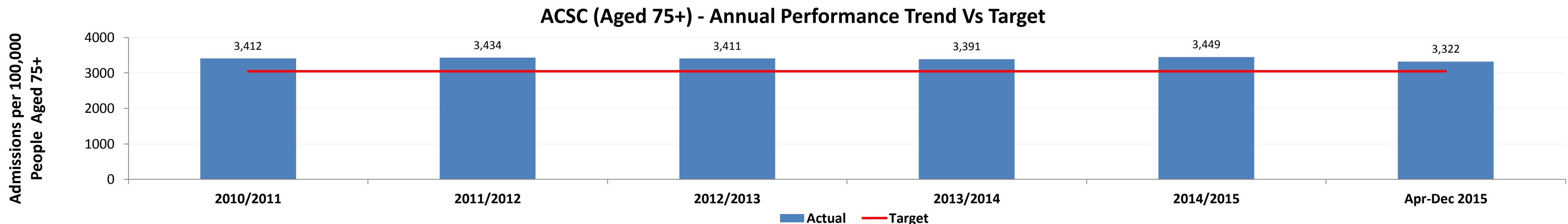
We are in the midst of an overall systematic change in how we deliver health care in partnership with our family physicians and are working in Partnership with the Divisions of Family Practice in each of our communities. We have implemented a Fraser Health wide service (BreatheWell/COPD) which is designed to provide patient respiratory assessment, diagnostic testing, patient education on COPD self-management, and patient health promotion to patients with complex COPD needs. BreatheWell is now available at all communities across Fraser Health and is in the process of expanding to all Residential Care homes in Fraser Health as well. We are continuously partnering with the division partners to support recruitment/ retention of primary care providers (Nurse Practitioners and GPs) to better support patients in the community. Finally, we are identifying and implementing structural, performance and outcome measures for Primary Health Care. This will help monitor and drive program direction and will help better target this population.

What can you do?

Fraser Health is committed to working with individuals, families, and communities to help people maintain as much health and independence as possible through prevention, early detection, and management of chronic conditions in their homes and communities. Ask your healthcare providers to help you learn how to manage your chronic condition before going to the Emergency Department. Some self-management reminders are exercise if appropriate for you, eat a healthy diet, and try to maintain a healthy weight.

Our Performance	Target *
3,322	<= ***3,048***

Performance timeline: Apr-Dec 2015 (Year-To-Date)
Data Source: MoH Measurement SharePoint
* Target Source: FHA Internal
Note *: Population data provided by BC STATS (P.E.O.P.L.E. 40), previously reported data were adjusted accordingly*



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Hospital Standardized Mortality Ratio

What is our mortality rate compared to other Canadian hospitals?

What are we measuring?

The number of patient deaths in our hospitals, compared to the average Canadian experience.

Why?

Hospital Standardized Mortality Ratio (HSMR) is an important measure to improve patient safety and quality of care in our hospitals. We use it to identify areas for improvement to help reduce hospital deaths, track changes in our performance and strengthen the quality of patient care. Taking action quickly to treat patients who suddenly become much more ill than expected is key to reducing hospital deaths.

How do we measure it?

The HSMR is calculated as a ratio of the actual number of deaths to the expected number of deaths among patients in hospital. It takes into account factors that may affect mortality rates, such as the age, sex, diagnosis and admission status of patients. It uses the national baseline average from 2012/13.

Our Performance	Target *
92	***<= 90***

Performance timeline: 2015/2016

Data Source: Canadian Institute for Health Information (CIHI)

* Target Source: BC average 2014/15

***Note** : From Oct 2015, Fraser Health is using a recalculated series from CIHI. The new recalculated series tracks FH performance compared to the national average in 2012/13, as opposed to the 2009/10 baseline used in previous reports. The target was adjusted accordingly to reflect BC average under the new recalculated series*

How are we doing?

Fraser Health's performance toward the target for HSMR continues to improve. Fraser Health has had the best performance since 2010/11, with a 2015/16 overall performance of 92. There are numerous sites within Fraser Health that are performing well below the target value for HSMR.

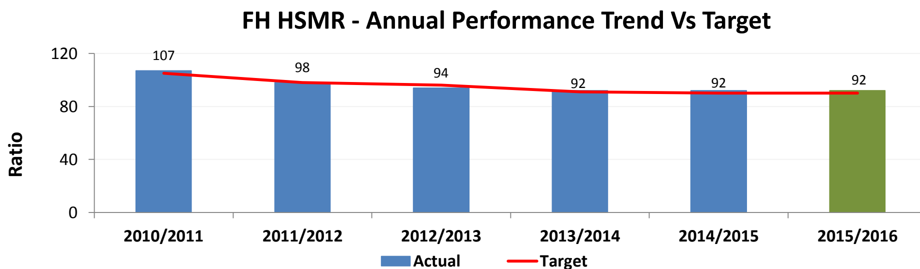
All sites within Fraser Health are dedicated to ensuring that they have the best practice and performance in place for patients and families. We will continue to make every effort to improve our performance in the area of HSMR.

