Our Health Care Report Card

Fraser Health

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

No	Measure Name	Last Available Update	Target	Actual	Status	Preferred Direction
	QUALITY AND SAFETY					
1	In-Hospital *Clostridioides Difficile* Infection (CDI) Incidence	Apr-Oct 2021	*4.5*	*3.0*	●	↓
2	In-Hospital Methicillin-Resistant *Staphylococcus aureus* (MRSA) Incidence	Apr-Oct 2021	*5.5*	*3.5*	●	↓
3	Hand Hygiene Compliance	Apr-Oct 2021	*80%*	*86.0%*	●	↑
4	In-Hospital Sepsis Rate	Apr-Aug 2021	*3.8*	*4.6*	◆	↓
5	In-Hospital Acquired Delirium	Apr-Aug 2021	*7.3*	*10.4*	◆	↓
6	In-Hospital Acquired Non-Aspiration Pneumonia	Apr-Aug 2021	*7.3*	*9.1*	◆	↓
7	In-Hospital Acquired Urinary Tract Infection	Apr-Aug 2021	*10.0*	*15.4*	◆	↓
8	Hospital Standardized Mortality Ratio	Apr-Jun 2021	*93*	*87.1*	●	↓
9	Worsened Pressure Ulcer in Long Term Care Facilities	Apr-Jun 2021	*1.6%*	*2.4%*	◆	↓
	CAPACITY AND CARE ACROSS ALL SECTORS					
10	Emergency Patients Admitted to Hospital Within 10 Hours	Apr-Oct 2021	*65.0%*	*25.0%*	◆	↑
11	Admitted Patients Waiting for Inpatient Bed Placement	Apr-Oct 2021	*130*	*183.1*	◆	↓
12	Patients Length of Stay Relative to Expected Length of Stay	2020/2021	*0.95*	*0.983*	△	↓
13	Long Stay Patients	Apr-Oct 2021	*455*	*367.2*	●	↓
14	Alternate Level of Care (ALC) Days	Apr-Aug 2021	*12.9%*	*10.9%*	●	↓
15	Hospitalization Rates for Residents (Age 70+)	2020/2021	*238.0*	*224.4*	●	↓
16	Hospital Readmission Rates Overall	2020/2021	*10.0%*	*10.6%*	△	↓
17	Mental Health & Substance Use Patients Hospital Readmission Rate (Age 15+)	2020/2021	*13.3%*	*15.4%*	◆	↓
18	Patients with Chronic Conditions Admitted to Hospital (Age 75+)	2020/2021	*3,448*	*2,331*	●	↓
19	Low Acuity Emergency Visits by Community	Apr-Oct 2021	*100.0*	*101.7*	△	↓
20	Home Health Services Provided Within Benchmark Time	Apr-Oct 2021	*50.0%*	*51.4%*	●	↑
21	Wait Time for Home Health Assessment (RAI-HC)	Apr-Oct 2021	*30.0*	*17.4*	●	↓
22	Admissions to Long Term Care within 30 Days	Apr-Oct 2021	*75.0%*	*77.8%*	●	↑
23	Emergency Visits by Home Health Clients	Sep2020-Sep2021	*75.8*	*88.4*	◆	↓
24	Emergency Visits by Long Term Care Clients	Sep2020-Sep2021	*30.0*	*38.4*	◆	↓
25	Non-emergency Surgeries Completed Within 26 Weeks	Apr-Oct 2021	*95%*	*87.1%*	△	↑
26	Non-Emergency Surgeries Waiting Longer Than 26 Weeks	Apr-Oct 2021	*22.8%*	*28.9%*	◆	↓
	POPULATION & PUBLIC HEALTH MEASURES					
27	Percent of 2-Year Olds with Up-To-Date Immunizations	Apr-Sep 2021	*85%*	*70.6%*	◆	↑
28	Health Protection Program Response Time to Public Complaints	Apr-Sep 2021	*95%*	*97.5%*	●	↑
29	Prenatal Registrations	Apr-Sep 2021	*75%*	*56.6%*	◆	↑
	STAFF					
30	Nursing and Allied Professional Sick Time	Apr-Oct 2021	*5.8%*	*5.3%*	●	↓
31	Nursing and Allied Professional Overtime	Apr-Oct 2021	*3.9%*	*7.4%*	◆	↓
32	Lost Time Claims Rate	Apr-Jun 2021	*5.3*	*6.2*	◆	↓
33	Long Term Disability Claims Rate	Jan-Jun 2021	*2.25*	*2.07*	●	↓
34	Turnover Rate In The First Year Of Service	Apr-Sep 2021	*2.5%*	*8.2%*	◆	↓
	BUDGET ACCOUNTABILITY					
35	Budget Performance Ratio	Apr-Oct 2021	*1.000*	*1.031*	△	↓

Notes:

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

KPI Count By Status		
Meeting Target	●	14
Within 10% of Target	△	5
Not Meeting Target	◆	16

Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

In-Hospital *Clostridioides Difficile* Infection (CDI) Incidence

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

What are we measuring?

Number of new facility-associated CDI cases at the FH acute care site where CDI was most likely associated 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?

Clostridioides difficile is the most common cause of facility-associated infectious diarrhea. CDI occurs when antibiotics kill good bacteria in the gut, allowing the *Clostridioides difficile* bacteria to grow and produce toxins that can damage the bowel.

How do we measure it?

([Number of new facility-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?

Fraser Health's CDI incidence rate, which is the number of new acute care cases per population-at-risk, is 3.0 year-to-date in 2021/22, which is meeting the current FHA internal target of ≤ 4.5 cases per 10,000 patient days. In previous fiscal years from 2015/16 to 2020/21, the rate of CDI remained below the FHA internal target set for each respective year. Please see figures below.

What are we doing?

Fraser Health actively monitors and reports CDI rates by carrying out surveillance and providing units and acute care sites with regular reports that show the number of newly acquired cases. The Infection Prevention and Control (IPC) Practitioners conduct detailed reviews of each CDI case to understand the factors that may have contributed to the infection. This information helps staff develop quality improvement action plans to reduce CDI transmissions.

The IPC program works with Environmental Services to ensure that all rooms of patients with suspected or known CDI are cleaned twice a day with a sporicidal agent, and also collaborates with acute care sites to implement ultra-violet germicidal irradiation technology and quality improvement action plans to reduce healthcare-associated CDI. In addition, hand hygiene practices of healthcare providers are monitored across FH to support IPC best practices.

What can you do?

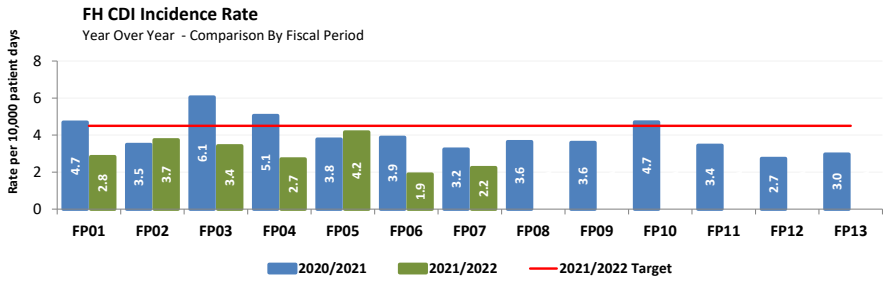
One of the most important things you can do is to clean your hands when entering and exiting a facility or patient room, and support your family or loved ones to clean their hands as frequently as possible. When visiting, please follow all instructions and signs posted on the unit to decrease the chance of spreading germs.

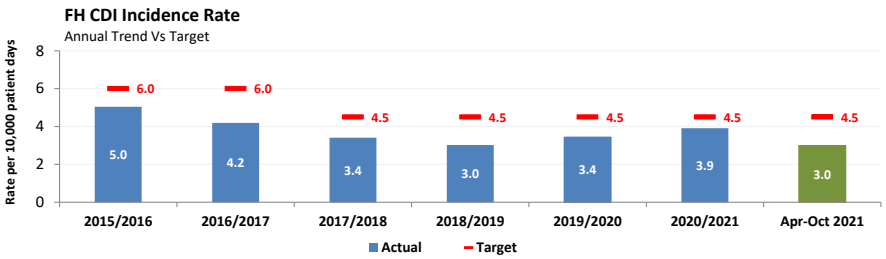
Our Performance	Target *
3.0	<= 4.5
Unit of Measure: Number of infections / 10,000 patient days	

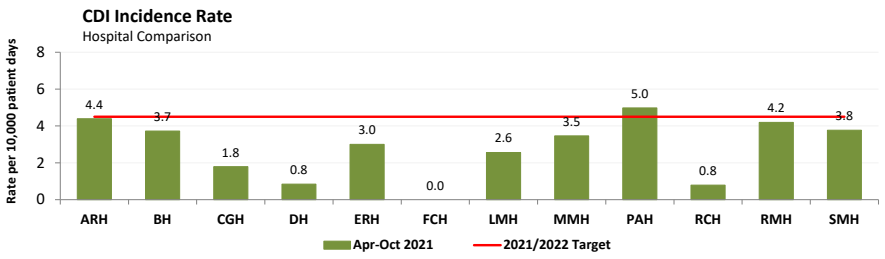
Performance timeline:	Apr-Oct 2021
Data source:	FH Infection Prevention and Control Database
* Target Source:	FHA Internal

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

2) MSA acute care data were combined with ARH from April 1, 2015 (FP01, 2018/19) to July 25, 2019 (FP04, 2019/20)







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Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

In-Hospital 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 facility-associated MRSA cases at the FH acute care site where MRSA was most likely associated 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)

How are we doing?

Fraser Health's MRSA incidence rate, which is the number of new acute care cases per population-at-risk, has decreased from 7.1 in 2015/16 to 3.5 year-to-date in 2021/22, which is below the current FHA internal target of ≤ 5.5 cases per 10,000 patient days. In previous fiscal years from 2016/17 to 2020/21, the rate of MRSA remained below the FHA internal target set for each respective year. Please see figures below.

Why?

Staphylococcus aureus is a bacterium that normally lives on skin and in noses. Many people are carriers of *Staphylococcus aureus* and never have symptoms. Others may develop an infection, usually involving the skin. Occasionally, more serious problems can occur 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.

What are we doing?

Fraser Health actively monitors and reports MRSA rates by carrying out surveillance and providing units and acute care sites with regular reports that show the number of newly acquired cases. Fraser Health's Infection Prevention and Control program works collaboratively with units to develop quality improvement action plans to reduce MRSA transmissions and address infection control best practice gaps.

Many of the initiatives to reduce *Clostridioides difficile* infections are also used to reduce MRSA infections in acute care sites – particularly hand cleaning with ABHR (alcohol-based hand rub) and following Infection Prevention and Control best practices (e.g., wearing gloves and a gown).

How do we measure it?

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

What can you do?

One of the most important things you can do is to clean your hands when entering and exiting a facility or patient room, and support your family or loved ones to clean their hands as frequently as possible. When visiting, please follow all instructions and signs posted on the unit to decrease the chance of spreading germs.

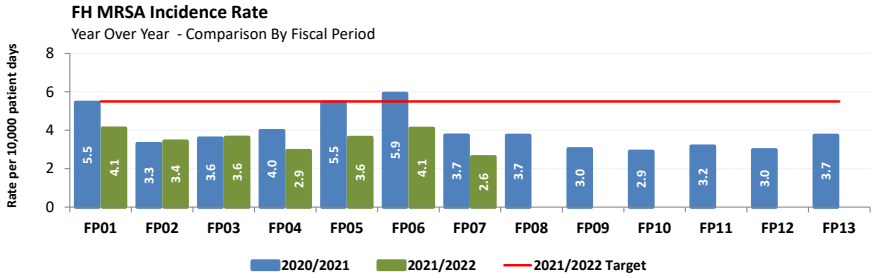
Our Performance	Target *
3.5	<= 5.5

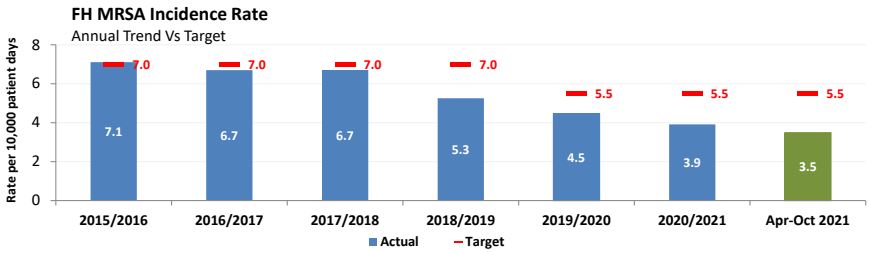
Unit of Measure: Number of infections / 10,000 patient days

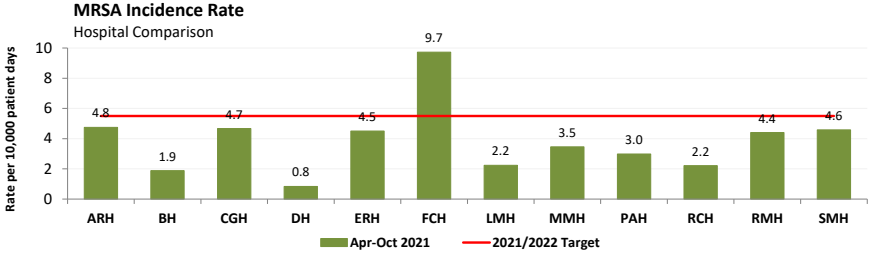
Performance timeline:	Apr-Oct 2021
Data Source:	FH Infection Prevention and Control Database
* Target Source:	FHA Internal

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

2) MSA acute care data were combined with ARH from April 1, 2015 (FP01, 2018/19) to July 25, 2019 (FP04, 2019/20)







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Hand Hygiene Compliance

What percentage of healthcare providers perform hand hygiene according to FH policy/protocols in acute care facilities?

What are we measuring?

The percentage of times that healthcare providers correctly perform hand hygiene while providing direct patient care. Opportunities measured for hand hygiene include before-and-after entering/exiting the patient environment. Use of soap and water or alcohol-based hand rub (ABHR) is acceptable. Missed opportunities are times when hand hygiene should have been carried out but was not.

How are we doing?

Fraser Health's overall hand hygiene compliance improved over the years from 79.6% in 2018/19 to 86.0% year-to-date in 2021/22. The regional hand hygiene audit program was suspended in April 2020 due to the COVID-19 pandemic, and resumed in September 2020. Based on the currently available results, Fraser Health is meeting the provincial target of >=80%.

Why?

Hand hygiene is an essential patient safety initiative and one of the most effective, well-known measures to reduce the transmission of healthcare infections. Hand hygiene education and training is provided annually and through new employee orientation sessions. Fraser Health's hand hygiene program aligns with Accreditation Canada's Required Organizational Practices, as well as with the BC Ministry of Health's provincial auditing and reporting requirements for hand hygiene compliance.

What are we doing?

Hand hygiene compliance audits are conducted regularly to reinforce that hand cleaning is important and to determine how well healthcare providers are cleaning their hands. The new audit methodology includes in-the-moment feedback to staff, helping them identify gaps in their hand hygiene practice and supporting practice improvement. The Infection Prevention and Control program also provides educational support for healthcare providers and their units and assists in developing quality improvement action plans if required. Fraser Health facilities publish and distribute hand hygiene compliance rates to support quality improvement initiatives.

How do we measure it?

([Number of times healthcare providers correctly performed hand hygiene while providing direct patient care] / [Total number of times that hand hygiene should have been performed by those same healthcare providers] * 100) for a specified reporting period

What can you do?

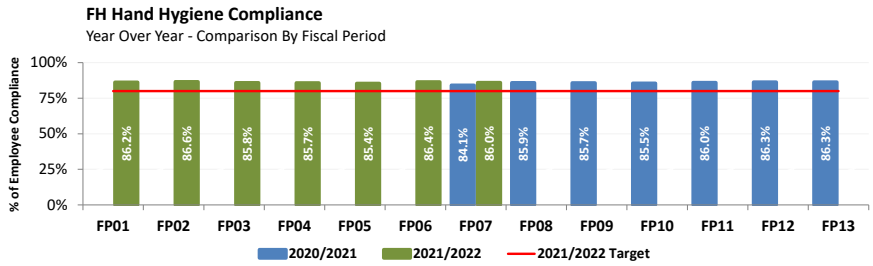
One of the most important things you can do is to clean your hands when entering and exiting a facility or patient room, and support your family or loved ones to clean their hands as frequently as possible.

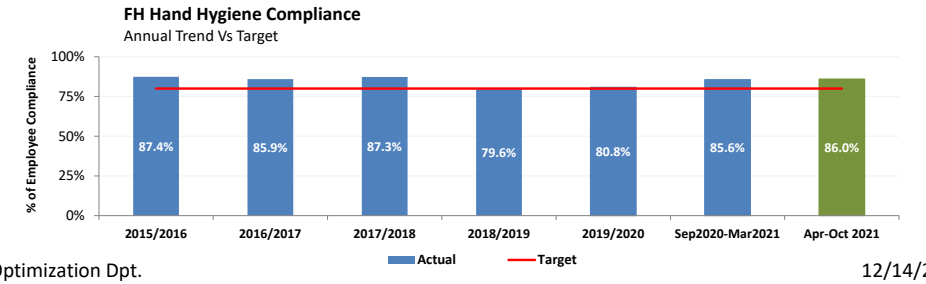
Our Performance	Target *
86.0%	>= 80%

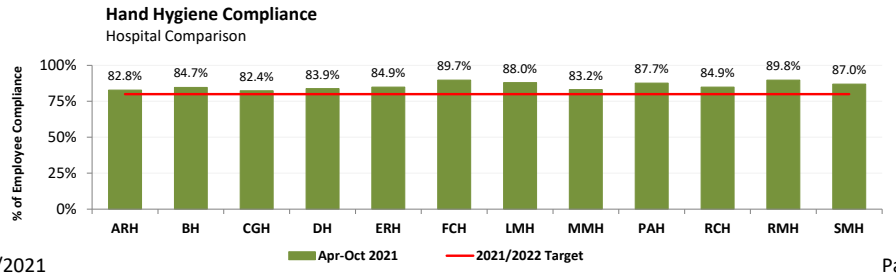
Unit of Measure: Percent of compliant employees

Performance timeline:	Apr-Oct 2021
Data Source:	FH Infection Prevention and Control Program Hand Hygiene System (FormAudit)
* Target Source:	Provincial Target

Notes: *1) Data are examined and updated on a regular basis, therefore numbers may change slightly based on adjustments.*
2) As of July 2018, only observation data collected by the regional hand hygiene auditors will be included in fiscal period/year compliance rates. Hand hygiene audit data collected by site auditors for fiscal period, alerts/outbreaks, outpatient clinics and other quality improvement initiatives will not be included in fiscal period reports. The hand hygiene compliance rate for FY 2018/19 is calculated based on audit data from July 2018 (FP1904) onwards.
3) MSA acute care data were combined with ARH from April 1, 2015 (FP01, 2018/19) to July 25, 2019 (FP04, 2019/20)







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In-Hospital Sepsis Rate

Are our patients receiving a high quality of care which aims to reduce acquired sepsis during their hospital stay?

What are we measuring?

We are measuring the rate of sepsis infection within our acute care inpatients population that occurs during their hospital stay. It could occur when a patient is unintentionally harmed and infected with Sepsis as a result of their care and treatment during their hospital stay.

Why?

As a clinical syndrome, sepsis occurs as a complication of infections. It could be a leading cause of mortality and is linked to increased healthcare resource utilization and prolonged stay in hospital intensive care units. Appropriate preventive and therapeutic measures during a hospital stay can reduce the rate of infections and/or progression of infection. This indicator helps us to evaluate how effective we are in preventing the development of sepsis during patients stay in our acute care facilities.

How do we measure it?

We take the number of patients 1 year or older who have acquired Sepsis while in hospital and divide it by the total number of discharged acute care inpatients (excluding Mental Health and Palliative care) 1 year or older in that hospital. The rate we report is per 1,000 patient discharges.

How are we doing?

