

Our Health Care Report Card

Fraser Health

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

No	Measure Name	Last Available Update	Target	Actual	Status	Preferred Direction
QUALITY AND SAFETY						
1	In-Hospital <i>Clostridioides Difficile</i> Infection (CDI) Incidence	Apr-May 2020	4.5	4.2	●	↓
2	In-Hospital Methicillin-Resistant <i>Staphylococcus aureus</i> (MRSA) Incidence	Apr-May 2020	5.5	4.5	●	↓
3	Hand Hygiene Compliance	2019/2020	80%	80.4%	●	↑
4	In-Hospital Sepsis Rate	2019/2020	3.8	3.3	●	↓
5	In-Hospital Acquired Delirium	2019/2020	7.3	10.2	◆	↓
6	In-Hospital Acquired Non-Aspiration Pneumonia	2019/2020	7.3	8.7	◆	↓
7	In-Hospital Acquired Urinary Tract Infection	2019/2020	10.0	15.2	◆	↓
8	Hospital Standardized Mortality Ratio	Apr-Dec 2019	96	95.8	●	↓
9	Worsened Pressure Ulcer in Long Term Care Facilities	Apr-Dec 2019	1.6%	1.9%	◆	↓
CAPACITY AND CARE ACROSS ALL SECTORS						
10	Emergency Patients Admitted to Hospital Within 10 Hours	Apr-May 2020	65.0%	59.4%	▲	↑
11	Admitted Patients Waiting for Inpatient Bed Placement	Apr-May 2020	160	53.7	●	↓
12	Patients Length of Stay Relative to Expected Length of Stay	Apr-Dec 2019	0.95	1.01	▲	↓
13	Long Stay Patients	Apr-May 2020	455	296.4	●	↓
14	Alternate Level of Care (ALC) Days	2019/2020	12.9%	16.0%	◆	↓
15	Hospitalization Rates for Residents (Age 70+)	2018/2019	250.8	259.7	▲	↓
16	Hospital Readmission Rates Overall	Apr-Dec 2019	10.0%	10.1%	▲	↓
17	Mental Health & Substance Use Patients Hospital Readmission Rate (Age 15+)	Apr-Dec 2019	13.3%	13.1%	●	↓
18	Patients with Chronic Conditions Admitted to Hospital (Age 75+)	Apr-Dec 2019	3,448	2,906	●	↓
19	Low Acuity Emergency Visits by Community	Apr-May 2020	102.7	65.7	●	↓
20	Home Health Services Provided Within Benchmark Time	Apr-May 2020	50.0%	57.2%	●	↑
21	Wait Time for Home Health Assessment (RAI-HC)	Apr-May 2020	30.0	34.0	◆	↓
22	Admissions to Long Term Care within 30 Days	Apr-May 2020	75.0%	71.2%	▲	↑
23	Emergency Visits by Home Health Clients	2019/2020	75.8	99.8	◆	↓
24	Emergency Visits by Long Term Care Clients	2019/2020	30.0	44.1	◆	↓
25	Non-emergency Surgeries Completed Within 26 Weeks	Apr-May 2020	95%	90.4%	▲	↑
26	Non-Emergency Surgeries Waiting Longer Than 26 Weeks	Apr-May 2020	22.8%	38.8%	◆	↓
POPULATION & PUBLIC HEALTH MEASURES						
27	Percent of 2-Year Olds with Up-To-Date Immunizations	2019/2020	85%	72.9%	◆	↑
28	Health Protection Program Response Time to Public Complaints	2019/2020	95%	98.7%	●	↑
29	Prenatal Registrations	2019/2020	75%	68.5%	▲	↑
30	Life Expectancy Disparity within Fraser Health Communities	2013-2017	7.0	8.7	◆	↓
STAFF						
31	Nursing and Allied Professional Sick Time	Apr-May 2020	5.8%	4.3%	●	↓
32	Nursing and Allied Professional Overtime	Apr-May 2020	3.9%	2.7%	●	↓
33	Lost Time Claims Rate	Apr-Dec 2019	5.3	6.6	◆	↓
34	Long Term Disability Claims Rate	2019	2.25	1.98	●	↓
35	Turnover Rate In The First Year Of Service	2019/2020	2.5%	3.5%	◆	↓
BUDGET ACCOUNTABILITY						
36	Budget Performance Ratio	Apr-May 2020	1.000	1.030	▲	↓

Notes:

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

KPI Count By Status

Meeting Target	●	15
Within 10% of Target	▲	8
Not Meeting Target	◆	13

Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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

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

What are we measuring?

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

Why?

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

How do we measure it?

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

How are we doing?

Fraser Health's CDI incidence rate, which is the number of new acute care cases per population-at-risk, is 4.2 year-to-date in 2020/21, 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 2018/19, 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 acute care sites to implement ultra-violet germicidal irradiation technology as well as canine scent detection to further reduce healthcare-associated CDI. 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.

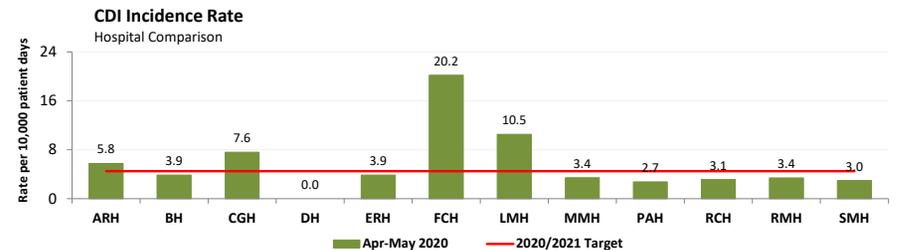
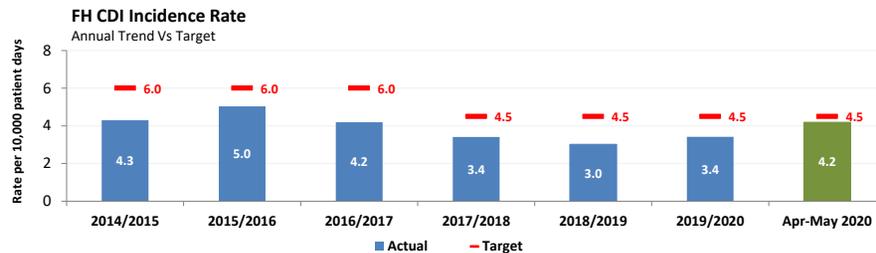
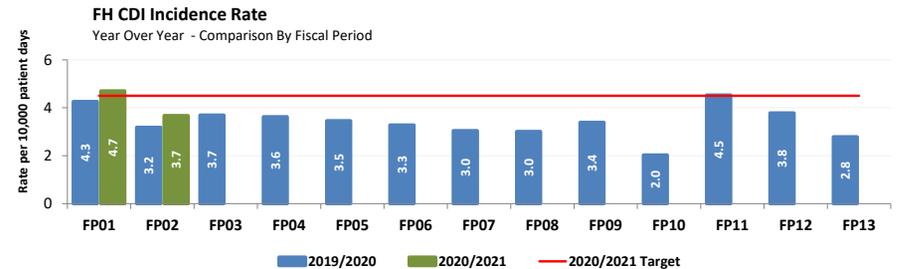
What can you do?

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 Performance	Target *
4.2 ●	≤ 4.5
Unit of Measure: Number of infections / 10,000 patient days	

Performance timeline: Apr-May 2020
 Data source: FH Infection Prevention and Control Database
 * Target Source: FHA Internal

Notes: 1) Data are examined and updated on a regular basis, therefore numbers may change slightly based on adjustments
 2) MSA acute care data were combined with ARH from April 1, 2015 (FP01, 2018/19) to July 25, 2019 (FP04, 2019/20)



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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?

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

How are we doing?

Fraser Health's annual MRSA incidence rate, which is the number of new acute care cases per population-at-risk, has decreased from 6.8 in 2014/15 to 4.5 year-to-date in 2020/21, which is below the current FHA internal target of ≤ 5.5 cases per 10,000 patient days. In previous fiscal years from 2016/17 to 2018/19, the rate of MRSA 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 MRSA rates by carrying out surveillance and providing units and acute care sites with regular reports that show the number of newly acquired cases. Fraser Health's Infection Prevention and Control program works collaboratively with units to develop quality improvement action plans to reduce MRSA transmissions and address infection control best practice gaps.

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

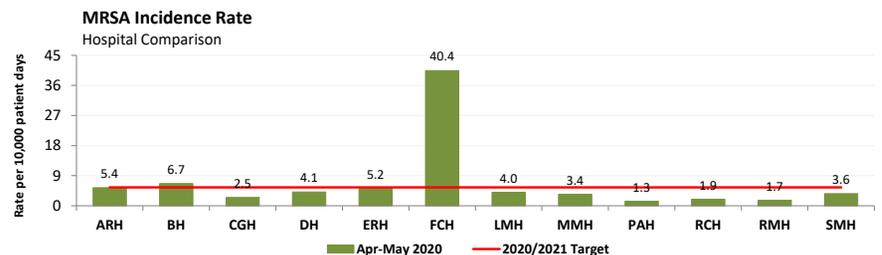
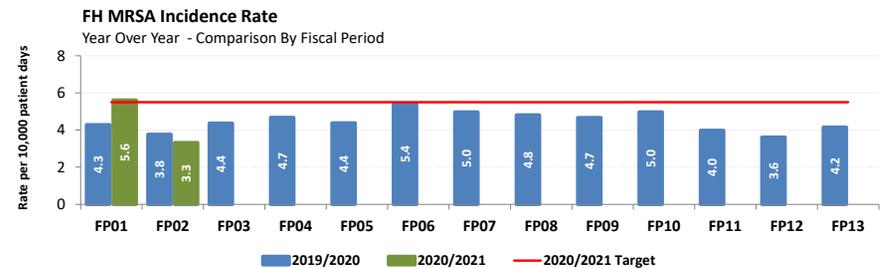
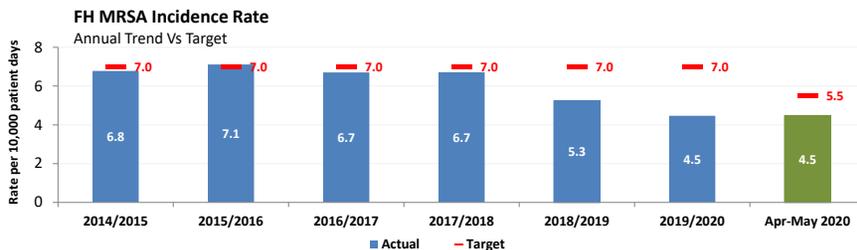
What can you do?

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. When visiting, please follow all instructions and signs posted on the unit to decrease the chance of spreading germs.