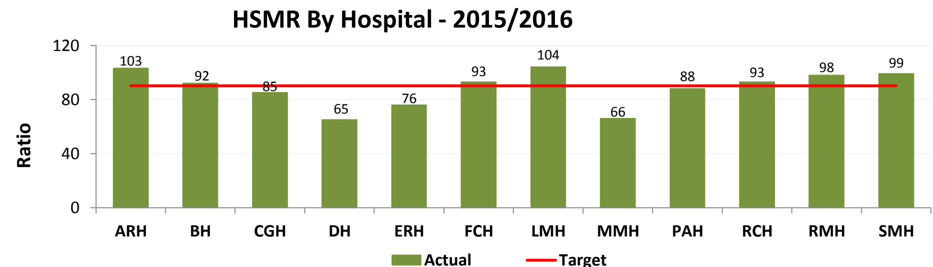
What are we doing?

Improving care for patients whose condition unexpectedly worsens has had good results at sites with highest decrease in their mortality rates. Early recognition and rapid response to sudden worsening of patient condition is a key area of focus to reduce HSMR at Fraser Health. Best practice includes communication of critical patient information between healthcare team members, reviewing patients' health records to identify ways to make care safer, and ensuring patients' medical treatment wishes are communicated with the healthcare team. Improvements have also been made across the organization in the 'Code Blue' system to respond to patients in cardiac and respiratory arrest.

What can you do?

No matter what stage of life or health you are at, consider having an End of Life conversation with your physician and family. Identify how much health care treatment you would want in a sudden healthcare emergency. If you are a patient, participate as much as possible in setting goals and planning your care while in hospital.





Falls that Result in An Injury in Residential Care Facilities

How many fall-related injuries can be prevented in residential care facilities?

What are we measuring?

Number of residents having a fall resulting in injury requiring physician intervention or transfer to hospital

How are we doing?

Our current performance is meeting our target. This is an improvement compared to 2014/15, when our rate of falls per 100 residents was 2.4.

Why?

Residents are at additional risk for falling due to factors associated with their health. Falls resulting in injuries can impact a resident's freedom of movement, autonomy, dignity, independence and quality of life thus it is important to minimizes risks related to falls and falls related injuries while maximizing resident's freedom of movement.

What are we doing?

We have implemented universal falls precaution interventions (safe environment, assistance with mobility, fall risk reduction, and resident and caregiver engagement). We continue to implement additional targeted interventions to residents based on individual risk factors for injuries and falls. We are enhancing our culture to balance resident safety, independence and autonomy. We continue to provide educational resources for staff, residents and family members.

How do we measure it?

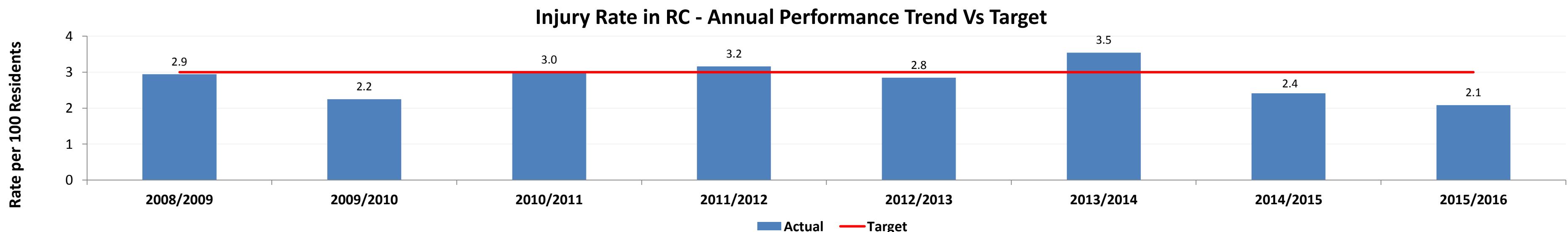
We take the number of residents who fell and had an injury requiring physician attention or transfer to hospital and divide that by the total number of residents in the facility during the reporting period. We then divide the ratio by 100 to represent the falls per 100 residents.

What can you do?

Residents and Family members are encouraged to read and follow the recommendations in the "Family/Resident Brochure-Your Guide to Reducing Falls and Injuries" and to speak with the care team if they have any questions or concerns.

Our Performance	Target *
2.1	<= ***3.0***

Performance timeline:	2015/2016
Data Source:	Strata Health Pathways
* Target Source:	FHA Internal



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Ministry of Health Measure

Report Generated: **September, 2016**

Emergency Patient Experience

Are patients happy with our emergency department services?

What are we measuring?