Fraser Health's year-to-date 2021/22 performance for hospital sepsis is 4.6. Our hospitals' results show that two sites (Chilliwack General and Fraser Canyon) are meeting their internal targets. There was an increase in hospital acquired sepsis with patients who acquired COVID 19.

What are we doing?

Hospital acquired sepsis is a Patient Safety Priority for Fraser Health and is monitored closely by clinical leaders at all 12 acute care sites. Site leadership is focused on prevention of all hospital acquired infections which can develop into sepsis as well as treatment of infections, and behavioural changes. Accountabilities at all levels of leadership will support reducing hospital acquired sepsis rates by highlighting and sustaining best practices already in place throughout FH acute care sites. Early recognition through screening of patients is key to reducing sepsis.

What can you do?

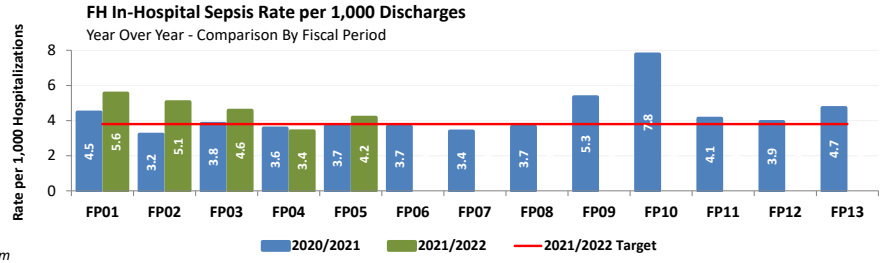
You are encouraged to get vaccinated against COVID-19, the flu, pneumonia, and any other infections that could lead to sepsis. Practice of practice good hygiene (e.g. brushing your teeth, hand washing, bathing regularly) is especially important while in the hospital. Tell your health care provider immediately if you have any of the following symptoms: fever, chills, dizziness, rapid breathing and heart rate, rash, confusion or disorientation. We also have a patient education phamplet on Sepsis. Please ask your health care provider for this as we would like you to be familiar with what sepsis is and to communicate early to your health care provider if you may feel any of the signs and symptoms. You are an important part of the team, and we encourage you to bring your voice forward. Together, we can help to reduce the risk of acquiring infection and sepsis during your hospital stay.

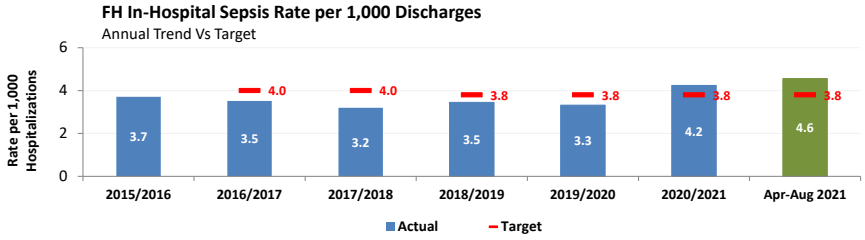
Our Performance	Target *
4.6 ◆	<= 3.8

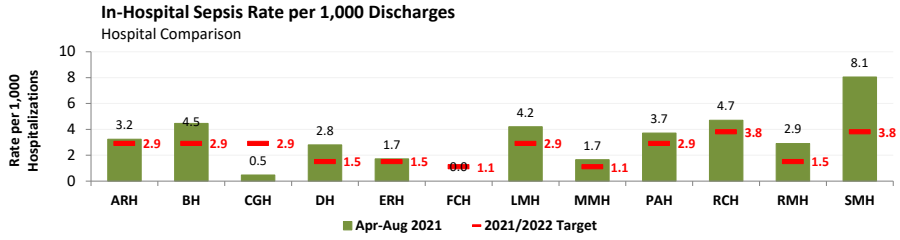
Unit of Measure: Infections per 1,000 Discharges

Performance timeline:	Apr-Aug 2021
Data Source:	Med2020
* Target Source:	FHA Internal
BC Average (2014/15)	4.2
National Average (2014/15)	4.1
BC and National Average Source:	CIHI - Your Health System

Notes: *Hospital specific targets were derived based on the different types Fraser health operates (Teaching Hospitals, Large, Medium and Small size community hospitals) as specified by the Canadian Institute of Health information (CIHI), and each site historical performance.*







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In-Hospital Acquired Delirium

Are our patients receiving a high quality of care which aims to reduce acquired Delirium during their hospital stay?

What are we measuring?

We are measuring the rate of in-hospital acquired delirium for all acute care inpatients (excluding Mental Health and Substance Use). While all patients have some risk of acquiring delirium in hospital, older adults with significant risk factors, such as dementia, chronic illness, and frailty, are at increased risk of acquiring delirium while in hospital.

Why?

Delirium is a medical emergency that contributes to a deterioration in physical and cognitive functioning, a decreased quality of life, and increased costs of care and resource utilization by the health care system. Approximately 15% of older adults come into hospital with delirium and another 15% on general medical units acquire delirium during their hospital stay. Acquired delirium rates can also be higher on surgical, orthopedic, and intensive care units. Best practice prevention strategies, early identification, and treatment can prevent up to 40% of cases and reduce the severity and duration of delirium in patients with the illness (Fong, Tulebaev & Inouye 2009).

How are we doing?

Fraser Health's year-to-date 2021/22 performance for in-hospital acquired delirium is 10.4. Five sites (Delta, Eagle Ridge, Langley Memorial, Mission Memorial and Peace Arch) are meeting their internal targets. We will continue to work with our sites and programs to promote best practice prevention strategies, early recognition of delirium, and the identification of high-risk patients.

What are we doing?

Hospital acquired delirium is a Patient Safety Priority for Fraser Health and is monitored closely by clinical leaders at all 12 acute care sites. Site leadership continues 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 prevention.

Fraser Health is focused on an interprofessional, multi-faceted approach for delirium. This approach includes: education; the implementation and sustainment of the revised Delirium Pre-Printed Orders (PPO) and Clinical Practice Guideline (CPG); improved utilization of the Confusion Assessment Method (CAM) and associated Care and Discharge Planning Tools; revised Patient and Family Guide; and integration with other Patient Safety Priorities and initiatives. The regional Delirium Steering Committee is also exploring opportunities for upstream identification of patients at increased risk of delirium; improved documentation/charting/coding; and enhancing delirium prevention and recognition in the community ("pre-admission"). Quality improvement efforts in delirium recognition and charting/coding is showing an increase in the delirium prevalence data as we re-calibrate to the true prevalence. Launching of the delirium dashboard, prevention, recognition and management information is slated for a comprehensive roll-out over the next year with a Delirium Summit in December. In addition, there will be a focused spread initiative for delirium through SSC.

How do we measure it?

We take the number of patients who have acquired In-Hospital Delirium while in hospital and divide it by the total number of discharged acute care inpatients (excluding Mental Health and Substance Use) from that hospital. The rate we report is per 1,000 patient discharges.

Our Performance	Target *
10.4 ◆	<= 7.3

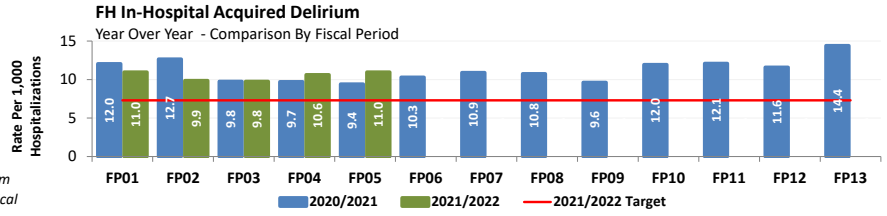
Unit of Measure: Infections per 1,000 Discharges

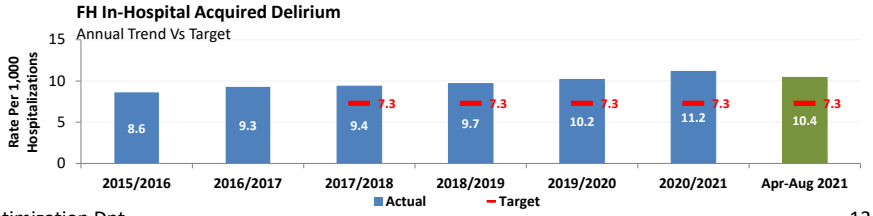
Performance timeline:	Apr-Aug 2021
Data Source:	Med2020 Abstracting and Coding system
* Target Source:	FHA Internal

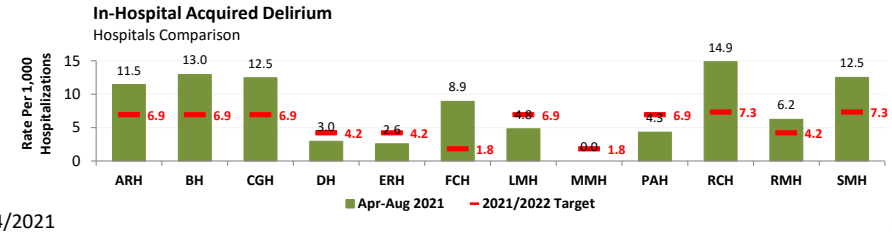
Notes: *Hospital specific targets were derived based on the different types Fraser health operates (Teaching Hospitals, Large, Medium and Small size community hospitals) as specified by the Canadian Institute of Health information (CIHI), and each site historical performance.*

What can you do?

As a family member, you know the person best. Please tell staff if you see any unusual change in behaviour. Within COVID restrictions, you can help by visiting and bringing in familiar items from home, such as favorite music and pictures. Ask your family member to use their walking aid, hearing aids, dentures, and glasses. Tell your family member the date and where they are. Talk to them about current events and favorite activities. Work with the hospital staff to keep them safe and to establish a regular and consistent routine. For more information, see https://www.fraserhealth.ca/health-topics-a-to-z/seniors/delirium







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In-Hospital Acquired Non-Aspiration Pneumonia

Are our patients receiving a high quality of care which aims to reduce acquired Pneumonia during their hospital stay?

What are we measuring?

We are measuring the rate of In-Hospital Acquired Non-Aspiration Pneumonia for all acute care inpatients (excluding Mental Health and Substance Use and patients with a length of stay less than 2 days). This adverse event can occur when a patient is unintentionally harmed as a result of their care and treatment during their hospital stay.

Why?

Our goal is to provide the best care to our patients. Appropriate preventative therapeutic measures along with evidence informed practice (oral care, frequent ambulation, hand hygiene, etc.) during a hospital stay reduces the rate of infections. The inter-professional care team provides evidence informed practices for optimal health outcomes and recovery. This enhances communication with patients, families, and providers as to their role in health promotion and prevention during a patient's hospital admission. Everyone understanding their role in the application of evidence informed practice is the foundation to preventing hospital acquired infections and the progression to sepsis.

How do we measure it?

We take the number of patients who have acquired In-Hospital Non-Aspiration Pneumonia while in hospital, with a LOS >= 2 days, and divide it by the total number of discharged acute care inpatients (excluding Mental Health and Substance Use and patients with a LOS < 2 days) from that hospital. The rate we report is per 1,000 patient discharges.

How are we doing?

Fraser Health's year-to-date 2021/22 performance for hospital acquired non-aspiration pneumonia is 9.1. Four sites (Chilliwack General, Eagle Ridge, Langley Memorial, and Peace Arch) are meeting their internal targets. We will continue to work with our sites and programs that have opportunities to reduce this infection which can impact a patient's stay in our facilities. COVID-19 has negatively influenced our hospital acquired pneumonia numbers as patients on outbreak units who acquired COVID-19 while in hospital and it lead to pneumonia are included in the increase in numbers.

What are we doing?

Hospital acquired pneumonia is an infection in the lungs. It is a Patient Safety Priority for Fraser Health and is monitored closely by clinical leaders at all 12 acute care sites. Site leadership continues 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 prevention. This includes enhanced communication with patients and families as to their role in health promotion and prevention during a hospital admission. Everyone understanding their role in the application of evidence-informed practice is the foundation to preventing hospital-acquired infections and reducing the progression to sepsis.

What can you do?

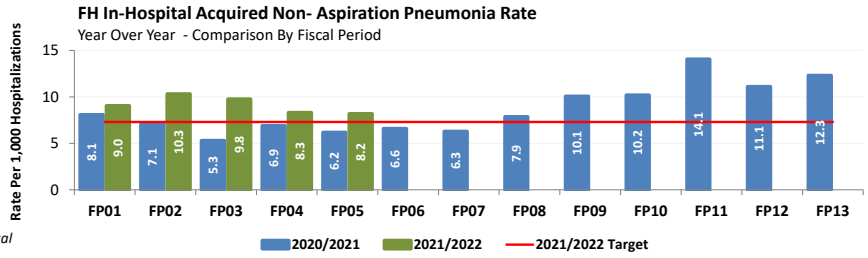
You are encouraged to mobilize if able, take deep breaths and cough every hour to reduce the risk of acquiring pneumonia. Cleaning your hands frequently as well as cleaning your teeth in the morning, after each meal and at bedtime, aids in reducing the risk. Together, we can help to reduce the risk of acquiring infection and pneumonia during your hospital stay.

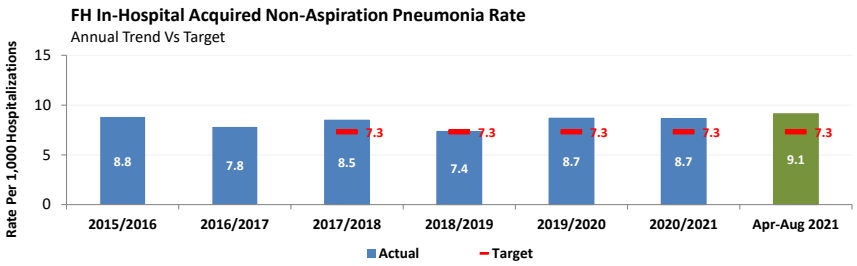
Our Performance	Target *
9.1 ◆	<= 7.3

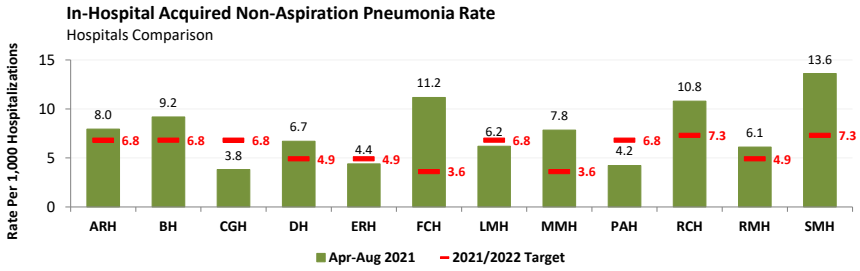
Unit of Measure: Infections per 1,000 Discharges

Performance timeline:	Apr-Aug 2021
Data Source:	Med2020 Abstracting and Coding system
* Target Source:	FHA Internal

Notes: *Hospital specific targets were derived based on the different types Fraser health operates (Teaching Hospitals, Large, Medium and Small size community hospitals) as specified by the Canadian Institute of Health information (CIHI), and each site's historical performance.*







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

In-Hospital Acquired Urinary Tract Infection

Are our patients receiving a high quality of care which aims to reduce acquired Urinary Tract Infection (UTI) during their hospital stay?

What are we measuring?

We are measuring the rate of In-Hospital Acquired Urinary Tract Infections for all acute care inpatients (excluding Mental Health and Substance Use and patients with a length of stay less than 2 days). This adverse event can occur when a patient is unintentionally harmed as a result of their care and treatment during their hospital stay.

How are we doing?

Fraser Health's year-to-date 2021/22 performance for in-hospital acquired UTI is 15.4. Of the 12 hospitals, Fraser Canyon and Royal Columbian are below the target. Abbotsford General and Surrey Memorial hospitals are close to the target and should be acknowledged for their ongoing efforts. We will continue to work with our sites and programs that have opportunities to reduce this infection which can impact a patient's stay in our facilities.

Why?

Our goal is to provide the best care to our patients. Appropriate preventative therapeutic measures along with evidence informed practice (oral care, frequent ambulation, hand hygiene, etc.) during a hospital stay reduces the rate of infections. The inter-professional care team provides evidence informed practices for optimal health outcomes and recovery. This enhances communication with patients, families, and providers as to their role in health promotion and prevention during a patient's hospital admission. Everyone understanding their role in the application of evidence informed practice is the foundation to preventing hospital acquired infections and the progression to sepsis.

What are we doing?

Hospital acquired urinary tract infection is a Patient Safety Priority for Fraser Health and is monitored closely by clinical leaders at all 12 acute care sites. Site leadership continues 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.

The UTI Task Force continues to drive regional strategies focused on prevention, diagnosis, treatment and measurement. In addition, two community sites have chosen reducing UTIs as a primary focus of their quality improvement work.

How do we measure it?

We take the number of patients who have acquired In-Hospital UTIs while in hospital, with a LOS >= 2 days, and divide it by the total number of discharged acute care inpatients (excluding Mental Health and Substance Use and patients with a LOS < 2 days) from that hospital. The rate we report is per 1,000 patient discharges.

What can you do?

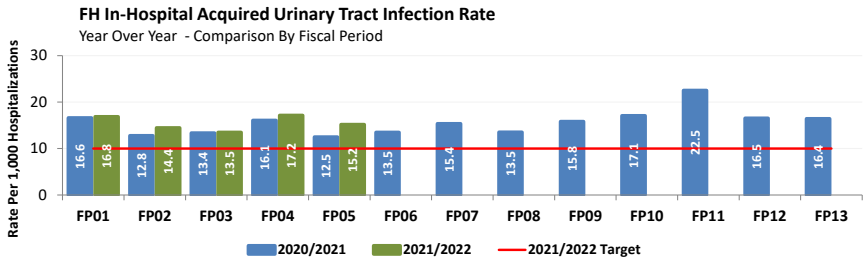
It is important to mobilize, hydrate and empty your bladder every few hours to reduce the risk of acquiring a urinary tract infection. Together, we can help to reduce the risk of acquiring an infection or injury during your hospital stay.

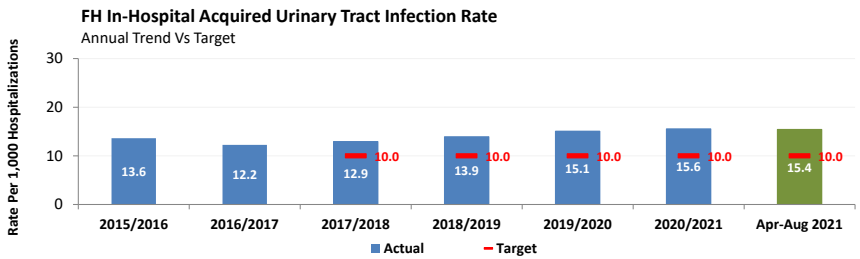
Our Performance	Target *
15.4 ◆	<= 10.0

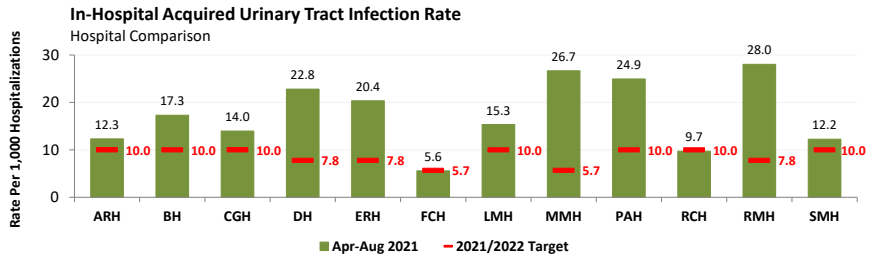
Unit of Measure: Infections per 1,000 Discharges

Performance timeline:	Apr-Aug 2021
Data Source:	Med2020 Abstracting and Coding system
* Target Source:	FHA Internal

Notes: *Hospital specific targets were derived based on the different types Fraser health operates (Teaching Hospitals, Large, Medium and Small size community hospitals) as specified by the Canadian Institute of Health information (CIHI), and each site historical performance.*







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Hospital Standardized Mortality Ratio

What are the mortality rates at Fraser Health hospitals?

