

Our Health Care Report Card

Fraser Health

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

No	Measure Name	Last Available Update	Target	Actual	Status	Preferred Direction
QUALITY AND SAFETY						
1	In-Hospital <i>Clostridium Difficile</i> Infection (CDI) Incidence	Apr-Oct 2018	4.5	2.9	●	↓
2	In-Hospital Methicillin-Resistant <i>Staphylococcus Aureus</i> (MRSA) Incidence	Apr-Oct 2018	7.0	5.9	●	↓
3	Hand Hygiene Compliance	Jul-Oct 2018	80%	79.3%	▲	↑
4	In-Hospital Sepsis Rate	Apr-Jul 2018	3.8	3.5	●	↓
5	In-Hospital Acquired Delirium	Apr-Jul 2018	7.3	9.4	◆	↓
6	In-Hospital Acquired Non-Aspiration Pneumonia	Apr-Jul 2018	7.3	7.6	▲	↓
7	In-Hospital Acquired Urinary Tract Infection	Apr-Jul 2018	10.0	13.4	◆	↓
8	Hospital Standardized Mortality Ratio	Apr-Jun 2018	87	87.8	▲	↓
9	Worsened Pressure Ulcer in Residential Care Facilities	Apr-Jun 2018	2.0%	1.5%	●	↓
CAPACITY AND CARE ACROSS ALL SECTORS						
10	Emergency Patients Admitted to Hospital Within 10 Hours	Apr-Oct 2018	44.0%	34.4%	◆	↑
11	Admitted Patients Waiting for Inpatient Bed Placement	Apr-Oct 2018	160	187.9	◆	↓
12	Patients Length of Stay Relative to Expected Length of Stay	Apr-Jun 2018	0.95	1.01	▲	↓
13	Long Stay Patients	Apr-Oct 2018	455	439.7	●	↓
14	Alternate Level of Care Days	Apr-Jul 2018	10.0%	14.0%	◆	↓
15	Hospitalization Rates for Residents (Age 70+)	2017/2018	257.7	260.6	▲	↓
16	Hospital Readmission Rates Overall	2017/2018	10.0%	10.7%	▲	↓
17	Mental Health & Substance Use Patients Hospital Readmission Rate (Age 15+)	2017/2018	12.0%	13.2%	◆	↓
18	Patients with Chronic Conditions Admitted to Hospital (Age 75+)	Apr-Jun 2018	3,411	3,332	●	↓
19	Low Acuity Emergency Visits by Community	Apr-Oct 2018	102.7	111.4	▲	↓
20	Home Health Services Provided Within Benchmark Time	Apr-Oct 2018	50.0%	46.5%	▲	↑
21	Wait Time for Home Health Assessment	Apr-Oct 2018	38.2	38.8	▲	↓
22	Admissions to Residential Care within 30 Days	Apr-Oct 2018	75.0%	78.3%	●	↑
23	Emergency Visits by Home Health Clients	Sep2017-Sep2018	75.8	95.8	◆	↓
24	Emergency Visits by Residential Care Clients	Sep2017-Sep2018	30.0	49.2	◆	↓
25	Non-emergency Surgeries Completed Within 26 Weeks	Apr-Oct 2018	95%	84.7%	◆	↑
26	Non-Emergency Surgeries Waiting Longer Than 26 Weeks	Apr-Oct 2018	22.8%	23.1%	▲	↓
POPULATION & PUBLIC HEALTH MEASURES						
27	Percent of 2-Year Olds with Up-To-Date Immunizations	Apr-Sep 2018	80%	78.6%	▲	↑
28	Health Protection Program Response Time to Public Complaints	Apr-Sep 2018	95%	98.5%	●	↑
29	Prenatal Registrations	Apr-Sep 2018	75%	68.7%	▲	↑
30	Life Expectancy Disparity within Fraser Health Communities	2011-2015	7.0	8.6	◆	↓
STAFF						
31	Sick Time Rate	Apr-Oct 2018	5.0%	4.86%	●	↓
32	Overtime Rate	Apr-Oct 2018	2.8%	3.36%	◆	↓
33	Lost Time Claims Rate	Apr-Jun 2018	5.4	5.9	▲	↓
34	Long Term Disability Claims Rate	Jan-Jun 2018	2.25	2.16	●	↓
35	Turnover Rate In The First Year Of Service	Apr-Sep 2018	2.5%	4.1%	◆	↓
BUDGET ACCOUNTABILITY						
36	Budget Performance Ratio	Apr-Oct 2018	1.000	1.014	▲	↓

Notes:

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

KPI Count By Status

Meeting Target	●	10
Within 10% of Target	▲	14
Not Meeting Target	◆	12

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

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

What are we measuring?

Number of new 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?

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

How do we measure it?

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

Our Performance	Target *
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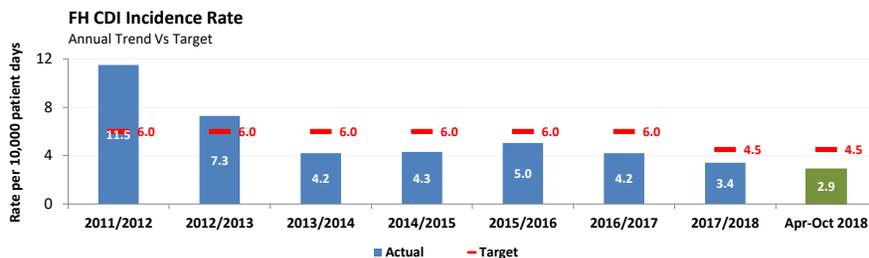
2.9 ●

≤ 4.5

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

Performance timeline:	Apr-Oct 2018
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) Starting Apr 1, 2015, MSA acute care data are combined with ARH data
 3) Starting Apr 1, 2015, YR acute care data are combined with SMH data



How are we doing?

Fraser Health's annual CDI incidence rate, which is the number of new acute care cases per population-at-risk, has decreased from 7.3 in 2012/13 to 2.9 year-to-date in 2018/19, which is below the current FHA internal target of ≤ 4.5 cases per 10,000 patient days. In previous fiscal years from 2013/14 to 2017/18, the rate of CDI remained below the FHA internal target set for each respective year. Please see figures below.

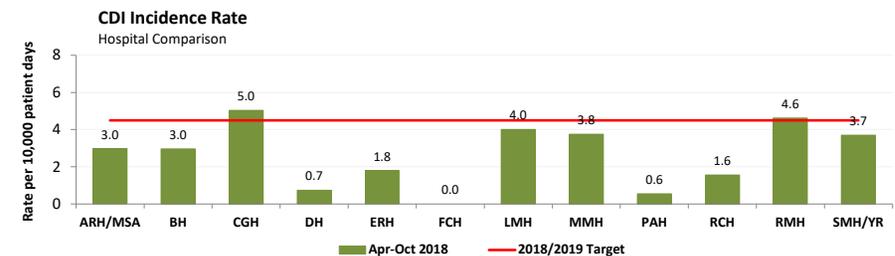
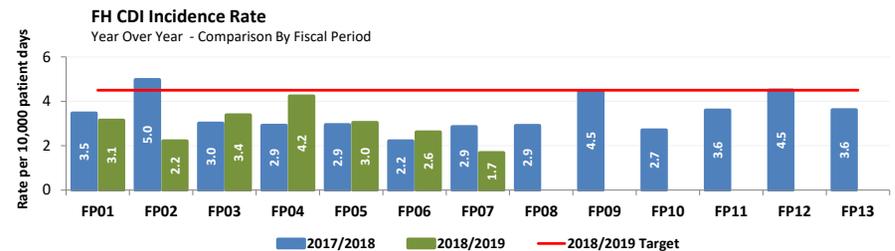
What are we doing?

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. This information helps staff develop quality improvement action plans to reduce CDI transmissions.

The Infection Prevention and Control (IPC) program works with hospital pharmacists and physicians to promote appropriate antibiotic treatment, and with Environmental Services to ensure that all rooms of patients with suspected or known CDI are cleaned twice a day with a sporicidal agent. The IPC program also collaborates with certain acute care sites to implement ultra-violet germicidal irradiation technology as well as canine scent detection to further reduce healthcare-associated CDI in those sites. The IPC Practitioners conduct detailed reviews of each CDI case to understand the factors that may have contributed to the infection. 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 to prevent the spread of infections is to clean your hands when entering and exiting a patient room and the facility; please remind others to do the same. When visiting, please follow all instructions and signs posted on the unit to decrease the chance of spreading germs.



Our Health Care Report Card

Fiscal Period: FP07, 2018/19 - Ending Oct 18, 2018

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)

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.

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

How are we doing?

Fraser Health's MRSA incidence rate, which is the number of new acute care cases per population-at-risk, has risen from 5.0 in 2013/14 to 5.9 year-to-date in 2018/19. The year-to-date 2018/19 MRSA incidence rate is below the target of 7.0 cases per 10,000 patient days. Please see figures below.

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 *Clostridium 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).

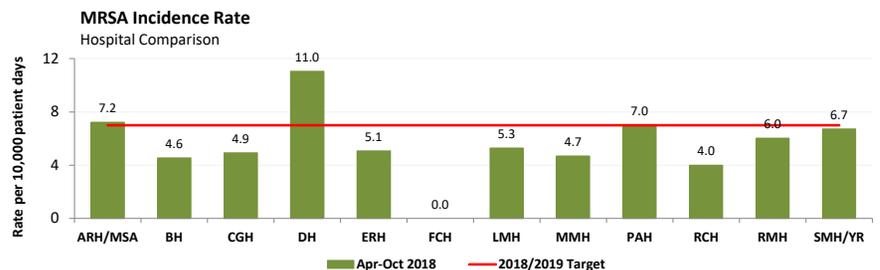
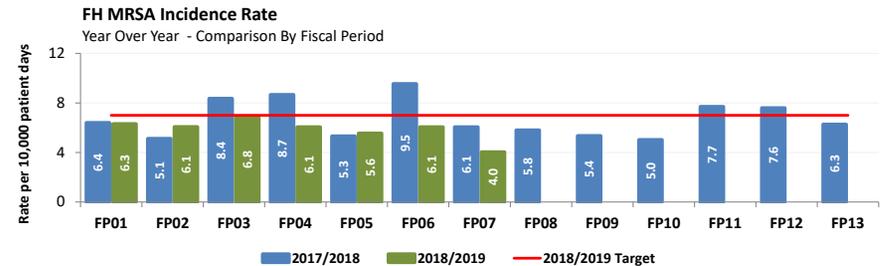
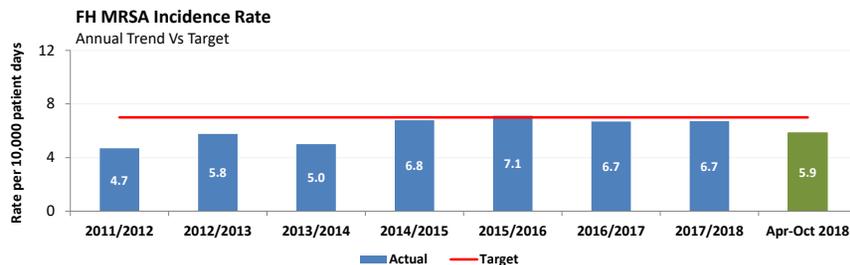
What can you do?

One of the most important things you can do to stop the spread of infections is to clean your hands when entering and exiting a patient room and the facility; please remind others to do the same.



Performance timeline: Apr-Oct 2018
 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) Starting Apr 1, 2015, MSA acute care data are combined with ARH data
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Our Health Care Report Card

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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.

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.

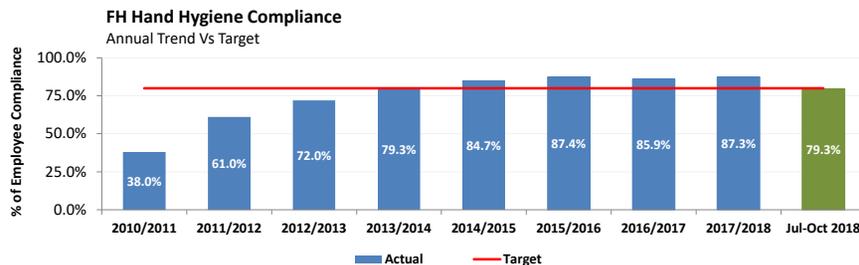
How do we measure it?

[(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

Our Performance	Target *
79.3% ▲	>= 80%
Unit of Measure: Percent of compliant employees	

Performance timeline: Jul-Oct 2018
 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) Starting Apr 1, 2015, MSA acute care data are combined with ARH data.
 - 3) Starting Apr 1, 2015, YR acute care data are combined with SMH data.
 - 4) 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 year-to-date hand hygiene compliance rate is calculated based on audit data from July 2018 (FP 1904) onwards.



How are we doing?

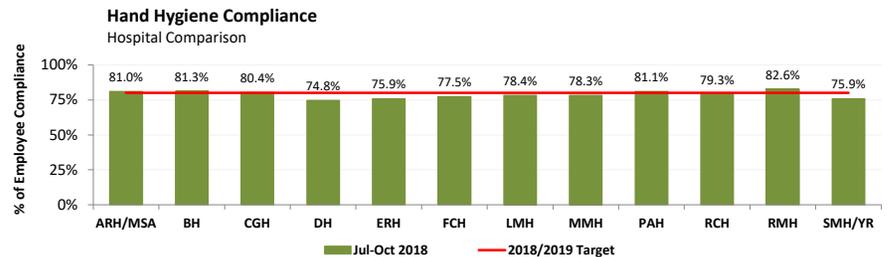
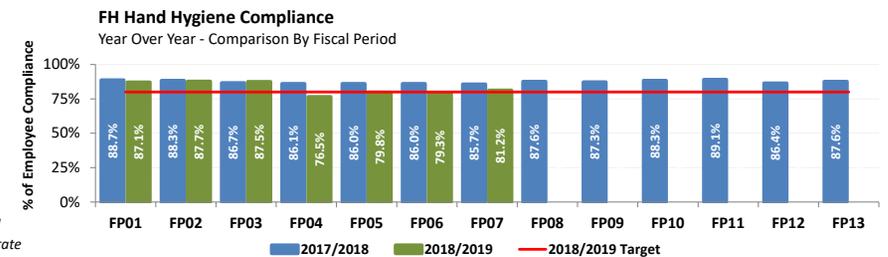
Fraser Health's overall hand hygiene compliance improved over the years from 38.0% in 2010/11 to 87.3% in 2017/18, then decreased to 79.3% since July 2018. The decrease in hand hygiene compliance rate in July is likely attributable to the change in hand hygiene audit methodology of using regional hand hygiene auditors for acute care inpatient units. Based on the current results, Fraser Health is not meeting the provincial target of >=80%.

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.

What can you do?

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



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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 current performance for hospital sepsis is 3.5, which is meeting the target of 3.8. We continue to perform better than the national average on this indicator. Our hospitals' year-to-date results show that all but six sites (Chilliwack General, Delta, Fraser Canyon, Langley Memorial, Royal Columbian, and Surrey Memorial) are meeting their internal targets.