The percentage of emergency department patients who rate the care they received at the hospital positively

Why?

Our patient experience surveys provide us with valuable information about the way patients feel about our services. We use the feedback to identify areas for improvement so that we can continue to provide high-quality health care.

How do we measure it?

We take the total number of responses that answered “good”, “very good” or “excellent” to the overall quality of care question and divide by the total number of non-blank responses to the overall quality of care questions.

Our Performance	Target *
78.4%	*>= 90%*

Performance timeline: 2014/2015
Data Source: FHA Accreditation & Quality Improvement Depeartment
* Target Source: BC Ministry of Health

How are we doing?

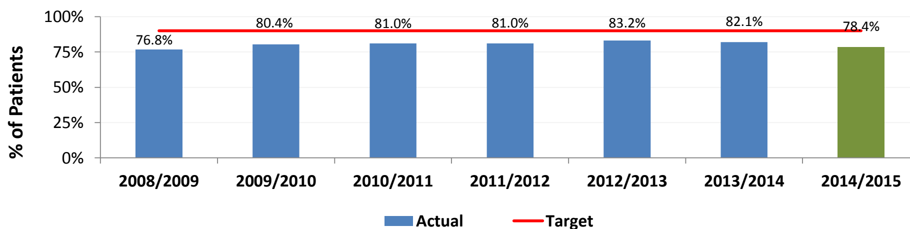
We have not met our target for Emergency Patient satisfaction. There is opportunity for improvement. Our scores for Emergency Department Patient Experience for April 2014- April 2015. 8/11 of our Emergency sites satisfaction percentages have dropped from the previous year. The results are calculated from 503,134 FH ED visits with a response rate of 1,304 patients.

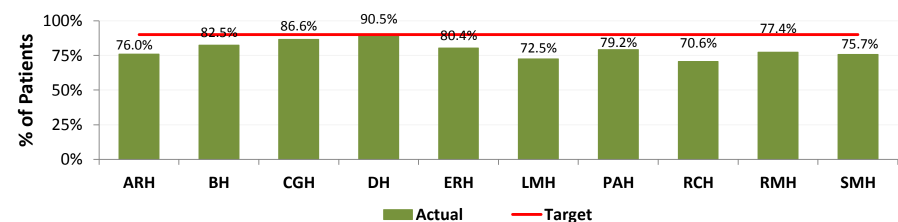
What are we doing?

We are continue to improved the "streaming" and "flow" of our Emergency Departments (EDs). We have an opportunity to provide care more efficiently. Three of our EDs (Peace Arch, Delta and SMH) continue collecting 'Real Time' patient satisfaction survey information using iPads as patients and their families leave the department. The results provide the opportunity to make "real time" improvements such as: temperature control, noise levels, explanation of test results and pain management and issues with wait times. The results are shared with the Emergency staff. Staff have been very appreciative of the comments. Each ED is working hard at the site level to improve our '10 hour rule' performance. This contributes to improved patient satisfaction through decreased wait times. The Emergency program has launched our Discharge Information package which includes lab and test results, and follow up information. The Discharge Information packages have been well received by patients. Emergency Physicians are aware of patient comments regarding "wait times"- Some EDs have adjusted physician coverage and/or adjusted time in coverage.

What can you do?

When possible use alternate service providers as appropriate (GP, BC nurse line, Walk in clinics). When attending the Emergency Department utilize our staff and volunteers to assist with questions and requests. Please read our brochures in each ED on how to improve your Emergency Room visit with information provided. Provide us with feedback on how we are doing and ask us about your care if you have questions. We are here to help!





Percent of 2-Year Olds with Up-To-Date Immunizations

What percentage of 2-year olds are up-to-date with all their immunizations.

What are we measuring?

The percentage of 2-year olds that are up to date for the following immunizations - 4 doses diphtheria/tetanus/pertussis, 3 doses hepatitis B, 1 dose measles/mumps/rubella, 3 doses polio, at least 1 dose of Haemophilus influenzae type b after 15 months of age, 1 dose varicella (or recorded exemption for varicella due to previous disease or protective antibody levels), and up-to-date for pneumococcal conjugate and meningococcal C conjugate as defined by age of first dose.

Why?

To ensure young children are protected against diseases easily preventable by vaccine.

How do we measure it?

This statistic is produced quarterly by the BC Centre for Disease Control. The number of children is pulled from the Panorama system. It is calculated as the number of children who have completed the routine child immunization schedule by 2 years of age divided by the number of children turning 2 years old during the designated time period.

Our Performance	Target *
75.9%	>= ***80%***

Performance timeline: Jan-Jun 2016

Data Source: Current data extracted from Panorama. Historic data extracted from Integrated Public Health Information System (iPHIS)

* Target Source: FHA Internal

How are we doing?