What are we measuring?

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

How are we doing?

Fraser Health's 2021/22 year-to-date HSMR rate of 87.1 is meeting the target of 93. At the hospital level, eight sites (Chilliwack General, Delta, Eagle Ridge, Fraser Canyon, Langley Memorial, Mission Memorial, Peace Arch and Royal Columbian) are meeting the target. All sites within Fraser Health are dedicated to ensuring that we 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 Hospital Standardized Mortality Rate.

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.

What are we doing?

Early recognition of at risk patients, rapid response to sudden worsening of a patient's condition, and appropriate transition of care is a key area of focus to reduce Hospital Standardized Mortality Rates. An area of focus is monitoring the Fraser Health Patient Safety Priorities (hospital acquired sepsis, hospital acquired urinary tract infection, hospital acquired pneumonia and delirium.) In addition, staff are focusing on sharing critical patient information between healthcare team members, key early identification of patient clinical indicators that are recognized as signs and symptoms for further investigation, and ensuring interventions are clear for the nurses and physicians. Sites that are not meeting their targets are evaluating the HSMR methodology to understand the data for areas of improvement.

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.

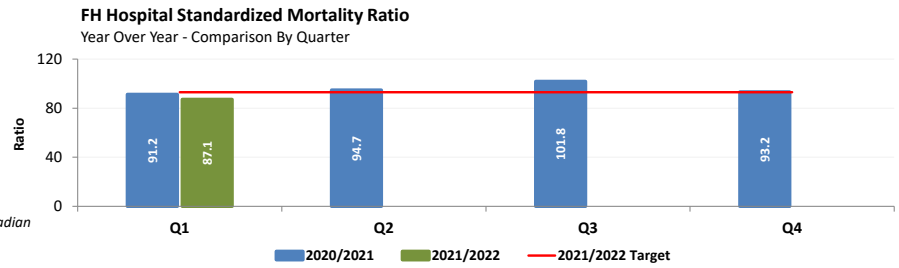
What can you do?

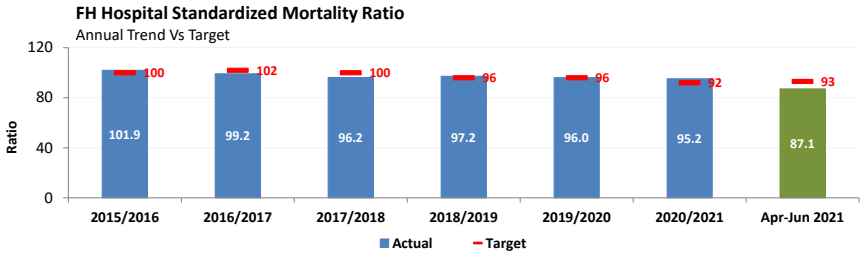
No matter what stage of life or health you are at, communication with your healthcare team regarding what you or your family are seeing or experiencing is vital to ensure appropriate treatment and levels of intervention. If you are a patient, we encourage you to participate as much as possible in setting goals and planning your care while in hospital.

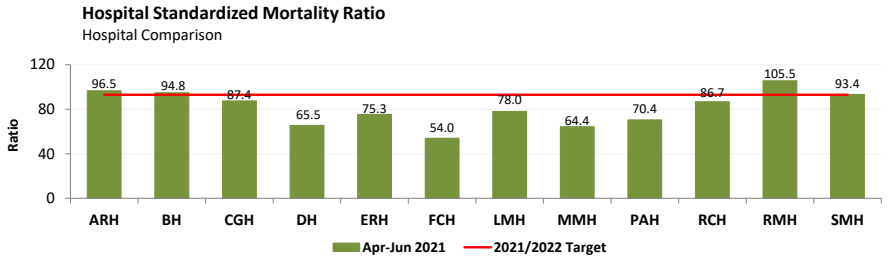
Our Performance	Target *
87.1	<= 93

Unit of Measure: Hospital Mortality Ratio	
Performance timeline:	Apr-Jun 2021
Data Source:	Canadian Institute for Health Information (CIHI)
* Target Source:	FHA Internal
BC Average (2020/21)	93
BC Average Source:	CIHI - Your Health System

Notes: *1) In September 2019, CIHI updated the HSMR indicator methodology and the years of data used to establish the pan-Canadian baseline. All results were re-calculates with the new methodology (using 2015-2016 to 2017/2018 data)*
2) The target was adjusted to reflect BC average for the corresponding year







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Worsened Pressure Ulcer in Long Term Care Facilities

What is the percentage of residents who suffered from a worsened pressure ulcer while living in a Long Term Care Home?

What are we measuring?

This indicator measures the percentage of Long Term Care residents whose stage 2, 3, and 4 pressure ulcers had worsened since their previous InterRAI assessment.

Why?

Our goal is to provide evidence informed care to residents with the intention to avoid worsening of pressure ulcers, and ultimately to support healing of existing pressure ulcers. This measure raises awareness and is an opportunity for the care team at the Long Term Care home to monitor their care for residents with pressure ulcers. Residents will have optimal health outcomes and recovery if evidence-informed practices, including preventative care are provided by the inter-professional care team.

How do we measure it?

This indicator examines the percentage of residents whose stage 2 to 4 pressure ulcer had worsened since the previous assessment. It is calculated by dividing the number of residents whose stage 2 to 4 pressure ulcer worsened by the number of all residents with valid assessments (excluding those who maintained a stage 4 ulcer) within the applicable time period. The indicator is helpful for regular monitoring, prevention, and treatment of pressure ulcers and with quality care we expect to see a reduction in the prevalence of pressure ulcer and indirectly a reduction of morbidity among the residents. Also it offers a standard approach to wound care assessment and treatment across Canada. (This FH quality indicator is similar to the CIHI Quality indicator)

How are we doing?

Our 2021/22 year-to-date performance of 2.4% did not meet our internal-set target of ≤ 1.6%. At the community-level, eleven have an incidence rate higher than 1.6%, with Langley being just slightly higher than the target. It is important to note that residents are moving in to long term care later in their journey of life and at higher levels of frailty than before. There is also evidence to support that age, frailty and the additional impacts of the global pandemic are factors associated with a higher risk for developing a Pressure Ulcer. We are taking the steps below to reduce the risks for residents.

What are we doing?

Care providers are aware of the many factors that contribute to the optimal health of the individuals living in long-term care. Fraser Health also works with care facilities on an minimum annual basis to review each care homes policies and practice surrounding skin care and wound prevention and management. The Wound Care Clinicians continue to coach and mentor site staff on using best practices when they are on site conducting consultations. In addition, team based education and monthly online drop sessions are offered. A confidential, standardized electronic referral process for wound care consultation has been initiated, and is able to track facility acquired pressure ulcers to be able to target and provide additional support to care homes when there is an identified need. Four online modules for Health Care Assistants on pressure prevention will be launch in 2022.

What can you do?

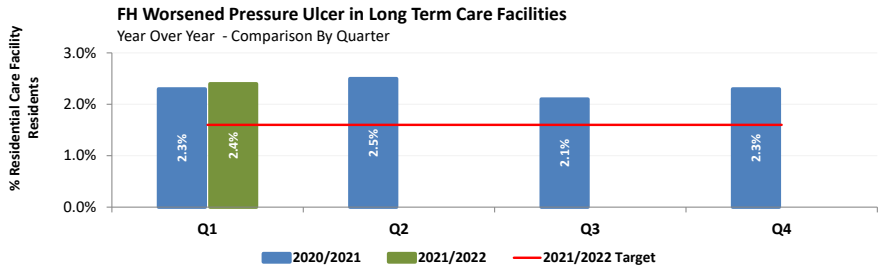
As always, family members are an important part of long term care team. If you have a loved one who resides in a long term care home, please encourage and support them to receive adequate nutrition and hydration since it has an important impact on “skin health” and healing of ulcers. If you observe any skin redness (particularly over bony prominences), please ensure that nursing staff are aware.

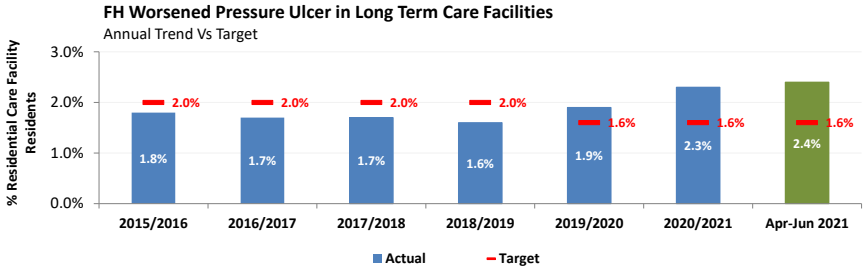
Our Performance	Target *
2.4% ◆	<= 1.6%

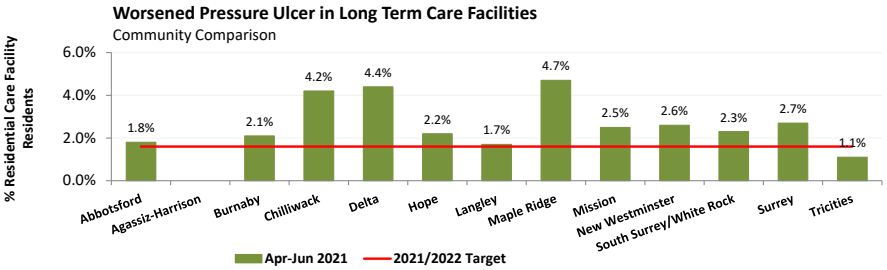
Unit of Measure: Percent of residential care clients

Performance timeline:	Apr-Jun 2021
Data Source:	FHA Database (RAI compliance table)
* Target Source:	FHA Internal

Notes: *Some variation between these values and CIHI's figures are expected as CIHI applies a risk-standardization methodology to their results while results published in the report card will be crude rates. CIHI published figures include Private Pay clients, while FHA figures exclude them.*







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

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?

Fraser Health strives for continuous improvement. Target was increased from 46% in 2019/20 to 65% in 2020/21. Fraser Health's current performance of 25.0% is not meeting our new internal target. While none of the 12 hospitals are currently meeting the target the time patients are waiting for an inpatient bed has improved significantly. We have seen a sharp increase in ED visits and an increased admit rate through Wave 4 of the Covid-19 pandemic. We will continue to work with our sites and programs to reduce acute care and emergency department congestion.

What are we doing?

Emergency Patients Admitted to Hospital within 10 hours' is a Patient Safety Priority for Fraser Health and monitored closely by clinical leaders at all 12 acute care sites. To improve performance in patient-centred care and discharge planning and ensure that you receive your care in the right place at the right time, we are taking a focused and deliberate approach by strengthening our expectations of communication between health care teams, patients and families. Consistent use of best practices in daily care and discharge planning and monitoring our transfer processes are essential for improving patient outcomes, flow, and reducing avoidable readmissions to hospital. Core components of care and discharge planning in our hospitals include baseline screening and proactive interdisciplinary care planning, early identification of Estimated Discharge Dates (EDD), structured interdisciplinary rounds, and the use of bedside whiteboards to support two-way communication with patients and families.

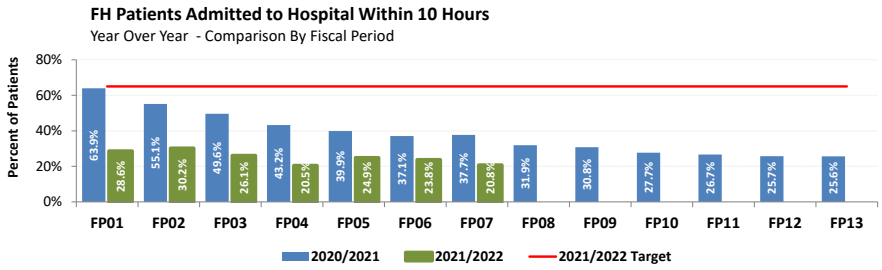
What can you do?

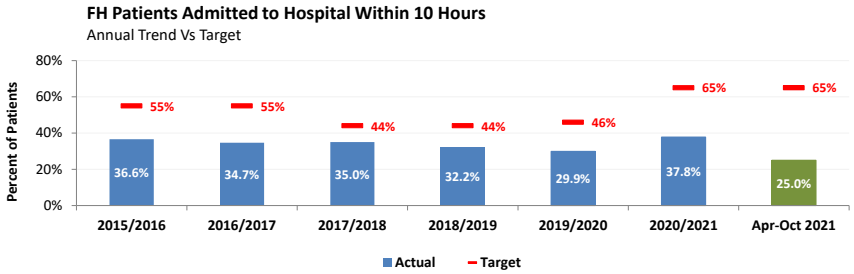
Fraser Health is committed to working with the communities that we serve to place more emphasis on the promotion of health and on preventing or delaying chronic diseases, disabilities, and injuries. Doing this will improve quality of life while reducing disparities and the impact these conditions have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

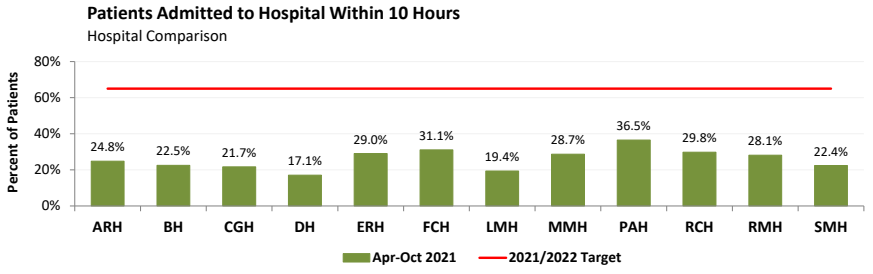
Our Performance	Target *
25.0% ◆	>= *65.0%*

Unit of Measure: Percent of patients admitted within 10 hours

Performance timeline:	Apr-Oct 2021
Data Source:	NACRS as measured by FHA
* Target Source:	BC Ministry of Health







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Admitted Patients Waiting for Inpatient Bed Placement

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 risk of adverse safety and quality of care events. 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.

How are we doing?

Fraser Health strives for continuous improvement. 2021/22 target is decreased from 160 in 2020/21 to 130. Our 2021/22's year-to-date performance of 183.1 is not meeting our new internal target. The anticipated improvement in the volume of patients admitted in our Emergency Departments as a result of the COVID-19 situation resulted in a 59% reduction in the number of patients awaiting inpatient beds during the first 4 periods of 2020/21. The unprecedented reduction in Emergency visits and admissions meant that we were able to efficiently move our patients from the Emergency Department to appropriate ward beds. The fourth wave of the pandemic saw a significant increase in presentations to hospital averaging 115% of the volumes compared to the same time the previous year. Despite this we are seeing continuous, incremental, improvements in the number of admitted patients being held in our EDs.

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. Achieving this target requires both short and long term strategies that improve hospital efficiency and build capacity for care in the community. For example, in our hospitals we are building partnerships between hospital and community care teams to support earlier transitions back to community settings. In the community, we are improving integration of Fraser Health services with community General Practitioners to provide more care in the community and reduce the need for hospital admissions. Creation of a Regional Access and Flow Coordination Centre has brought new focus to creating capacity throughout the system and moving patients to the right place at the right time.

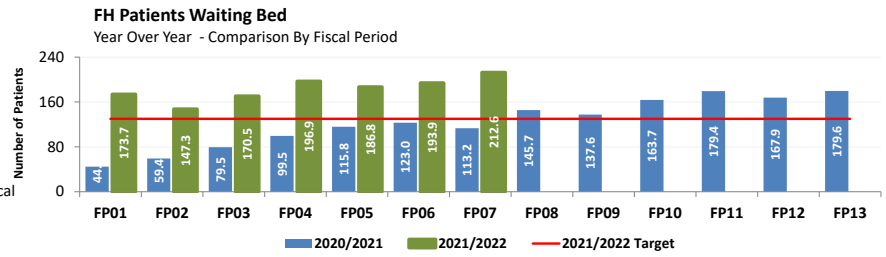
Our Performance	Target *
183.1 ◆	<= 130

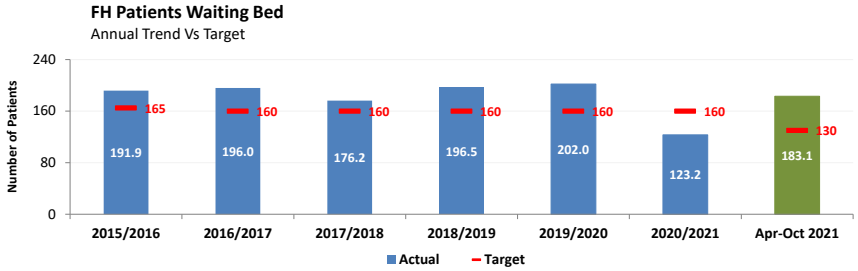
Unit of Measure: Number of patients waiting for Inpatient bed

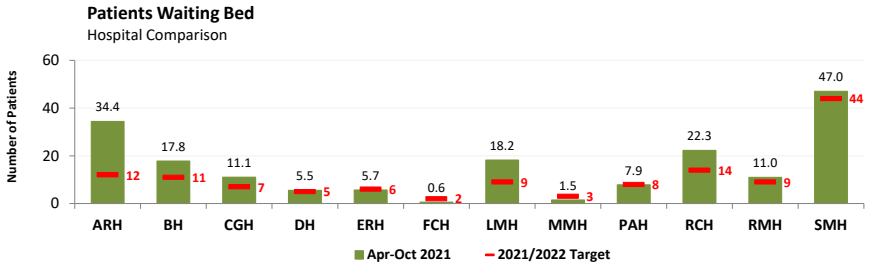
Performance timeline: Apr-Oct 2021

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

* Target Source: FHA Internal







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Patients Length of Stay Relative to Expected Length of Stay

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?

Fraser Health patients' actual length of stay relative to expected length of stay is slightly above our internal target; four of our hospitals are meeting the target for this indicator (Abbotsford General, Langley Memorial, Mission Memorial and Royal Columbian). We are seeing improvement compared to the previous year and are experiencing longer lengths of stay for patients recovering from Covid.

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?

Effective care and discharge planning helps Fraser Health provide quality care for our patients while supporting improvement for this indicator. Core components of care and discharge planning in our hospitals includes baseline patient screening on admission and interdisciplinary team care planning, daily structured rounds, and the use of bedside whiteboards to support two-way communication with patients and families. We are committed to increasing our performance in these areas and have ongoing quality improvement projects for the key elements of this performance indicator.

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.

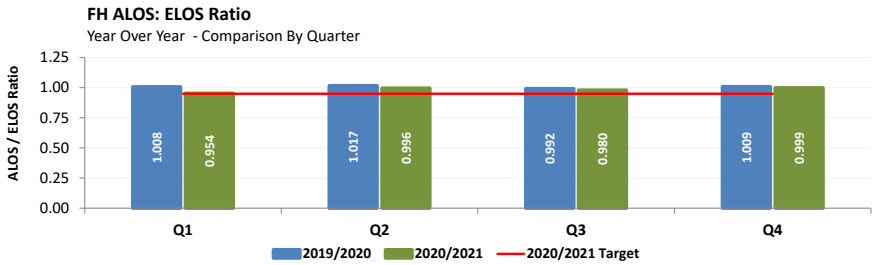
What can you do?

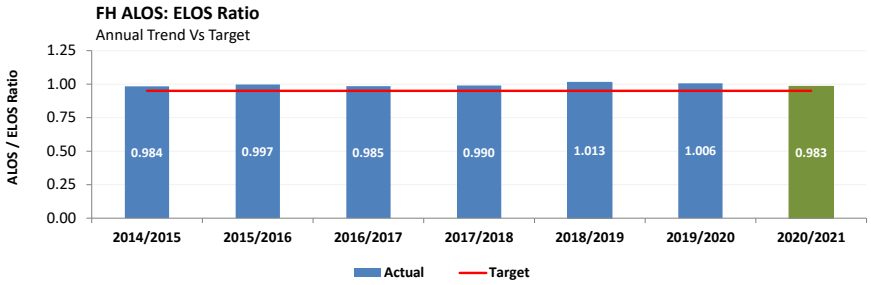
Take an active role in your plan of care. Ask questions about your medical condition and participate in setting your goals for care. Inform your care providers about what we need to know about you so we can give you the best care possible and feel confident when you leave the hospital.