What are we doing?

In-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 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. Part of this is to educate all Healthcare Providers on early prevention, recognition and treatment of Hospital Acquired Sepsis and to improve the uptake and utilization of tools for the healthcare teams to identify and treat hospital acquired sepsis and diagnose it early.

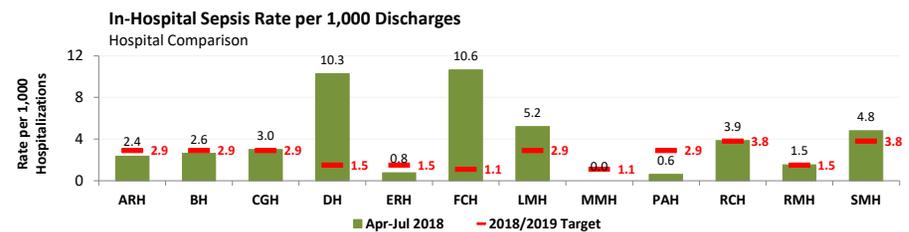
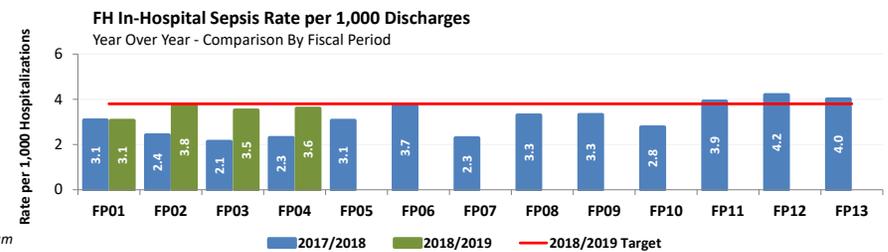
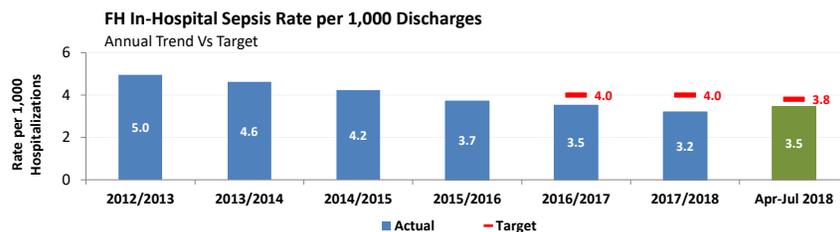
The Patient Safety and Sensitive Adverse Events core teams are available to sites to provide support and guidance related to action plan development to reduce hospital acquired sepsis. Successful action planning is focused on prevention, treatment, and behavioural changes. Accountabilities at all levels of leadership will support reducing hospital acquired sepsis rates by highlighting and sustaining best practices.

What can you do?

You are encouraged to get vaccinated against the flu, pneumonia, and any other infections that could lead to sepsis and practice good hygiene (e.g. handwashing, bathing regularly) especially while in the hospital. Tell your health care provider immediately if you have any of the following symptoms: fever, chills, rapid breathing and heart rate, rash, confusion, or disorientation. Together, we can help to reduce the risk of acquiring infection and sepsis during your hospital stay.

Our Performance	Target *
3.5 ●	≤ 3.8
Unit of Measure: Infections per 1,000 Discharges	
Performance timeline:	Apr-Jul 2018
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 devised 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

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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). This adverse event can occur when a patient is unintentionally harmed as a result of their care and treatment during their hospital stay.

Why?

Delirium is a medical emergency which contributes to deterioration of physical and cognitive functioning, decreased quality of life as well as increased costs of care and resource utilization by the health care system.¹ Literature indicates up to 56% of older adults experience delirium during their hospitalization.² Prevention, early recognition, and treatment of delirium are key to improved patient safety and care. □

¹ Foreman & Milisen, 2004 □

² Inouye, 2006

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.

How are we doing?

Fraser Health's current performance for in-hospital Acquired Delirium is 9.4, which is not meeting the target of 7.3. Six sites (Abbotsford Regional, Chilliwack General, Fraser Canyon, Mission Memorial, Peace Arch, and Ridge Meadows) are meeting their internal targets. We will continue to work with our sites and programs to promote early recognition of Delirium and identify high-risk patients.

What are we doing?

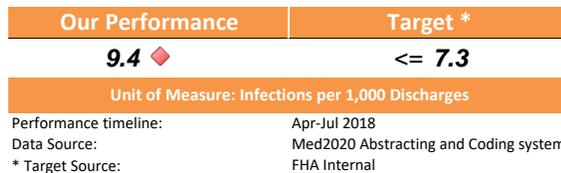
In-hospital acquired delirium is a Patient Safety Priority for Fraser Health and is monitored closely by clinical leaders at all 12 acute care sites. Site leadership continues to develop quality and safety-focused action plans that incorporate best practices to prevent care-sensitive adverse events, both at the patient care unit level and at an overall site perspective, focusing on prevention. The Patient Safety and Sensitive Adverse Events core teams are available to sites to provide support and guidance related to action plan development to reduce the in-hospital acquired pneumonia rate.

Fraser Health is focused on an interdisciplinary, multi-faceted approach for delirium. This includes: education; implementation and sustainment of the revised Delirium Pre-Printed Orders (PPO) and Clinical Practice Guidelines (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. Quality improvement efforts in delirium recognition and charting/coding are likely to result in an initial increase in the delirium prevalence data as we re-calibrate to the true prevalence.

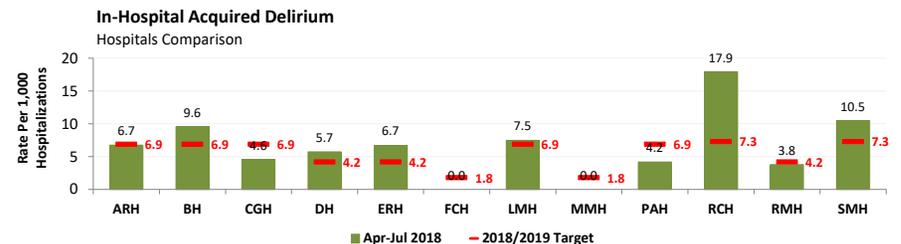
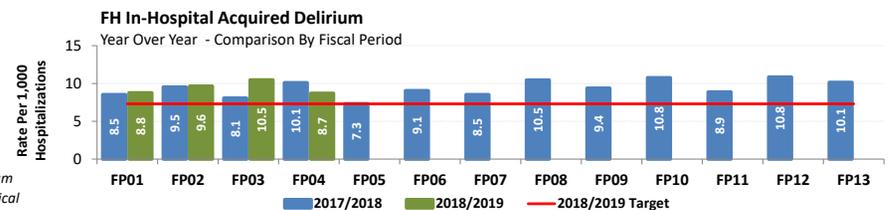
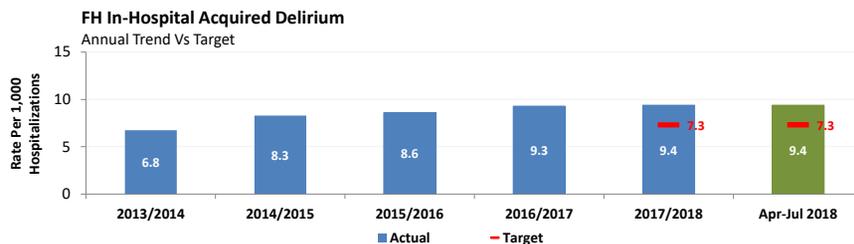
The Regional Steering Committee is also exploring opportunities for upstream identification of patients at increased risk of delirium; improved documentation/charting/coding; and enhancing delirium prevention and recognition in the community ("pre-admission").

What can you do?

As a family member, you know the person best. Please tell the staff if you see any unusual change in behaviours. Other ways you can help your family member include being supportive and consistently telling your loved one that this will pass; visit as regularly as possible and bring familiar items from home such as favourite music, pictures, and blanket; ensure that prescription glasses, hearing aid, and dentures are in good repair and used; and work with the hospital staff to establish a regular and consistent routine. For more information, see <https://www.fraserhealth.ca/health-topics-a-to-z/seniors/delirium>



Notes: Hospital specific targets were devised 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 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 current performance for hospital acquired non-aspiration pneumonia is 7.6, which is not meeting the target of 7.3. Four sites (Chilliwack General, Eagle Ridge, Fraser Canyon, 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 that impacts a patient's stay in our facilities.

What are we doing?

In-hospital acquired pneumonia 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. The Patient Safety and Sensitive Adverse Events core teams are available to sites to provide support and guidance related to action plan development to reduce the in-hospital acquired pneumonia rate. 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 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?

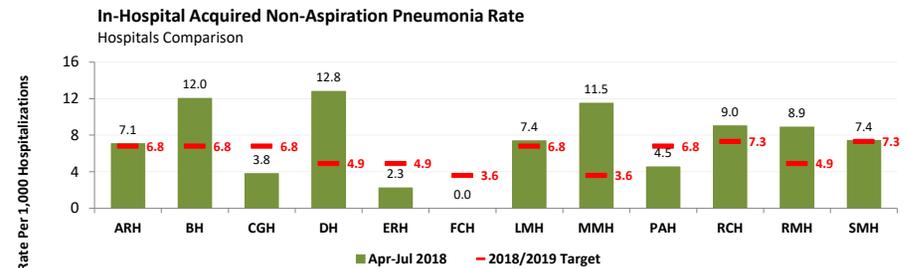
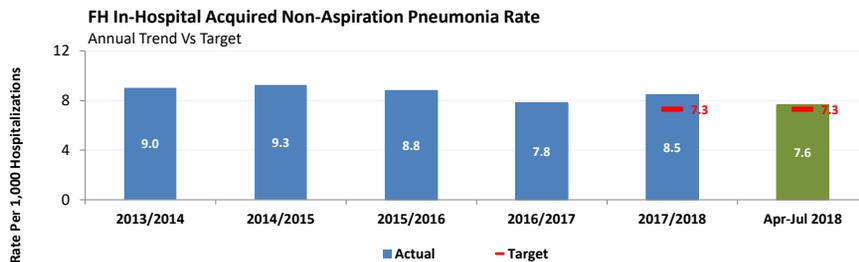
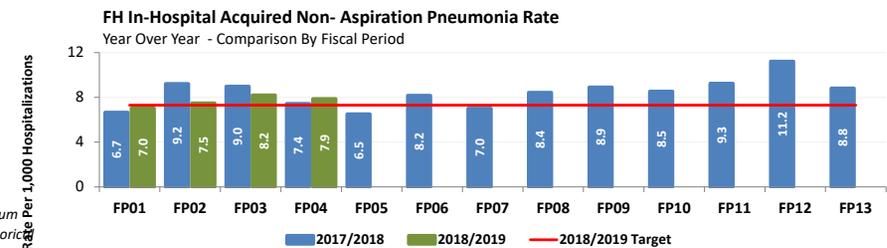
You are encouraged to take deep breaths and cough every hour to reduce the risk of acquiring pneumonia. Cleaning your hands frequently as well as cleaning your teeth in the morning, after each meal and at bedtime, aids in doing this. Together, we can help to reduce the risk of acquiring infection and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

Our Performance	Target *
7.6 ▲	<= 7.3

Unit of Measure: Infections per 1,000 Discharges

Performance timeline:	Apr-Jul 2018
Data Source:	Med2020 Abstracting and Coding system
* Target Source:	FHA Internal

Notes: Hospital specific targets were devised 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 (CHI), and each site's historical performance.



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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.

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 UTIs while in hospital, with a LOS \geq 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 current performance for in-hospital acquired UTI is 13.4, which is not meeting the target of 10.0. One site (Surrey Memorial) is meeting their internal targets. We will continue to work with our sites and programs that have opportunities to reduce this infection that impacts a patient's stay in our facilities.

What are we doing?

In-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, focusing on prevention. The Patient Safety and Sensitive Adverse Events core teams are available to sites to provide support and guidance related to action plan development to reduce the rate of in-hospital acquired urinary tract infections.

Appropriate preventative therapeutic measures, along with evidence-informed practice (reduced urinary catheter days, frequent ambulation and toileting, 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 their 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.

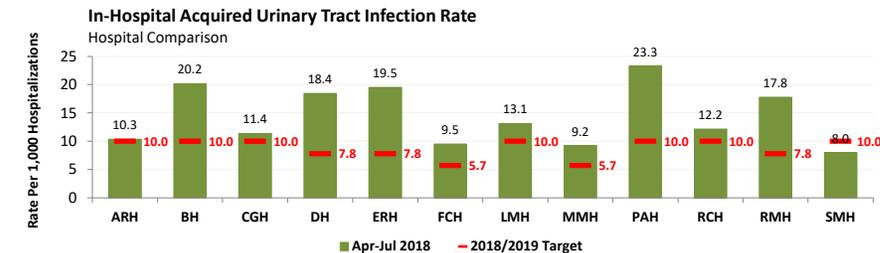
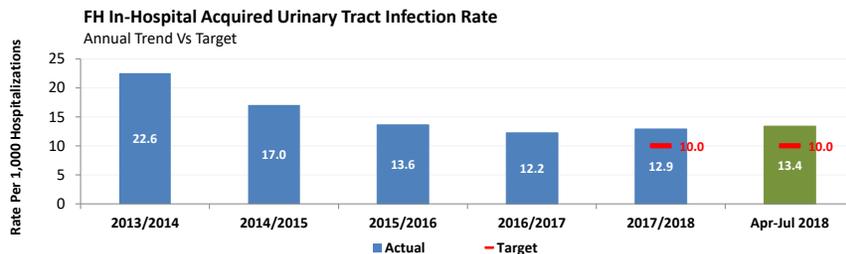
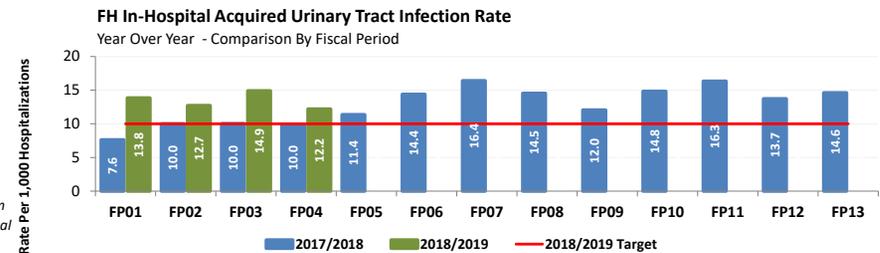
What can you do?

It is important to 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 *
13.4 ◆	\leq 10.0
Unit of Measure: Infections per 1,000 Discharges	

Performance timeline: Apr-Jul 2018
 Data Source: Med2020 Abstracting and Coding system
 * Target Source: FHA Internal

Notes: Hospital specific targets were devised 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, 201819 - Ending Oct 18, 2018

Hospital Standardized Mortality Ratio

What are the mortality rates at Fraser Health hospitals?

NEW TARGET

What are we measuring?

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

How are we doing?