Our Performance	Target *
4.5 ●	≤ 5.5
Unit of Measure: Number of infections / 10,000 patient days	

Performance timeline: Apr-May 2020
 Data Source: FH Infection Prevention and Control Database
 * Target Source: FHA Internal

Notes: 1) Data are examined and updated on a regular basis, therefore numbers may change slightly based on adjustments
 2) MSA acute care data were combined with ARH from April 1, 2015 (FP01, 2018/19) to July 25, 2019 (FP04, 2019/20)



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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?

$\left[\frac{\text{Number of times healthcare providers correctly performed hand hygiene while providing direct patient care}}{\text{Total number of times that hand hygiene should have been performed by those same healthcare providers}} \times 100 \right]$ for a specified reporting period

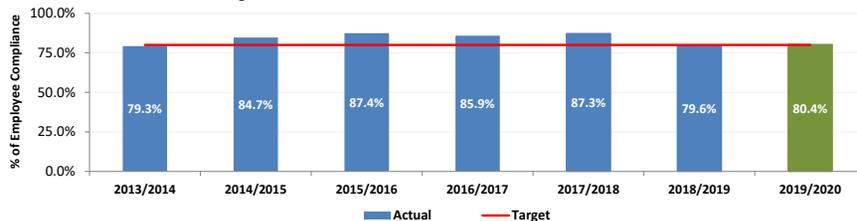


Performance timeline: 2019/2020
 Data Source: FH Infection Prevention and Control Program Hand Hygiene System (FormAudit)
 * Target Source: Provincial Target

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

FH Hand Hygiene Compliance

Annual Trend Vs Target



How are we doing?

Fraser Health's overall hand hygiene compliance improved over the years from 79.3% in 2013/14 to 87.3% in 2017/18, then decreased to 80.4% in 2019/20. The decrease in hand hygiene compliance rate is likely attributable to the change in hand hygiene audit methodology of using regional hand hygiene auditors for acute care inpatient units beginning July 2018. The regional hand hygiene audit program was suspended in January 2020 due to the COVID-19 pandemic, and will resume in September 2020. Based on the currently available results, Fraser Health is meeting the provincial target of >=80%.

What are we doing?

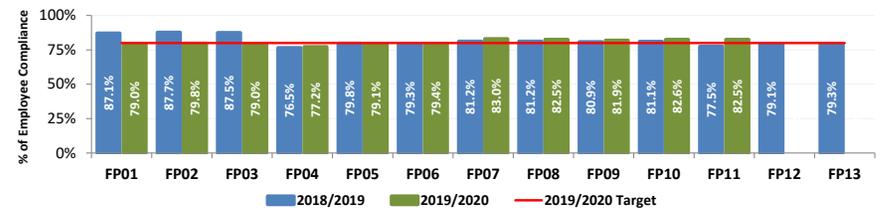
Hand hygiene compliance audits are conducted regularly to reinforce that hand cleaning is important and to determine how well healthcare providers are cleaning their hands. The new audit methodology includes in-the-moment feedback to staff, helping them identify gaps in their hand hygiene practice and 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.

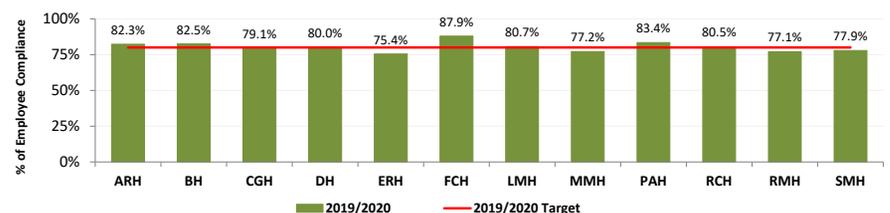
FH Hand Hygiene Compliance

Year Over Year - Comparison By Fiscal Period



Hand Hygiene Compliance

Hospital Comparison



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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 2019/20 performance for hospital sepsis is 3.3, which is meeting the target of 3.8. We continue to perform better than the historical national average and B.C. average on this indicator. Our hospitals' year-to-date results show that four sites (Fraser Canyon, Mission Memorial, Peace Arch and Royal Columbian) are meeting their internal targets.

What are we doing?

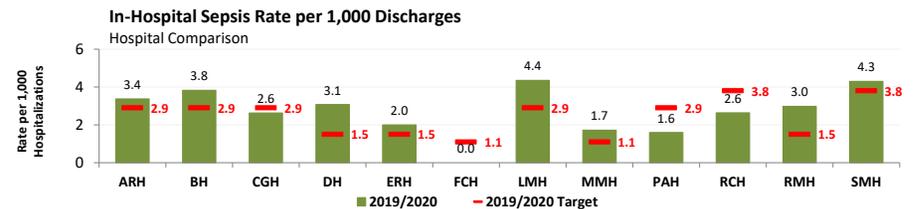
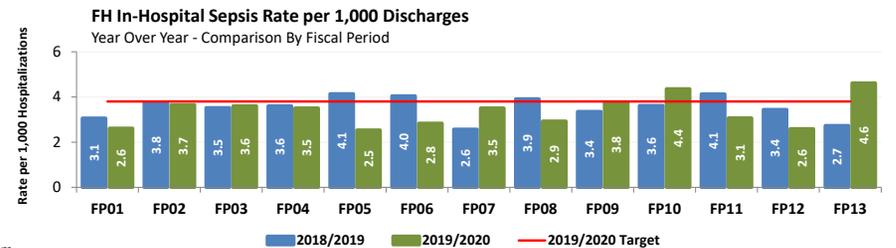
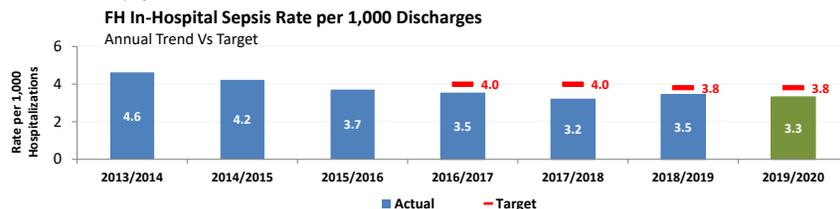
In-hospital acquired sepsis is a Patient Safety Priority for Fraser Health and is monitored closely by clinical leaders at all 12 acute care sites. Site leadership continues to develop quality and safety-focused action plans that incorporate best practices to prevent care-sensitive adverse events, both 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. We have an active regional Hospitalist working group that has revised the Sepsis Pre-Printed Orders (PPO) and we are working to support nurses in utilizing the Sepsis Screening Tool on our inpatient units for early detection and recognition of Sepsis. Quality improvement efforts in sepsis recognition and documentation are likely to result in an increase in the sepsis prevalence data. This will support us to obtain a more accurate value of the true prevalence of Sepsis. The Patient Safety Priority 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. brushing your teeth, hand washing, bathing regularly) especially while in the hospital. Tell your health care provider immediately if you have any of the following symptoms: fever, chills, dizziness, rapid breathing and heart rate, rash, confusion or disorientation. We also have a patient education pamphlet on Sepsis. Please ask your health care provider for this as we would like you to be familiar with what sepsis is and to communicate early to your health care provider if you may feel any of the signs and symptoms. You are an important part of the team, and we encourage you to bring your voice forward. Together, we can help to reduce the risk of acquiring infection and sepsis during your hospital stay.

Our Performance	Target *
3.3	<= 3.8
Unit of Measure: Infections per 1,000 Discharges	
Performance timeline:	2019/2020
Data Source:	Med2020
* Target Source:	FHA Internal
BC Average (2014/15)	4.2
National Average (2014/15)	4.1
BC and National Average Source:	CIHI - Your Health System

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



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

In-Hospital Acquired Delirium

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

What are we measuring?

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

Why?

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

How 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 2019/20 performance for in-hospital acquired delirium is 10.2, which is not meeting our internal target of 7.3. Three sites (Chilliwack, Langley Memorial and Peace Arch) are meeting their internal targets. We will continue to work with our sites and programs to promote best practice prevention strategies, early recognition of delirium, and the identification of high-risk patients.

What are we doing?

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 delirium rate. Fraser Health is focused on an interdisciplinary, multi-faceted approach for delirium. This approach includes: education; the implementation and sustainment of the revised Delirium Pre-Printed Orders (PPO) and Clinical Practice Guideline (CPG); improved utilization of the Confusion Assessment Method (CAM) and associated Care and Discharge Planning Tools; revised Patient and Family Guide; and integration with other Patient Safety Priorities and initiatives. 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.

Note: An increase in delirium prevalence is not felt to be representative of more patients with delirium, but rather a more accurate value. We expect these numbers to go up as we initiate measures to both better identify delirium and improve charting. The regional Delirium Steering Committee is also exploring opportunities for upstream identification of patients at increased risk of delirium; improved documentation/charting/coding; and enhancing delirium prevention and recognition in the community ("pre-admission").

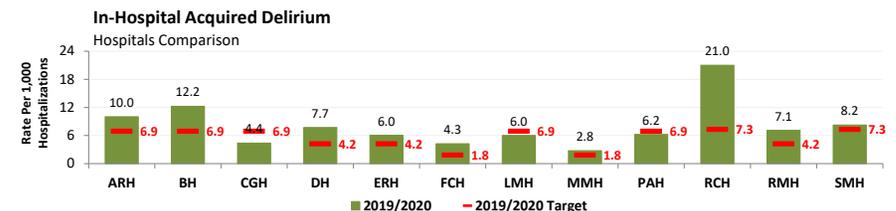
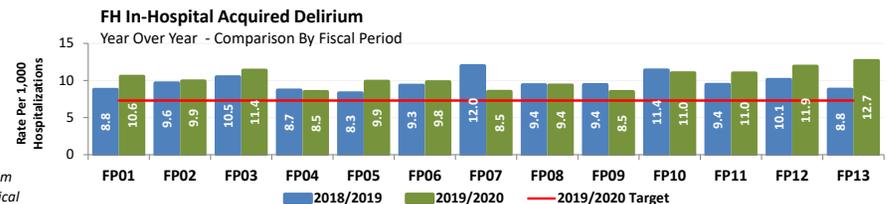
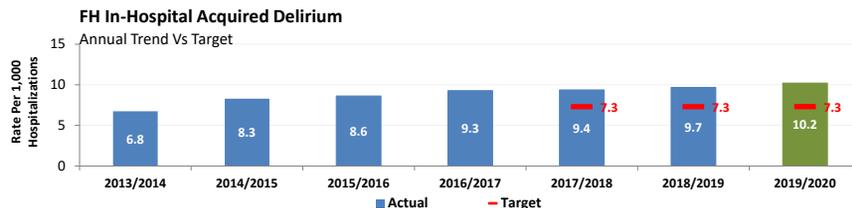
What can you do?

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

Our Performance	Target *
10.2	≤ 7.3
Unit of Measure: Infections per 1,000 Discharges	

Performance timeline: 2019/2020
 Data Source: Med2020 Abstracting and Coding system
 * Target Source: FHA Internal

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



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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 2019/20 performance for hospital acquired non-aspiration pneumonia is 8.7, which is not meeting our internal target of 7.3. Three sites (Chilliwack, 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 which can impact a patient's stay in our facilities.