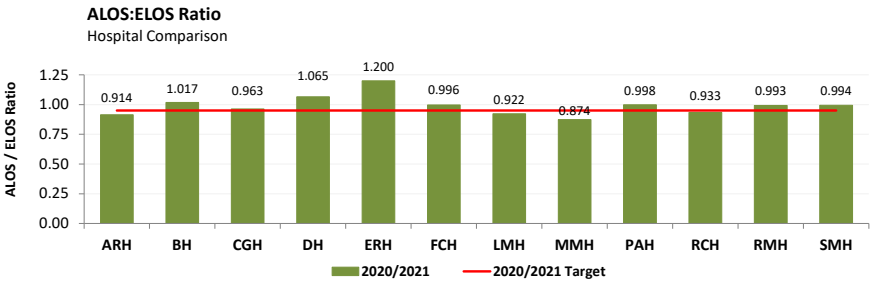
Our Performance	Target *
0.983 △	<= *0.95*

Unit of Measure: Ratio of Actual to Expected Length of Stay

Performance timeline:	2020/2021
Data Source	MOH Measurement SharePoint
* Target Source:	FHA Internal







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Long Stay Patients

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.

How are we doing?

Fraser Health's 2021/22 year-to-date performance of 367.2 is meeting our internal target of 455. Last year, we saw a significant improvement in the long length of stay as we navigated the early stages of the COVID-19 situation something we expected and our experience has borne this out. As we have progressed through the various transitional stages of the pandemic we have seen an increase towards pre-covid levels of activity. However the length of stay remains significantly below target. Despite the increased demand we have sustained the gains we made and continue to see improved length of stay.

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.

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 have established a regional structure within the organization to promote collaboration and provide real time, 7 day a week oversight and monitoring of patient transitions while facilitating real times decisions concerning patient movement both within sites and across our system. With strong and sustained involvement from our community partners we have been able to make progress towards transitioning patients to the correct care locations in a more timely manner.

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.

What can you do?

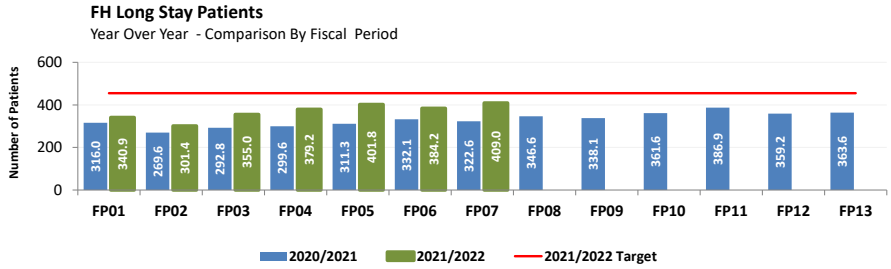
You are encouraged to talk with your health care team early in your stay about when you are likely to be discharged and what supports you may need to return home.

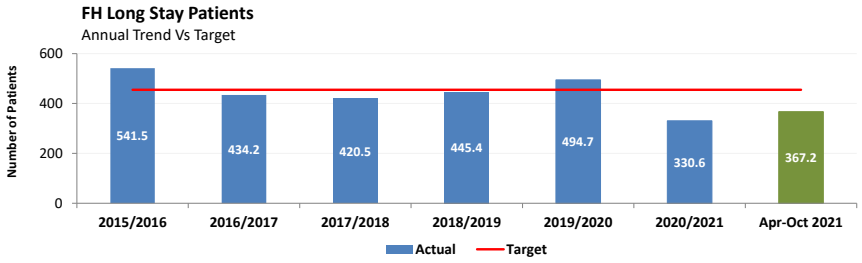
Our Performance	Target *
367.2	<= 455

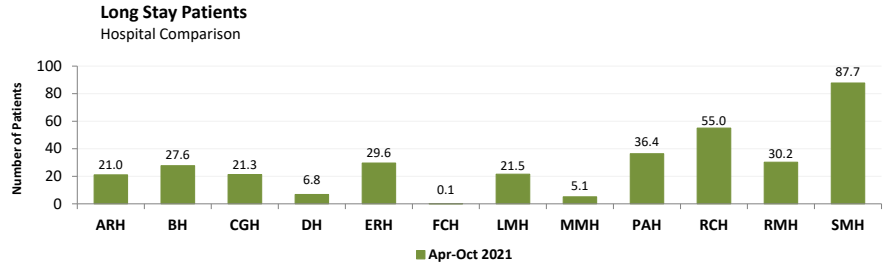
Unit of Measure: Number of patients staying longer than 30 days

Performance timeline:	Apr-Oct 2021
Data Source:	Meditech
* Target Source:	FHA Internal

Notes: *Target is set to 8% improvement from 2013/14*







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Alternate Level of Care (ALC) 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.

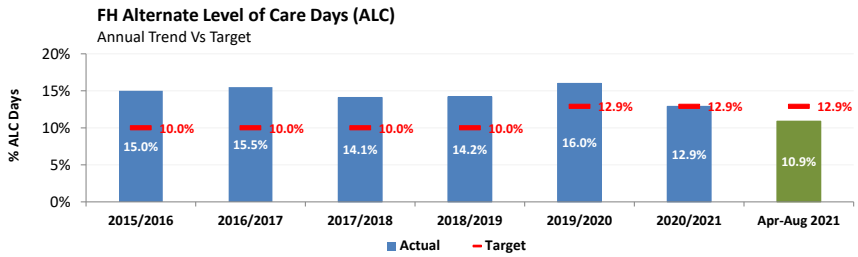
How do we measure it?

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.

Our Performance	Target *
10.9%	*<= 12.9%*

Unit of Measure: Percent of ALC days to total days

Performance timeline:	Apr-Aug 2021
Data Source:	Med2020 Abstracting and Coding System
* Target Source:	BC Ministry of Health



How are we doing?

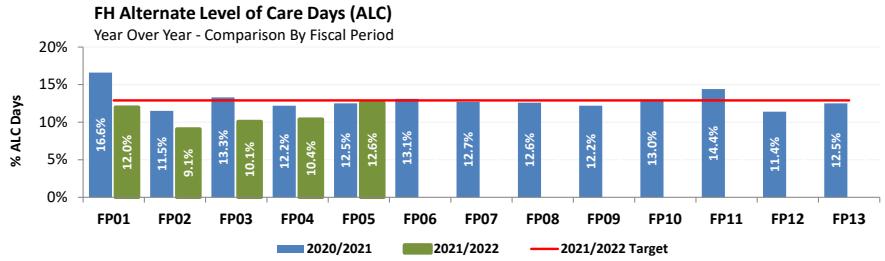
Fraser Health’s 2021/22 year-to-date performance of 10.9% meets the target for this indicator. Eight hospitals are meeting the target (Abbotsford Regional, Burnaby, Chilliwack General, Delta, Fraser Canyon, Royal Columbian, Ridge Meadows and Surrey Memorial), while the remainder of our hospitals are above target. We have seen significant improvement in ALC occupancy and long length of stay for our inpatients in acute care. The volume of patients awaiting placement into Long Term Care Beds has also been significantly reduced as we continue to work on ensuring the right patient receives the right care in the right location.

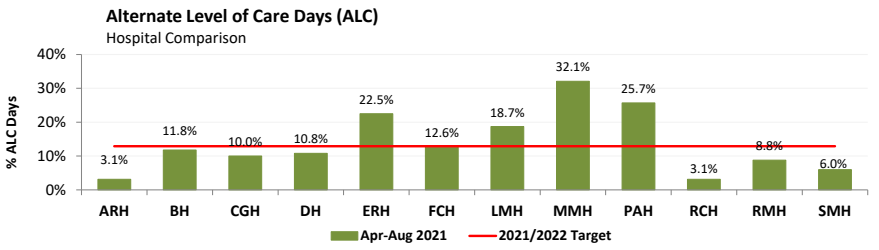
What are we doing?

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 that appropriate and sufficient community resources are available, such as home support and long term care beds. Over the past four years Fraser Health has added 435 new long term care beds across our different communities, allowing patients and families to receive care in their communities and minimize hospitalizations. Multiple home health care intake phone lines have been consolidated into one centralized call centre to provide user-friendly access to community resources. We are identifying and facilitating safe discharge home plans for those individuals awaiting long term care through the Home First initiative. Home Health has many initiatives underway to optimize capacity of resources to increase supports at home. One of these program includes home health nurses contacting patients after hospital discharge to identify any unmet care needs or concerns. For those patients and families that need inpatient services, we have refreshed our Care and Discharge planning framework to ensure that we are proactively working with patients and families early in their care to identify concerns that could delay a transition to home or other recovery locations.

What can you do?

Collaborate with your health care team to help us understand what a successful discharge looks like for you. Our goal is to establish a safe and appropriate transition to home or other recovery location, including access to appropriate community resources.





Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Hospitalization Rates for 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).

How are we doing?

The standardized hospitalization rate for seniors has been in steady decline over the last five years. The 2020/21 regional rate of 224.4 has achieved the targeted rate of 238.0 hospitalizations per 1,000 seniors. Rates vary by community with some better than the target, while other have opportunity for improvement. Rates are trending in a positive direction for the majority of our communities.

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 or Nurse Practitioner through Primary Care Networks. These networks are under development across Fraser Health, in partnership with local Divisions Of Family Practice. Their main focus is to increase access to the services you need when you need it. We are also strengthening linkages between Family Doctors and Nurse Practitioners with the Specialized Community Services Programs for Seniors and Adults with Complex Medical Conditions and/or Frailty to better support patients and families access the care they need in the community and remain at home as along as possible. This will be possible through the connection with appropriate community based resources including: Nursing, Physiotherapy, Occupational Therapy, Social Work, Palliative Care, End of Life Care, Respite for care providers, Assisted Living options, Long Term Care as well as rapid access to specialized clinics. Urgent & Primary Care Centres are also attaching those that do not have a regular primary care provider.

What can you do?

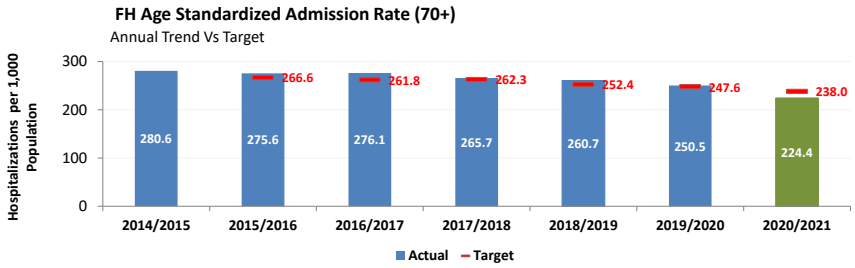
Ensure that you have a family doctor, and/or Nurse practitioner. Use the available community based services and programs to meet your health and social care needs. Ask your family physician and health care team to help you learn how you can best manage your chronic conditions as well as and help you know early warning signs and symptoms to avoid a deterioration of your health. Request community supports such as home health or home support to help manage your condition. Know what to do in the event of emergency. Exercise if you can. Eat a healthy diet, and try to maintain a healthy weight. For additional support for advice of how to meet your health care needs call HealthLink BC (dial 8-1-1) which is available 24 hours,7 days a week to speak to a Registered Nurse or call Fraser Health's Virtual Care service to get you connected to health services in your communities for non-urgent or emergent care needs and is available seven days a week from 10 AM to 10 PM at 1-800-314-0999.

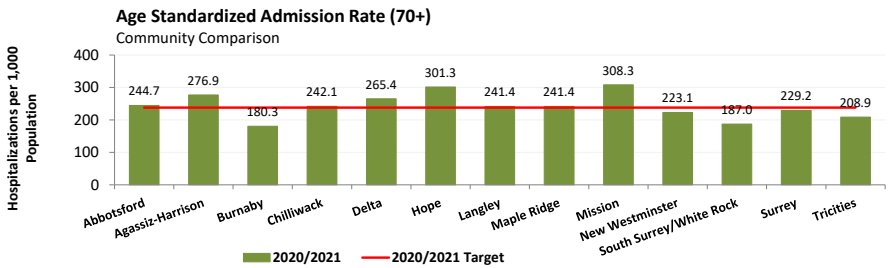
Our Performance	Target *
224.4	<= 238.0

Unit of Measure: Number of patients hospitalized/1,000 Population

Performance timeline:	2020/2021
Data Source:	Healthideas BC
* Target Source:	FHA Internal

Notes: *1) All rates are standardized using the direct method; All rates are per 1000 population; The standard population used is Census 2011; Based on BC Hospital Discharge Data; Population data provided by BC STATS (P.E.O.P.L.E. 2019);*
2) In the most recent update, MOH updated the report by using P.E.O.P.L.E. 2020 instead of P.E.O.P.L.E. 2019. Previously reported numbers have been restated and targets have been adjusted accordingly.





Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Hospital Readmission Rates Overall

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.

How are we doing?

Fraser Health's 2020/21 hospital readmission rate of 10.6% is not meeting our internal target of 10%. Year over year, however, the readmission rate is trending in the desired direction in the first 3 quarters. Four of our communities are meeting our internal targets (Agassiz-Harrison, Burnaby, Maple Ridge and South Surrey/ White Rock), three communities (Langley, New West and Tricities) are performing very close to the target. All other communities have the opportunity to improve on this indicator.

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.

What are we doing?

We have established a Transitions Working Group that is focusing on initiatives to support 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. We continue to look for strategies that will enhance our performance for this indicator.

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.

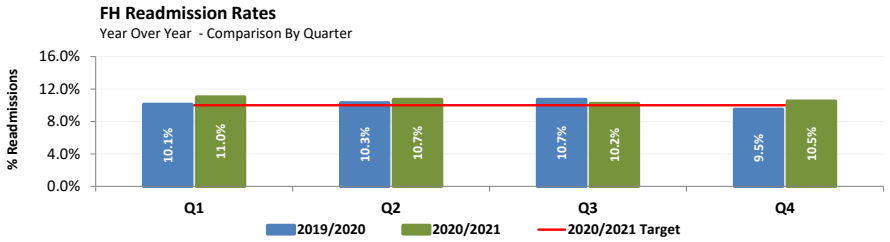
What can you do?

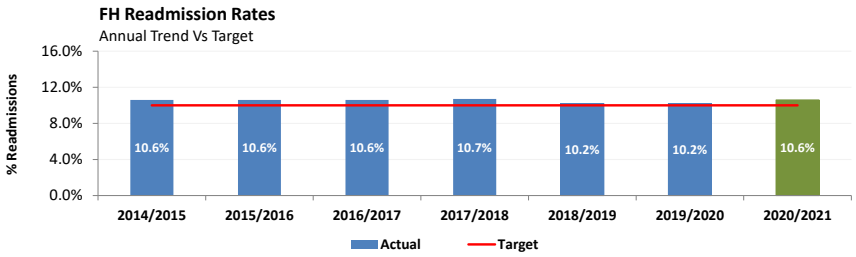
If you or your loved one needs to stay in one of our hospitals, discuss with our healthcare providers the discharge plan at the beginning of the stay. The plan could include information about the type of care required, activities that will help with the recovery, medications, diet and/or equipment. Let 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 recovery.

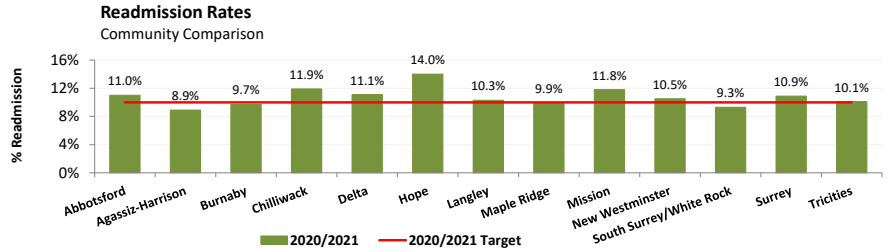
Our Performance	Target *
10.6% △	<= *10.0%*

Unit of Measure: Percent of patients readmitted

Performance timeline:	2020/2021
Data Source:	MOH Measurement SharePoint
* Target Source:	FHA Internal
BC Average (2020/21)	11.3%
BC Average Source:	MOH Measurement SharePoint







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Mental Health & Substance Use Patients Hospital Readmission Rate (Age 15+)

How many FHA residents with Mental Health and Substance Use had a hospital readmission within 30 days?

What are we measuring?

Rate of readmission for FHA residents with Mental Health and Substance Use issues to an acute care hospital within 30 days of an inpatient episode of care, when the reason for readmission is related to a mental illness similar to the initial hospitalization for mental illness. This is based on the place of residence of the patient, not the location of the hospital.

Why?

We are trying to improve patient health outcomes and reduced hospitalizations for those with mental health and substance use issues through effective community services, primary care and outpatient programs. Returns to hospital are difficult for patients and family members, 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 for mental illness helps us understand the effectiveness of hospital care, and how well we support mental health patients after they leave the hospital.

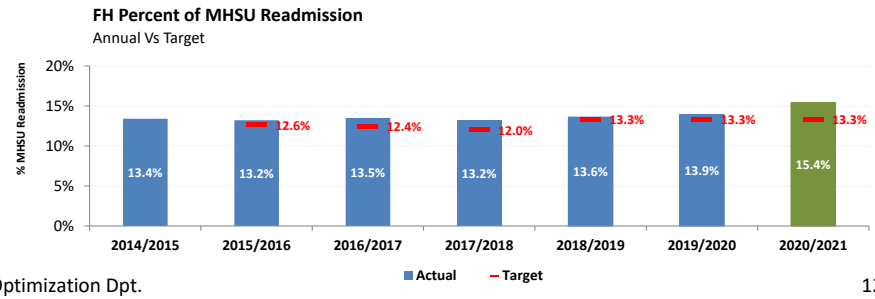
How do we measure it?

We take the number of FHA residents with mental health and substance use issues who are at least 15 years old. Then out of this population we count the number of episodes of care for patients who were readmitted to an acute care hospital within 30 days of an inpatient episode of care, and divide this number by the total number of all inpatient episodes of care for mental health and substance use issues. This includes patients discharged between April 1 and March 1 of the fiscal year recorded for FHA residents and allows 30 days following discharge to ensure all readmission are captured.

Our Performance	Target *
15.4% ◆	<= 13.3%

Unit of Measure: Percent of patients readmitted

Performance timeline:	2020/2021
Data Source:	MOH Measurement SharePoint
* Target Source:	BC Ministry of Health



How are we doing?

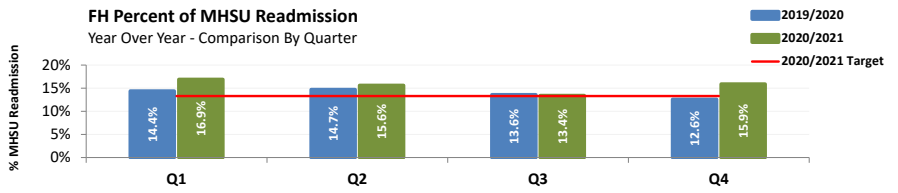
The readmission rate for MHSU in Q4 of 2020/21 is 15.9%, increasing from Q3 (13.4%) and Q2 (15.6%) of 2020/21, but decreasing from Q1 of 2020/21 (16.9%). It is also increasing significantly when we compare it with Q4 of 2019/20 (12.6%). This shows a similar pattern for other quarters, with an increase from Q1 and Q2 of 2019/20 but not for Q3 of 2019/20. The readmission rates in 2020/21 Q1 and Q2 have increased compared to the same quarters in 2019/2020, Q1 (14.4%) and Q2 (14.7%), while the readmission rate in Q3 represents a slight decrease from 13.6% to 13.4%. When comparing Fraser Health communities on their readmission rate for Q4 2020/21, readmission rates vary considerably, ranging from 8.0% in Agassiz-Harrison to 23.2% in Hope. More specifically, only two Fraser Health communities, Agassiz-Harrison (8.0%) and Maple Ridge (11.6%) met the target for readmission rate. None of the other 10 Fraser Health communities met the 13.3% target for readmission, ranging from rates of 13.6% in Mission to 23.2% in Hope.