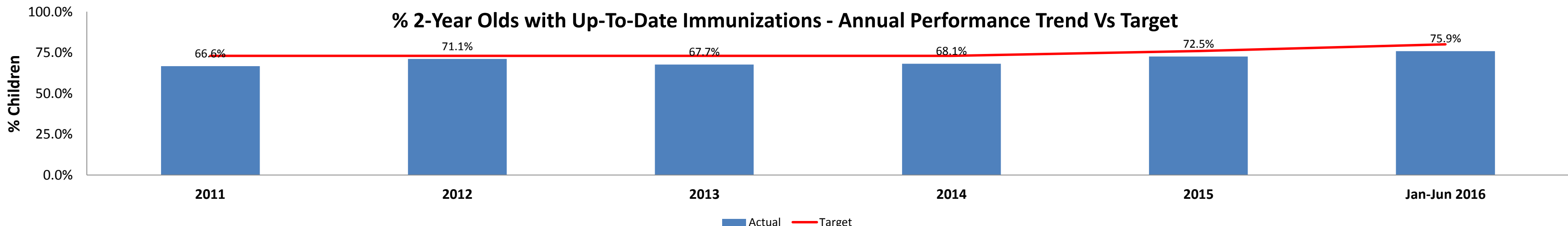
In Calendar Year (CY) 2016 (January to June), 75.9% of 2-year-olds had up-to-date immunizations. This rate is 3.4 percentage points above the overall 2015 rate and 4.1 percentage points below the 2016/17 goal (80%)

What are we doing?

Implementation of focused improvements is well underway to increase 2 year old immunization coverage rates. A multi-faceted approach based on LEAN management principles is being taken to improve business processes, physician engagement, health promotion and technological infrastructure. By increasing clinic efficiency and strengthening understanding of client needs and utilization, we are increasing accessibility to our clinics and therefore the number of children immunized. We remind parents of newborns to immunize their children on time. For children who are delayed in immunizations at 8 months of age, 14 months of age, 21 months of age and KG students, we remind their parents that their children are past due in immunizations. We have increased the degree of rigor in our internal surveillance and reporting of 2-year old immunizations, and increased the focus on reducing wait times and accelerating recruitment, to facilitate nimble operational responses to boost the rate. We continue to work with our physician partners to facilitate record sharing and uptake of immunization practice. Lastly, our website is being transformed to make it more relevant and informative for the general public.

What can you do?

Immunize your children on time with all the vaccines they need. Immunization is the most effective way to protect children from vaccine-preventable diseases. All parents are encouraged to ensure their children's immunizations are up to date and documented. Parents can sign up for free text reminders at immunizebc.ca and are encouraged to download the ImmunizeCA app (immunize.ca) on their smart phones to keep track of their children's immunizations. Parents are also encourage to report their child's immunization records to Fraser Health.



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Percent of Drinking Water Systems Complying with Microbial Monitoring Requirements

Are our drinking water systems complying with microbial monitoring requirements?

What are we measuring?

The Percent of drinking water systems submitting at least 80% of the samples required for microbial monitoring, according to the Drinking Water Protection Act/Regulation, Schedule B.

How are we doing?

The percentage of drinking water systems complying with 80% of microbial monitoring requirements decreased from 95.0% in Calendar Year (CY) 2015 to 93.5% in 2016 (January to June). The 2016 YTD rate is below the 2016 target of 96%

Why?

i. To determine Fraser Health's 460 drinking water system's level of legislative compliance in monitoring the microbiological water quality (Total Coliform and E.coli) of drinking water on a regular basis. ii. To ensure that drinking water in Fraser Health is potable and safe to drink. iii. To identify those water systems that do not meet the minimum goal of 80% compliance and follow-up by contacting the water systems to voluntarily comply or impose progressive enforcement by way of Orders and possible Fines.

What are we doing?

Drinking Water staff are continuing to communicate with water system operators that are not meeting the required monitoring frequencies; reminding them of their legislated responsibilities and providing advice on how they can improve their compliance. Drinking Water staff are following up on non-compliant water systems by contacting them personally, by inspections, by phone, by letters and, if necessary, by Orders.

How do we measure it?

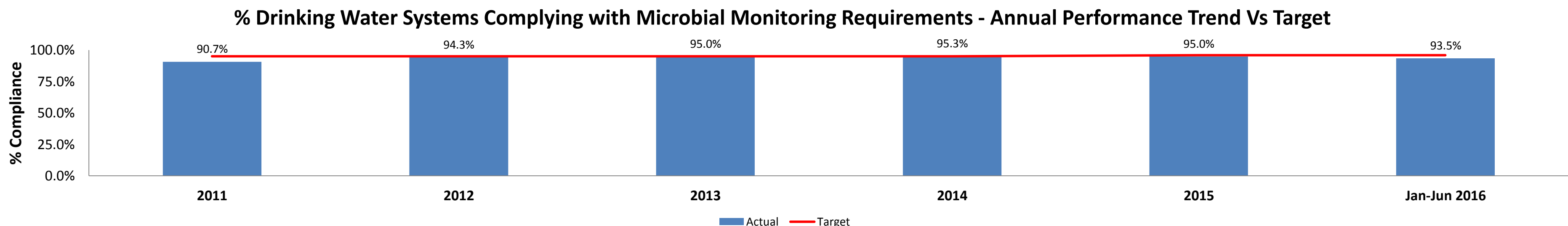
Bacteriological water quality test results from analytical laboratories are regularly downloaded into Fraser Health's HealthSpace database. On a quarter-annual basis the monitoring data for each water system is reviewed and summarized by Drinking Water Environmental Health Officers.