Our current year to date rate of 87.8 is not meeting the target. There are six hospitals, Abbotsford Regional, Chilliwack, Fraser Canyon, Royal Columbian, Ridge Meadows, and Surrey Memorial which are not 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?

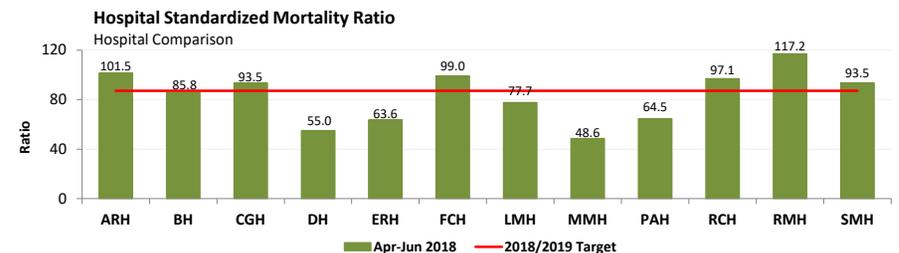
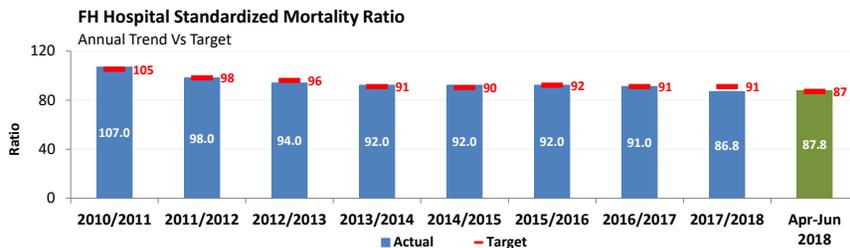
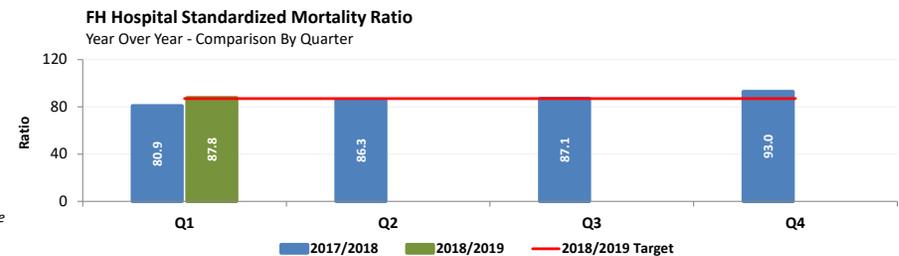
We have identified areas for improving care for patients whose condition unexpectedly worsens. We are beginning to see results at sites as their Hospital Mortality rates are beginning to decrease. Early recognition and rapid response to sudden worsening of a patient's condition is a key area of focus to reduce Hospital Standardized Mortality Rates. An area that we are focusing on is Hospital Acquired Sepsis, with enhanced training and education and resources for nurses and physicians. Best practice includes communication of critical patient information between healthcare team members, early identification of patient clinical indicators that are signs and symptoms for further investigation, and ensuring interventions are clear for the nurses and physicians.

How do we measure it?

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

Our Performance	Target *
87.8 ▲	<= 87
Unit of Measure: Hospital Mortality Ratio	
Performance timeline:	Apr-Jun 2018
Data Source:	Canadian Institute for Health Information (CIHI)
* Target Source:	FHA Internal
BC Average (2017/18)	87
BC Average Source:	CIHI - Your Health System

Notes: 1) From Oct 2015, Fraser Health is using a recalculated series from CIHI. The new recalculated series tracks FH performance compared to the national average in 2012/13, as opposed to the 2009/10 baseline used in previous reports.
2) The target was adjusted to reflect BC average for the corresponding year



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

Worsened Pressure Ulcer in Residential Care Facilities

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

What are we measuring?

This indicator measures the percentage of residential 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 Residential 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 2018/19 YTD performance of 1.5% meets our internal-set target of $\leq 2.0\%$. At the community-level, the aggregate facility performance of one Fraser Health community (Chilliwack) has an incidence rate higher than 2%. It is important to note that residents are moving in to residential complex care home later in their journey of life at higher levels of frailty than before. It has been regularly discussed in the literature that age is an important factor associated with a higher risk for developing Pressure Ulcer and therefore they are at higher risk of having or developing pressure ulcers in care. We are taking the steps below to reduce these risks for our residents.

What are we doing?

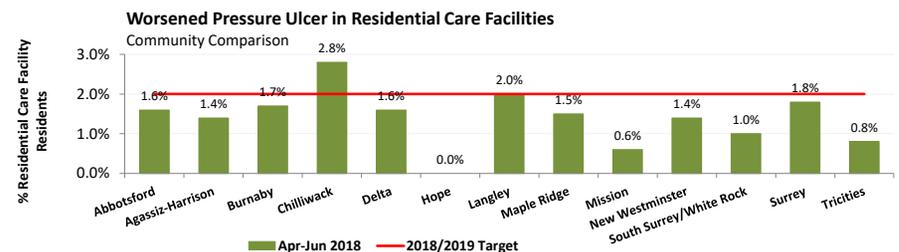
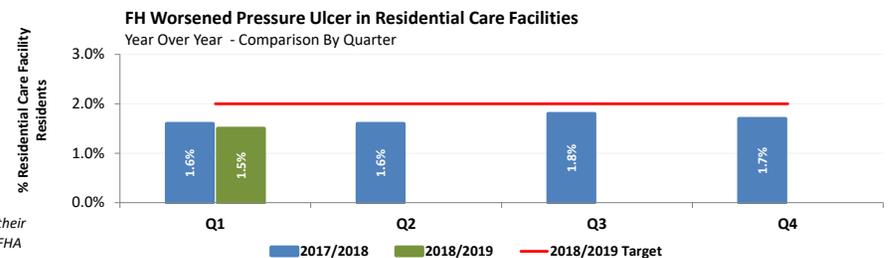
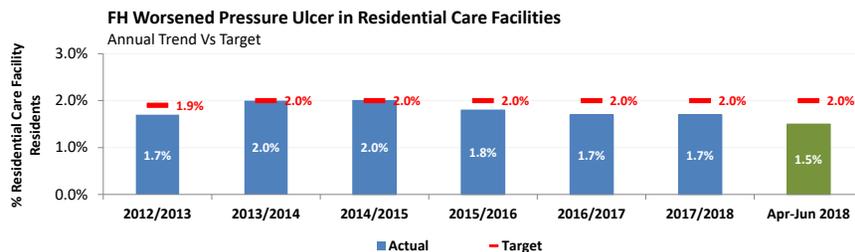
All residential complex care providers are familiar with the care required by this frail population and responsible to ensure that high quality care occurs. Beginning in 2016/17, each residential care home now receives on a quarterly basis a quality indicators report that includes percent of residents who had stage 2-4 pressure ulcers. These Quarterly quality indicators report support care homes' monitoring the prevalence of pressure ulcer and associated quality improvement activities. In addition, the Residential Care Clinical Practice Support Team has hosted two year long wound care collaboratives (in 17/18 and 18/19) whereby almost 40 care homes joined together to learn how to better prevent, monitor, and treat pressure ulcers; and to enhance resident's quality of life.

What can you do?

As always, family members are an important part of residential care team. If you have a loved one who resides in a residential 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 *
1.5% ●	$\leq 2.0\%$
Unit of Measure: Percent of residential care clients	
Performance timeline:	Apr-Jun 2018
Data Source:	FHA Database (RAI compliance table)
* Target Source:	FHA Internal
BC Average (2016/17)	2.0%
BC Average Source:	CIHI - Your Health System

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, 201819 - Ending Oct 18, 2018

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's current performance of 34.4% is not meeting our target. Of our 12 hospitals, three are meeting their target (Burnaby, Eagle Ridge and Mission Memorial). We will continue to work with our sites and programs to reduce acute care and emergency department congestion.

What are we doing?

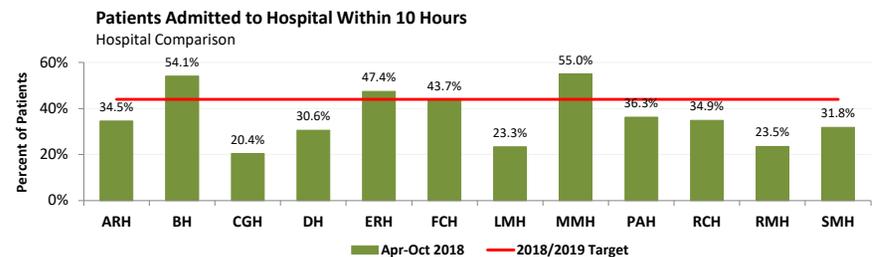
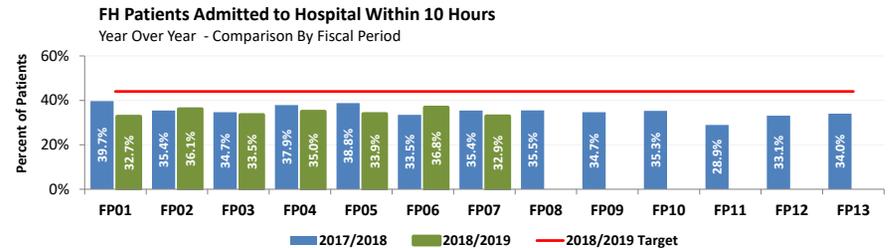
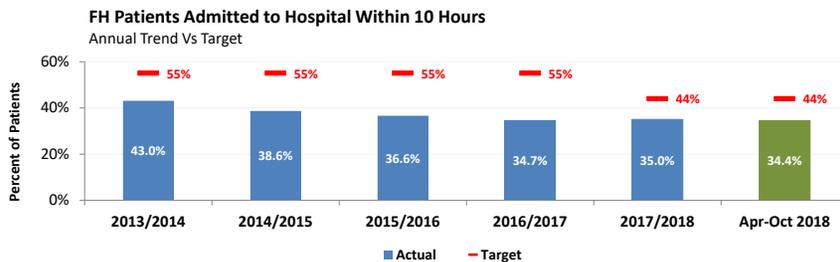
Emergency Patients Admitted to Hospital within 10 hours is a Patient Safety Priority for Fraser Health and is monitored closely by clinical leaders at all 12 acute care sites. Site leadership continues to develop quality and safety-focused action plans that incorporate best practices to ensure that you receive your care in the right place at the right time. We are monitoring our transfer processes and have identified opportunities for improvement. The largest opportunities to ensure performance of this indicator is effective care and discharge planning to help us provide quality care for our patients. Core components of care and discharge planning in our hospitals include screening and care planning (48/6), 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 the quality of life while reducing disparities in health and the impact these conditions have on individuals, families, communities, and the health-care system.

Our Performance	Target *
34.4% ◆	>= 44.0%
Unit of Measure: Percent of patients admitted within 10 hours	
Performance timeline: Apr-Oct 2018	
Data Source: NACRS as measured by FHA	
* Target Source: FHA Internal	
BC Average (2016/17): 44.0%	
BC Average Source: MOH Measurement SharePoint	

Notes: Target is set to BC average for 2016/17



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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 safety and quality of care risks. Moving admitted patients quickly out of the Emergency Department (ED) also allows our ED teams to respond to patients who require emergency care.

How do we measure it?

Every day at 2pm, we count the number of inpatients in our hospitals that are in locations that are not typically designated for clinical care (including Emergency Departments). We then take the average for all days for the reporting period.

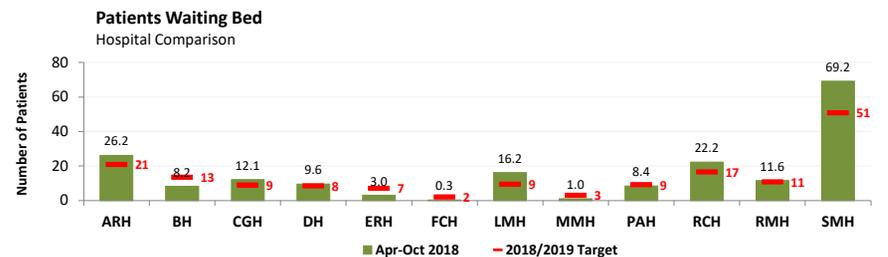
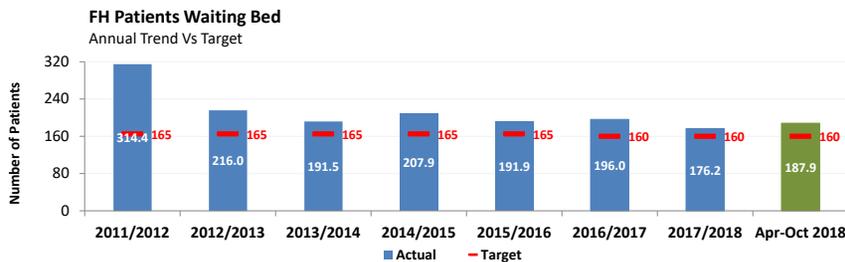
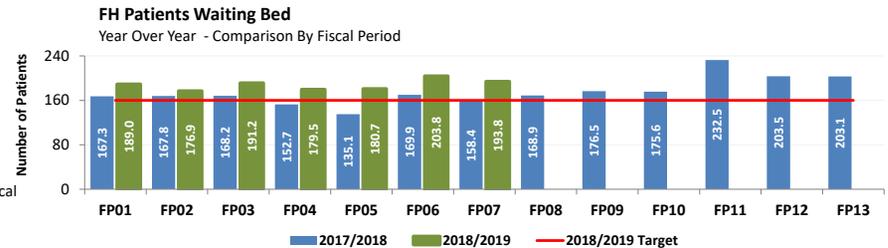
How are we doing?

Fraser Health's year to date 2018/19 performance was 187.9 which does not meet the internally-set target of 160.0. The year over year chart shows more patients are waiting for an inpatient beds in the first seven fiscal periods of this year compared to the same periods in the previous year. At the hospital-level, five of our hospitals (Burnaby, Eagle Ridge, Fraser Canyon, Mission and Peace Arch) are meeting their targets with Ridge Meadows almost there. The remaining hospitals are working hard to achieve their targets.

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. We have recently refined our initiatives in these areas to continue pursuing improvements and we are carefully monitoring performance.

Our Performance	Target *
187.9 ◆	<= 160
Unit of Measure: Number of patients waiting for inpatient bed	
Performance timeline: Data Source:	Apr-Oct 2018 Meditech Client Server (Admissions), Master Bed Map spreadsheet (Clinical Capacity Optimization and Finance) FHA Internal
* Target Source:	



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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.

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.

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.

How are we doing?

Fraser Health patients' actual length of stay relative to expected length of stay is not meeting our internal target. Three of our hospitals are meeting the target for this indicator (Fraser Canyon, Peace Arch, and Royal Columbian). During this time, nine of our hospitals (Abbotsford, Burnaby, Chilliwack, Delta, Eagle Ridge, Langley Memorial, Mission Memorial, Ridge Meadows, and Surrey Memorial) had opportunities to improve their performance.