What are we doing?

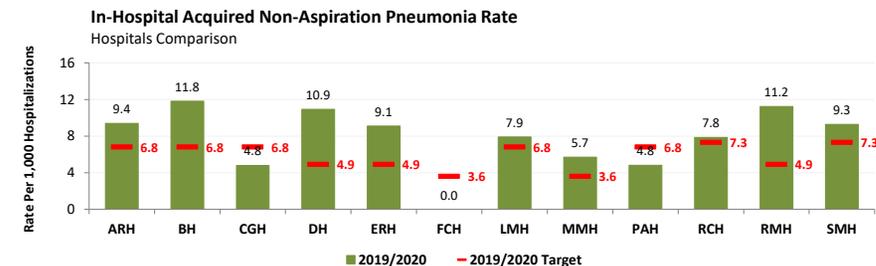
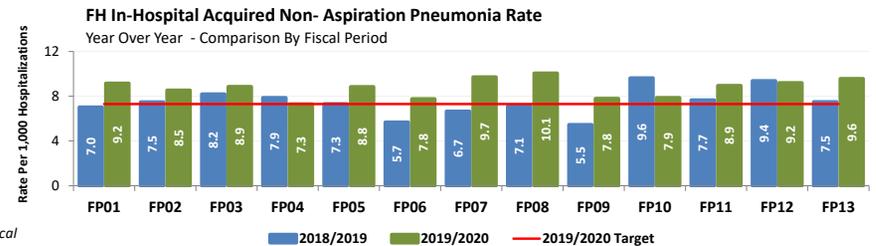
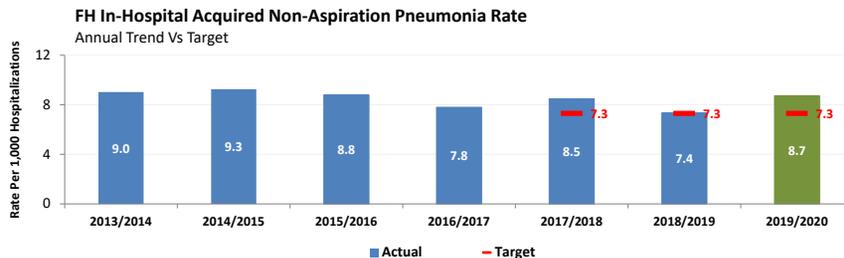
In-hospital acquired pneumonia is a Patient Safety Priority for Fraser Health and is monitored closely by clinical leaders at all 12 acute care sites. Site leadership continues to develop quality and safety-focused action plans that incorporate best practices to prevent care-sensitive adverse events, both at the patient care unit level and at an overall site perspective, focusing on prevention. The Patient Safety Priority 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 reduce 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 reducing the risk. Together, we can help to reduce the risk of acquiring infection and pneumonia during your hospital stay.

Our Performance	Target *
8.7 ◆	<= 7.3
Unit of Measure: Infections per 1,000 Discharges	
Performance timeline:	2019/2020
Data Source:	Med2020 Abstracting and Coding system
* Target Source:	FHA Internal

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



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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?

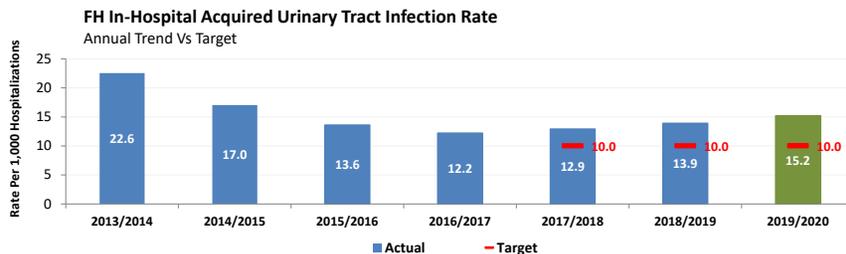
Our goal is to provide the best care to our patients. Appropriate preventative therapeutic measures along with evidence informed practice (oral care, frequent ambulation, hand hygiene, etc.) during a hospital stay reduces the rate of infections. The inter-professional care team provides evidence informed 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 >= 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.

Our Performance	Target *
15.2 ◆	<= 10.0
Unit of Measure: Infections per 1,000 Discharges	
Performance timeline:	2019/2020
Data Source:	Med2020 Abstracting and Coding system
* Target Source:	FHA Internal

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



How are we doing?

Fraser Health's 2019/20 performance for in-hospital acquired UTI is 15.2, which is not meeting our internal target of 10.0. Of the 12 hospitals, Chilliwack, Fraser Canyon and Surrey Memorial are meeting their target. We will continue to work with our sites and programs that have opportunities to reduce this infection which can impact a patient's stay in our facilities.

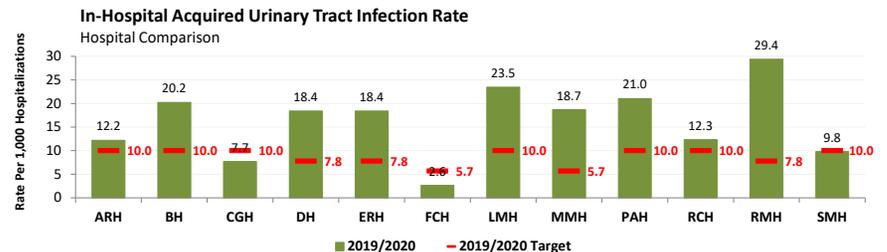
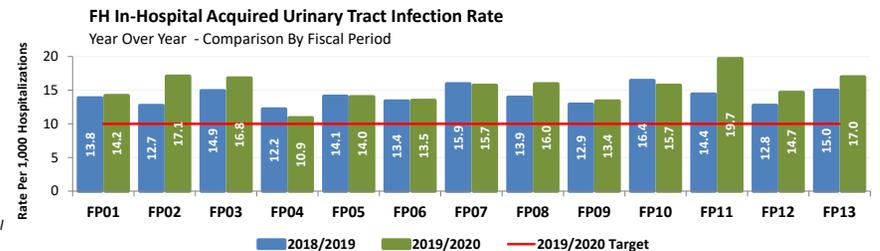
What are we doing?

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 Priority 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 Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

Hospital Standardized Mortality Ratio

What are the mortality rates at Fraser Health hospitals?

What are we measuring?

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

Why?

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

How do we measure it?

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

How are we doing?

Fraser Health's 2019/20 year-to-date HSMR rate of 95.8 is meeting the target of 96. At the hospital level, eight sites (Burnaby, Chilliwack, Delta, Eagle Ridge, Fraser Canyon, Langley Memorial, Mission Memorial and Peace Arch) are meeting the target. All sites within Fraser Health are dedicated to ensuring that we have the best practice and performance in place for patients and families. We will continue to make every effort to improve our performance in the area of Hospital Standardized Mortality Rate.

What are we doing?

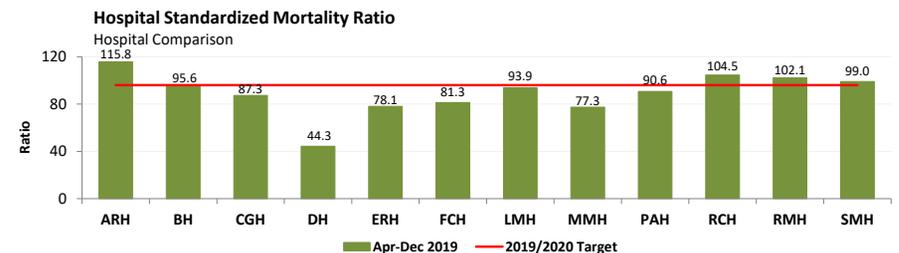
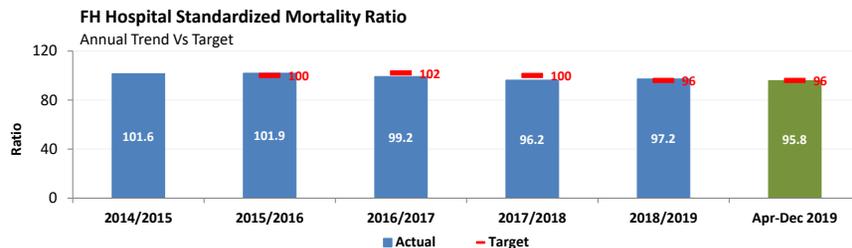
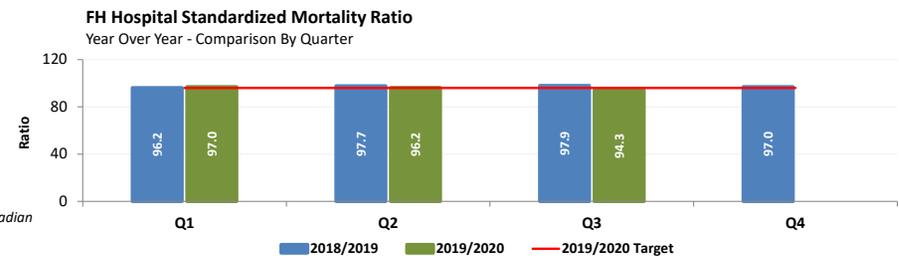
Early recognition on admission, rapid response to sudden worsening of a patient's condition, and appropriate transition of care is a key area of focus to reduce Hospital Standardized Mortality Rates. An area of focus is monitoring the Fraser Health Patient Safety Priorities (hospital acquired sepsis,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

What can you do?

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

Our Performance	Target *
95.8 ●	≤ 96
Unit of Measure: Hospital Mortality Ratio	
Performance timeline:	Apr-Dec 2019
Data Source:	Canadian Institute for Health Information (CIHI)
* Target Source:	FHA Internal
BC Average (2018/19)	96
BC Average Source:	CIHI - Your Health System

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



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

Worsened Pressure Ulcer in Long Term Care Facilities

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

What are we measuring?

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

Why?

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

How do we measure it?

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

How are we doing?

Our 2019/20 year-to-date performance of 1.9% did not meet our new internal-set target of $\leq 1.6\%$, and the year over year chart shows that it's trending in the wrong direction. At the community-level, eight are having an incidence rate higher than 1.6%, with Delta and Surrey being exactly at the target. It is important to note that residents are moving in to long term 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 a 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?