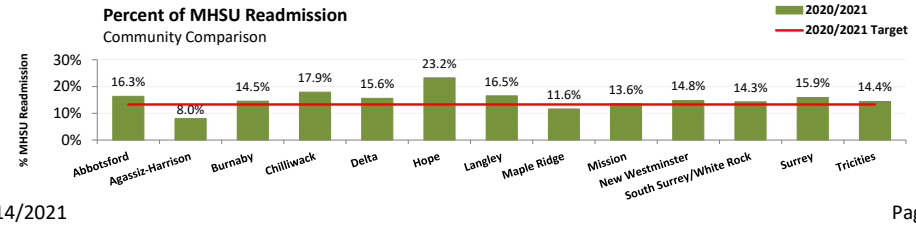
What are we doing?

MHSU continues to take several actions to reduce readmission rates. This includes conducting a systematic review of literature to identify factors contributing to readmission rates. The goal is to create a guideline to inform practitioners / clinicians about actions that can potentially decrease readmission rates. MHSU has also made improvements in the service delivery model to respond to the needs of MHSU clients while preventing the spread of COVID-19. Many services are being delivered virtually, including group and individual counselling and assessment, discharge from acute, and transition between services. MHSU has established a team of substance use clinicians and staff to support, coordinate, and facilitate access to Substance Use Services and Integrated Response Centres and Isolation Centres. Moreover, several Rehabilitation and Recovery services such as occupational therapy, recreation therapy, exercise therapy, vocational counselling, and family support, are now being provided online. The change in service delivery has provided us with the opportunity to evaluate the impact of all virtual health services on MHSU clients, including their readmission rate to acute. The expansion of virtual health is in addition to existing services such as Urgent Care Response Centre (UCRC) in Surrey, which provides central access for adults with mental health and substance use concerns, including those with opioid use disorder. The UCRC opened on July 24 2019 and provides low-barrier and timely access to assessment, initiation of treatment, and connection to appropriate services. The extended hours of service has reduced wait-times for MHSU services in Surrey and has resulted in decreased readmission rates. The Regional Substance Use Services Access Team (SUSAT) proactively follows up with patients who present to hospitals with an overdose, with the goal of engaging them in treatment and reducing the danger of further overdose and readmission. Other initiatives, such as Integrated Transition of Care Teams (ITCT), focus on timely follow-up with clients discharged from acute services. MHSU has also established four Intensive Case Management (ICM) teams (in Maple Ridge, Langley, Surrey, and Chilliwack). ICM serves vulnerable clients who are living with serious addictions and other comorbidities, and who are homeless or at risk of homelessness. The Fraser Health Crisis line proactively reaches out to individuals who require extra support evenings and weekends. MHSU is enhancing discharge planning to include improved communication with patients, families/supporters, and community providers to ensure that they have the information they need for post-discharge continuity of care, self-management, and relapse prevention.

What can you do?

If you or your loved one stays in one of our hospitals due to mental health or substance use issues, discuss the discharge plan with healthcare providers before going home. The plan could include information about the type of care required, activities that will help with the recovery process, medications, diet and / or equipment, resources available in the community, and what to do when in crisis. Let your healthcare provider know as soon as possible if you have any questions. Familiarize yourself with the discharge instructions and the contact information provided. Connect with the suggested mental health and substance use community providers regarding any concerns about you or your loved one's recovery.





Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Patients with Chronic Conditions Admitted to Hospital (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 are we doing?

Fraser Health's performance has remained relatively stable the past several years and continued trending in the desired direction. The 2020/21 admission rate of 2,331 is below our target of 3,448. Of the FHA communities, all except Agassiz-Harrison and Mission have met the target. We continue to examine opportunities to improve.

What are we doing?

Fraser Health (FH) continues to work in partnership with Family Physicians and the Divisions of Family Practice (DOFP) on primary and community care redesign, including the development of the Primary Care Networks. This work has a specific emphasis on improving attachment, access to primary care and chronic disease management services, and care for seniors and individuals with medical complexity. New initiatives have been locally planned and implemented to ensure the needs of the local population needs are being addressed.
All communities within FH have now commenced activities that aim to optimize access to primary and community care services. Fraser Health is currently putting in place Urgent Primary Care Centres, Community Health Centres and Primary Care Networks over the next 3-years, which will deliver faster access to primary care and reduce the need for emergency department visits. Virtual Health and home health monitoring initiatives continue for patients with chronic conditions such as heart failure, COPD, and diabetes. The goal is to improve patient self-management and reduce exacerbations requiring emergency or acute care.

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. Please note that the MOH annualizes the rate in order to allow for comparability between quarters and full years. Quarterly rates are annualized using the rolling four quarters calculation.

What can you do?

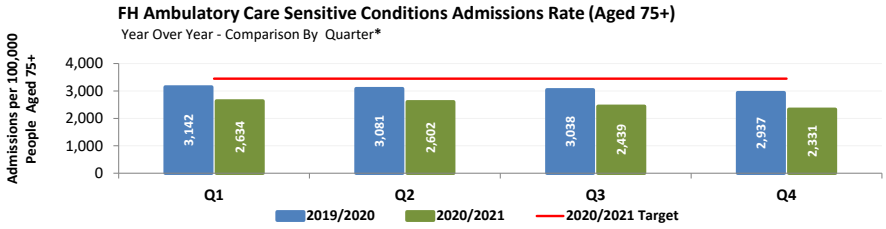
Fraser Health is committed to working with individuals, families, and communities to help people maintain as much health and independence as possible through prevention, early detection, and management of chronic conditions in their homes and communities. Ask your healthcare providers to help you learn 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 *
2,331	<= 3,448

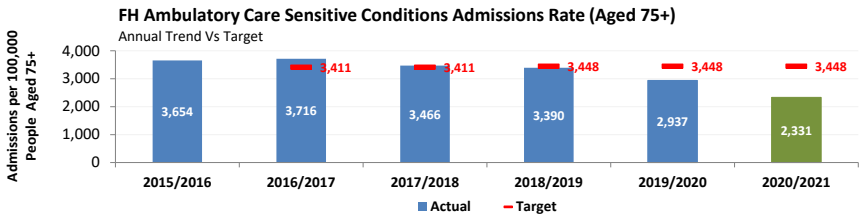
Unit of Measure: Number of patients admitted / 100,000 Population

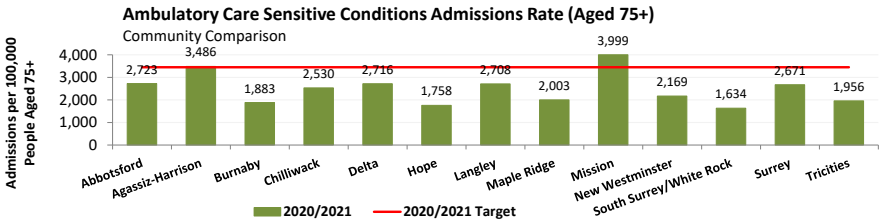
Performance timeline:	2020/2021
Data Source:	MOH Measurement SharePoint
* Target Source:	BC Ministry of Health

Notes: *1. All rates are standardized using the direct method; All rates are per 100,000 population; The standard population used is Census 2011; Population data provided by BC STATS (P.E.O.P.L.E. 2019);*
2. Previously reported data has been restated based on new MOH report



** Quarterly rates are annualized using the method documented in MOH report*





Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Low Acuity Emergency Visits by Community

How many ED visits are for non-urgent issues identified by Canadian Triage and Acuity Scale (CTAS) levels 4 and 5?

What are we measuring?

We are measuring the number of low acuity visits to our emergency department per 1,000 population. We classify a visit as low acuity if the patient's medical problem has been identified as less- or non-urgent at the time of triage based on the Canadian Triage and Acuity Scale (CTAS levels 4 and 5).

Why?

Our community visits the emergency department (ED) frequently, often for minor medical problems that might be more appropriately treated in another setting. However, EDs give priority to patients with urgent needs who require highly skilled care. It is important to provide opportunities to shift patients with more minor medical problems away from the ED to other settings (such as doctors' offices), which may improve a patient's continuity of care and overall experience. Such opportunities could also benefit our overall health care system, by allowing ED resources to focus on those who more appropriately require them.

How do we measure it?

We take the count of low acuity visits to our emergency rooms by patients that reside in a Fraser Health LHA and multiply by 1,000/[LHA Population], and normalize by the length of the fiscal period for comparability to annual figures result * 365 / [# Days in Period]

How are we doing?

Visit volumes have been steadily increasing in the first 5 periods and is going down again in the most recent 2 periods. Data reports from MoH clearly demonstrate that the ratios of virtual to in-person visits have not rebounded to pre-COVID levels. It is estimated that this increase in lower acuity patient utilization of the emergency department may be related to GP's not entirely resuming previous patterns of in person visits in alignment with the decrease in restrictions. In the smaller, more rural communities it is the local Family physicians who also staff the Emergency rooms resulting in more of their patients seen them in the ER verses the tradition office.

What are we doing?

The Ministry of Health has provided a written correspondence to physicians asking them to resume pre-COVID practice patterns, as well this matter was discussed at ISC. Communities continue to work with their Divisions of Family Practice to ensure that everyone who want a family doctor has access to one. Virtual health services continue to be developed and announced across FH improving access to health care services and teams including Physicians.

What can you do?

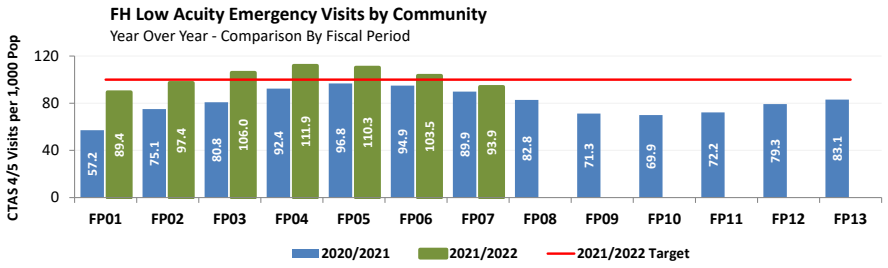
You can attend Urgent & Primary Care Clinics (UPCC) located in many communities to access a doctor and the health care team to meet your care needs. If you have a family doctor or nurse practitioner continue to work with them to identify ways to keep healthy, including knowing early warning signs that your health is changing and take early steps to manage it. Additionally, you can call HealthLinkBC (8-1-1) to speak to a Registered Nurse to provide advice to help you manage your health care needs. Fraser Health's Virtual Care service gets you connected to health services in your communities for non-urgent or emergent care needs and is available seven days a week from 10 AM to 10 PM at 1-800-314-0999.

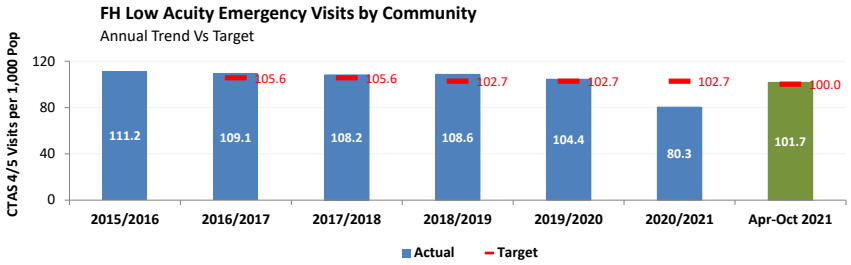
Our Performance	Target *
101.7 △	<= *100.0*

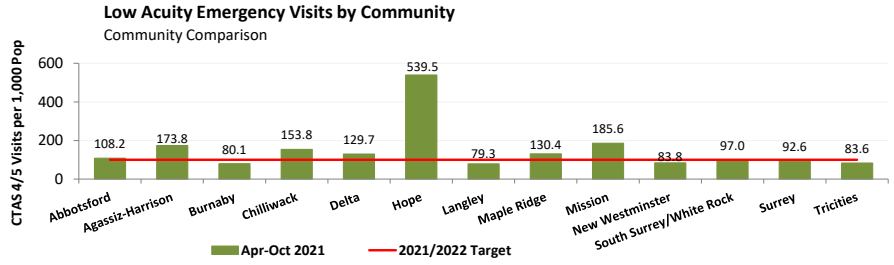
Unit of Measure: Number of CTAS 4 and 5 ER Visits /1,000 Population

Performance timeline:	Apr-Oct 2021
Data Source:	Amcare and Meditech for the numerator and P.E.O.P.L.E.2015 (BC Stats) for the denominator
* Target Source:	FHA Internal

Notes: *Target is set to 5% improvement from 2017/18.*







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Home Health Services Provided Within Benchmark Time

What is the percentage of Home Health clients starting Home Health services within the required service benchmark?

What are we measuring?

We are measuring the percentage of people who receive home care service within the benchmark time for their assessed priority level. Services include nursing, case management/community care, occupational therapy, physiotherapy, social work, dietitian, and HSCL (health services for community living). Each client referral gets assigned a priority code based on the high probability of immediate negative outcome to the health, safety of client/family and/or the development of primary and/or secondary complications if the client is not contacted within a certain timeline. Benchmark timeline ranges from 12 hrs. for Priority 1A to 14 days for Priority 5. Priority for all new referrals. Priority level is assigned by Home Health Service Line Clinicians, Quick Response Case Managers, and Home Health Liaisons.

How are we doing?

The use of virtual health technology has been implemented across all communities to support clients / families access the health care team and improve the percentage of home health services that are provided within benchmark time. Currently the FH percentage of Home Health Services provided is over our target of 50% at 51.4%. However it is slightly down from last report due to increased staffing challenges directly related to the on-going pandemic.

Why?

Timeliness is crucial to the effectiveness and outcome of patients. This indicator was developed as a measure of access to health care. Home health service wait times may be influenced by availability of home health professionals and organizational practices such as referral and wait list management.

What are we doing?

The Specialized Community Services Programs for Seniors and Adults with Complex Medical Conditions and/or Frailty team continue to review the data during the ongoing pandemic (monthly) to monitor progress towards the goal and adjust activities as appropriate based on learnings. Use of technology has been embedded into to standard work flows for assessments and follow up care. Building clinical practice standards for all Virtual care interventions. Work continues across all communities to close gaps in staffing levels.

How do we measure it?

We take the number of clients starting a specific home health service in a given period whose wait time from referral to service start was within the recommended wait time limit and divide by the total number of clients who began service in that same period.

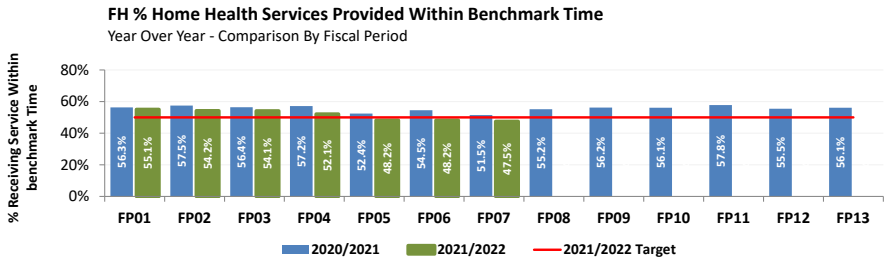
What can you do?

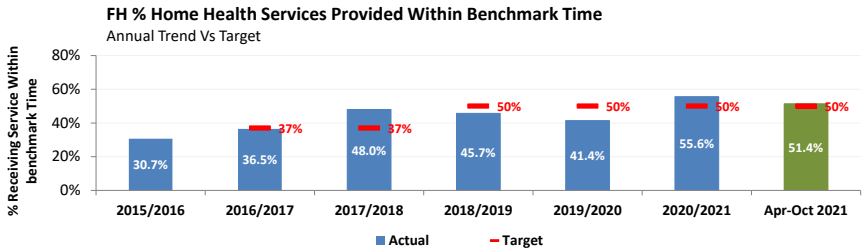
If you have not been contacted by Home Health to set up the services you need please call you local office. Alternately, you can ask your Doctor or Nurse Practitioner to help you connect with Home health through their Community Health Nurse contact. If you do not have a primary care provider call the Home Health Services Line to request assistance at 1-855-412-2121.

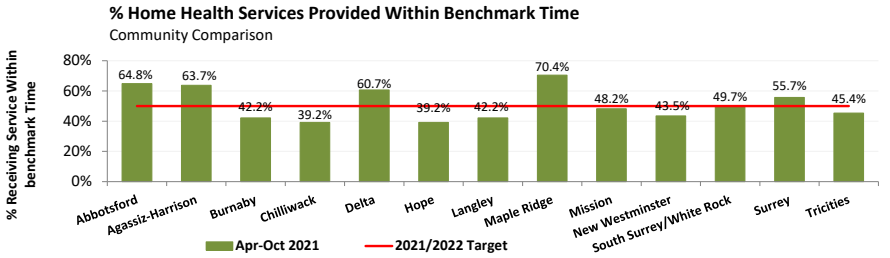
Our Performance	Target *
51.4%	>= 50.0%

Unit of Measure: Percent of Services provided within benchmark

Performance timeline:	Apr-Oct 2021
Data Source:	PARIS System
* Target Source:	FHA Internal







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Wait Time for Home Health Assessment (RAI-HC)

How long are clients waiting for their initial Resident Assessment Instrument (RAI) assessment for Home Care (HC) Services?

What are we measuring?

This indicator measures the average wait time (in days) for the initial RAI-HC assessment after a client has been admitted to the Home Health Case Management (HHCM) program.

How are we doing?

Fraser Health's year-to-date performance of 17.4 is meeting our internally set target of less than 30 days. It is also an improvement from the last report reducing wait times by 8 days on average. Twelve communities have achieved client wait times below the 30 day target. Langley is closer to 40 days on average.

Why?

This indicator reflects our capacity, relative to need, for conducting the initial RAI-HC assessment in a timely manner, which is important for understanding the clients' health status and care needs as well as facilitating the provision of additional long term care services.

What are we doing?

Virtual care (VC) options have been implemented in all communities and we are now able to track VC through our electronic documentation system. New Westminster and Langley leaderships with be contacted to build a strategy to move their wait times for assessments towards the target (30 days) and then the FH average of 20 days by March 2022. Will suggest to senior leadership to lower the target to 20 days from 30.

How do we measure it?

We take the sum of wait times between Home Health Case Management program admission and initial RAI-HC assessments, and divide by the number of clients receiving initial assessments within the reporting time period.

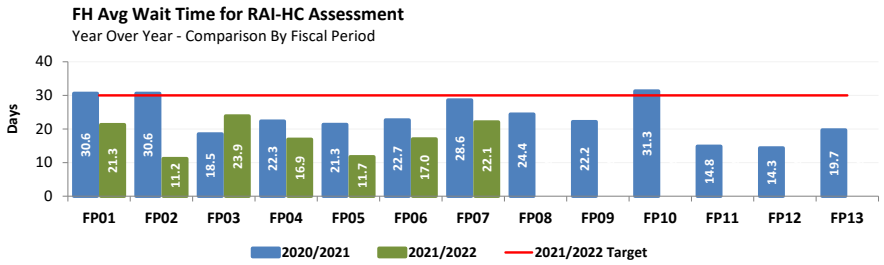
What can you do?

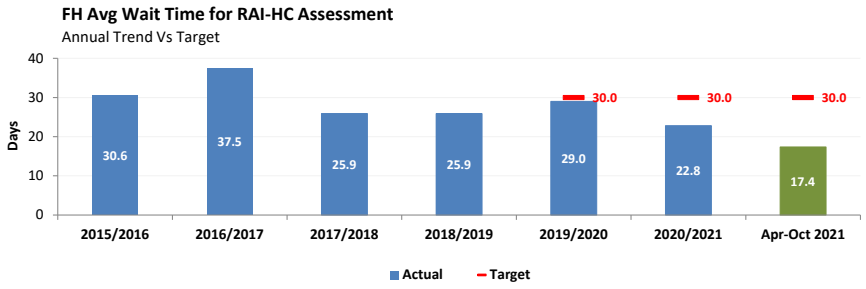
If you have not been contacted by your local home health office to update your assessments or schedule the services you expect please call your local home health office. Clients and families can call the home health service line on 1-855-412-2121 to ensure your contact information is up to date and connect with your local home health office should you need assistance.