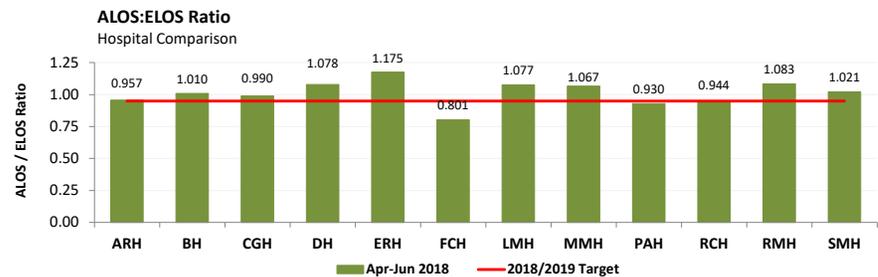
What are we doing?

Effective Care & 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 include screening and care planning, 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 improvement projects ongoing for the key elements of this performance indicator.

What can you do?

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

Our Performance	Target *
1.011 ▲	<= 0.95
Unit of Measure: Ratio of Actual to Expected Length of Stay	
Performance timeline: Apr-Jun 2018	MOH Measurement SharePoint
Data Source: FHA Internal	FHA Internal
* Target Source:	



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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.

Why?

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

How do we measure it?

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

How are we doing?

At 439.7, the year to date average number of long-stay patients is meeting Fraser Health's internal target of 455. The year-over-year chart shows our hospitals cared for more long stay patients in the first seven fiscal periods of this year compared to the same periods last year. We look to improve and sustain our performance to ensure that patients are receiving the right level of care at the right time in their health care journey.

What are we doing?

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

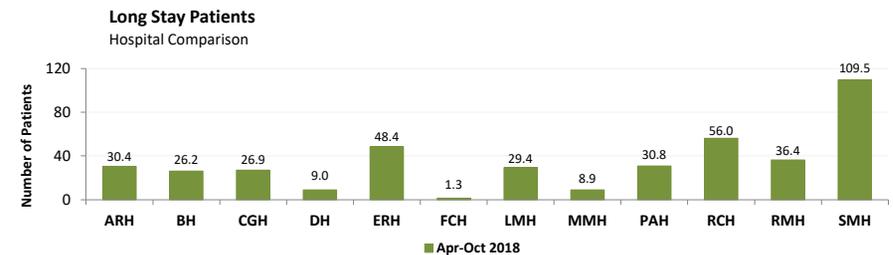
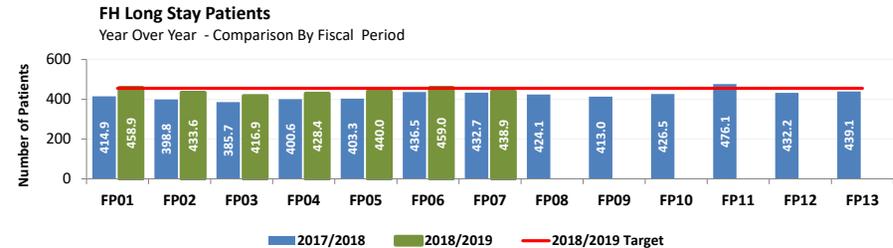
What can you do?

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

Our Performance	Target *
439.7 ●	<= 455
Unit of Measure: Number of patients staying longer than 30 days	

Performance timeline: Apr-Oct 2018
 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, 201819 - Ending Oct 18, 2018

Alternate Level of Care Days

How many "extra" days do patients spend in hospital?

What are we measuring?

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

Why?

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

How do we measure it?

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

How are we doing?

Fraser Health's current performance of 14.0% is not meeting the target for this indicator. Two hospitals are meeting the target (Abbotsford and Royal Columbian), while our other 10 hospitals are above target.

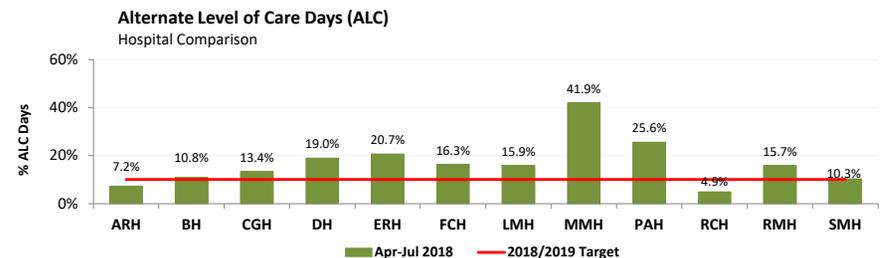
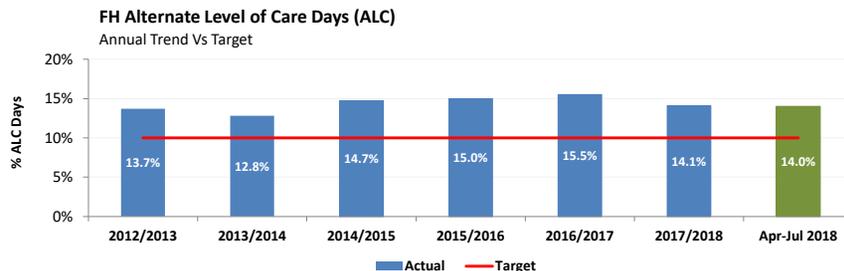
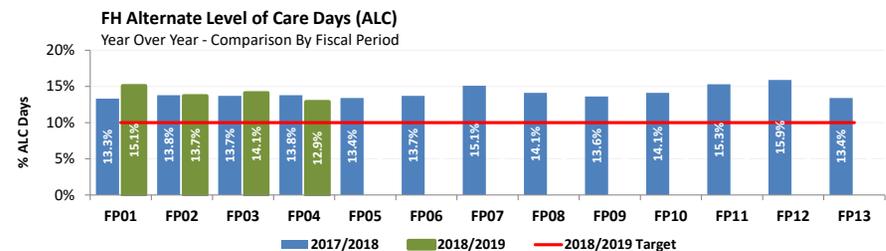
What are we doing?

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 residential care beds. In April 2015, 35 new residential care beds were added in Burnaby. In 2016, a total of 403 new residential care beds were added across White Rock, Surrey and the Tri-Cities. 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 residential care through the Home First initiative. Home Health nurses are contacting patients after hospital discharge to identify any unmet needs. Home Health has many initiatives underway to optimize capacity of resources to increase supports at home. For those patients and families that need inpatient service, we have refreshed our Care and Discharge planning framework to ensure that we are working with patients and families early in their care to identify concerns that could delay a transition to home or other recovery location.

What can you do?

Collaborate with your health care team in care and discharge planning to establish a safe and appropriate transition to home or other recovery location, including access to appropriate community resources.

Our Performance	Target *
14.0% ◆	<= 10.0%
Unit of Measure: Percent of ALC days to total days	
Performance timeline: Apr-Jul 2018	Apr-Jul 2018
Data Source: Med2020 Abstracting and Coding System	Med2020 Abstracting and Coding System
* Target Source: FHA Internal	FHA Internal



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

Hospitalization Rates for Residents (Age 70+)

How many seniors in our region have been hospitalized?

NEW TARGET

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 six years. However, with a regional rate of 260.6, we have not yet achieved the targeted rate of 257.7 hospitalizations per 1,000 seniors. Five communities, Agassiz-Harrison, Burnaby, Langley, South Surrey/White Rock, and the Tri-cities are at a level better than the target. Rates are trending in a positive direction in all but two of our communities (Agassiz/Harrison and Mission).

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

What can you do?

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

Our Performance	Target *
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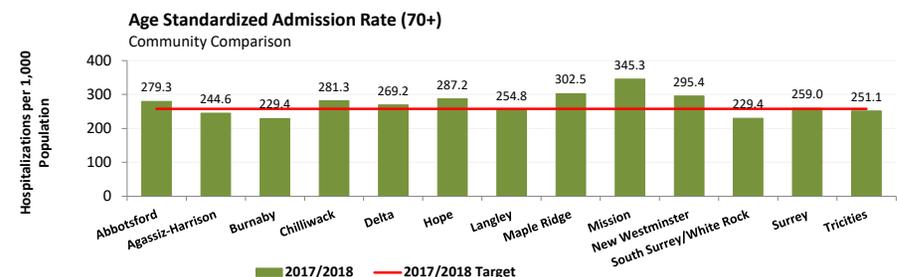
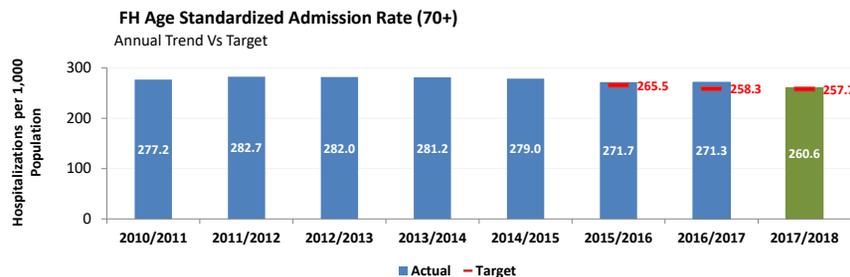
260.6 ▲

<= 257.7

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

Performance timeline:	2017/2018
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. 2017);
2) In late 2016, MOH changed the calculation methodology for standardization by using Census 2011 instead of Census 1991. Previous numbers have been restated and target has been adjusted accordingly.



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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.

Why?

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

How do we measure it?

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

How are we doing?

Fraser Health's hospital readmission rate is not meeting our internal target of 10%. We performed near the B.C. average for this indicator. Two of our communities are meeting our internal targets (Langley and Tricities). There are several of our communities that have the opportunity to improve on this indicator (Abbotsford, Agassiz-Harrison, Burnaby, Chilliwack, Delta, Hope, Maple Ridge, Mission, New Westminster, South Surrey White Rock, and Surrey).

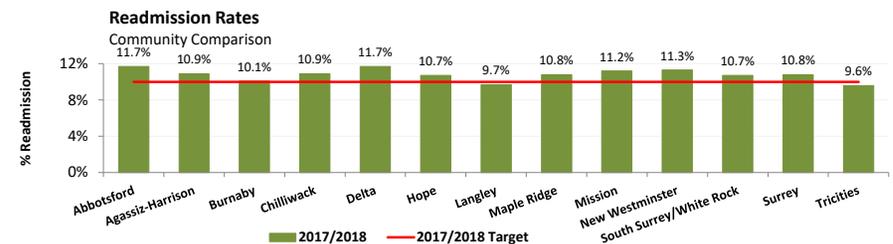
What are we doing?

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.

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 *
10.7% ▲	<= 10.0%
Unit of Measure: Percent of patients readmitted	
Performance timeline:	2017/2018
Data Source:	MOH Measurement SharePoint
* Target Source:	FHA Internal
BC Average (2014/15)	10.8%
BC Average Source:	MOH Measurement SharePoint



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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.

How are we doing?

The readmission rate for MHSU in Q4 of 2017/18 is 11.1%; this is a significant reduction from the 13.5% readmission rate in Q3 and Q2 of 2017/18, and from the 13.9% readmission rate in Q1 of 2017/18. This is also a significant reduction for the same quarter in 2016/17 (12.4%). Although the overall readmission rate for 2017/18 (13.2%) does not meet the target for 2017/18 (12.0%), it is a reduction from the readmission rate in 2016/17 (13.5%). Readmission rate in Q4 2017/18 is also a record low compared to the previous seven quarters (13.5%, 13.5%, 13.9%, 12.4%, 13.7%, 14.4%, and 13.1% respectively). When comparing readmission rate for 2017/18 among Fraser Health communities, there is huge variation, ranging from 5.3% in Agassiz-Harrison to 16.6% in Abbotsford. During 2017/18, nine out of 13 Fraser Health communities did not meet the 12.0% target, ranging from rates of 13.0% in both Burnaby and Surrey to 16.6% in Abbotsford. Four communities met the readmission rate target, with rates ranging from 5.3% in Agassiz-Harrison to 10.3% in Langley and Maple Ridge.

What are we doing?

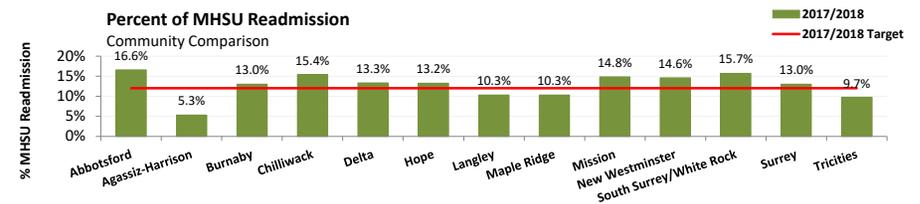
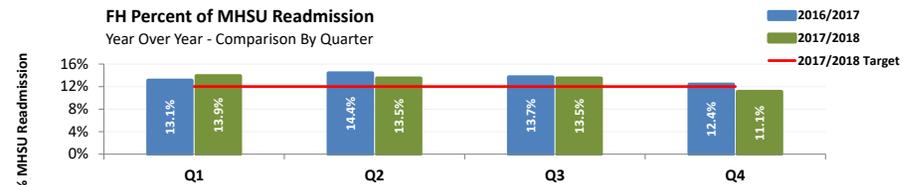
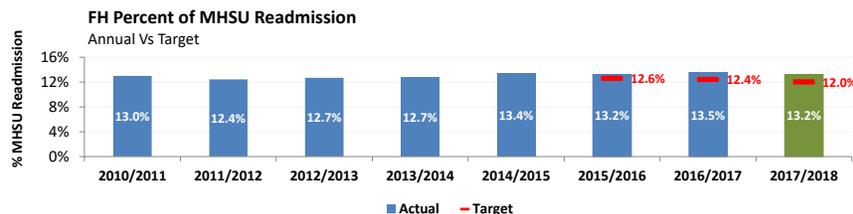
MHSU has recently established a team of substance use clinicians and staff to support, coordinate, and facilitate access to Substance Use Services. The team also proactively follows up with patients who present to hospitals with overdose, with the goal of engaging them in treatment and reducing the danger of further overdose and readmission. MHSU is also in the process of establishing an Urgent Care Response Centre (UCRC) in Surrey to provide central access for adults with mental health and substance use concerns, including those with opioid use disorder. The UCRC will open in July 2019 and will provide low-barrier and timely access to assessment, initiation of treatment, and connection to appropriate services. The extended hours of service will reduce wait-times for MHSU services and should result in decreased readmission rates. Other initiatives, such as Integrated Transition of Care Teams (ITCT) focus on timely follow-up with clients discharged from acute services. This appears to reduce readmission rates at three of FHA's regional hospitals that provide coverage to six communities. MHSU has also established three Intensive Case Management (ICM) teams (in Maple Ridge, Langley, and Surrey) and is expanding to having teams in Chilliwack. ICM serves vulnerable clients who are living with serious addictions and other comorbidities, and who are homeless or at risk of homelessness. Among other initiatives, it is expected that this service will also reduce acute readmission rates for this at-risk group. 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. The MHSU Dashboard includes 14 indicators, enabling physicians and administration leaders to review acute, community and tertiary sites and take necessary actions for improvement. One indicator measuring readmission rates monitors FH hospitals to ensure quality improvement initiatives result in reduced hospital readmission rates.