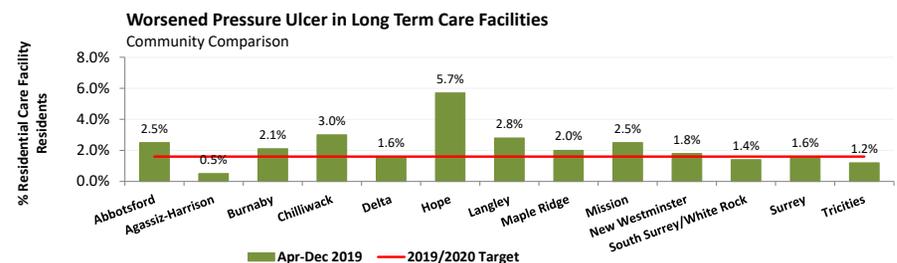
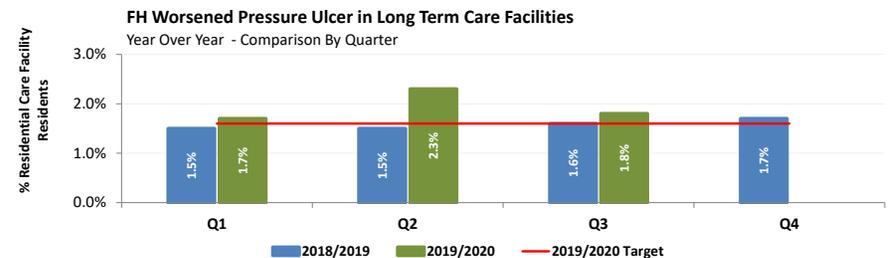
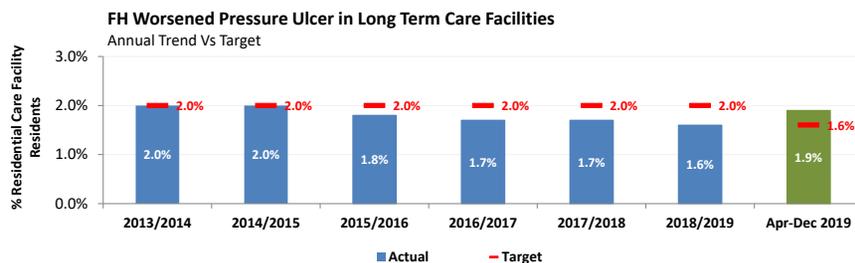
All long term complex care providers are familiar with the care required by this frail population and responsible to ensure that high quality care occurs. Quarterly performance indicator data continues to be shared with each LTC site so appropriate site-based action can be taken to address issues. A telehealth process for wound care consultation has been introduced in 2019/20, in addition to Wound Care Clinician site visits, to support timely wound assessment and intervention. This initiative will continue to spread to all sites over the course of this year. The Wound Care Clinicians continue to coach and mentor site staff on using best practices when they are on site conducting consultations. Hydration, which is an important factor in reducing pressure ulcers, has been reinforced during recent region-wide initiatives to reduce urinary tract infections and pneumonia.

What can you do?

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

Our Performance	Target *
1.9% ◆	$\leq 1.6\%$
Unit of Measure: Percent of residential care clients	
Performance timeline:	Apr-Dec 2019
Data Source:	FHA Database (RAI compliance table)
* Target Source:	FHA Internal

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



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

Emergency Patients Admitted to Hospital Within 10 Hours

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

What are we measuring?

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

Why?

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

How do we measure it?

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

How are we doing?

Fraser Health strives for continuous improvement. 2020/21 target is increased from 46% in 2019/20 to 65%. Fraser Health's current performance of 59.4% is not meeting our new internal target. Two hospitals (Eagle Ridge and Peace Arch) are currently meeting the target, three hospitals are performing close to the target (Delta, Royal Columbian and Ridge Meadow). Due to COVID-19, Emergency visits were reduced significantly, during first 2 periods, percentage of patients admitted to hospital within 10 hours has increased 125% and 54% respectively compared to same periods last year. We will continue to work with our sites and programs to reduce acute care and emergency department congestion.

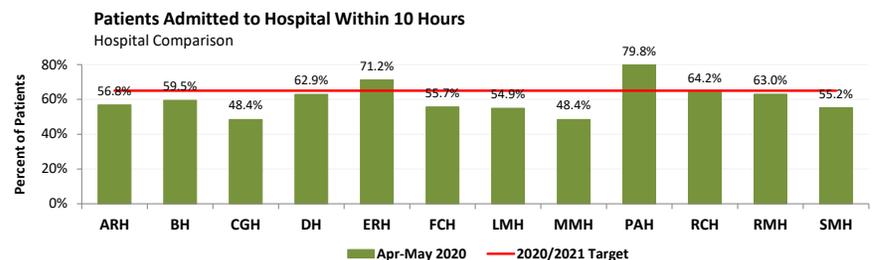
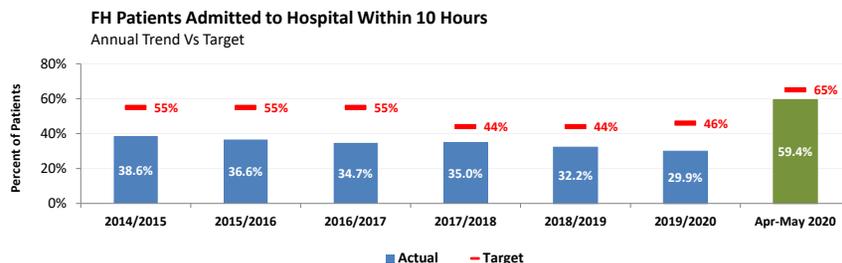
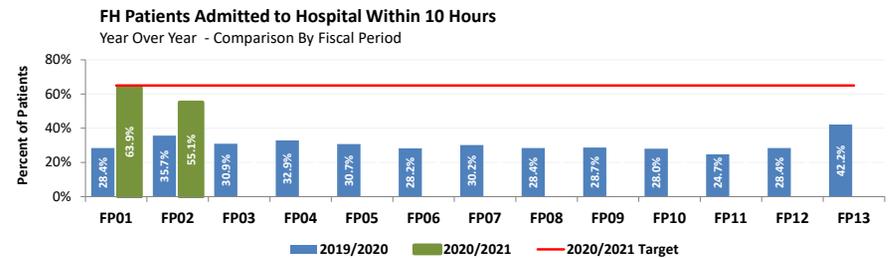
What are we doing?

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

What can you do?

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

Our Performance	Target *
59.4% ▲	>= 65.0%
Unit of Measure: Percent of patients admitted within 10 hours	
Performance timeline: Apr-May 2020	NACRS as measured by FHA
Data Source: BC Ministry of Health	BC Ministry of Health
* Target Source:	



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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.

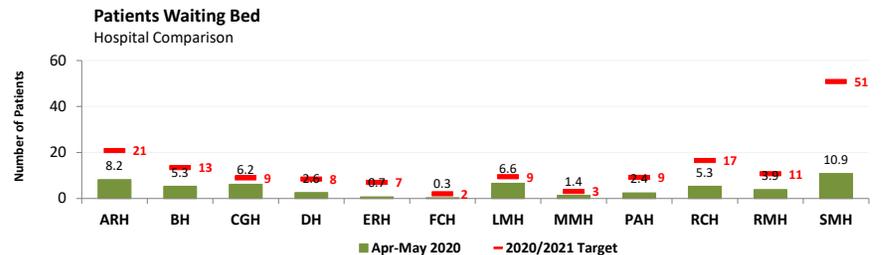
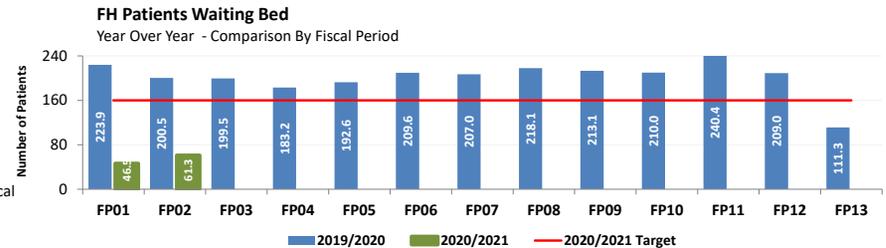
How are we doing?

Our year-to-date 2020/21 performance of 53.7 is meeting the internally-set target of 160.0. The anticipated improvement in the volume of patients admitted in our Emergency Departments as a result of the COVID 19 situation resulted in a 75% reduction in the number of patients awaiting inpatient beds during the first 2 periods. The unprecedented reduction in Emergency visits and admissions means that we have been able to efficiently move our patients from the Emergency Department to appropriate ward beds.

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 renewed emphasis on our initiatives in these areas to continue pursuing improvements and have enhanced oversight in monitoring performance.

Our Performance	Target *
53.7	<= 160
Unit of Measure: Number of patients waiting for inpatient bed	
Performance timeline: Data Source:	Apr-May 2020 Meditech Client Server (Admissions), Master Bed Map spreadsheet (Clinical Capacity Optimization and Finance) FHA Internal
* Target Source:	



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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; two of our hospitals are meeting the target for this indicator (Peace Arch and Royal Columbian). During this time, ten of our hospitals had opportunities to improve their performance.

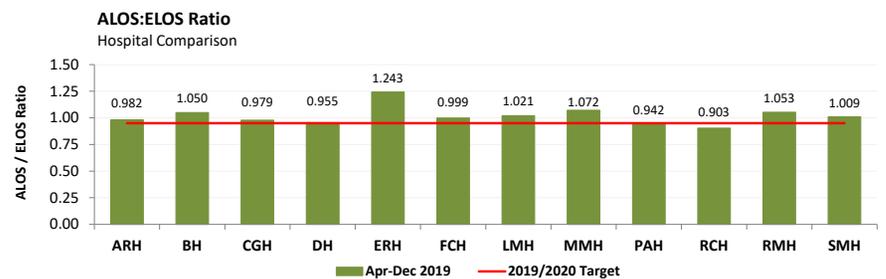
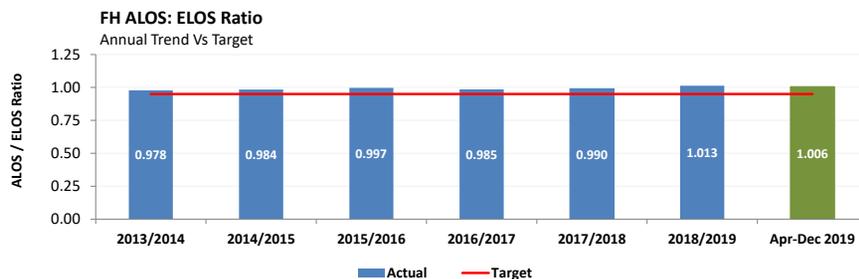
What are we doing?

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

What can you do?

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

Our Performance	Target *
1.006 ▲	<= 0.95
Unit of Measure: Ratio of Actual to Expected Length of Stay	
Performance timeline:	Apr-Dec 2019
Data Source:	MOH Measurement SharePoint
* Target Source:	FHA Internal



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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?

While at 296.4, 2020/21 average number of long-stay patients is meeting our internal target of 455. In the first 2 fiscal periods, we see a significant improvement in the long length of stay as we navigate the current CoVID 19 situation and our experience has borne this out. We have experienced unprecedented reductions in demand on inpatient beds although that is starting to change again.