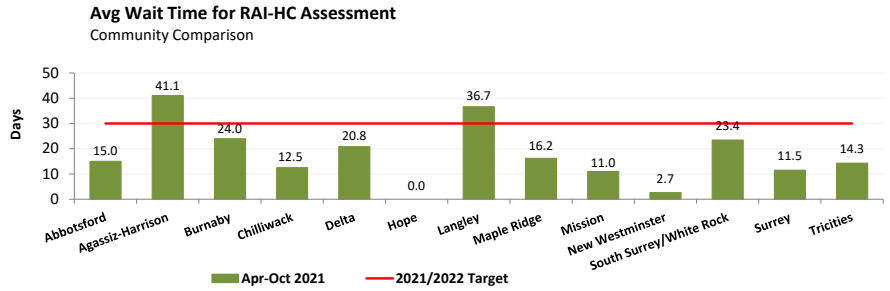
Our Performance	Target *
17.4	<= 30.0

Unit of Measure: Number of days clients waiting for Assessment

Performance timeline:	Apr-Oct 2021
Data Source:	GoldCare System
* Target Source:	FHA Internal







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Admissions to Long Term Care within 30 Days

What percent of Long Term Care (LTC) clients are admitted within 30 days of being assessed and approved for services?

What are we measuring?

Percentage of new Long Term Care clients admitted to a facility within 30 days of being assessed and approved for services.

How are we doing?

In the first seven periods of 2021/22, 77.8% of clients being admitted to long term care within Fraser Health did so within 30 days, exceeding the regional target of 75%. Our ability to meet target this period was impacted by changing COVID-19 trends in the broader community, allowing for more timely access than has been possible during earlier waves of the pandemic. It is noted that the rate has been increasing steadily throughout 2021 and eight communities showed sustained growth and exceeded target. The rate of admissions within 30 days is now at the highest level since 2018/19 and continuing to grow.

Why?

Our goal is to provide the best quality of care for our patients. Provincially, this is a measure identified to monitor one aspect of the use and adequacy of the continuum of services offered by the health care system. It assumes that individuals assessed as needing long term care have reached a significant level of frailty, and have exhausted all other support options such that they now require more adequate long term care in a Residential setting. Once residential long term care is deemed the most appropriate care setting it is presumed that a wait of up to 30 days is logistically reasonable, anything more suggests the system is not adequately resourced to provide the right care, in the right place at the right time.

What are we doing?

Fraser Health has implemented a redesigned collaborative process that reviews individuals put forward for LTC and identified those whose care needs can be met at home or in the community with different resources, ensuring that those who are referred to LTC are suitable. In addition, significant efforts have been taken across Fraser Health to identify opportunities to optimize safe, timely admissions for clients requiring LTC.

How do we measure it?

We take the number of clients placed in Long Term Care with a wait time of 30 days or less and divide by the total number of clients placed in the same period. These figures exclude clients receiving Long Term Care services (including temp beds and ACMD) on their dates of acceptance. Communities are grouped based on admission locations, not sending (referral) locations.

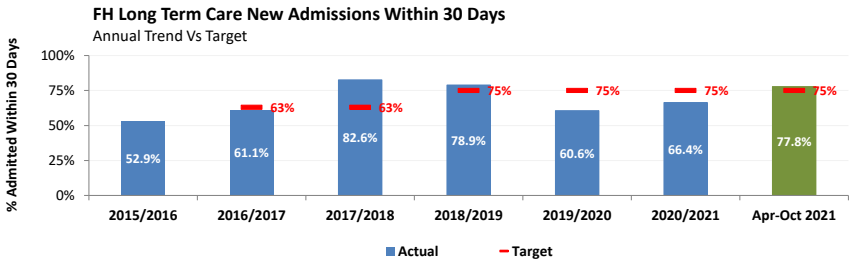
What can you do?

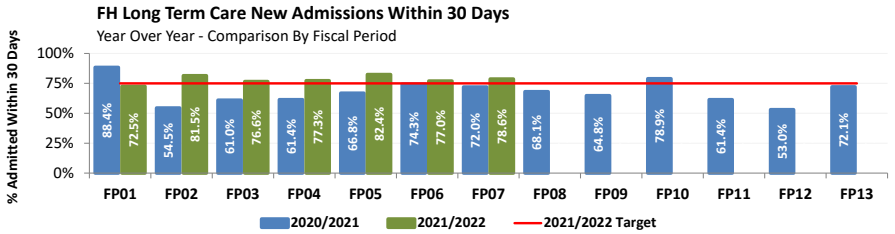
If you are a healthy senior, consider making choices now to keep yourself healthy so you may remain at home as long as possible. However, know that Fraser Health's long term care facilities will be here for you when you need them.

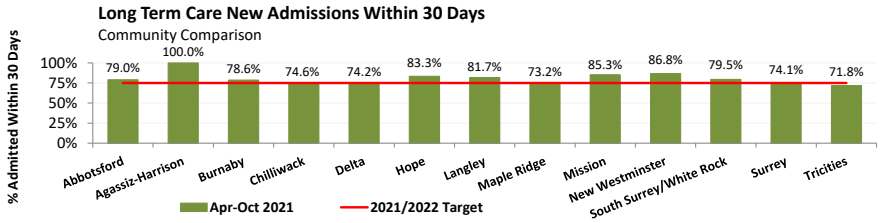
Our Performance	Target *
77.8%	>= 75%

Unit of Measure: Percent of clients admitted within 30 days

Performance timeline:	Apr-Oct 2021
Data Source:	Strata Health Pathway
* Target Source:	FHA Internal







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Emergency Visits by Home Health Clients

What is the rate of home health clients making unscheduled visits to hospital emergency departments?

What are we measuring?

This indicator measures the total number of unscheduled visits made by home health clients to Fraser Health emergency departments, as a proportion of the total number of clients receiving home health services. Unscheduled visits are defined as all ED visits that were not for IV therapy, Imaging, or scheduled physician consultations.

Why?

The purpose of this measure is to identify the extent to which unscheduled visits to emergency departments by home health clients occur.

How do we measure it?

We take the number of unscheduled ED visits by home health clients in a given period and divide by the number of clients who were receiving home health services at the end of that period, and multiply by 100 to get the rate. Clients who receive services from multiple Local Health Areas, Home Support and Adult Day Programs are excluded. Those clients are captured via their Case Management services and attributed to the corresponding Local Health Area. Quarterly and year-to-date rates are annualized using a rolling four quarter method to enable comparisons with historical annual rates.

How are we doing?

HH use of the Emergency Room (ER) has been significantly lower due to the CoVID19 pandemic as the entire population reduced their use of ER during this time. We don't have the data to know if they were able to reach their physicians for a phone visit or not but that might have been used as an alternate.

What are we doing?

Low urgency visits by Home Health clients to Emergency has been recognized as an area where significant improvements can be made, as clients are already known to the health care system. Urgent response services for known home health clients are in place, or being developed, in all Fraser Health communities. The CoVID19 pandemic has significantly affected service delivery of these services.

What can you do?

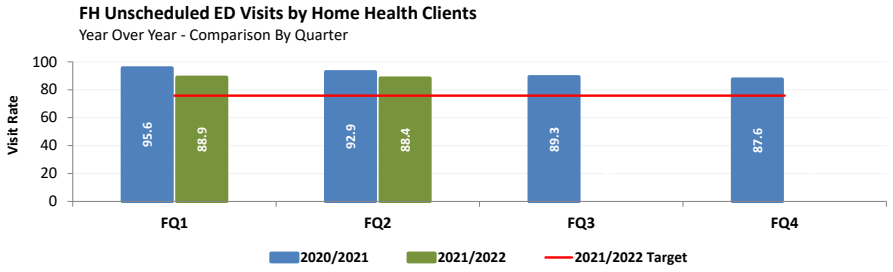
If you are receiving Home Health services and need additional support to keep you at safely at home connect with your home health office or your community health nurse to assist you access the care and services you need.

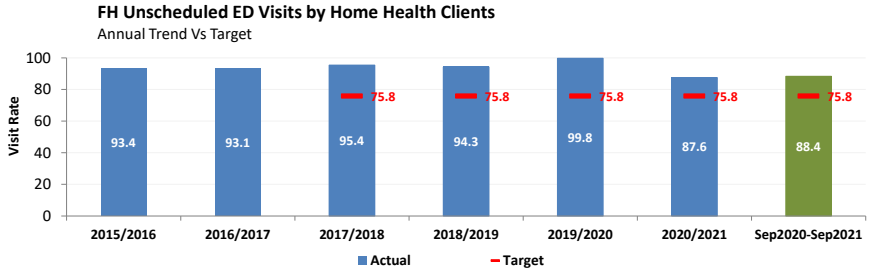
Our Performance	Target *
88.4 ◆	<= 75.8

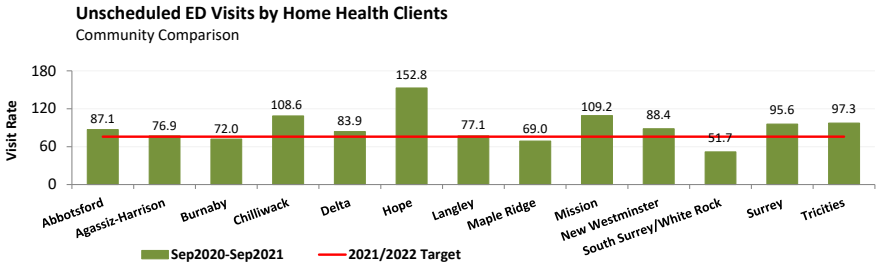
Unit of Measure: Number of ER visits / 100 Home Health Clients

Performance timeline:	Sep2020-Sep2021
Data Source:	PARIS System, Meditech and NACRS
* Target Source:	FHA Internal

Notes: *Achievable reduction in the area of ER visits by home health clients of 20% is designed to be the first step in a targeted reduction we expect to see over the next 3 years in this population. Work on the primary care home expansion, as well as outreach into our residential facilities for provision of previously excluded services will be factors in achieving this goal.*







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Emergency Visits by Long Term Care Clients

What is the rate of Long Term Care clients making unscheduled visits to hospital emergency departments?

What are we measuring?

This indicator measures the total number of unscheduled visits made by Long Term Care clients to Fraser Health emergency departments, as a proportion of the total number of Long Term Care clients in that time period. Unscheduled visits are defined as all ED visits that were not for IV therapy, Imaging, or scheduled physician consultations.

Why?

Long Term Care clients generally have conditions which make them very frail, and are in the final phase of their life journey. As such, their personal care goals are typically better aligned with optimizing the quality of their days according to their preferences, rather than increasing the length of their days. This is the focus of care in a Long Term Care facility. Health care interventions do not always benefit older adults with frailty and should be chosen with discretion. Nevertheless, there are times when their health deteriorates and medical diagnosis or treatment is required. A Long Term Care facility is not designed, staffed or equipped to diagnose or treat individuals with acute conditions therefore, there will always be residents who appropriately visit the ED for acute onset of symptoms & conditions. The goal is to reduce unscheduled transfers to ED for conditions that can be managed with on-site physician assessment and treatment, knowledgeable and skilled facility staff, and family/residents who make informed decisions about goals of care.

How do we measure it?

We take the number of ED visits by Long Term Care clients in a given period and divide by the average number of clients who were receiving Long Term Care services at any time during the period, and multiply by 100 to get the rate. Quarterly and year-to-date rates are annualized using a rolling four quarter method to enable comparisons with historical annual rates.

How are we doing?

There was a slight increase noted in visits by LTC Clients to the Emergency Department in the most recent period.

What are we doing?

The province-wide Long-Term Care Initiative delivered by the Divisions of Family Practice aims to decrease unscheduled visits to the ER from long-term care homes in all 10 communities in FH. When possible, FH Long-Term Care Services collaborates with each Division to develop and implement quality improvement projects to reduce such visits.
FH Long Term Care Services continues to practice a palliative approach to care to ensure that residents are able to make their wishes for care known to all (and ease the burden of family having to make the decisions) and to find ways to better support residents who wish comfort care only when their health deteriorates.
Each care home receives a quarterly report of their performance (relative to the target which is 7.5 per 100 residents per quarter) which raises awareness and provides opportunity for each facility to develop a site specific action plan to decrease unscheduled transfers to ED.

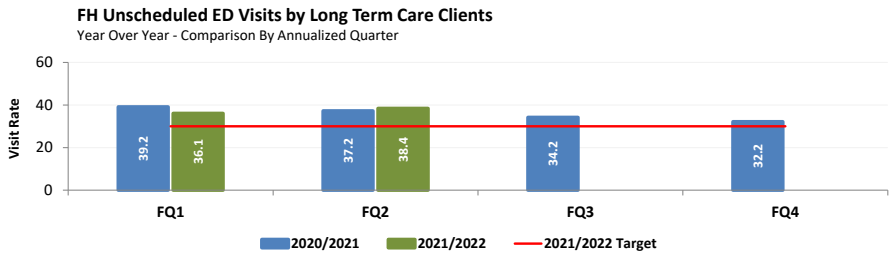
What can you do?

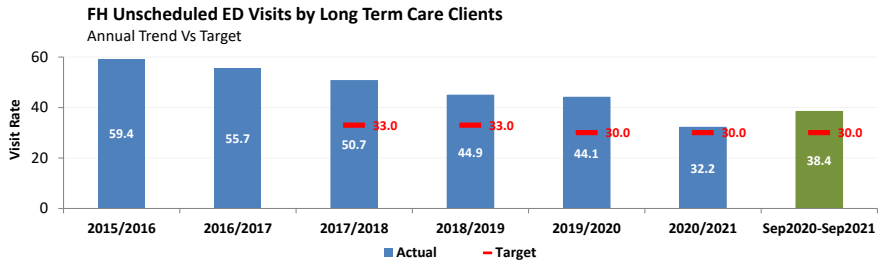
Go to Ministry of Health website, search for My Choice document, review it and discuss with significant people in your life what you want in the event that your health deteriorates. Don't make others make the choices for you.

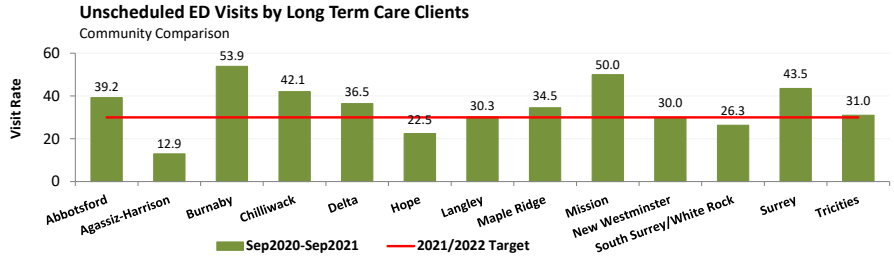
Our Performance	Target *
38.4 ◆	<= 30.0

Unit of Measure: Number of ER visits/100 residential care clients

Performance timeline:	Sep2020-Sep2021
Data Source:	PARIS System, Meditech and NACRS
* Target Source:	FHA Internal







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Non-emergency Surgeries Completed Within 26 Weeks

How many patients had their non-emergency surgeries completed within 26 weeks?

What are we measuring?

Percentage of scheduled surgeries completed within 26 weeks. Wait time measurement is calculated from the date the hospital received a booking form to the surgery date.

How are we doing?

The proportion of non-emergency surgeries completed within 26 weeks remained at 87.1% in the most recent period.

Why?

Our goal is to provide timely access to quality care for our patients. Fraser Health supports the provincial goal of all patients undergoing scheduled surgery waiting less than 26 weeks from when patients are ready for surgery.

What are we doing?

Fraser Health is working to restore surgical capacity to levels prior to COVID-19 and pursuing all available options to extend capacity to rebook surgeries impacted by the pandemic.

How do we measure it?

We take the number of scheduled surgeries completed within 26 weeks of receiving a booking form and divide it by the total number of scheduled surgeries completed from the waitlist.
Emergency/ unscheduled surgeries are not considered in this indicator. Wait times are calculated exclusive of periods of time when the patient is unavailable for surgery.

What can you do?

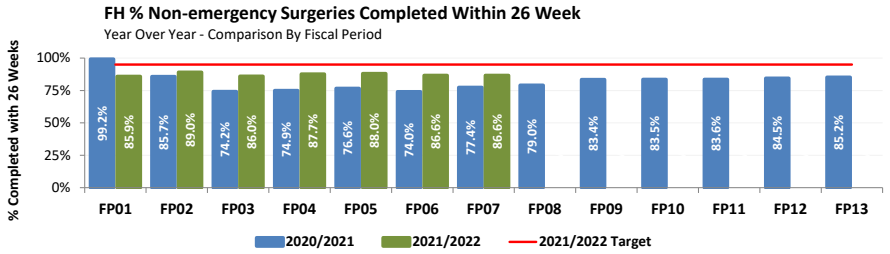
Review the Fraser Health soonest surgery dashboard to check for surgeons that may be able to perform your surgery sooner. Discuss directing or redirecting your referral with your GP if this is your preference. Make every effort to accept the surgery date offered by your surgeon. Notify your surgeon's office if your situation changes - for example if you will not be available for surgery for a period of time.

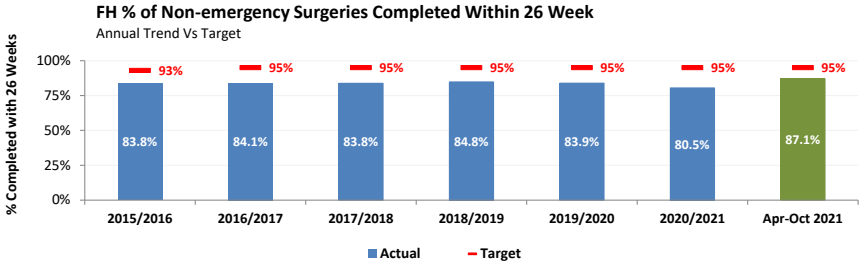
Our Performance	Target *
87.1% △	>= 95%

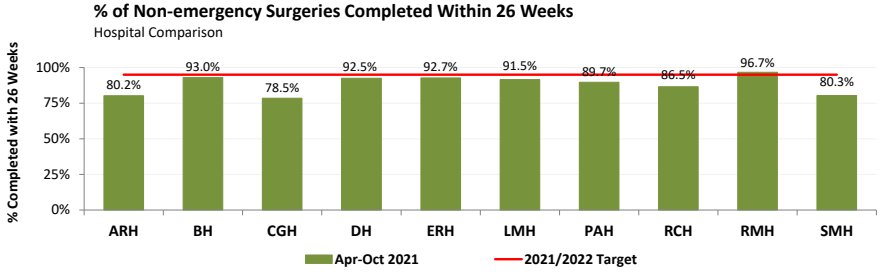
Unit of Measure: Percent of surgeries completed within 26 weeks

Performance timeline:	Apr-Oct 2021
Data Source:	BC Surgical Patient Registry
* Target Source:	BC Ministry of Health

Notes: *Target is based on the current MOH service plan.*







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Non-Emergency Surgeries Waiting Longer Than 26 Weeks

How many patients on the waitlist for non-emergency surgery have waited longer that 26 weeks?

What are we measuring?

The percentage of scheduled surgeries on a given waitlist snapshot that have waited longer than 26 weeks from that date when the hospital received a booking form.

How are we doing?

The proportion of patients on surgery waitlists who have waited longer than 26 weeks decreased from 29.8% to 28.9% in the most recent period.

Why?

Our goal is to provide timely access to quality care for our patients. Fraser Health supports the provincial goal of all patients undergoing scheduled surgery waiting less than 26 weeks from when patients are ready for surgery.

What are we doing?

Fraser Health is working to restore surgical capacity to levels prior to COVID-19 and pursuing all available options to extend capacity to rebook surgeries impacted by the pandemic.

How do we measure it?