What can you do?

If you use a small water system that serves 500 people or less, contact the water system's owner/operator to confirm that the system is being monitored on a regular basis (generally 4 times per month), and ask for the bacteriological test results. Health Protection Drinking Water staff are available to assist with interpretation of results. The link below has more information on our Drinking Water Program, including inspection histories for water systems, and our contact information.
http://www.fraserhealth.ca/health-info/health-topics/drinking-water/

Our Performance	Target *
93.5%	>= ***96%***

Performance timeline:	Jan-Jun 2016
Data Source:	Healthspace
* Target Source:	FHA Public Health



Report Generated: **September, 2016**

WorkSafeBC (WSBC) Claims Duration

What are we measuring?
Duration of “lost time injury” claims expressed in days lost per claim

How are we doing?
Claims durations continue to mature and change over time as claims are accepted or decisions are appealed by employees. Therefore duration required several quarters to mature, but as indicated FH has generally maintained or slightly improved over the past several years. Durable, early and safe return to work are our primary goals in reducing claims duration. The current quarter duration will rise as claims mature and are closed. Majority of claims are less than 30 days in duration, but at any one time Fraser Health will have 10-20 claims that are very long duration driving the rates at some of the sites.

Why?
Duration of claim is the primary driver of costs related to occupational injury and illness in healthcare. Measuring duration will provide Fraser Health with the ability to track successes related to disability management, early intervention programs and relative staff availability. Increased duration of claim affects overtime costs as regular staff are unable to work due to injury requiring coverage. Duration of claim also drives the assessment costs paid to WorkSafe BC

What are we doing?
Our Workplace Health team, in partnership with WSBC, is involved in several process improvement projects to lower claim duration through prompt and effective reporting, early and targeted access to services and facilitating early connection and return to work. Contracts with specialized rehab providers are now in place to provide our employees with early and active rehab services. Shoulder injuries have a designated care path. This was created to provide specialized services that address the severity of these injuries.

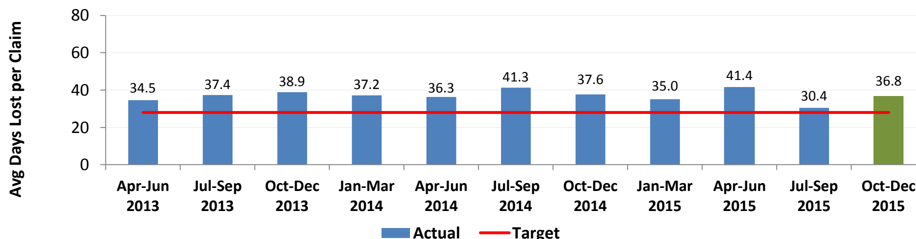
How do we measure it?
Days lost/duration per claim data is obtained from regular downloads from WorkSafeBC and is calculated as days lost accumulated for claims started in each quarter. Claims will continue to accumulate duration until employees return to work, so duration does increase over time. Therefore historical/longer-term averages are a better indicator of program performance.

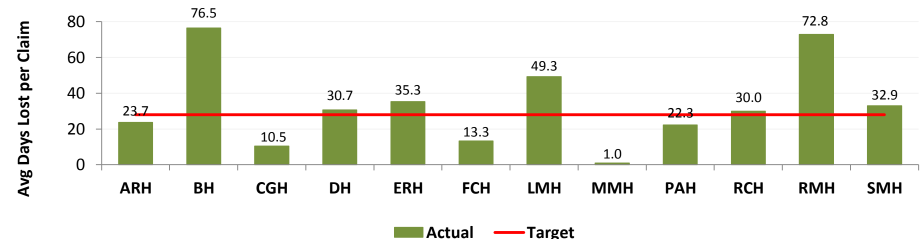
What can you do?
The healthcare setting has well known risks for injury. Fraser Health is working with every staff member to identify, assess, and eliminate or minimize factors in their workplaces that may expose workers to the risk of musculoskeletal injury. Fraser Health provides education and training that support ergonomics risk assessment, degree of risk, and risk reduction or elimination prevention strategies. Workers must be informed about the risk factors they are exposed to and have tools and techniques available to reduce their risk of injury at work.