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 have renewed emphasis on implementing strategies to improve our performance in all areas related to patient access and flow.

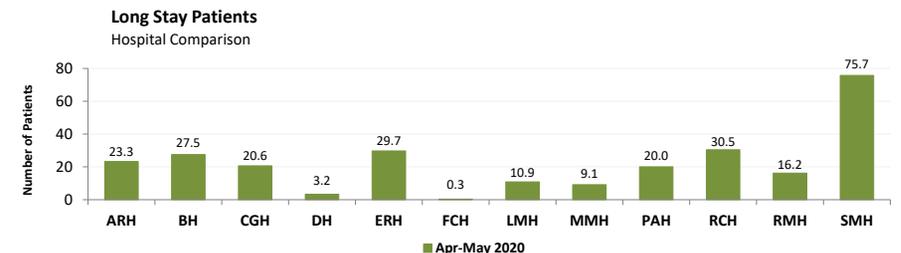
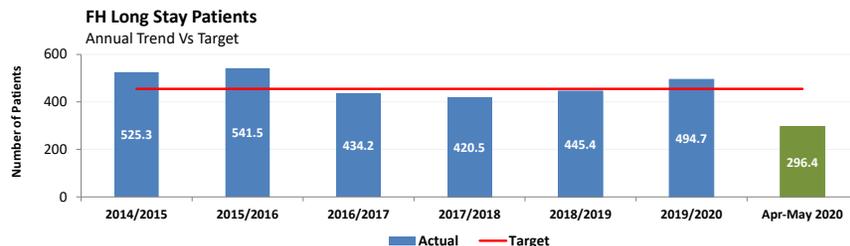
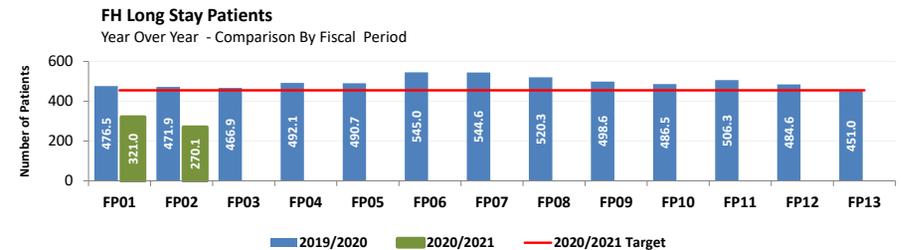
What can you do?

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 *
296.4 ●	≤ 455
Unit of Measure: Number of patients staying longer than 30 days	

Performance timeline: Apr-May 2020
 Data Source: Meditech
 * Target Source: FHA Internal

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



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

Alternate Level of Care (ALC) Days

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

What are we measuring?

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

Why?

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

How do we measure it?

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

How are we doing?

Fraser Health's 2019/20 performance of 16.0% is not meeting the target for this indicator. Three hospitals are meeting the target (Abbotsford, Royal Columbian and Surrey Memorial), while our nine other hospitals are above target.

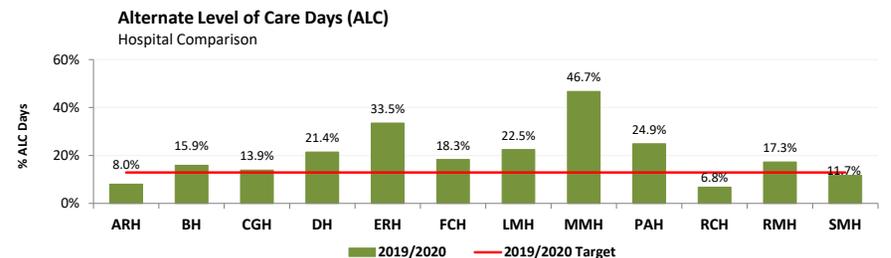
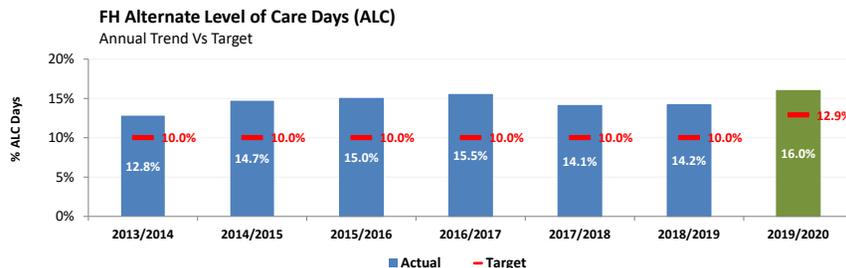
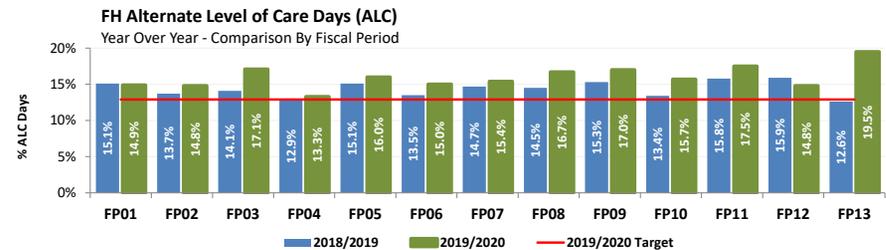
What are we doing?

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

What can you do?

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

Our Performance	Target *
16.0% ◆	<= 12.9%
Unit of Measure: Percent of ALC days to total days	
Performance timeline: 2019/2020	
Data Source: Med2020 Abstracting and Coding System	
* Target Source: BC Ministry of Health	



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

Hospitalization Rates for Residents (Age 70+)

How many seniors in our region have been hospitalized?

What are we measuring?

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

Why?

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

How do we measure it?

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

How are we doing?

The standardized hospitalization rate for seniors has been in steady decline over the last six years. However, with a regional rate of 259.7, we have not yet achieved the targeted rate of 250.8 hospitalizations per 1,000 seniors. Rates vary by community with some better than the target, while other have opportunity for improvement. Rates are trending in a positive direction for the majority of our communities.

What are we doing?

We are seeking to reduce unnecessary hospitalizations by ensuring people aged 70 and older have access to a most responsible physician or Nurse Practitioner through Primary Care Networks. These networks are under development across Fraser Health, in partnership with local Divisions Of Family Practice. Their main focus is to increase access to the services you need when you need it. We are also strengthening linkages between Family Doctors and Nurse Practitioners with the Specialized Community Services Programs for Seniors and Adults with Complex Medical Conditions and/or Frailty to better support patients and families access the care they need in the community and remain at home as long as possible. This will be possible through the connection with appropriate community based resources including: Nursing, Physiotherapy, Occupational Therapy, Social Work, Palliative Care, End of Life Care, Respite for care providers, Assisted Living options, Long Term Care as well as rapid access to specialized clinics.

What can you do?

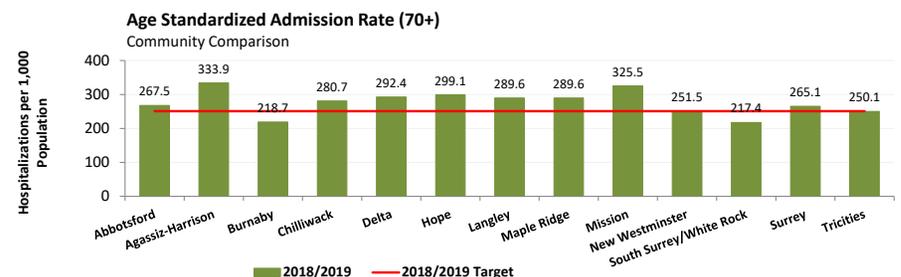
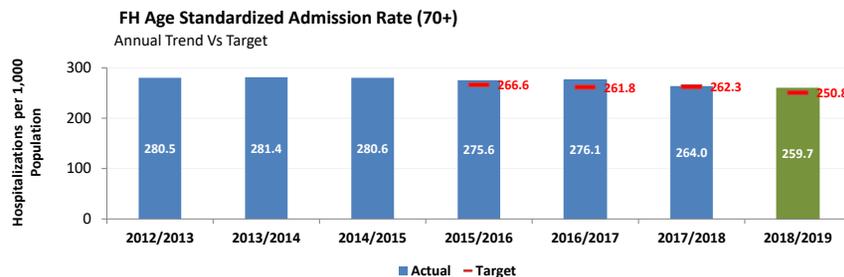
Ensure that you have a family doctor, and/or Nurse practitioner. Use the available community based services and programs to meet your health and social care needs. Ask your family physician and health care team to help you learn how you can best manage your chronic conditions as well as and help you know early warning signs and symptoms to avoid a deterioration of your health. Request community supports such as home health or home support to help manage your condition. Know what to do in the event of emergency. Exercise if you can. Eat a healthy diet, and try to maintain a healthy weight.

Our Performance	Target *
259.7 ▲	<= 250.8

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

Performance timeline: 2018/2019
 Data Source: Healthideas BC
 * Target Source: FHA Internal

Notes: 1) All rates are standardized using the direct method; All rates are per 1000 population; The standard population used is Census 2011; Based on BC Hospital Discharge Data; Population data provided by BC STATS (P.E.O.P.L.E. 2019);
 2) In late 2019, MOH updated the report by using P.E.O.P.L.E. 2019 instead of P.E.O.P.L.E. 2017. Previously reported numbers have been restated and targets have been adjusted accordingly.



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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 year-to-date hospital readmission rate of 10.1% is not meeting our internal target of 10%. We performed below the B.C. average for this indicator. Year over year we've decreased our readmission rate in first three quarters of this year. Three of our communities are meeting our internal targets (Burnaby, New Westminster and Tri-cities). All other communities have the opportunity to improve on this indicator.

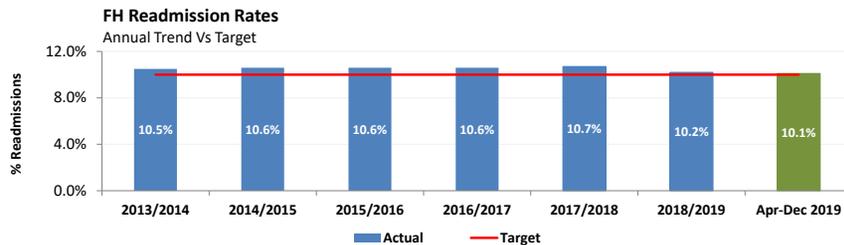
What are we doing?