The number of scheduled surgeries waiting longer than 26 weeks is divided by the total number of scheduled surgeries waiting per the waitlist (snapshot) as of date. For the purpose of this report the waitlist snapshots are taken at the end of each fiscal period and fiscal year. Scheduled surgery wait time is calculated from the date the hospital received a booking form to the date of the waitlist snapshot.
Emergency/ unscheduled surgeries are not considered in this indicator. Wait times are calculated exclusive of periods of time when the patient is unavailable for surgery.

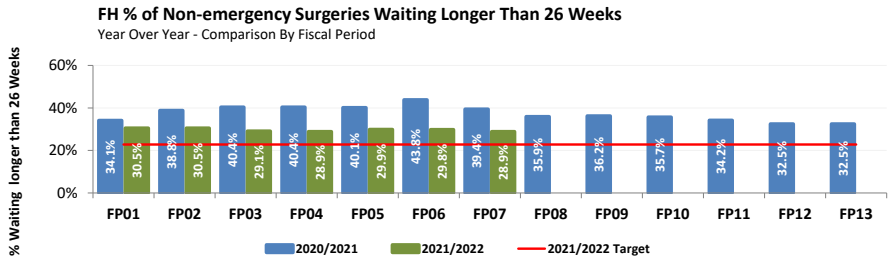
What can you do?

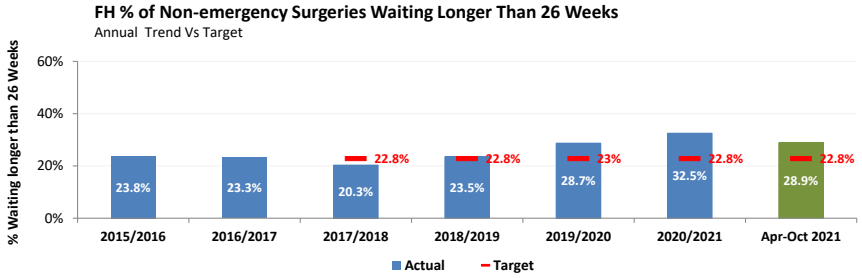
Review the Fraser Health soonest surgery dashboard to check for surgeons that may be able to perform your surgery sooner. Discuss directing or redirecting your referral with your GP if this is your preference. Make every effort to accept the surgery date offered by your surgeon. Notify your surgeon's office if your situation changes - for example if you will not be available for surgery for a period of time.

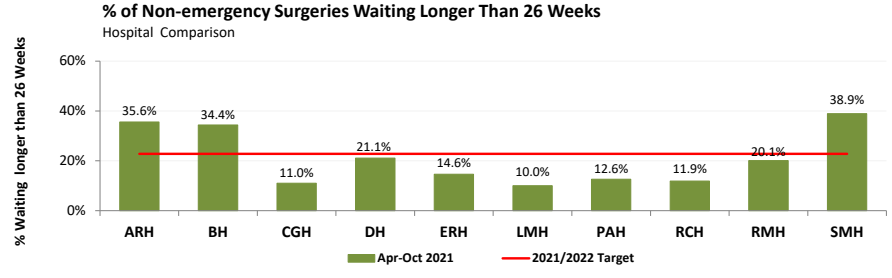
Our Performance	Target *
28.9% ◆	<= 22.8%

Unit of Measure: Percent of surgeries waiting Longer than 26 weeks

Performance timeline:	Apr-Oct 2021
Data Source:	BC Surgical Patient Registry
* Target Source:	FHA Internal







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

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?

Immunization is the most effective health measure for protecting children and adults from vaccine-preventable disease. Recent outbreaks among children in the Fraser Health Authority (FHA) remind us of the need to be vigilant in maintaining high immunization coverage rates. Because infants and toddlers are the most vulnerable and because most immunizations in an individual's life are received before the age of two, FHA monitors the percent of 2-year olds with up-to-date Immunizations to ensure that 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.

How are we doing?

In Fiscal Quarter (FQ) 2 2021/22 (July to September, 2021) 72.7% of 2-year-olds were up-to-date with their immunizations. This rate represents a 4.2 percentage point increase with respect to FQ 1 2021/22 (April to June, 2021). This increase breaks with seven consecutive quarters of rate declines. However, the overall fiscal year-to-date rate was 14.4 percentage points below the Fraser Health target of 85%.

What are we doing?

The majority of childhood immunizations in Fraser Health are given at our Public Health Units. We have expanded the days and hours that our Public Health Units are open to offer more immunization appointments during evenings and weekends.

We phone families with children age 0-2 to remind them that their children are due for immunizations and offer them immunization appointments. We are also developing new communications to remind families when their children are due for immunizations and to reinforce the importance of getting their children immunized on time.

In addition, Fraser Health's Primary Care team is working closely with the Divisions of Family Practice to promote increased delivery of childhood immunizations in physicians' offices and community clinics (e.g., maternal health clinics, Primary Care Network clinics). Mentorship and training opportunities are being developed to refresh the skills of physicians who have not provided childhood immunizations recently.

This work to engage a broader range of healthcare professionals will help to diversify the workforce that delivers childhood immunizations in our communities. In the long term, this will help to increase access to immunization and protect against future disruptions that could result from an emerging or urgent health issue that redirects resources from one part of the healthcare system.

What can you do?

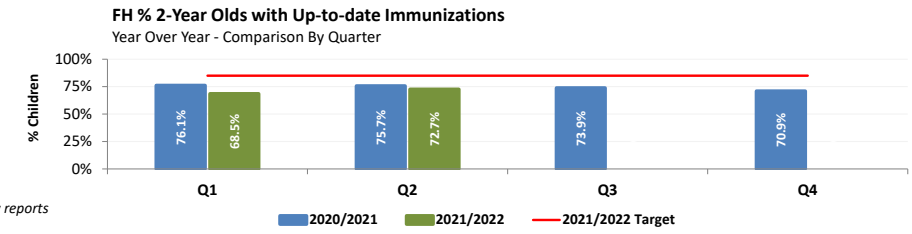
The most important thing you can do is immunize your children on time with all the vaccines they need. Immunizations for children aged 2 months - 6 years of age continue to be available during the COVID-19 pandemic and remain the most effective way to protect children from vaccine-preventable diseases. Parents can sign up for free text reminders at immunizebc.ca and are encouraged to download the CANImmunize app (www.canimmunize.ca) on their smart phones to keep track of their children's immunizations. Visit www.fraserhealth.ca/immunization to find out how to get immunized.

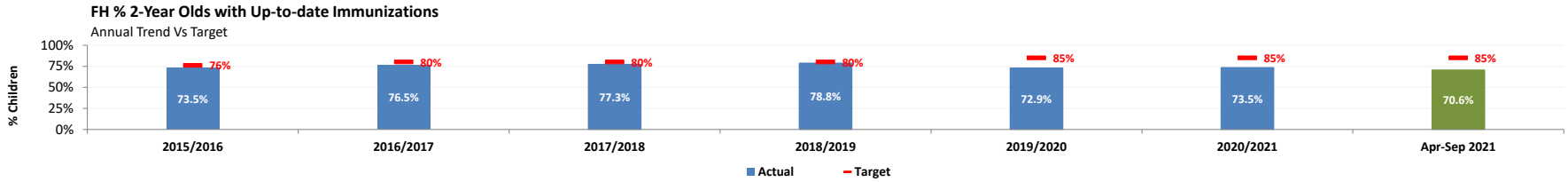
Parents are also encouraged to ensure their children's immunizations are documented with public health. You can check your child's status at https://immunizebc.ca/vaccination-status-indicator. If children are immunized by their family doctor or receive their immunizations from Vancouver Coastal Public Health, parents should report their child's immunizations to Fraser Health by calling their local Health Unit or online at www.fraserhealth.ca/immunizationform.

Our Performance	Target *
70.6% ◆	>= 85%
Unit of Measure: Percent of 2-year olds	

Performance timeline:	Apr-Sep 2021
Data Source:	Current data extracted from Panorama. Historic data extracted from Integrated Public Health Information System (iPHIS)
* Target Source:	FHA Internal

Notes: *Data for the 2014/2015 fiscal year are based from BCCDC's "Immunization coverage by 2nd birthday, BC HSDA" quarterly reports whereas data for the 2015/2016 fiscal years and onwards were extracted from Panorama directly*





Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Health Protection Program Response Time to Public Complaints

Is the public receiving a timely response to complaints?

What are we measuring?

Percentage of complaints where initial response time met target within each of the six Health Protection program areas (Food Safety, Recreational Water Safety, Personal Service Establishments, Community Sanitation, Drinking Water, Community Care Facilities Licensing) and reported by fiscal quarter.

How are we doing?

The rate of Responding to Public Complaints Within Targets (RPCWT) increased from 96.8% in FQ1 2021/22 (April to June, 2021) to 97.2 % in Fiscal Quarter (FQ) 2 2021/22 (July to September, 2021). The Fiscal year-to-date rate (April to September 2021) for this indicator is 2.5 percentage points above the overall target of 95%.

Why?

The Fraser Health Authority (FHA) protects human health by quickly responding to potential population health risks through the identification, prevention, control and mitigation of adverse physical, chemical or biological conditions. Identifying and responding to health hazards in a timely manner is critical to reducing the potential for public exposure. Therefore, FHA monitors the efficiency of the health protection programs such as food safety and drinking water systems through the “Health Protection program response time to public complaints” indicator.

What are we doing?

Health Protection staff receive public complaints via telephone, email or the FH Feedback system. Staff then assess the particulars of the complaint and respond as necessary to mitigate any health hazards that may be present. Often a site visit to the premises or affected area is conducted. Wherever necessary, the health officer may require the premises operator to take action to rectify the situation. Response time targets vary depending on the level of risk associated with the type of complaint. This ensures resources are directed towards those situations that present the highest level of risk to the public.

How do we measure it?

The sum of complaints across 6 program areas meeting the program initial response time target divide it by the sum of complaints across the 6 program areas (rolling sum by quarter).

What can you do?

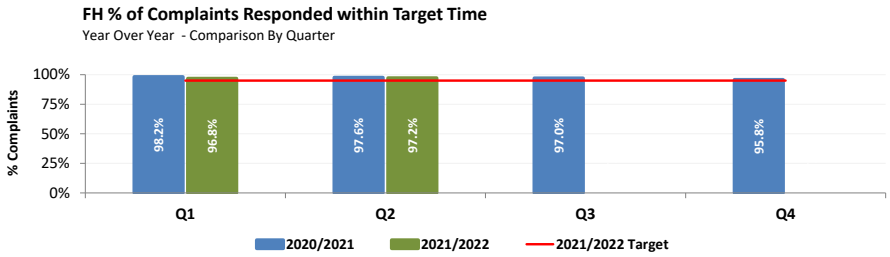
The public can notify their local Health Protection office to report a complaint. Licensing Officers follow up on concerns in licensed care facilities (day cares and residential care). Environmental Health Officers follow up on community environmental complaints (food safety, recreational water safety, personal service establishments, drinking water and community sanitation).

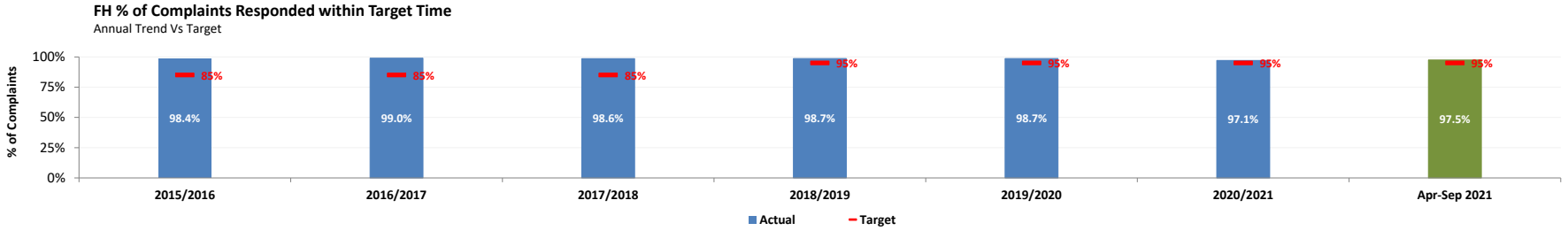
Our Performance	Target *
97.5%	***>= 95.0%***

Unit of Measure: Percent of complaints

Performance timeline:	Apr-Sep 2021
Data Source:	HealthSpace
* Target Source:	FHA Internal

Notes: *New indicator target of 95% is based on previous years average performance across the 6 programs areas.*





Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Prenatal Registrations

What percentage of women who give birth in FHA hospitals register with the Best Beginnings program during their pregnancy (i.e., prenatally; prior to giving birth)?

What are we measuring?

Percentage of women who give birth in FHA hospitals who register with the Best Beginnings program in FHA during their pregnancy (i.e. prenatally) and reported by fiscal period.

Why?

Prenatal registration provides expectant mothers with access to nursing services to support their pregnancy. This is particularly important for vulnerable women, such as teen mothers or those with high-risk pregnancies, who can benefit from targeted programs like the Nurse-Family Partnership. The prenatal registration rate is an indication of the acceptability and accessibility of the broader Best Beginnings program to pregnant women.

How do we measure it?

Number of women who deliver in FHA who register with Best Beginnings prenatally divided it by total number of women who deliver in FHA

How are we doing?

In Fiscal Quarter (FQ) 2 2021/22 (July to September, 2021), 55.3% of women who gave birth in FH hospitals were registered with the Best Beginnings program during their pregnancy. This rate represents a 2.2 percentage point decrease with respect to FQ1 2021/22 (April to June, 2021). FQ2 2021/22 is the quarter with the lowest prenatal registration rate since data started to be reported. Moreover, this indicator has declined for 10 consecutive quarters and overall the percentage of prenatal registrations in 2021/2022 fiscal year to date (April to September 2021) is 18.4 percentage points below the overall target of 75%.

What are we doing?

Population and Public Health (PPH) continues working with stakeholders such as GPs and maternity clinics and other community partners to facilitate early registration and awareness of program. PPH is currently exploring contributing factors as well as opportunities to increase prenatal registration in these areas; such as a Facebook campaign. Since 2013, PPH has been encouraging electronic registration through the Fraser Health website (fraserhealth.ca/parenting) and a mobile version of the registration website has been launched. Despite current efforts, competing priorities such as the overdose crisis and COVID-19 have prevented PPH from achieving the prenatal registration target. In June 2018, PPH launched SmartMOM, a text push notification service, that provides pregnant individuals with key health messages according to their gestational age. In order to receive this service, women must go through the pre-natal registration page which will hopefully encourage more individuals to register sooner. Covid-19 has presented another competing priority; there is currently limited capacity to promote prenatal registration. Throughout the pandemic, we continue to support vulnerable women in the prenatal and postpartum period. We are using virtual health technology to provide service to our vulnerable clients where possible and in person service where needed. With the resumption/restart of PPH services post Covid-19, a re-engagement plan with GPs, maternity clinics and other community partners and a refresh of promotional materials is underway.

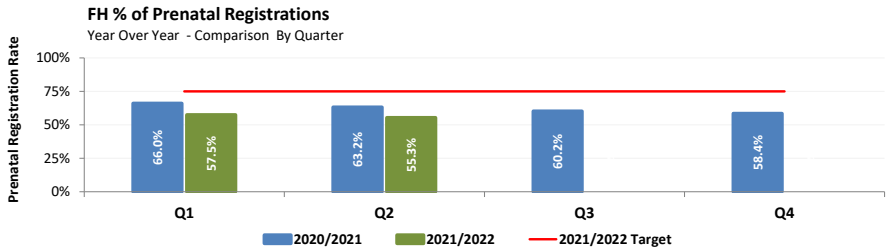
What can you do?

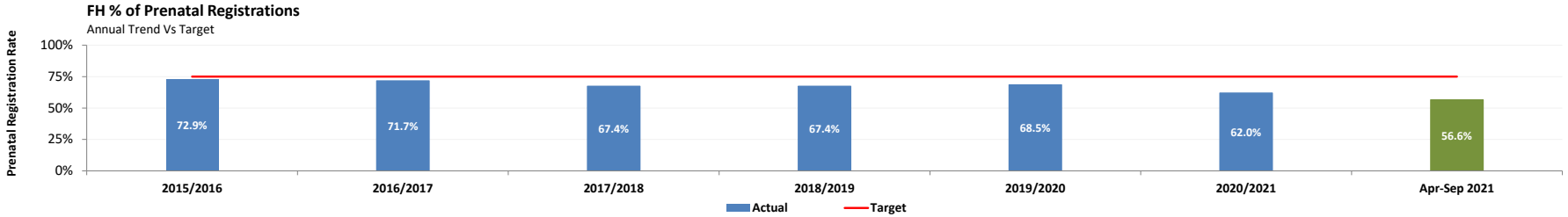
In order to receive the full benefits of Public Health services, and improve maternal and child health outcomes, particularly for vulnerable women and those with high-risk pregnancies, pregnant women should register on line at bestbeginnings.fraserhealth.ca or with their local public health unit as early as possible.

Our Performance	Target *
56.6% ◆	>= 75%
Unit of Measure: Percent of women registered	

Performance timeline:	Apr-Sep 2021
Data Source:	PARIS System
* Target Source:	FHA Internal

Notes: *Fraser Health transitioned from Panorama to Paris in Q1 of FY 2019/20. Therefore, from Q2 of FY 2019/20 on, the quarterly and YTD prenatal registration rates are calculated with PARIS data. However, for Q1 of FY 2019/20, Panorama data was used because there was a gap in the recorded birth hospital in Paris for most of the births in April to early June of 2019. Birth hospital is a required factor in calculating the prenatal registration rate for Fraser Health hospital births. Therefore, the Panorama data for Q1 was more complete, although it only covered April 1st to June 19th of 2019.*





Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Nursing and Allied Professional Sick Time

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

What are we measuring?

This measure tracks the percentage of time health care workers (Nurses and Allied Health Professionals) are away from work on sick leave relative to total productive hours.

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.

How are we doing?

The 2021/22 year-to-date performance of 5.26% remains below our target of 5.8% for Nurses and Allied Health professionals, however it has been steady increased over the last seven periods. Eight of our hospitals are performing well and remain below the set target. It should be noted that the 2021-22 fiscal period sick time rates are consistently trending higher than the same time last year (FP1 through 4),

What are we doing?

Key messaging to staff during COVID-19 continues to be "if you are sick do not come to work". While the formal Attendance Support Program has been suspended during the pandemic, messaging to staff regarding the importance of their sick bank as their financial safety net in the form of their Short-term Disability Benefit continues. The Attendance Support team continues to support employees that may be struggling in the workplace. We have seen a 50% increase in temporary work accommodations that have been put in place since the onset of the pandemic, supporting employees to continue to manage their health and continue to attend work productively.

Supportive resources remain available to all staff who may be impacted negatively due to present health conditions or fear or anxiety related to the pandemic. The Starling Minds Mental Fitness online CBT support program has been renewed with a 2-year contract starting April 2021. This program uses online cognitive behavioural therapy and is available to support employees in building resiliency to stress, anxiety and depression. Special modules having been created by the developers to address increased anxiety related to COVID-19 specifically.

Additional supportive resources are available through both the Absence and Disability Management program at Fraser Health, as well as through the Recovery and Resiliency Campaign focused on maintaining the overall well-being of Fraser Health staff and physicians.

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.

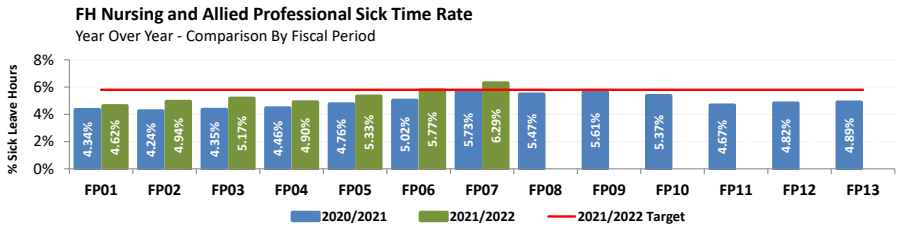
What can you do?