Our Performance	Target *
36.8	***<= 28***

Performance timeline:	Oct-Dec 2015
Data source:	FHA Workplace Health
* Target Source:	FHA Workplace Health

***Note** : Starting in November report, the indicator will have a 2 quarters lag to allow for the metric to fully reflect the information of all claims and its duration (which is recorded until they are closed when the employee returns to work)*





Our Health Care Report Card

Report Generated: **September, 2016**

WorkSafeBC (WSBC) Claims / 100 FTE

What are we measuring?

Employee safety by tracking the frequency of WSBC Claims over time. This measures the number of WSBC accepted claims resulting in lost time per 100 FTEs.

How are we doing?

Our WSBC Claims/100 FTE rate has dropped 19% over the past 5 years. Injury rates remain higher in the Residential Care and Home Support sectors due to the type of work performed and the increased acuity of residents and clients in these sectors. Acute care represents our largest pool of employees and as such tends to drive our aggregate average. Musculoskeletal injuries (strains/sprains, over-exertion) sustained by our employees who provide direct patient care account for the greatest proportion of lost time claims. Slips and falls place second. Lost time claims caused by aggression place third. Other risks to healthcare workers include exposure to communicable diseases through blood and body fluids.

Why?

This indicator is a nationally comparable performance indicator, and is a measure of staff safety and well-being. It measures the overall extent to which FH is providing a safe work environment for its direct care employees by tracking the amount of time lost due to injury over time.

What are we doing?

Every year in Fraser Health, more than 400 WorkSafeBC claims occur due to patient/resident/client handling. For both client and caregiver safety and well-being, we support the importance of early and ongoing assessment of client mobility and care planning to promote mobility, including use of client handling equipment. This includes assessment of clients for bed mobility and transfer methods; selection and appropriate use of equipment to match patient/resident/client abilities; and, involvement of interdisciplinary team members in communication of changes in assessment/mobility. A similar approach applies to the prevention of violence. Point of care risk assessments, training and a safe physical environment are assessed through a detailed risk assessment process. Additionally, we have begun monitoring the timeliness of manager's incident investigations, with a goal of completing them in less than 48 hours. This will comply with WSBC regulations, and impact department safety sooner so we

How do we measure it?

We measure staff safety in the workplace by tracking the frequency of accepted lost-time WSBC Claims over time. This measures the number of WSBC accepted incidents per 100 FTEs. Numerator data is from the WHITE database and denominator (FTEs) from FH Payroll data.

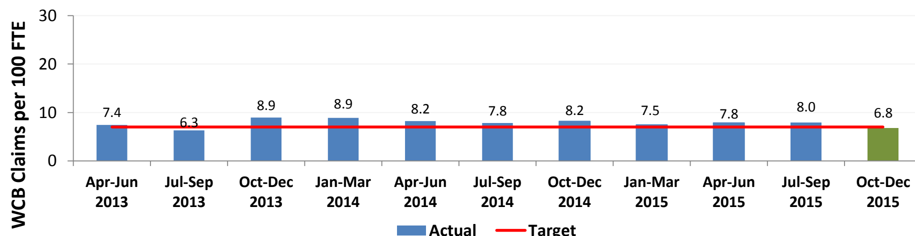
What can you do?

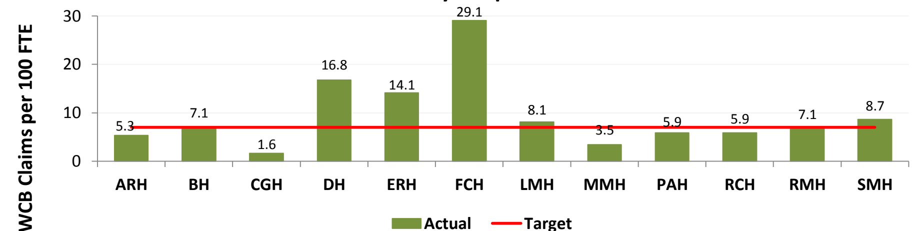
Ensure that all staff are oriented and trained in the application of mobility assessments, use of lifts and related equipment. Ensure that all reported hazards and investigations are investigated and hazardous conditions are corrected without delay.

Our Performance	Target *
6.8	***<= 7.0***

Performance timeline: Oct-Dec 2015
Data source: FHA Workplace Health
* Target Source: FHA Workplace Health

***Note** : Starting in November report, the indicator will have a 2 quarters lag to allow for the metric to fully reflect the information of all claims and its duration (which is recorded until they are closed when the employee returns to work)*





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Our Health Care Report Card

Ministry of Health Measure

Report Generated: **September, 2016**

Age-Standardized Hospitalization Rates for FH Residents (Age 70+)

How many seniors in our region have been hospitalized?

What are we measuring?

Direct age standardized hospitalization rates for FH residents 70 years old and older per 1,000 population

Why?