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 *
10.1% ▲	<= 10.0%
Unit of Measure: Percent of patients readmitted	
Performance timeline:	Apr-Dec 2019
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: FP02, 2020/21 - Ending May 28, 2020

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 Q3 of 2019/20 is 10.1%, meeting the target for this indicator. This is a huge improvement compared to the previous quarter, Q2 2019/20 (14.6%), Q1 2019/20 (14.3%) and to the 2018/19 Q3 (13.5%). Overall, the readmission rate for the first three quarters of 2019/20 is 13.1% and meets the target of 13.3%. When comparing readmission rate for the overall first three quarters of 2019/20 among Fraser Health communities, there is huge variation, ranging from 8.1% in South Surrey/White Rock to 28.0% in Agassiz-Harrison. More specifically during the first three quarters of 2019/20, six out of 13 Fraser Health communities did not meet the 13.3% target, ranging from rates of 13.6% in Burnaby to 28.0% in Agassiz-Harrison. The rest of communities met the readmission rate target, with rates ranging from 8.1% in South Surrey/White Rock to 13.0% in Delta.

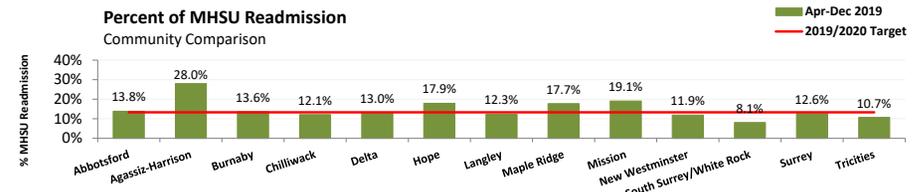
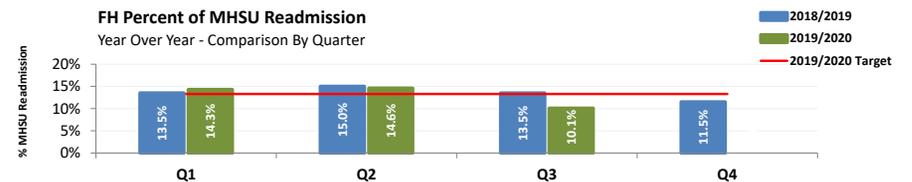
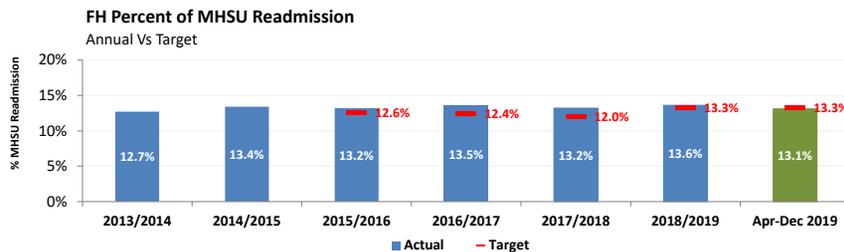
What are we doing?

During the COVID-19 Pandemic, in a very short time, MHSU has stepped up and made changes in their service delivery model to respond to the needs of MHSU clients while preventing the spread of COVID-19. Many services are being delivered virtually, including group and individual counselling, assessment, admission and discharge to acute, and transition between services. Moreover, several Rehab and Recovery services such as occupational therapy, recreation therapy, exercise therapy, vocational counselling, and family support, are now being provided online. The change in service delivery has provided us with the opportunity to evaluate the impact of all virtual health services on MHSU clients, including their readmission rate to acute. The expansion of virtual health is in addition to existing services such as Urgent Care Response Centre (UCRC) in Surrey, which provides central access for adults with mental health and substance use concerns, including those with opioid use disorder. The UCRC opened on July 24 2019 and provides low-barrier and timely access to assessment, initiation of treatment, and connection to appropriate services. The extended hours of service has reduced wait-times for MHSU services and has resulted in decreased readmission rates. The significant decrease in readmission rate from Q1 and Q2 2019/20 to Q3 2019/20 could be partially due to UCRC services. MHSU has 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 an overdose, with the goal of engaging them in treatment and reducing the danger of further overdose and readmission. Other initiatives, such as Integrated Transition of Care Teams (ITCT), focus on timely follow-up with clients discharged from acute services. MHSU has also established four Intensive Case Management (ICM) teams (in Maple Ridge, Langley, Surrey, and Chilliwack). ICM serves vulnerable clients who are living with serious addictions and other comorbidities, and who are homeless or at risk of homelessness. MHSU is enhancing discharge planning to include improved communication with patients, families/supporters, and community providers to ensure that they have the information they need for post-discharge continuity of care, self-management, and relapse prevention.

What can you do?

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

Our Performance	Target *
13.1% ●	<= 13.3%
Unit of Measure: Percent of patients readmitted	
Performance timeline:	Apr-Dec 2019
Data Source:	MOH Measurement SharePoint
* Target Source:	BC Ministry of Health



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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.

How are we doing?

Fraser Health's performance has remained relatively stable the past several years. The 2019/20 year to date admission rate of 2,906 is below our target of 3,448. Of the FHA communities, all except Mission have met the target. We continue to examine opportunities to improve.

What are we doing?

Fraser Health (FH) continues to work in partnership with Family Physicians and the Divisions of Family Practice (DOFP) on primary and community care redesign, including the development of the Primary Care Networks. This work has a specific emphasis on improving access to care for seniors and individuals with medical complexity, which includes chronic disease management. New initiatives have been locally planned and implemented to ensure the needs of the local population are being addressed.

All communities within FH have now commenced activities that aim to optimize access to primary and community care services. Fraser Health is currently putting in place Urgent Primary Care Centres and Community Health Centres over the next 3-years, which will deliver faster access to primary care and reduce the need for emergency department visits. Virtual Health and home health monitoring initiatives continue for patients with chronic conditions such as heart failure, COPD, and diabetes. The goal is to improve patient self-management and reduce exacerbations requiring emergency or acute care.

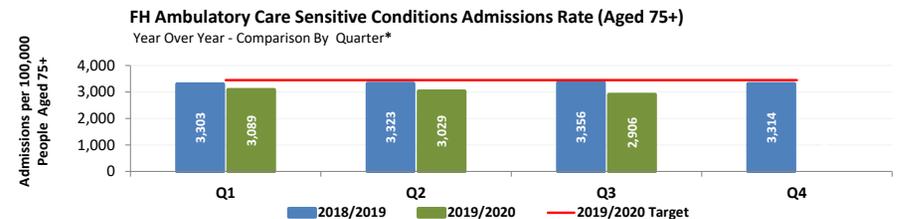
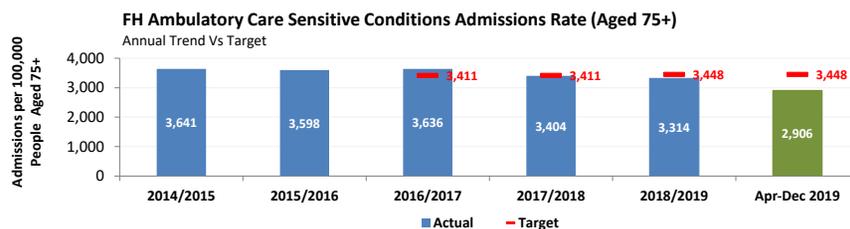
What can you do?

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.

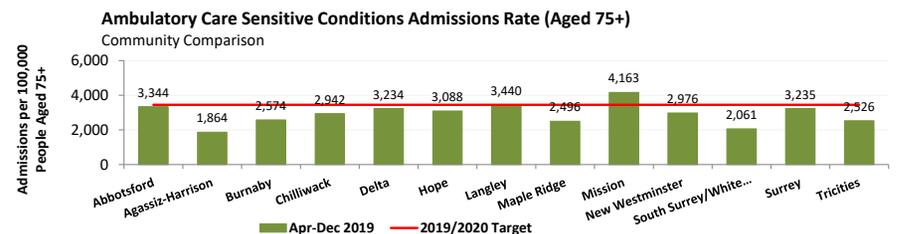


Performance timeline: Apr-Dec 2019
 Data Source: MOH Measurement SharePoint
 * Target Source: BC Ministry of Health

Notes: 1. All rates are standardized using the direct method; All rates are per 100,000 population; The standard population used is Census 2011; Population data provided by BC STATS (P.E.O.P.L.E. 2018);
 2. Previously reported data has been restated based on new MOH report



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



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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?

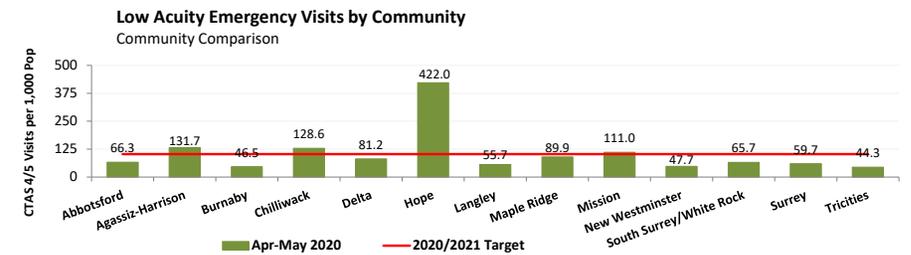
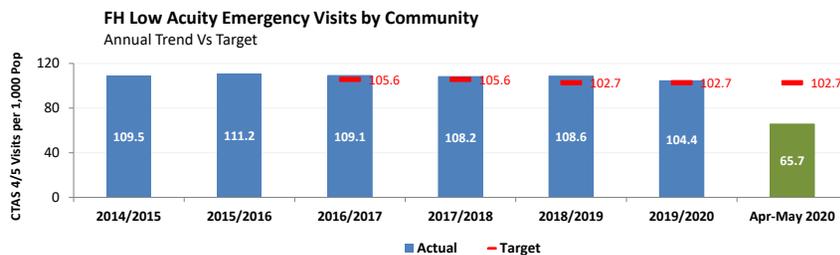
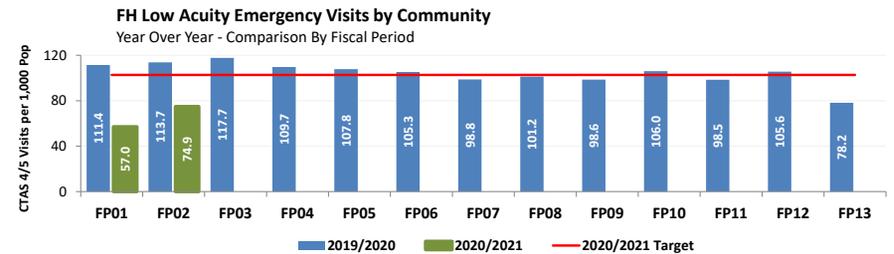
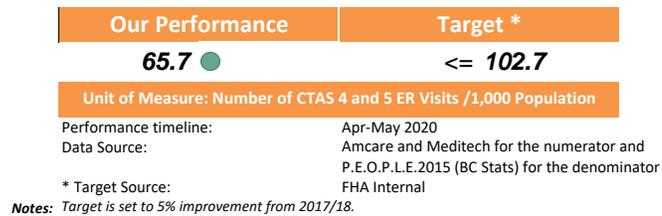
HH use of the Emergency Room (ER) has been significantly lower due to the CoVID19 pandemic as the entire population reduced their use of ER during this time. We don't have the data to know if they were able to reach their physicians for a phone visit or not as an alternative to going to the physicians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

What are we doing?