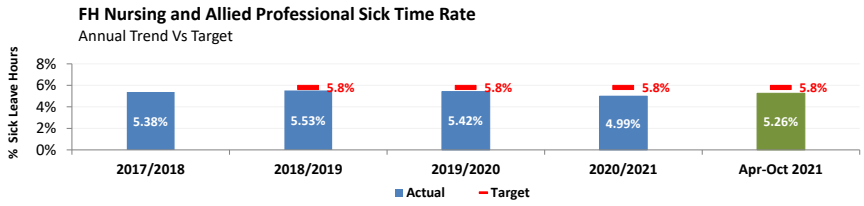
Ensure Optimum Health by creating a Healthy Balance of Rest and Relaxation. Evaluate your physical, mental and emotional health and how your work and home environments are contributing to your state of wellness. Maximize your happiness by increasing your hobbies, enjoying a holiday and reconnecting with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

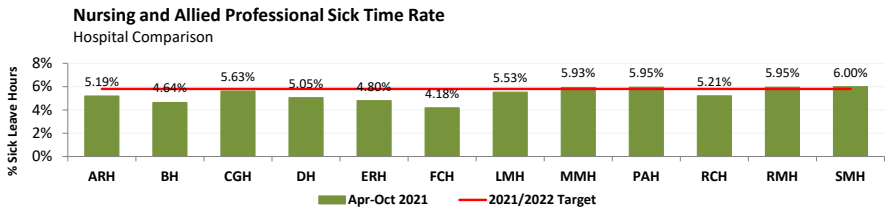
Our Performance	Target *
5.26%	<= 5.8%

Unit of Measure: Percent of sick hours to productive hours

Performance timeline:	Apr-Oct 2021
Data Source:	Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server
* Target Source:	BC Average for 2018/19







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Nursing and Allied Professional Overtime

How often do our staff work overtime?

What are we measuring?

This measure tracks the percentage of time health care workers (Nurses and Allied Health Professionals) worked as overtime relative to total productive hours.

How are we doing?

The reporting of overtime for 2020/21 focuses on Nursing and Allied Health, the target was increased for the fiscal year to 3.9%. The overtime rate for 2021/22 for Nursing and Allied Health is currently 7.35% year to date, which is above the new target. The 3rd wave of the COVID-19 pandemic started at fiscal period 01 2021/22 with more cases in the FH region, and none of the 12 hospitals met the target. For fiscal period 07, FH's OT was at 7.66%, which is 2.92% above the same period last year. This is likely as a result of the 3rd and 4th wave completion with increased pressure on Critical Care, an increase in Emergency room visits over previous years, and increased bed capacity across the region. Additional drivers of Overtime for this fiscal year is the increased volume of COVID-19 Testing and Immunization efforts throughout the Health Authority and ongoing vaccination needs for the community.

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.

What are we doing?

• Overtime is reported via a dashboard to the executive for review throughout the week. Testing and immunization needs continue to drive a component of our overtime. The majority of overtime is utilized by our Emergency and Critical Care departments.
• A Career Development Specialty Nursing Training program started in the fall, to supplement our BCIT programs to increase training capacity to address high need areas of vacancies. An additional 40 ER and Critical Care Registered Nurses are currently enrolled and will complete this education by mid December.

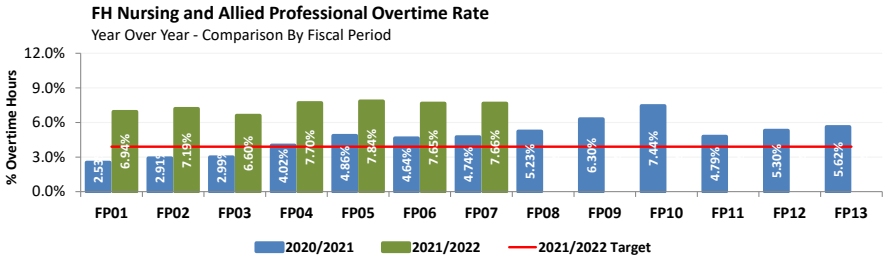
How do we measure it?

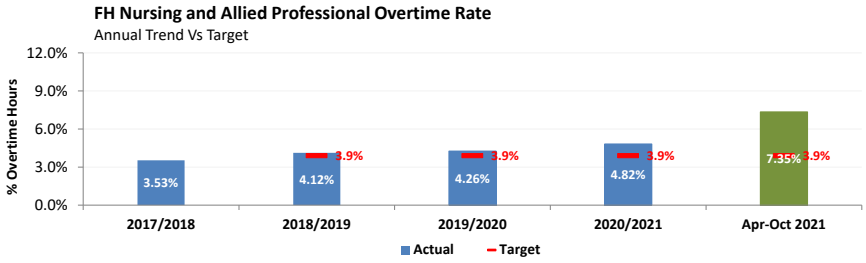
We take the total overtime hours and divide by total productive (working) hours.

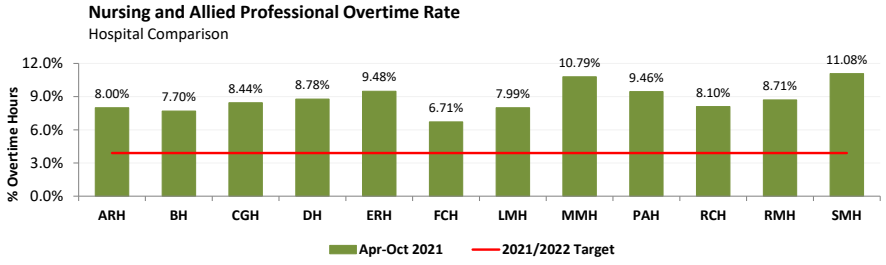
Our Performance	Target *
7.35% ◆	<= 3.9%

Unit of Measure: Percent of overtime hours to productive hours

Performance timeline:	Apr-Oct 2021
Data Source:	Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server
* Target Source:	BC Ministry of Health







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Lost Time Claims Rate

What is the rate of WSBC claims per 100 Full time Employees?

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 year-to-date 2021/22 performance of 6.2 is not meeting the target of 5.3. The claims rate has been substantially impacted by COVID-19 claims by adding several hundred claims to FH totals this fiscal year. 389 claims have been accepted for COVID so far in 20/21.

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?

Education to staff regarding following COVID-19 safety procedures (maintaining 6 feet apart, etc.) is ongoing to reduce the potential for transmission in non-clinical areas (i.e.. break rooms, changing rooms, nurses stations). COVID-19 data demonstrates that the greatest potential for transmission in the workplace is between staff, not from patient to staff. FH continues to sustain over 95% of staff in designated high risk areas have been trained in violence prevention. Needlesticks are at a 5 year low in occurrence. Primary causes of injury continue to be patient handling, slips trips and falls and violence. Managers and Directors are being held to key sets of KPIs in their safety management systems - through their performance plans and through planned activities with Health and Safety. Prevention plans include a focus on high priority units with an integrated prevention focus that includes bringing units up to standards for compliance, injury prevention/reduction plans and a series of planned management meetings to engage and make managers aware as to issues in their units.

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 divided by productive hours and then the result is multiplied by 1560*100 (per 100 FTE). Numerator data is from the WHITE database and denominator (FTEs) from FH Payroll data.

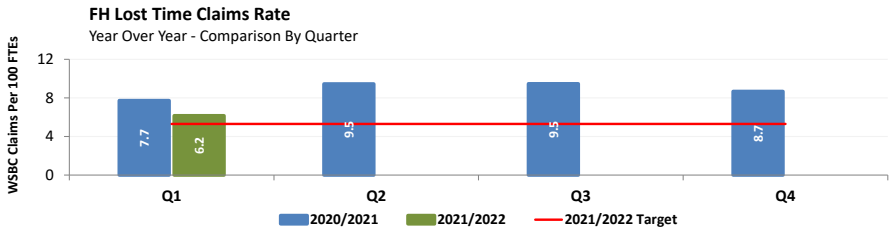
What can you do?

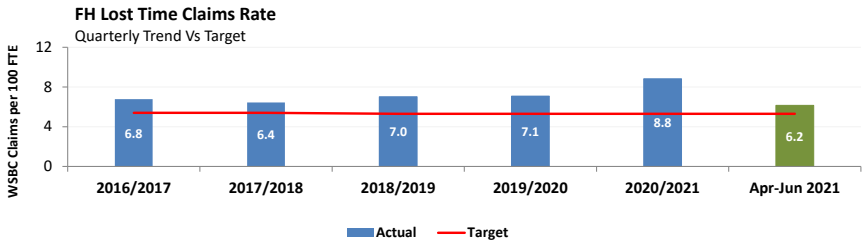
Ensure that all staff are oriented and trained in the application of mobility assessments, use of lifts and related equipment. Ensure that all reported hazards and investigations are investigated effectively and hazardous conditions are corrected without delay.

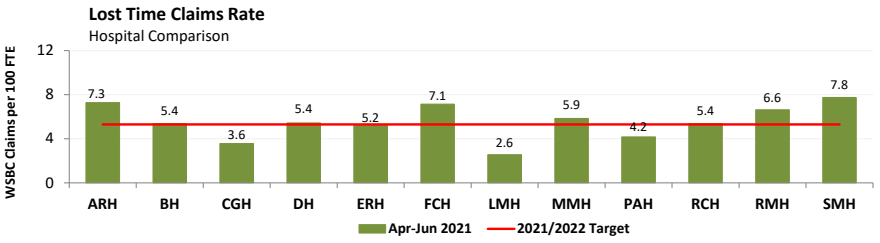
Our Performance	Target *
6.2 ◆	<= 5.3

Unit of Measure: Number of WSBC accepted claims / 100 FTEs

Performance timeline:	Apr-Jun 2021
Data source:	FHA Workplace Health
* Target Source:	BC Ministry of Health







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Long Term Disability Claims Rate

How many FHA employees starting long term disability claims benefits this reporting period?

What are we measuring?

The rate of Fraser Health Employees starting long term disability claims in the reported quarter per 100 Full Time Employees (FTEs)

How are we doing?

Our 2021 year-to-date performance of 2.07 is meeting the target of 2.25. The 2020 quarterly rates highlight significant volatility from quarter to quarter over the course of the year. Most notably there was a large spike in Q3 with a 59% increased rate over the previous quarter. This timeline corresponds to the qualifying period for disabilities that occurred at the onset of the first wave of COVID. A review and comparison of NEW claims each quarter highlights a consistent increase quarter over quarter in the number of claims with Mental Health as the primary cause. This consistent increase over the past year in Mental Health claims is likely an outcome that demonstrates the impact of the COVID-19 pandemic. The top four causes of new LTD claims remain consistent: 1) Mental Health; 2) Chronic MSI/Connective Tissue (i.e. Rheumatoid arthritis, etc.) 3) Accident/Injury (i.e. MVA); 4) Cancer. The annual incident rate has remained consistent, in part due to the general increase in FTEs at Fraser Health related to the expansion of the organization to address the pandemic workload as the total number of claims has increased.

Why?

Long Term Disability claims have a significant impact on Fraser Health Authority (Operations and staff) due to the cost of the claims and associated benefits as well as the lost productivity and personal impact of staff on claim. LTD claims are approximately 10x cost of the total WSBC claims and the hours lost working exceeds that of WSBC. We have about 1100 LTD claims at any time and about 350 new claims each year. 70% of the new claims are 1 year or less in duration and the remaining 30% could be from 1 to 30 years in duration depending on the individual circumstances. It is important measure for the organization to track, monitor and keep under control from a cost and human resources/productivity perspective.

What are we doing?

Workplace Health continues to focus efforts on early intervention to reduce the number of employees that require LTD to support an illness or injury.
The implementation of a Direct Referral service supporting employees with musculo-skeletal injuries and mental issues health has successfully increased the number of employees returning to work prior to the need for LTD.
Ongoing tracking of key performance metrics and outcomes inform ongoing practice enhancements. Managers continue to be provided with key status information for their employees who are involved with DM Services.
FH maintains best practices in LTD Case Management.

How do we measure it?

We divide the number of New LTD Claims starting benefits in the quarter by the Total number of Productive Hours (Regular hours + Overtime hours + Other Productive Hours)*195000 hours (80% of total working hours per 100 employee in the year)

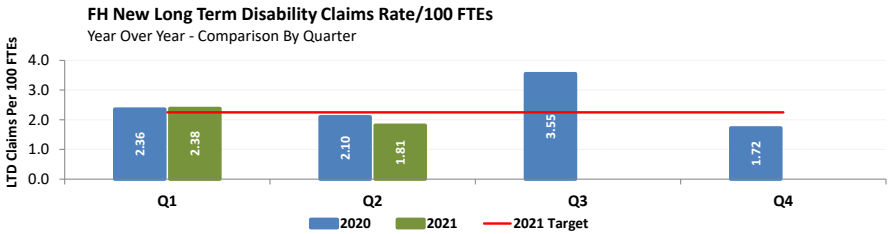
What can you do?

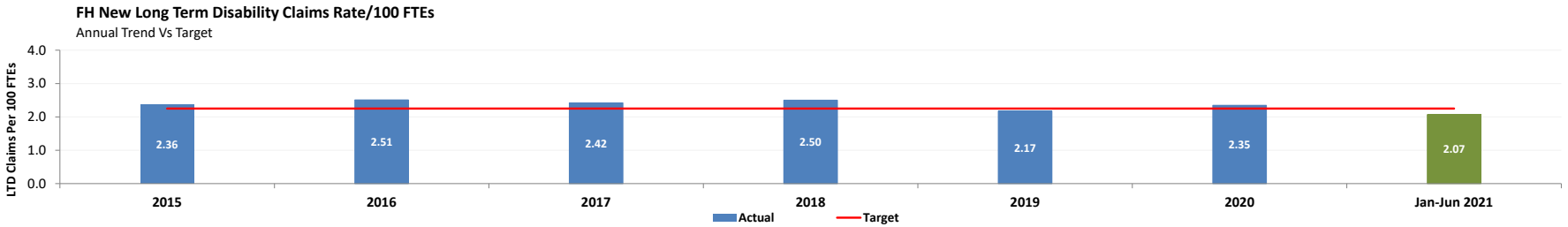
Management within Fraser Health can help reduce the LTD Claims Rate when they facilitate a return to work or an effective accommodation when approached by Disability Management about their employees that require such services

Our Performance	Target *
2.07	<= 2.25

Unit of Measure: Number of LTD claims / 100 FTEs

Performance timeline:	Jan-Jun 2021
Data source:	FHA Workplace Health White Database and FHA Meditch System
* Target Source:	FHA Internal





Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Turnover Rate In The First Year Of Service

What is the percentage of employees hired within the past year and left Fraser Health Authority?

What are we measuring?

Percent of Regular Status Employees who left Fraser Health Authority (Voluntary or Involuntary) within their first year of service

How are we doing?

Overall FH % First Year of Service Turnover has gone up by 1.9% for Q2 with 8.2% compared to last quarter 6.3%. When comparing to the last year Q2, the % has increased by 5.8% from 2.3% to 8.2%. Although the turnover % has increased, the numbers of hires have increased substantially due to the pandemic with hires more than doubling compared to last year Q2.

When the numbers are segregated by Designated Group, it is best to consider the numbers of Turnover as well as the %, as the counts become very small. When comparing Q2 2021/22 to Q2 2020/21, there have been varying changes. Community continues holds the largest % of all turnover with 112 Turnovers (30.5% of all Turnovers). Facilities also continues to holds the second largest % with 62 Turnovers (21.6% of all Turnovers). Excluded increased with 39 Turnovers (15.5% of all Turnovers). Nurses increased with 18 Turnovers (15.9% of all Turnovers). Paramedicals increased with 19 Turnovers (11.1% of all Turnovers). Nurses-LPN remain the lowest with 1 Turnovers (5.4% of all Turnovers).

Why?

Retention of individuals has a large impact on Fraser Health operations and staff. Measuring the percentage of employees with less than one year of service is one indicator of quality of hire and the quality of the work environment. A high percentage may signal a misalignment between employee and employer expectations, how effective the individuals are integrating into the organization and ensuring we are hiring the right fit.

What are we doing?

FH has several strategies in place to ensure we hire the right individuals and retain them within FH. New Hire Survey will continue to be sent out to all the new hires of FH within the 6 months of their hires. FH will be reviewing departments that have high numbers and will be following with the corresponding directors for further insight. Exit Survey are also completed when an employee's decide to leave FH.

How do we measure it?

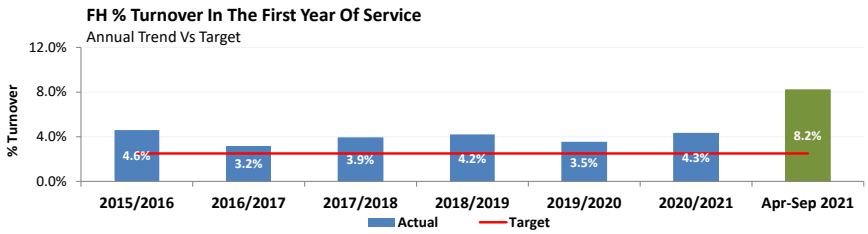
Divide employees who have been hired and terminated within the year over the employees who have been hired within the year. Termination includes voluntary and involuntary turnover. Termination due to retirement, transfers/mitigation as part of an organizational change or employees who pass away are not included. Only considered Regular Status employees.

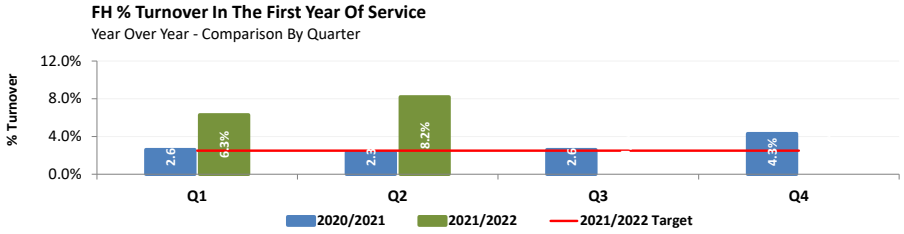
Our Performance	Target *
8.2% ◆	<= 2.5%

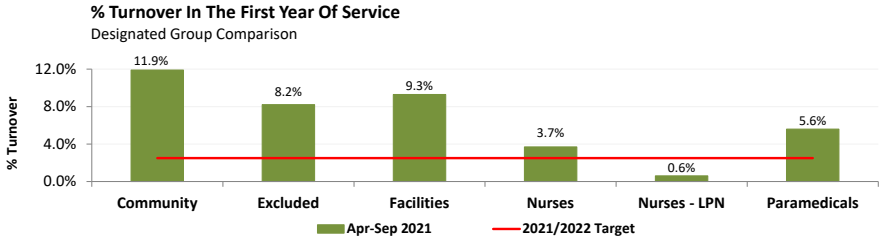
Unit of Measure: Percent of employees turnover

Performance timeline:	Apr-Sep 2021
Data Source:	Meditech
* Target Source:	FHA Internal

Notes: *Due to implementation of new employees types in our HR systems, employees were reassigned into the new types which resulted in change in numbers for the specific groups and some minor adjustments to the over all numbers at Fraser health level. All numbers were restated for consistency and accuracy of trending and comparison over time.*







Our Health Care Report Card

Fiscal Period: FP07, 2021/22 - Ending Oct 14, 2021

Budget Performance Ratio

How well are we performing compared to our budgeted plan?

What are we measuring?

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

How are we doing?

The seventh period ended with a year to date deficit of $74.6 million. The deficit included significant revenues and expenditures related to the COVID-19 pandemic response. Fraser Health continues to implement a number of ongoing mitigation strategies which continue to improve productivity, moderate spend against budget, transition care to the appropriate level and help allow Fraser Health to meet its overall financial commitments to the Ministry. Fraser Health is also working with the Ministry to mitigate the financial impacts of the ongoing pandemic response.

Why?

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

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.

How do we measure it?

Budgeted expenditures less net variance to budget over budgeted expenditures.

Our Performance	Target *
1.031 △	<= *1.000*
Unit of Measure: Actual to budget ratio	

Performance timeline:	Apr-Oct 2021
Data Source:	Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server
* Target Source:	FHA Internal