Hospitalization rate is an important indicator of hospital activities. Hospital activities are affected by a number of factors, including the demand for hospital services, the capacity of hospitals to treat patients, the ability of the primary care sector to prevent avoidable hospital admissions, and the availability of post-acute care settings to provide rehabilitative and long-term care services. This measure is an important indicator of the illness in the population, the utilization of inpatient hospital services over time, and the effectiveness of primary health care.

How do we measure it?

We track the number of discharged patients aged 70+ who have stayed at least one night in hospital and divide by the total population in our region. The rate is then standardized using Canada's population to remove any effects on the data due to changes in our population (size, age).

Our Performance	Target *
261	<= ***253***

Performance timeline:	2014/2015
Data Source:	Healthideas BC
* Target Source:	FHA Internal

***Notes** : All rates are standardized using the direct method; All rates are per 1000 population; The standard population used is Canada 1991; Based on BC Hospital Discharge Data; Population data provided by BC STATS (P.E.O.P.L.E. 39); Method of calculation was revised in 2015 by Healthideas BC, the target for this indicator has been updated accordingly.*

How are we doing?

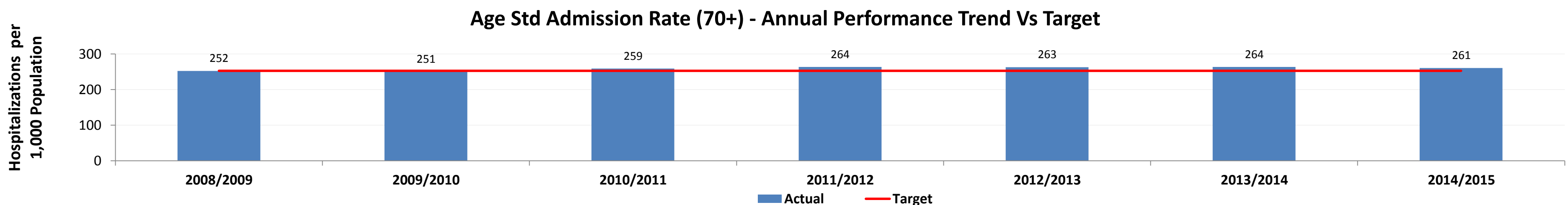
Fraser Health Age-Standardized Hospitalization (ASH) rates have shown a slight drop over the past year. However, this value has been relatively stable the past 4 years and have not met the target. We are currently taking actions as described below to drive the measure towards the target.

What are we doing?

We are seeking to reduce unnecessary hospitalizations by ensuring people aged 70 and older have access to a most responsible physician, and are partnering with that physician to maintain their health. Through the GP4Me initiative the Divisions Of Family Practice, in partnership with Fraser Health, are implementing strategies to enhance capacity of, and access to, GPs and Nurse Practitioners. This includes increasing visits to homebound patients. We are identifying models of expanded, or extended after-hour care, expanding Case Manager / GP collaboration in communities, and working to increase access to clinics/community resources for Specialized Geriatric, COPD, Outpatient Rehabilitation, and CHF. We are also strengthening the Quick Response Case Manager role, in partnership with the Geriatric Emergency Nurse clinician to better enable patients to connect with appropriate community resources.

What can you do?

Ensure that you have a family doctor, and/or are using other community health provider resources. Ask your family physician to help you learn how to manage any chronic conditions that you may have to avoid a deterioration of your health. Know what to do in the event of emergency. Build a relationship with your GP, or NP, and partner with them in keeping yourself well. Exercise if you can. Eat a healthy diet, and try to maintain a healthy weight.



Our Health Care Report Card

Ministry of Health Measure

Report Generated: **September, 2016**

Percent of Communities with Completed Healthy Living Strategic Plans

Do our communities promote healthy living?

What are we measuring?

Percent of communities that have completed Healthy Living Strategic Plans.

How are we doing?

In Fiscal Year (FY) 2015/16, 80% of Fraser Health communities (N=20) had a complete Healthy Living Strategic Plan (HLSP), which was the same in FY2014/15. It is expected to increase by September 2016, with one additional HLSP completed.

Why?

Everyone knows we are what we eat, but our health and well-being are also closely linked to where we live and what we do. We want to build on our work with our community partners to promote healthy living and address other health issues important to our communities. A Healthy Living Strategic Plan will help communities prioritize and promote important issues such as physical activity, tobacco reduction, their built environments, healthy aging and positive mental health. This plan also ensures those at greatest risk are considered and targeted.

What are we doing?

Each municipality has a FH Executive Director, Medical Health Officer and Community Health Specialist who work together to support each partnership to develop formal terms of reference, engage community stakeholders, assess community needs and identify areas for action and possible solutions. Clear processes for communication, coordination and collaboration lead to community empowerment and better community leadership for health promotion. Many of our communities have identified positive mental health and well-being, food security, Live 5-2-1-0, enhanced smoking bylaws, and active, healthy seniors as priorities to work on over the next year.