Over the next few months we will re-engage with our Divisions of Family Practice to ensure that everyone who want a family doctor has access to one. Gather key learnings, explore and implement key strategies related to Virtual Health.

What can you do?

If you do not have a family doctor and would like one you can call the Home health Services Line to link you to services. You can attend Urgent & Primary Care Clinics (UPCC) located in many communities to access a doctor and the health care team to meet your care needs. If you have a family doctor or nurse practitioner continue to work with them to identify ways to keep healthy, including knowing early warning signs that your health is changing and take early steps to manage it. Additionally, you can call 811 to speak with a healthcare professional to help you decide the best next steps to manage your health.



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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?

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

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?

The CoVID19 pandemic required supported clients and families access services in a different way through the use of technology; or through visiting the home using increased personal protection equipment. The use of virtual health to access the care team will be accelerated to improve the percentage of home health services that are provided within benchmark time.

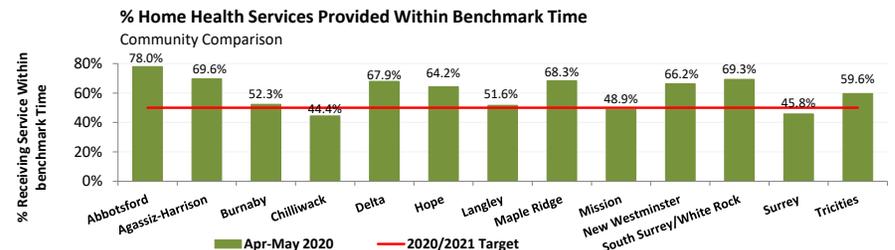
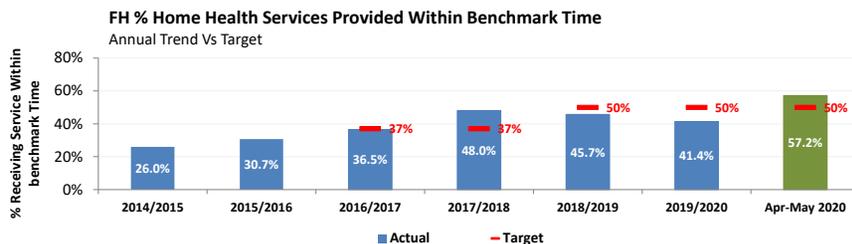
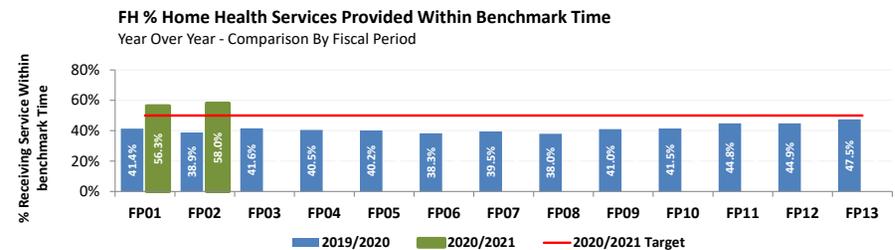
What are we doing?

The Specialized Community Services Programs for Seniors and Adults with Complex Medical Conditions and/or Frailty team will review the data during the pandemic and ongoing (monthly) to monitor progress towards the goal and adjust activities as appropriate based on learnings.

What can you do?

If you have not been contacted by Home Health to set up the services you need please call your local office. Alternately, you can ask your Doctor or nurse practitioner to help you connect with Home health. If you do not have a primary care provider call the home health services line to request assistance .

Our Performance	Target *
57.2% ●	>= 50.0%
Unit of Measure: Percent of Services provided within benchmark	
Performance timeline: Apr-May 2020	
Data Source: PARIS System	
* Target Source: FHA Internal	



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

Wait Time for Home Health Assessment (RAI-HC)

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

What are we measuring?

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

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

How are we doing?

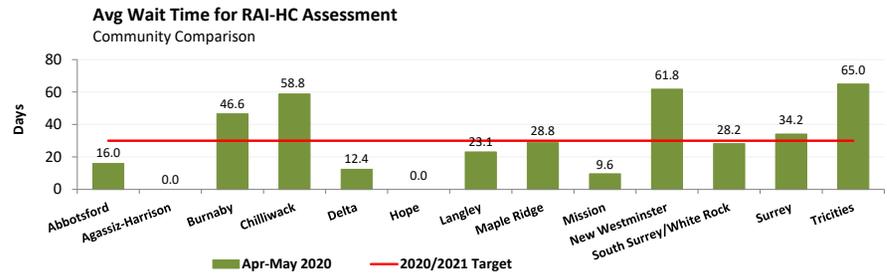
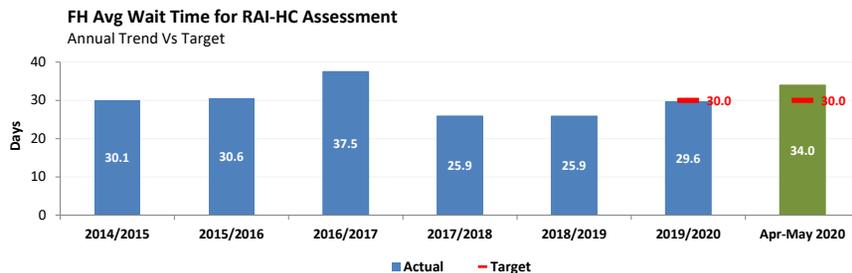
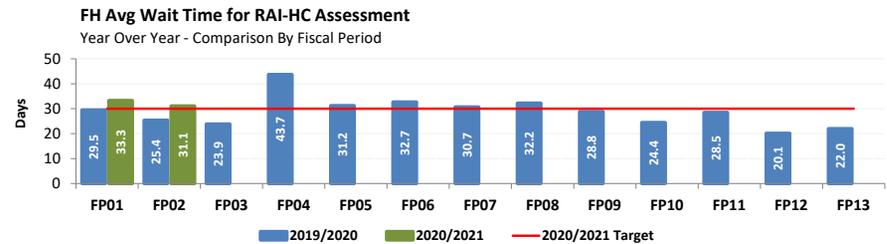
Fraser Health's year-to-date performance of 34 is not meeting our internally set target of 30. Eight communities have achieved client wait times below the 30 day target and one community is close to the target. The CoVID19 pandemic created an opportunity for clinicians to complete comprehensive reassessments to new clients in several communities through the use of virtual technology.

What are we doing?

The use of virtual technology in supporting reassessments in known clients will be expanded to support meeting assessment targets

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 Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

Admissions to Long Term Care within 30 Days

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

What are we measuring?

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

Why?

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

How do we measure it?

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

How are we doing?

Fraser Health's year to date performance of 71.2% is not meeting our internally set target (75.0%). Five communities (Delta, Hope, Mission, New Westminster and Surrey) are achieving the target. In some of our communities we continue to see unexpected volume of referrals along with a low volume of vacancies which is impacting performance in those 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. In addition the new Provincial Long Term Care Access Policy, implemented in July 2019 has likely increased the wait times due to clients on transfer lists and clients in the community choosing to wait for their preferred care home.

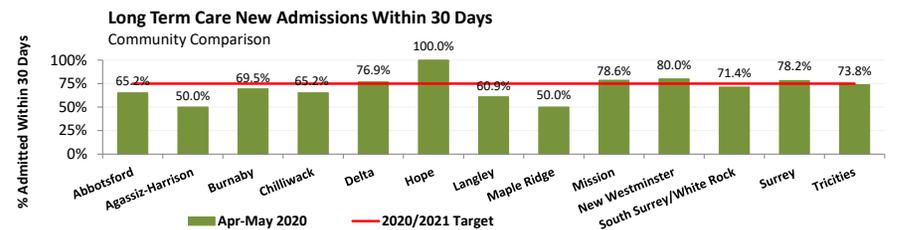
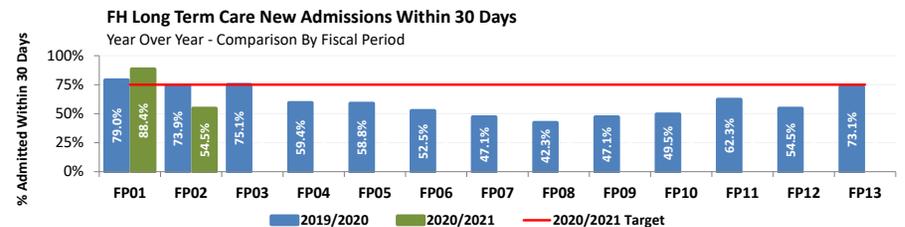
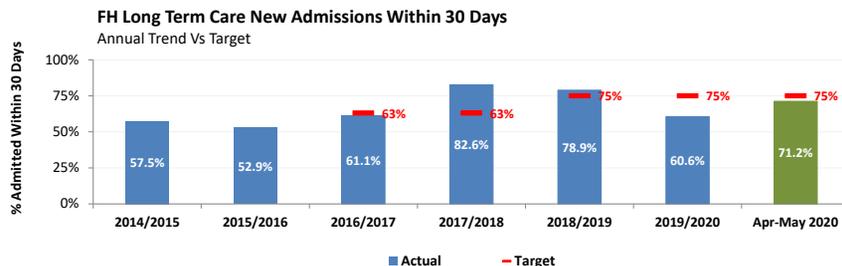
What are we doing?

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. In 17/18 FH Long Term Care Services, Home Health and Acute Care Services implemented redesigned collaborative processes that review individuals put forward for long term care and identify those whose care needs can be met at home or in the community with different resources. When followed, this ensures that long term care beds are available in a more timely manner to those individuals whose care needs can only be met in long term 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 *
71.2% ▲	>= 75%
Unit of Measure: Percent of clients admitted within 30 days	
Performance timeline:	Apr-May 2020
Data Source:	Strata Health Pathway
* Target Source:	FHA Internal



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

Emergency Visits by Home Health Clients

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

What are we measuring?

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

Why?

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

How do we measure it?

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

How are we doing?

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

What are we doing?

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

What can you do?