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 Performance	Target *
13.2% ◆	<= 12.0%
Unit of Measure: Percent of patients readmitted	
Performance timeline:	2017/2018
Data Source:	MOH Measurement SharePoint
* Target Source:	BC Ministry of Health
MOH 2017/18 Target for FHA	12.0%
BC Average (2017/18)	14.4%
BC Average and MOH Target Source:	MOH Measurement SharePoint

Notes: The annual FHA targets proposed by MOH for this metric are 12.6% for FY 2015/16, 12.4% for FY 2016/17 and 12% for FY 2017/18. The annual BC targets proposed for provincial average are 13.8%, 13.0%, and 12.0% for FY 2015/16 to FY 2017/18.



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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.

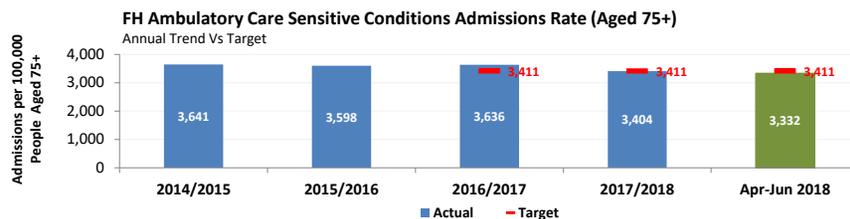
How do we measure it?

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.

Our Performance	Target *
3,332 ●	≤ 3,411
Unit of Measure: Number of patients admitted / 100,000 Population	

Performance timeline: Apr-Jun 2018
 Data Source: MOH Measurement SharePoint
 * Target Source: BC Ministry of Health

- Notes:**
- 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. 2018);
 - FY2015/16 target is based on MOH Service Plan for 2015/16-2017/18; FY2016/17 target is based on MOH Service Plan for 2016/17-2018/19.
 - Previously reported data has been restated based on new MOH report



How are we doing?

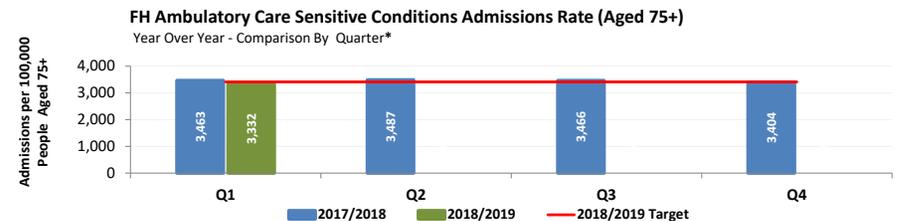
Fraser Health's performance has remained relatively stable the past several years. The 2018/19 Q1 admission rate of 3,332 is below our target of 3,411. Of the FHA communities, 7 (Agassiz-Harrison, Burnaby, Chilliwack, Langley, New Westminster, South Surrey/White Rock, and Tricities) are meeting target. We continue to examine opportunities to improve.

What are we doing?

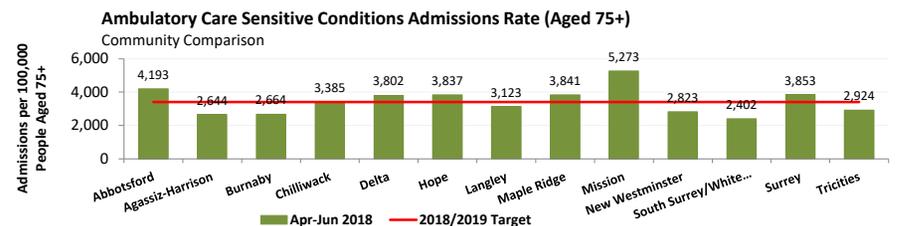
Fraser Health (FH) working in partnership with Family Physicians and the Divisions of Family Practice (DOFP) to examine opportunities to make systematic changes in how health care is delivered. This work has a specific emphasis on improving access to care for seniors, as well as individuals with medical complexity, which includes chronic disease management. New initiatives are being locally planned and implemented to ensure the needs of the local population are being addressed. All communities within FH have now commenced initiatives that aim to optimize access to primary and community care services. Services like the "CARES initiative" are gaining momentum. CARES aims to prevent or defer frailty and the associated health complexities; working in collaboration with the Family Physician individuals are identified as being susceptible to becoming frail and subsequently benefit from the program. Of note, the opening of FH's first Urgent Primary Care Centre (UPCC) in Surrey will deliver faster access to primary care and reduce the need for emergency department visits. Additional UPCC's are planned for other communities in Fraser Health over the next 3-years. Other initiatives are in progress throughout the region to support home health monitoring for patients with Heart Failure, COPD, and palliative care - with the goal to improve patient self-management and reduce exacerbations requiring emergency or acute care

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.



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



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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?

Overall performance continues to trend in the wrong direction and with an overall year-to-date rate of 111.4 low acuity emergency visits per 1,000 population, we did not meet the targeted rate of 102.7 or lower.

Performance varies greatly from community to community, with four communities achieving target (Burnaby, Langley, New Westminster, and Tri-cities). In general, communities in the east have rates much worse than target, with Hope, Chilliwack, Agassiz/Harrison, Mission, and Maple Ridge far exceeding target.

What are we doing?

We are working with our divisions of family practice to ensure that all individuals that want a family doctor have access to these services. Each community as part of the transition to community work is reviewing these data monthly to determine where more effective partnerships need to be built to ensure that patients have access to quick response appointments with general practitioners

What can you do?

Continue to work with your family doctor or nurse practitioner to determine how to meet your healthcare needs. If in doubt if you need to go to the emergency department, call 811 to speak with a healthcare professional.

Our Performance	Target *
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111.4 ▲

≤ 102.7

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

Performance timeline:
Data Source:

Apr-Oct 2018
Amcare and Meditech for the numerator and
P.E.O.P.L.E.2015 (BC Stats) for the denominator
FHA Internal

* Target Source:

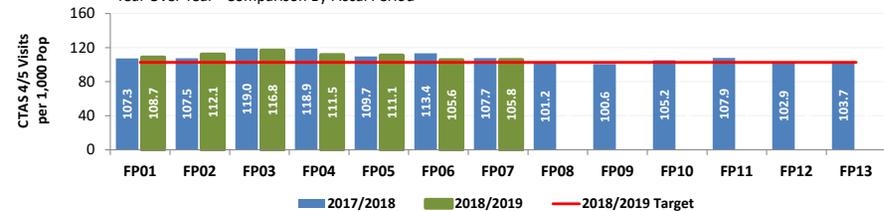
Notes: Target is set to 5% improvement from 2017/18.

FH Low Acuity Emergency Visits by Community
Annual Trend Vs Target



FH Low Acuity Emergency Visits by Community

Year Over Year - Comparison By Fiscal Period



Low Acuity Emergency Visits by Community
Community Comparison



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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.

Why?

Time 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.

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.

How are we doing?

With a year-to-date rate of 46.5%, overall performance continues to fall short of the targeted rate of having at least 50% of Home Health services provided within benchmark time. While trending in a positive direction year-over-year, period 7 saw a drop compared to period 6.

However, five communities successfully met the target; Burnaby, South Delta, Abbotsford, Maple Ridge/Pitt Meadows, and Langley each having more than 50% of Home Health services provided within benchmark.

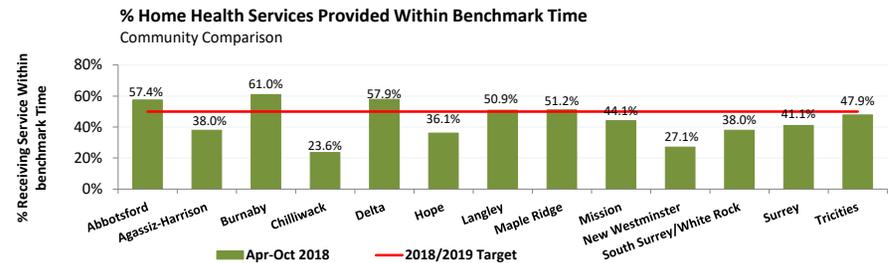
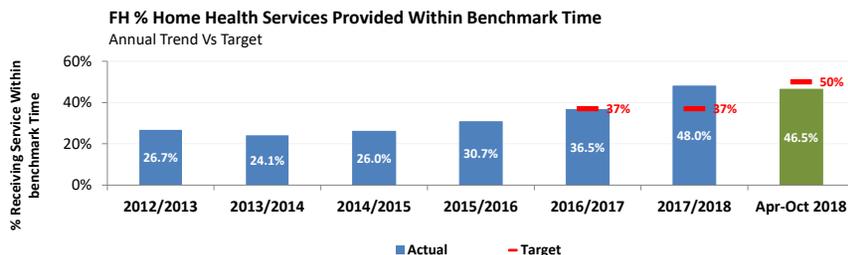
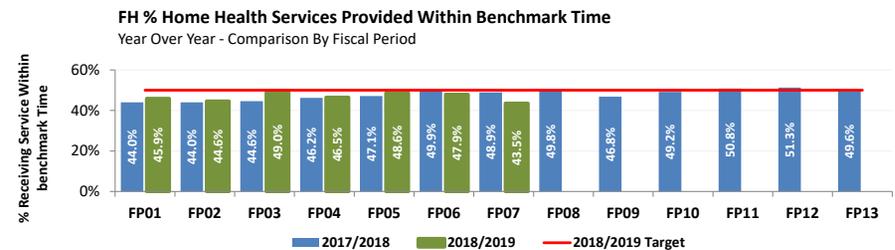
What are we doing?

Further work is being done to understand the information and to determine the reasons that these benchmarks are not being met. The communities will then be using this information to target their improvement efforts. A review of trends over the next 3 months will be completed by the home health network with the goal of process improvement to enable all areas to reach their targets. Areas with better performance will be evaluated to determine what the causal factors are so we can implement these strategies across the broader network.

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 the home health service line to ensure your contact information is up to date and you are connected with your local home health office.

Our Performance	Target *
46.5% ▲	>= 50.0%
Unit of Measure: Percent of Services provided within benchmark	
Performance timeline: Apr-Oct 2018	
Data Source: PARIS System	
* Target Source: FHA Internal	



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

Wait Time for Home Health Assessment

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 referred to the case management program. The first RAI-HC is assumed to occur at the first home visit by a community care professional.

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.

How do we measure it?

We take the sum of the wait times of every client who is visited by a case manager in a given period and divide by the number of those clients.

How are we doing?

With an average wait of 38.8 days for Home Health assessment as of period 7, we have not yet achieved the targeted average wait time of 38.2 days or less. Performance is trending in the wrong direction overall, but several communities are seeing positive trends.

Year-to-date, average wait times were longest in the communities of New Westminster, Tri-cities, Maple Ridge/Pitt Meadows, Burnaby and South Surrey/White Rock, with each seeing wait times longer than the target.

What are we doing?

Communities will be measuring this target and reviewing caseloads with their community care professionals to understand the reported delays and will work to reduce wait time for these assessment services. Multiple strategies are being employed by different communities and these are being reviewed at the home health network to determine most effective strategies to support these assessments being done within the benchmark timelines.

What can you do?

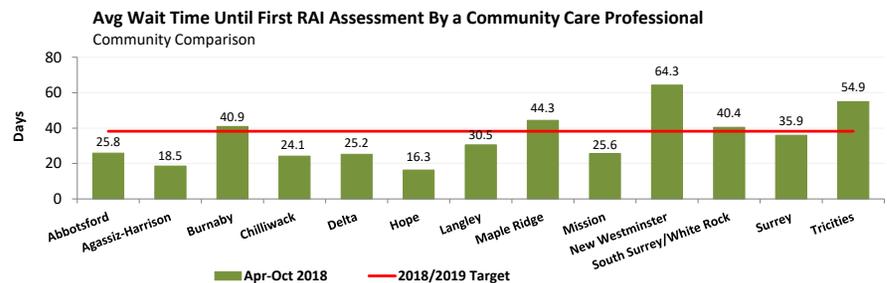
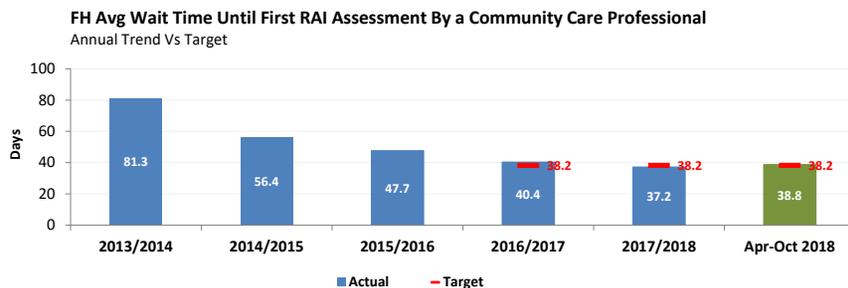
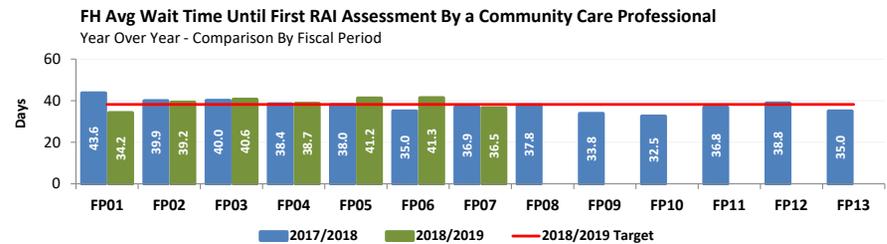
If you have not been contacted by your local home health office to update your assessments or schedule the services you expect please call the home health service line to ensure your contact information is up to date and you are connected with your local home health office.

Our Performance	Target *
38.8 ▲	<= 38.2

Unit of Measure: Number of days clients waiting for Assessment

Performance timeline: Apr-Oct 2018
 Data Source: PARIS System
 * Target Source: FHA Internal

Notes: 1. Target is set to 20% reduction from previous year for the first year of measurement to demonstrate a significant decrease in delays of patients waiting for service in the community



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

Admissions to Residential Care within 30 Days

What percent of residential care (RC) clients are admitted within 30 days of being assessed and approved for services?

What are we measuring?

Percentage of new residential care clients admitted to a facility within 30 days of being assessed and approved for services.

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 residential 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.

How do we measure it?

We take the number of clients placed in residential 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 residential care services (including temp beds and ACMD) on their dates of acceptance. Communities are grouped based on admission locations, not sending (referral) locations.

How are we doing?