How do we measure it?

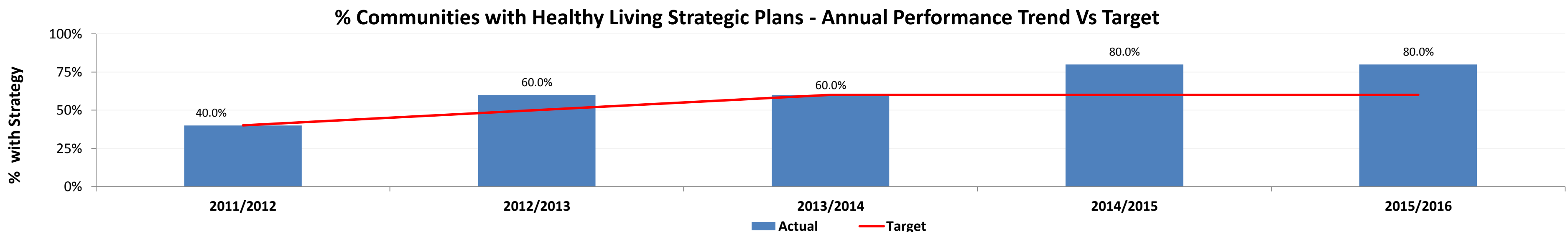
The FH Healthy Living, Healthy Communities team annually tracks how many FH communities have completed a Healthy Living Strategic Plan (also known as an action plan), and divide it by the total number of communities in our region. The number of communities is based on the Union of BC Municipalities.

What can you do?

Find out more about Healthier Community Partnerships at:
http://www.fraserhealth.ca/health-info/health-topics/healthier-communities/
Find out more about FH's Strategic Map to Better Health at:
http://www.fraserhealth.ca/about-us/strategic-direction/strategic-direction

Our Performance	Target *
80.0%	*>= 60%*

Performance timeline: 2015/2016
Data Source: MoH Measurement SharePoint
* Target Source: FHA Service Plan Target



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Our Health Care Report Card

Report Generated: **September, 2016**

Employee Engagement

A key measure of an employee's experience in FH that impacts patient quality.

What are we measuring?

A measure of an employee's psychological commitment (i.e. engagement) to their job. This level of engagement (aggregated to the manager/team level) will be measured by the Gallup Q12 tool across all health authorities in the province. The tool measures various aspects/drivers that are thought to contribute to one's engagement to their work, team and organization. The four primary areas we measure are: What do I get, What do I give, Do I belong, and How can we grow? Combined with these engagement questions are a set of three accountability index questions that ask employees about follow-up and actions implemented from the previous survey. Data clearly illustrates a linkage between engagement and post-survey follow-up activity.

Why?

The public expects to receive safe, quality care from FHA. Engaged employees are safer, more likely to stay, be more productive and are more patient centered. Valuing our staff and their contribution to the organization is foundational to Fraser Health's vision and values around respect, caring and trust.The highest quality of care cannot be established if employees are not engaged.

How do we measure it?

The Gallup Q12 survey tool provides each team with an 'engagement index' score that is derived from the average of the 12 engagement questions. The Gallup Q12 tool is a thoroughly researched, validated and widely adopted tool used to measure and enable employee engagement.

How are we doing?

-Three FH acute sites observed statistically significant increases in overall site engagement scores from 2010-2013. -Q8 of the survey ("The mission or purpose of my organization makes me feel my job is important") saw the largest statistically significant increase (+0.29). -June 2013 engagement survey results revealed that an overwhelming majority of Fraser Health workgroups score under the 25th percentile of Gallup's global healthcare database. -222 action plans currently linked to PerformanceLink link 1.1.7 (Gallup Q12 Employee Engagement Survey). Target is one action plan per manager/team. -150 Engagement Radicals recruited across Fraser Health. Target is one engagement radical per manager/team.

What are we doing?

Organization-wide engagement strategy targeting four key areas: frontline engagement, manager excellence, physician partnerships, senior leader engagement. Developing and supporting a network of 150+ Engagement Radicals (volunteer staff & physicians across FH). Monitoring the implementation and follow-up of post-survey action plans by 600 teams across FH. Implementation of a corporate communications plan to create and sustain awareness of engagement. 2015 survey administration planning currently underway.

What can you do?

Recognize and praise great work observed. Offer constructive feedback to staff and physicians. Community engagement with Fraser Health. Let us know how we are doing with our FH vision and focus on building thriving partnerships with you for your healthcare.

Our Performance	Target *
3.52	>= ***3.75***

Performance timeline:	2013/2014
Data Source:	Info from Gallup provided by FH Organizational Development
* Target Source:	FHA Internal