Fraser Health's year to date performance of 78.3% meets our internally set target (75.0%), a decline from the last period. Five of the communities are achieving the target with 3 communities (Chilliwack, Hope and Tricities) being a little short of target at about 70% and five communities (Abbotsford, Agassiz-Harrison, Maple Ridge, Langley, Mission) falling considerably short. In most communities we continue to see unexpected volume of referrals along with a low volume of vacancies which is impacting performance in a number of communities. This may be a reflection of the organizational changes in some communities with restructuring of community services; as well as the demands of a growing, older population.

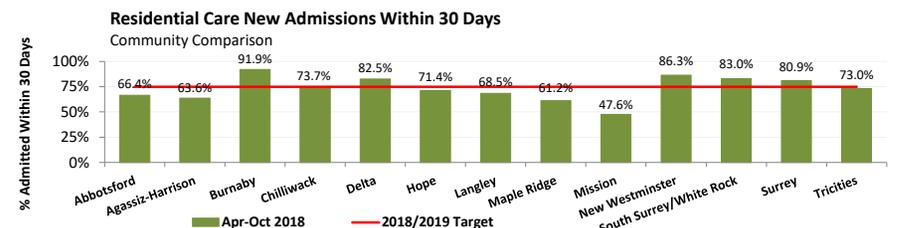
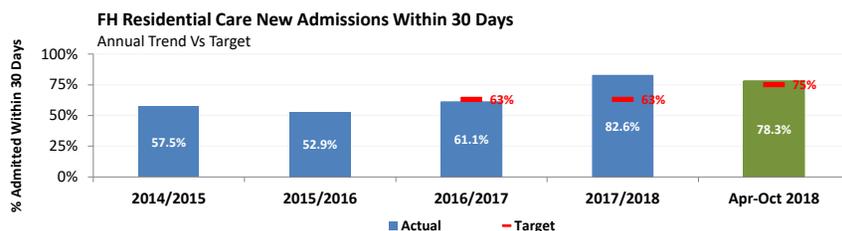
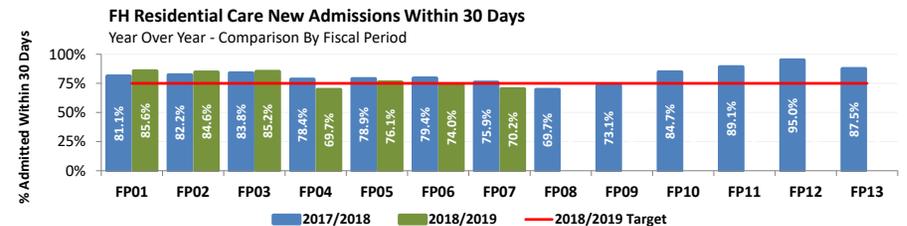
What are we doing?

FH continues to focus on improving primary & community care service delivery for the frail seniors population in order to better support frail seniors to live in their own homes where they want to be. Last fiscal year (17/18) FH Residential Care Services, Home Health and Acute Care Services implemented redesigned collaborative processes that review individuals put forward for residential care and identify those whose care needs can be met at home or in the community with different resources. When followed, this ensures that residential long term care beds are available in a more timely manner to those individuals whose care needs can only be met in residential care, and ensures that individuals who want to remain at home are supported to do so.

What can you do?

If you are a healthy senior, consider making choices now to keep yourself healthy and to work with your personal support networks to make it easier for them to assist you if and when frailty develops. Consider moving to a physical environment which can support you as your mobility decreases; one which will also provide you with a social outlet without having to travel far and keep connected with your family and friends. Set up your finances so bills are automatically paid, and you have funds available for mobility aids and a regular housekeeper. The right built environment, with some financial resources can allow you to remain confidently in your own home for the rest of your life journey. Less than 1 of 10 adults over 75 require long term residential care; most are able to remain in the community, in their own home, or within a type of congregated/supportive housing arrangement.

Our Performance	Target *
78.3% ●	>= 75%
Unit of Measure: Percent of clients admitted within 30 days	
Performance timeline:	Apr-Oct 2018
Data Source:	Strata Health Pathway
* Target Source:	FHA Internal
BC Average (2016/17)	61%
BC Average Source:	MOH Measurement SharePoint



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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?

So far this fiscal year, Fraser Health has seen 95.8 unplanned emergency visits for every 100 Home Health clients, which misses the targeted rate of 75.8 per 100 Home Health clients. We are trending higher than the same quarter last year, but given the long-term nature of this indicator, mitigation strategies will take time to reduce this rate.

While none of our communities have yet managed to meet the target, Chilliwack, Agassiz/Harrison, New Westminster, and Tri-cities have shown modest improvement over the last four quarters.

What are we doing?

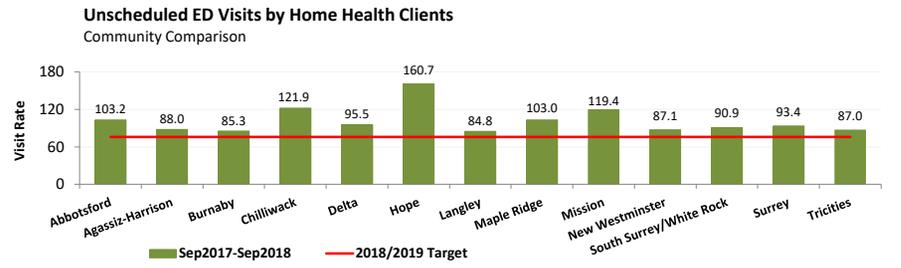
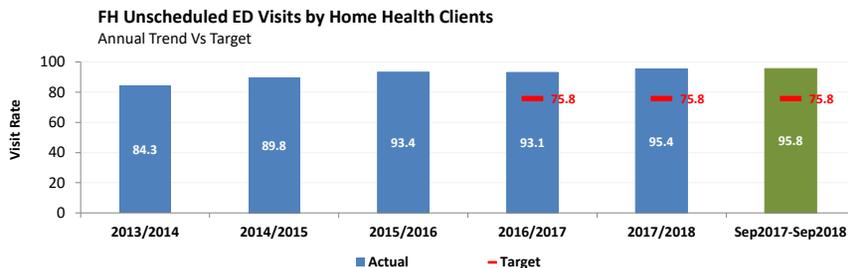
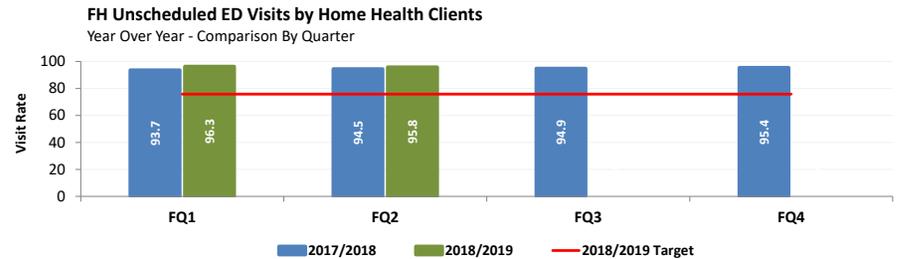
The reasons for these visits are being further explored to determine if there is more that home health services can do to assist people in not needing to go to hospital. Sometimes it is necessary to visit the emergency department, however we would like to better understand when it may not be needed and how to better respond to needs in the community.

What can you do?

If you are receiving Home Health services, please connect with your home health office or case manager to determine what community services are available to keep you healthy and well at home.

Our Performance	Target *
95.8 ◆	<= 75.8
Unit of Measure: Number of ER visits / 100 Home Health Clients	
Performance timeline:	Sep2017-Sep2018
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, 201819 - Ending Oct 18, 2018

Emergency Visits by Residential Care Clients

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

What are we measuring?

This indicator measures the total number of unscheduled visits made by Residential Care clients to Fraser Health emergency departments, as a proportion of the total number of Residential 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?

Residential 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 Residential 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 residential 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 Residential Care clients in a given period and divide by the average number of clients who were receiving Residential 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?

Fraser Health demonstrated a noticeable improvement in 2017/18 over the previous 4 years. The 2018/19 Q2 rate of 49.2 is close to a 10% improvement compared to the same quarter in the previous year, though we continue to work towards meeting our target of rate 30.0.

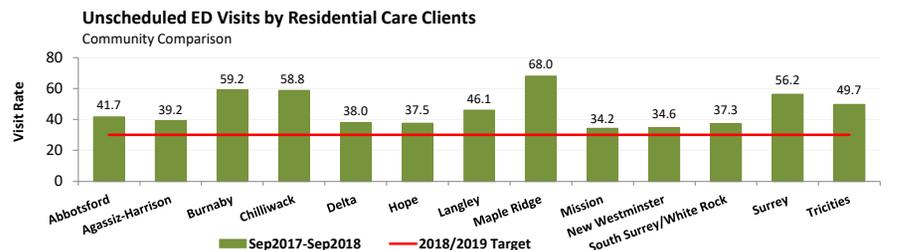
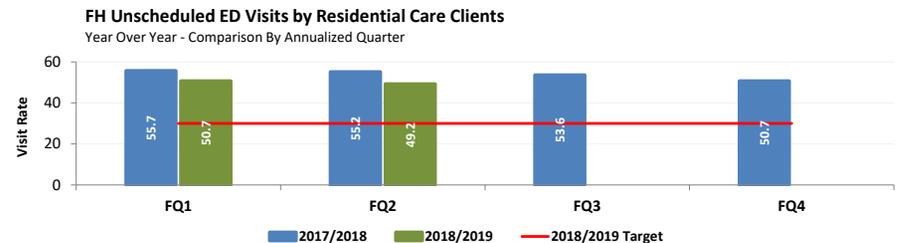
What are we doing?

The Residential Care Initiatives of the Family Practice Divisions have been initiated in all 10 communities in FH. This initiative is in early stages but provides funding for physicians to ensure 5 best practices for primary care are met for residents - including timely access to a physician when needed. As this initiative matures, we expect to see continued increased, proactive, on-site involvement by physicians at care facilities along with focussed on-call support which will have a positive impact on this measure. FH Residential Care Services is completing a 2 year initiative (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. This approach is being spread across all Fraser health care homes by March 2019. 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 *
49.2 ◆	<= 30.0
Unit of Measure: Number of ER visits/100 residential care clients	
Performance timeline: Sep2017-Sep2018	Sep2017-Sep2018
Data Source: PARIS System, Meditech and NACRS	PARIS System, Meditech and NACRS
* Target Source: FHA Internal	FHA Internal



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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.

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.

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.

How are we doing?

In the most recent month the proportion of non-emergency surgeries completed within 26 weeks decreased from 84.1% (FP06) to 84.0% (FP07), year-to-date performance decreased from 84.8% to 84.7%. Year-to-date performance increased at Abbotsford Regional Hospital and Cancer Centre, Chilliwack General Hospital, Langley Memorial Hospital, and decreased at Burnaby Hospital, Delta Hospital, Eagle Ridge Hospital, Peace Arch Hospital, Royal Columbian Hospital, and Ridge Meadows Hospital.

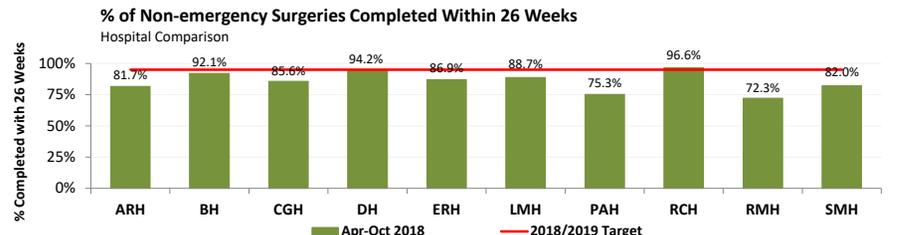
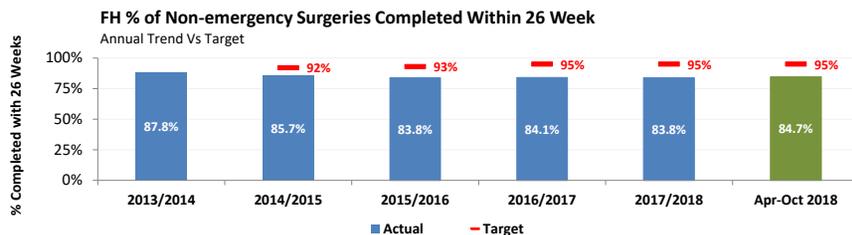
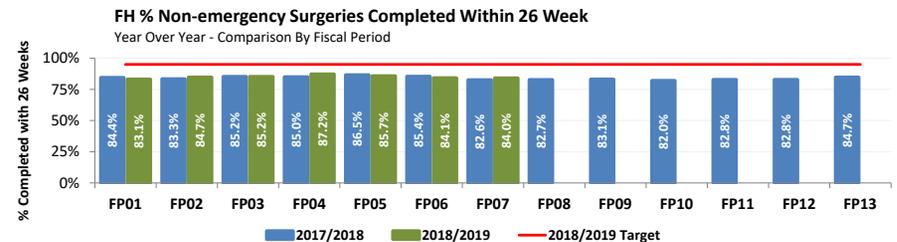
One hospital, Royal Columbian Hospital (96.6%), is above the 95% target, while Delta Hospital (94.2%) and Burnaby Hospital (92.1%) are close.

What are we doing?

This year Fraser Health will perform approximately 1,850 more surgeries, with a particular focus on joint replacements and dental surgeries. These extra surgeries will help reduce backlogs in waitlists, with the goal of patients not waiting more than 6 months from when your surgeon puts you on the waitlist for surgery. At Burnaby Hospital we now have a dedicated Central Intake and Optimization Clinic for arthroplasty. This provides a coordinated and integrated pathway through surgery, with the option to choose a particular surgeon or go with the next available surgeon for a shorter wait time. We are working to implement a central intake approach for hip/knee replacements at all of our FH sites by March 2019.

What can you do?

Review the FH Soonest Surgery Tool to see suggestions for surgeons who may be able to perform your surgery sooner. Discuss with your GP who can (re)direct your referral if this is what you want. Make every effort to be able to accept a surgery date offered by your surgeon. If your situation changes (e.g., you won't be available for a period of time), please notify your surgeon's office.



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

Non-Emergency Surgeries Waiting Longer Than 26 Weeks

How many patients on the waitlist for non-emergency surgery have waited longer than 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.

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.

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.

How are we doing?

Overall the proportion of patients on the waitlist for surgery in FH who are waiting longer than 26 weeks remains unchanged at 23.1% (FP07). By hospital, improvements (decrease in %) were seen at Abbotsford Regional Hospital and Cancer Centre, Burnaby Hospital, Langley Memorial Hospital, Royal Columbian Hospital. Increases were seen at Chilliwack General Hospital, Delta Hospital, Eagle Ridge Hospital, Peace Arch Hospital, Ridge Meadows Hospital, Surrey Memorial Hospital. Seven of the hospitals are meeting the 22.8% target. Ridge Meadows Hospital, Peace Arch Hospital, and Surrey Memorial Hospital have approx. 25.2%, 29.0% and 36.5% of patients, respectively, on the waitlist past 26 weeks.

What are we doing?

This year Fraser Health will perform approximately 1,850 more surgeries, with a particular focus on joint replacements and dental surgeries. These extra surgeries will help reduce backlogs in waitlists, with the goal of patients not waiting more than 6 months from when your surgeon puts you on the waitlist for surgery.

At Burnaby Hospital we now have a dedicated Central Intake and Optimization Clinic for arthroplasty. This provides a coordinated and integrated pathway through surgery, with the option to choose a particular surgeon or go with the next available surgeon for a shorter wait time. We are working to implement a central intake approach for hip/knee replacements at all of our FH sites by March 2019.

What can you do?

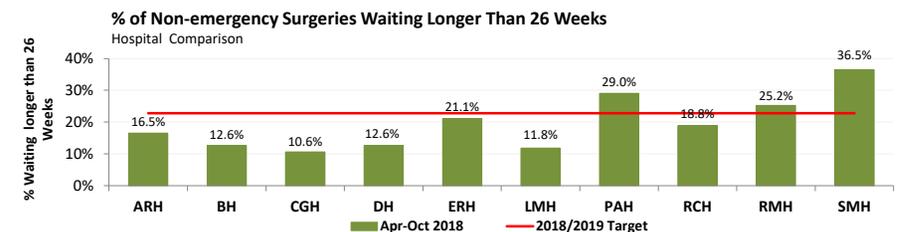
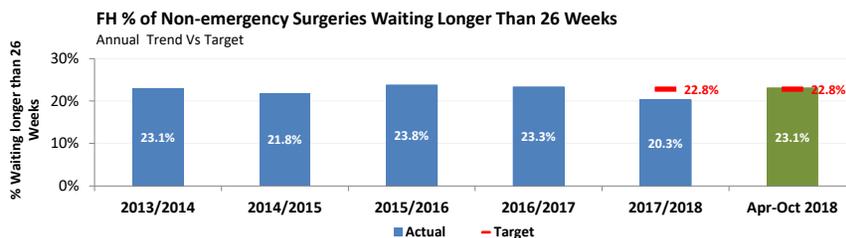
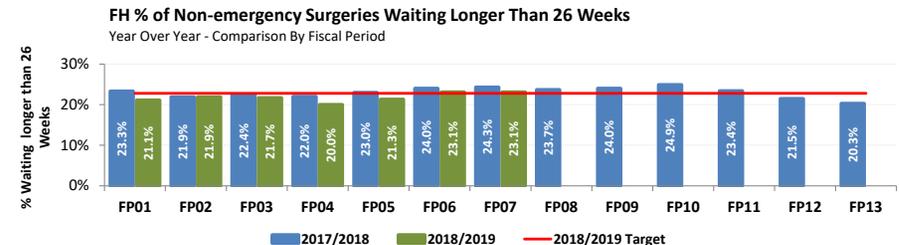
Review the FH Soonest Surgery Tool to see suggestions for which surgeon may be able to perform your surgery sooner. Discuss with your GP who can (re)direct your referral if this is what you want.

Make every effort to be able to accept a surgery date offered by your surgeon.

If your situation changes (e.g., you won't be available for a period of time), please notify your surgeon's office.

Our Performance	Target *
23.1% ▲	<= 22.8%
Unit of Measure: Percent of surgeries waiting Longer than 26 weeks	
Performance timeline:	Apr-Oct 2018
Data Source:	BC Surgical Patient Registry
* Target Source:	FHA Internal
BC Average (2017/18)	22.8%
BC Average Source:	MOH Measurement SharePoint

Notes: Target is set to BC average for 2016/17



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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 (July to September 2018) of Fiscal Year (FY) 2018/19 (April 2018 to March 2019), 78.6% of 2-year-olds were up-to-date with their immunizations. This rate was 0.3 percentage points below the FQ1 2018/19 rate (April to June 2018) and 1.4 percentage points below the target of 80%.

What are we doing?

To achieve our 80% target, a multi-faceted approach based on LEAN management principles is being taken to improve business processes and technological infrastructure, and increasing physician's awareness around immunization coverage. In addition, Population and Public Health (PPH) reminds parents of newborns to immunize their children on time. For children who are delayed in immunizations at 8 months of age, 14 months of age, 21 months of age and KG students, PPH reminds their parents that their children are past due in immunizations. PPH has increased the degree of rigor in our internal surveillance and reporting of 2-year old immunizations, and increased the focus on reducing wait times and accelerating recruitment, to facilitate nimble operational responses to boost the rate. PPH continues to work with our physician partners to facilitate record sharing and uptake of immunization practice. Lastly, the Fraser Health website is being transformed to make it more relevant and informative for the general public.

What can you do?

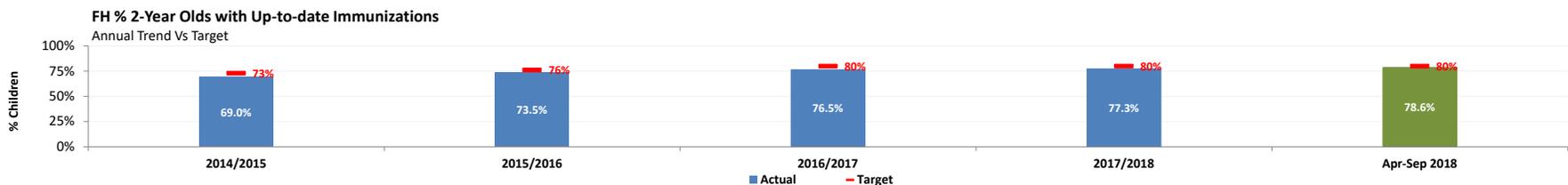
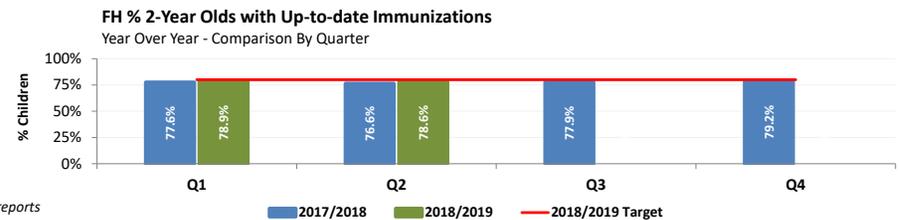
Immunize your children on time with all the vaccines they need. Immunization is the most effective way to protect children from vaccine-preventable diseases. All parents are encouraged to ensure their children's immunizations are up to date and documented. Parents can sign up for free text reminders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

Our Performance	Target *
78.6% ▲	>= 80%

Unit of Measure: Percent of 2-year olds

Performance timeline: Apr-Sep 2018
 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, 2018/19 - Ending Oct 18, 2018

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.

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.

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).

How are we doing?

The rate of Responding to Public Complaints Within Targets (RPCWT) decreased from 98.6% in Fiscal Quarter (FQ) 1, 2018/19 (April to June, 2018) to 98.4% in FQ2, 2018/19 (July to September 2018). However, the FQ2 2018/19 rate of RPCWT remained above the fixed annual target of 95%.

What are we doing?

Health Protection staff receive public complaints via telephone, email or the FH Feedback system. Staff then assesses 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.

What can you do?

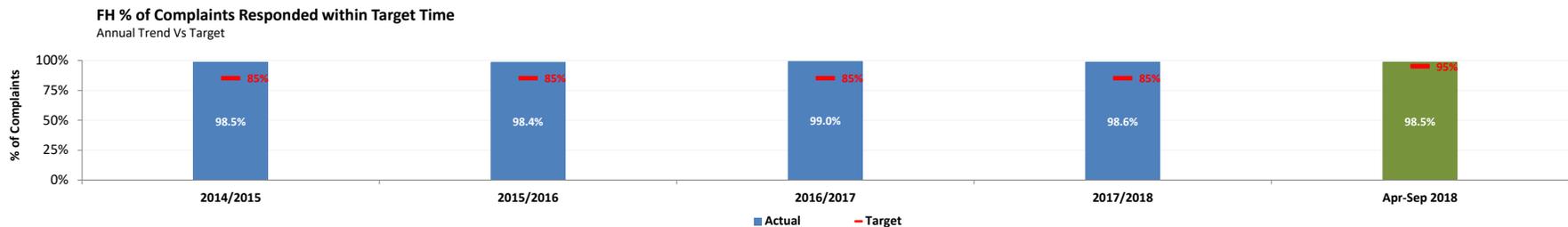
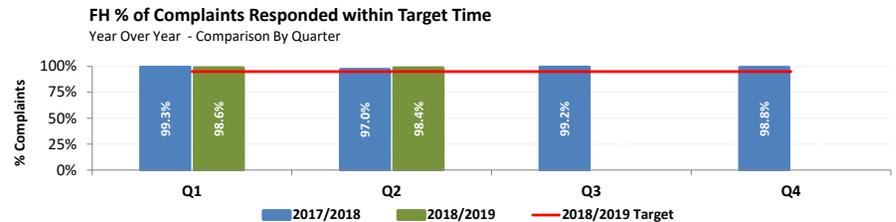
The public can notify their local Health Protection office to report a complaint. Licensing Officers follow up on concerns in licensed care facilities (day cares and residential care). Environmental Health Officers follow up on community environmental complaints (food safety, recreational water safety,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



Unit of Measure: Percent of complaints

Performance timeline: Apr-Sep 2018
 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, 201819 - Ending Oct 18, 2018

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 (July to September 2018) of Fiscal Year (FY) 2018/19 (April 2018 to March 2019), 68.3% of women who gave birth in FH hospitals were registered with the Best Beginnings program during their pregnancy. This rate was 0.8 percentage points below the FQ1 2018/19 rate (April to June 2018) and 6.7 percentage points below the target of 75%.

What are we doing?

Population and Public Health continues working with stakeholders such as GPs and maternity clinics and other community partners to facilitate early registration and awareness of program. We are currently exploring contributing factors as well as opportunities to increase prenatal registration in these areas; such as, 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 fentanyl overdose crisis have prevented PPH from achieving the prenatal registration target. In June, we 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 as well as sooner.

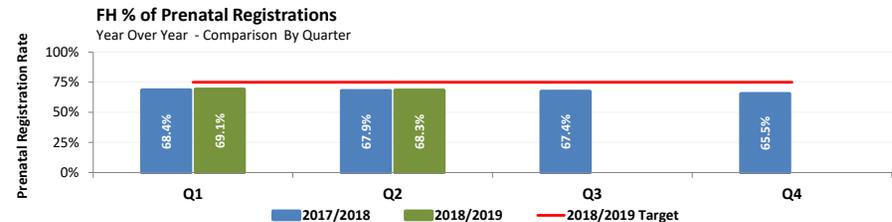
What can you do?

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 with their local public health unit as early as possible.

Our Performance	Target *
68.7% ▲	>= 75%
Unit of Measure: Percent of women registered	

Performance timeline: Apr-Sep 2018
 Data Source: Panorama System
 * Target Source: FHA Internal

Notes: The 75% target was established internally at FH for fiscal year 2015/16 and will be retained as the target for fiscal year 2016/17.



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

Life Expectancy Disparity within Fraser Health Communities

Are there inequalities in life expectancy across Fraser Health?

What are we measuring?

The difference in Life Expectancy (LE) between the Local Health Areas (LHA) in FH with the highest and lowest LE, measured for 5-year periods (i.e., report same value annually over each 5-year period).

Why?

Life Expectancy (LE) at birth is one of the most important measures of health. LE at birth indicates the average number of years a person may expect to live when they are born. Many factors, including health behaviours, socioeconomic status, and environmental conditions, can influence how long one lives. The Fraser Health Authority monitors LE disparities across its Local Health Areas (LHAs) to inform actions that can contribute to reduce the difference between the LHAs with the lowest and highest LE.

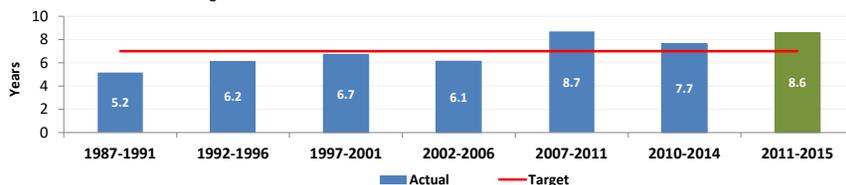
How do we measure it?

Life Expectancy (LE) in the LHA with the highest LE minus LE in the LHA with the lowest LE.

Our Performance	Target *
8.6 ♦	<= 7.0
Unit of Measure: Number of years different in life expectancy	
Performance timeline:	2011-2015
Data Source:	Vital Statistics
* Target Source:	FHA Internal
BC Average	9.8 Years

Notes: Target is set to 7 years based on internal data from previous six 5-year periods

FH Communities Life Expectancy Disparity
Annual Trend Vs Target



How are we doing?

Compared to the previous 5-year period (2010-2014), Burnaby and Hope remain the areas with the highest and lowest LE at birth among LHAs in Fraser Health, respectively. The LE across LHAs in 2011-2015 ranged from a high of 84.5 years in Burnaby to a low of 75.9 years in Hope. Overall, the LE disparity increased by almost one year, from an average of 7.7 years in 2010-2014 to 8.6 years in 2011-2015. The overall increase was driven by both a slight increase (3.5 months) in the average LE in Burnaby, and a decrease (6 months) in the average LE in Hope.

What are we doing?

Population and Public Health activities in health promotion, community engagement and community development contribute to improving LE across the region; focused efforts in these areas can reduce health disparities and improve life expectancy in geographic areas and populations where poorer health outcomes occur. □

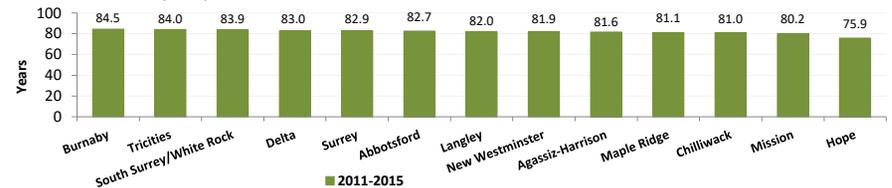
Community partnerships are foundational to this approach. A review is currently underway to build on the Healthier Community Partnerships to increase community capacity to address complex health problems of interest to the community. Community grants were established in 2015/2016 to support this work and Hope recently received \$500,000 for initiatives to improve population health in the area. □

Regional initiatives complement local efforts by ensuring appropriate interventions in populations with higher health risks, such as people who smoke, vulnerable mothers, or people who need housing. Improvements to Clinical Smoking Cessation Supports and progressive implementation of Fraser Health's Smoke Free Policy will ensure smokers are identified and supported to quit while at the same time minimizing exposure to others on Fraser Health property. Health Equity Impact Assessment Training for Population and Public Health staff will help ensure our programs and services account for and are responsive to the needs of the most vulnerable.

What can you do?

We can keep in mind how our communities around us, our economic conditions, education levels, built environments and social connections, amongst other factors, influence our health behaviours and can contribute to differences in health among Fraser Health residents. We can work together in our families, our communities and with our governments to ensure the conditions where we live, work and play give everyone an opportunity to reach their best health potential.

Life Expectancy By Age
Community Comparison



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

Sick Time Rate

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

What are we measuring?

Paid sick leave hours as a percent of total productive hours

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 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.

How are we doing?

Our current year to date performance for Fiscal Period 7 is 4.86% which is meeting the 5.0% target. Of our hospitals, six sites are meeting the target (Abbotsford Regional Hospital, Burnaby Hospital, Eagle Ridge Hospital, Mission Memorial Hospital, Royal Columbian Hospital and Ridge Meadows Hospital).

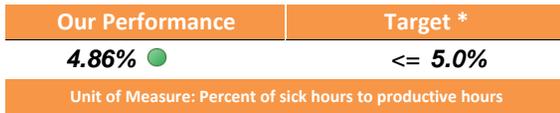
What are we doing?

Our Employee Experience team continues to proactively work with units and sites to develop and implement strategies to help mitigate sick time to support and maintain a positive and productive work environment including:

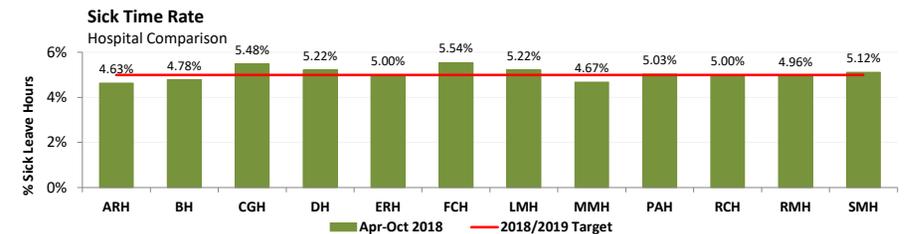
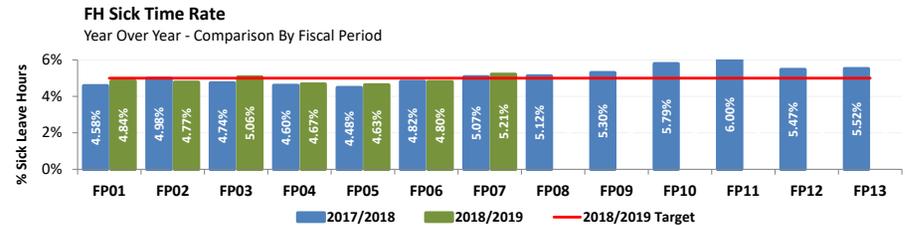
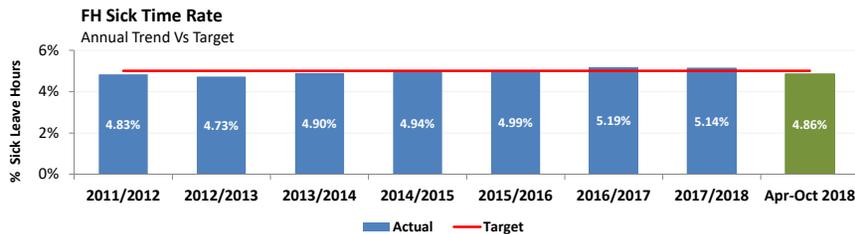
- New work launched in February 2017 to address casuals commitment and cancellation rate (sick or other).
- Creating communication tools for Managers to raise awareness at the department level regarding sick time usage and the impacts of it.
- Using systems like EARL to enable just in time conversations between FH Leaders and employees when an employee calls in sick.
- Communication, education and audits implemented to ensure coding occurs appropriately for all shifts including sick time.
- Enabling Managers through coaching on how to lead difficult conversations on sick time and other related topics.
- Initiating Automation for the Attendance Promotion Program to enhance support for the Managers.
- APP has transitioned to Workplace Health. Program is moving to an "Inform, Educate and Offer" model to ensure staff are aware of the impact of using sick time and increase integration and alignment within our current departments. Education sessions on the use of sick time and how it impacts employees from a leave and financial perspective are being offered at the sites with accompanying Communications for employees. 80% of staff who go on LTD do not have enough paid sick time to cover their qualifying period.

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.



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



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

Overtime Rate

How often do our staff work overtime?

What are we measuring?

Total overtime hours as a percent of total productive hours

How are we doing?

Period 7 over time rate for FH did not meet our new target of 2.8%. FH overall overtime rate exceeded our previous year Fiscal period 7 by 0.53% at 3.22%. The Overtime target for 2017/18 was reduced from 3.0% to 2.8% for this year. 1/12 sites are meeting this new target with Period 7 results showing a decrease of .32% from fiscal period 6.

Common challenges contributing to overtime include:

- Lack of available relief for short call shifts
- Relief vacancy positions remain challenging to fill due to lack of applicants

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?

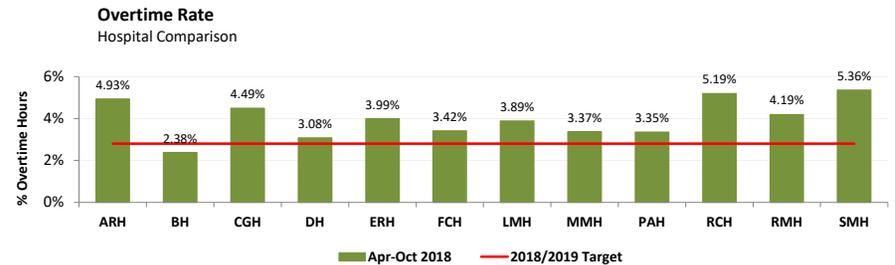
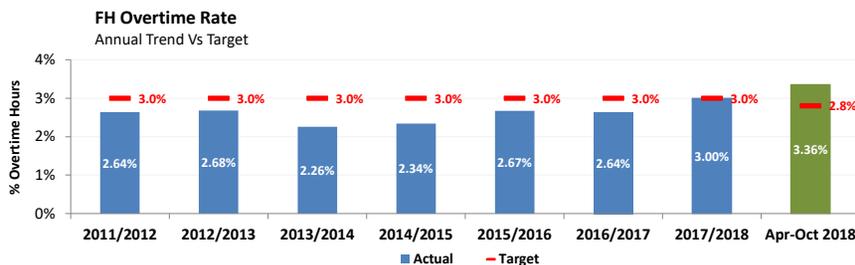
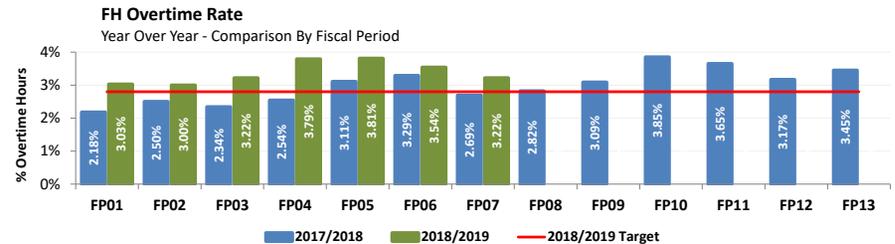
A manager information sheet was developed to assist managers in determining allowable leave quotas.

- Strategic HR continues to proactively meet and targets sites with high overtime, workload and/or sick time to develop mitigation strategies. In partnership with Finance, to date: 31 units have been reviewed in Period 1 -7 to determine cause of high overtime and develop strategies to reduce.
- Development of Information Sheet for managers on Overtime mitigation, will include education of managers on decision-making regarding short call replacement and workload needs. A decision-making algorithm has been developed and circulated to all managers and directors. Managers and /or Directors have implemented tighter overtime approval controls and monitoring.

How do we measure it?

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

Our Performance	Target *
3.36% ◆	<= 2.8%
Unit of Measure: Percent of overtime hours to productive hours	
Performance timeline: Data Source:	Apr-Oct 2018 Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server FHA Internal
* Target Source:	



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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.

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.

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.

How are we doing?

For the current quarter we saw an decrease in Claims Rate compared to the previous quarter. Claims volumes at SMH and BH continue to be of concern whereas variability in smaller sites is expected month to month due to smaller denominator. RCH rates show that large sites can meet targets consistently.

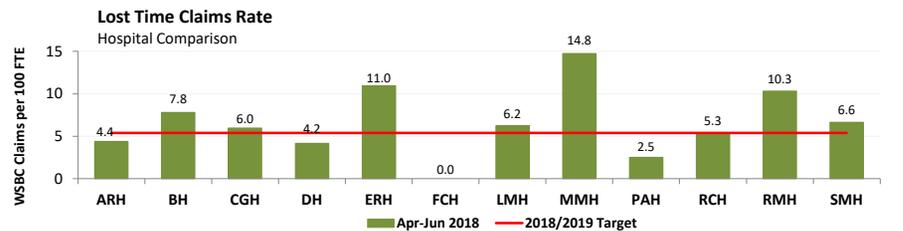
What are we doing?

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 related with more than 400 WorkSafeBC claims occurring annually. For both client and caregiver safety and well-being, we support the importance of early and ongoing assessment of client mobility and care planning to promote mobility, including use of client handling equipment. This includes assessment of clients for bed mobility and transfer methods; selection and appropriate use of equipment to match patient/resident/client abilities; and, involvement of interdisciplinary team members in communication of changes in assessment/mobility. A similar approach applies to the prevention of violence. 18/19 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.

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 *
5.9 ▲	<= 5.4
Unit of Measure: Number of WSBC accepted claims / 100 FTEs	
Performance timeline: Apr-Jun 2018	FHA Workplace Health
Data source: FHA Internal	FHA Internal
* Target Source:	



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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)

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.

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)

How are we doing?

New LTD Claims rates continue to be stable and slightly below target despite increasing challenges with volume of cases in disability management. We closed as many claims as were opened in 2017 but continued a higher rate of new claims as shown in the graph. For 2018, new claims adjudication is lagging so the total will increase slightly as the decisions on claims are made and the data matures.

What are we doing?

There are full reporting/monitoring environments in place to track performance measures and outcomes for leading and lagging indicators on our FH Management Centre for managers to know the status of all their employees who are in Dis Mgmt services. Workplace Health is completing a full redesign of Disability management services with a launch of September 2018. Overall goal is the prevention of new LTD claims - this KPI is our primary indicator as to program success. FH currently has best practices in the LTD case management, the upfront and "triage" process is being redesigned and augmented for future success keeping our employees at work and supported.

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 *
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2.16 ●

<= 2.25

Unit of Measure: Number of LTD claims / 100 FTEs

Performance timeline:

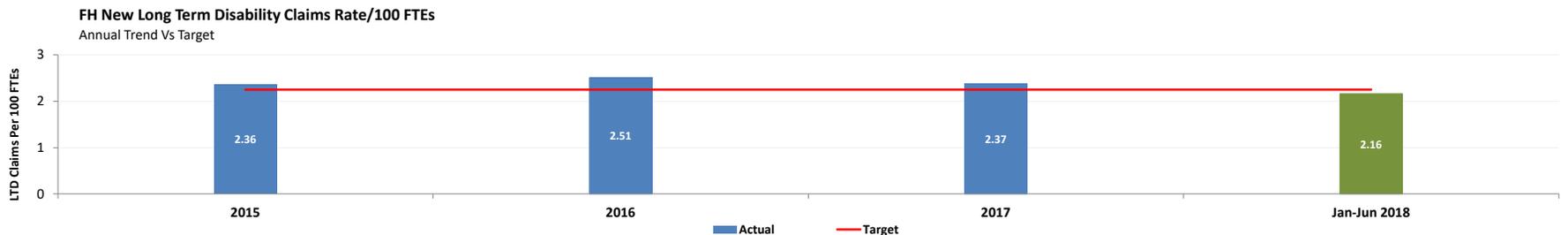
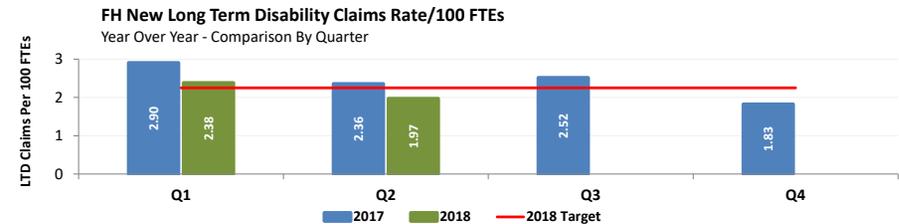
Jan-Jun 2018

Data source:

FHA Workplace Health White Database and FHA Meditech System

* Target Source:

FHA Internal



Our Health Care Report Card

Fiscal Period: FP07, 2018/19 - Ending Oct 18, 2018

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 0.1% for Q2 with 4.1% (38 terminations within the 924 new hires) compared to last quarter 4.0% (37 terminations within the 918 new hires). Compared to the last year Q2, the % has increased by 0.2% (30 terminations within the 768 new hires). □

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 2018/19 to Q2 2017/16, there have been varying changes. Community continues to have the highest Turnover % and the highest number of Turnover; compared to last year Community had 11 Turnover (28.9% of all Turnovers) in 2018/19 to 10 Turnover (33.3% of all Turnovers) in 2017/18. Facilities have increase with 7 Turnover (18.4% of all Turnovers) in 2018/19 and 5 Turnover (16.7% of all Turnovers) in 2017/18. Paramedics have increased dramatically with 9 Turnover (23.7% of all Turnovers) in 2018/19 and 3 Turnover (0.03% of all Turnovers) in 2017/18. Excluded, Nurses, and Nurses-LPN Turnover numbers have remained fairly consistent when comparing the two periods with either no fluctuation or fluctuation by only 1.

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 *
4.1% ◆	<= 2.5%

Unit of Measure: Percent of employees turnover

Performance timeline:	Apr-Sep 2018
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.

FH % Turnover In The First Year Of Service

Annual Trend Vs Target



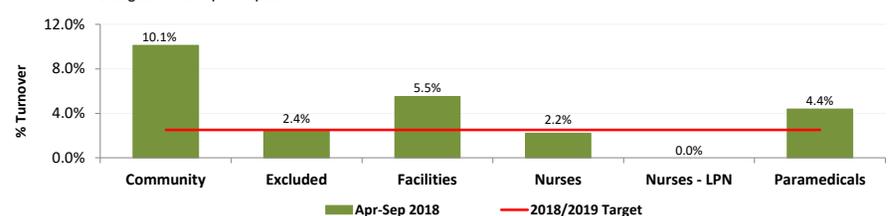
FH % Turnover In The First Year Of Service

Year Over Year - Comparison By Quarter



% Turnover In The First Year Of Service

Designated Group Comparison



Our Health Care Report Card

Fiscal Period: FP07, 201819 - Ending Oct 18, 2018

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.

Why?

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

How do we measure it?

Budgeted expenditures less net variance to budget over budgeted expenditures.

How are we doing?

The seventh fiscal period ended with a year to date deficit of \$28.0 million. Fraser Health is implementing a number of new and ongoing mitigation strategies which will 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.

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.

Our Performance	Target *
1.014 ▲	<= 1.000
Unit of Measure: Actual to budget ratio	
Performance timeline: Data Source:	Apr-Oct 2018 Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server
* Target Source:	FHA Internal