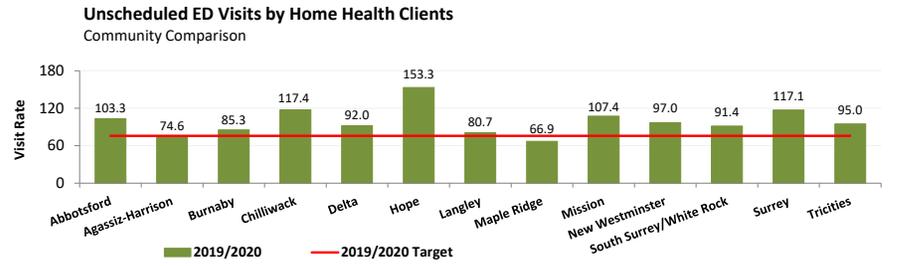
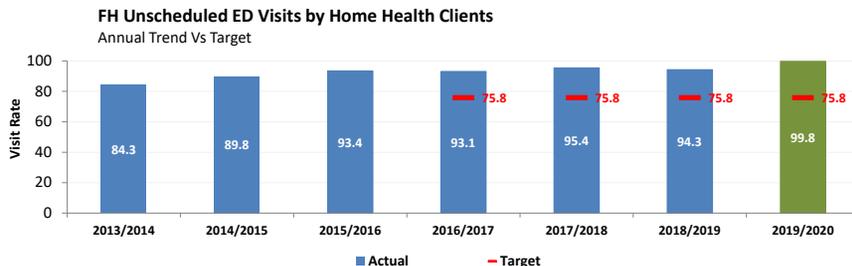
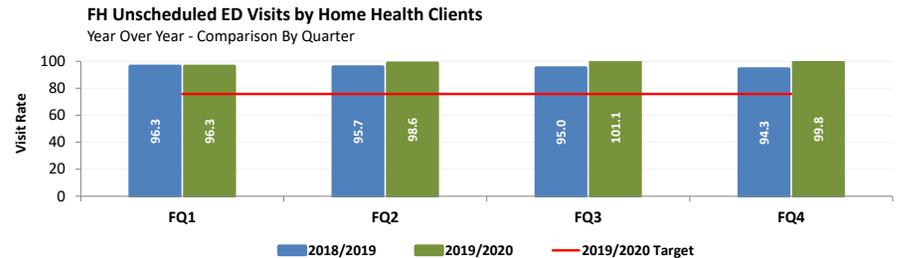
If you are receiving Home Health services and need additional support to keep you at safely at home connect with your home health office or your community health nurse to assist you access the care and services you need.

Our Performance	Target *
99.8 ◆	<= 75.8

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

Performance timeline: 2019/2020
 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: FP02, 2020/21 - Ending May 28, 2020

Emergency Visits by Long Term Care Clients

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

What are we measuring?

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

Why?

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

How do we measure it?

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

How are we doing?

Fraser Health demonstrated a noticeable improvement in 2018/19 over the previous 4 years. Performance is continued trending in the desired direction, a lower rate is observed in all quarters in 2019/20 compared to the same quarters last year. We continue to work towards meeting our target rate of 30.0.

What are we doing?

The province-wide Long-Term Care Initiative delivered by the Divisions of Family Practice aims to decrease unscheduled visits to the ER from long-term care homes in all 10 communities in FH. When possible, FH Long-Term Care Services collaborates with each Division to develop and implement quality improvement projects to reduce such visits.

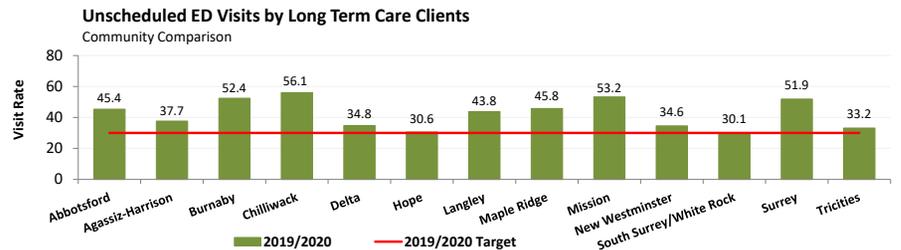
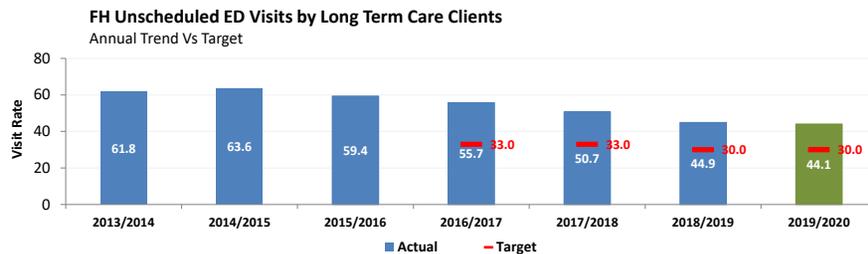
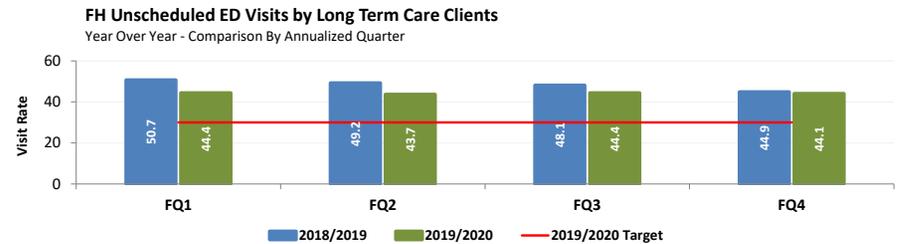
FH Long Term Care Services continues to practice a palliative approach to care to ensure that residents are able to make their wishes for care known to all (and ease the burden of family having to make the decisions) and to find ways to better support residents who wish comfort care only when their health deteriorates.

Each care home receives a quarterly report of their performance (relative to the target which is 7.5 per 100 residents per quarter) which raises awareness and provides opportunity for each facility to develop a site specific action plan to decrease unscheduled transfers to ED.

What can you do?

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

Our Performance	Target *
44.1 ◆	<= 30.0
Unit of Measure: Number of ER visits/100 residential care clients	
Performance timeline:	2019/2020
Data Source:	PARIS System, Meditech and NACRS
* Target Source:	FHA Internal



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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?

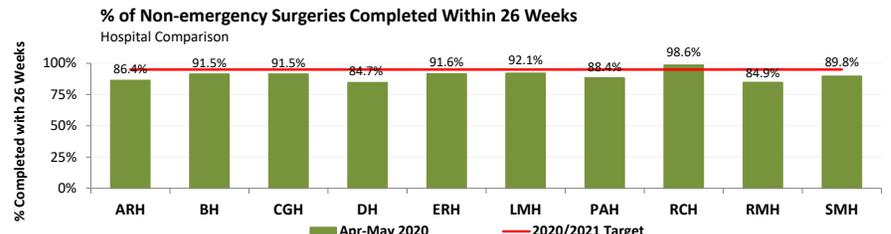
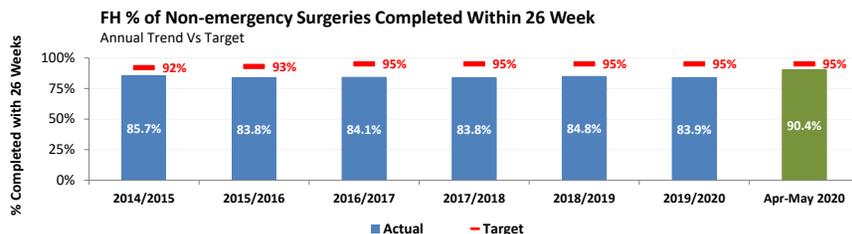
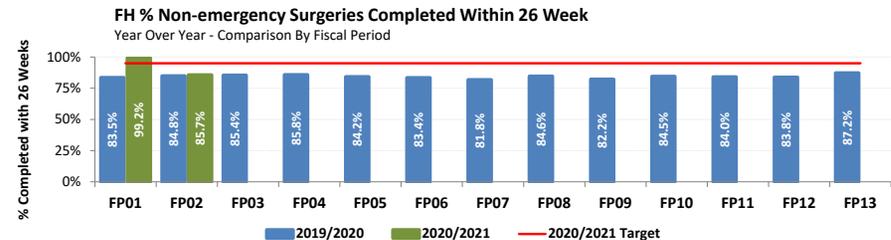
The proportion of non-emergency surgeries completed within 26 weeks decreased from 99.2% to 85.7% in the most recent period. This is driven by recent prioritisation of surgery capacity for urgent/emergent surgeries during the COVID-19 reductions.

What are we doing?

Fraser Health is working to restore surgical capacity to levels prior to COVID-19 and pursuing all available options to extend capacity to make up for lost surgeries during spring 2020.

What can you do?

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



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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?

The proportion of patients on surgery waitlists who have waited longer than 26 weeks increased significantly from 34.1% to 38.8% in the most recent period. This is driven by recent prioritisation of surgery capacity for urgent/emergent surgeries during the COVID-19 reductions.

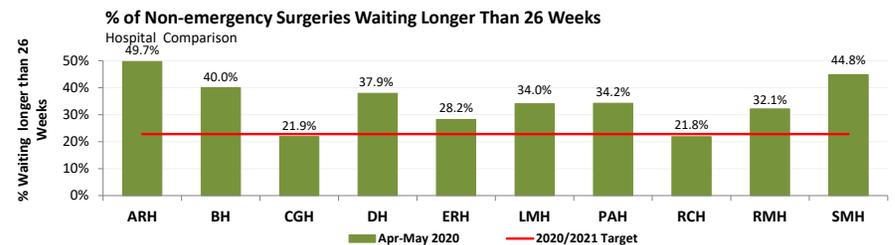
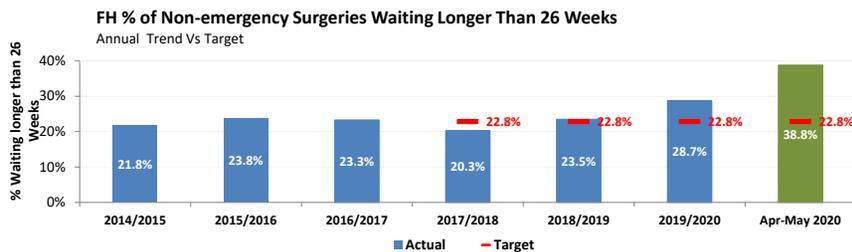
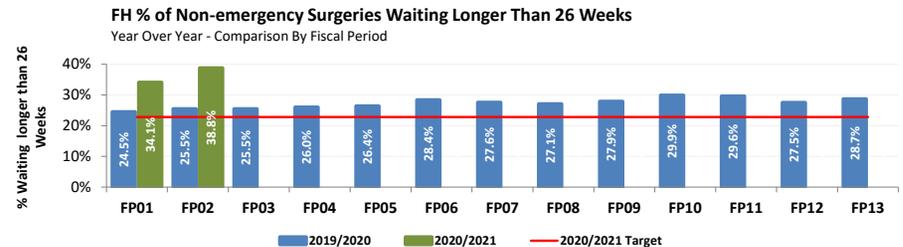
What are we doing?

Fraser Health is working to restore surgical capacity to levels prior to COVID-19 and pursuing all available options to extend capacity to make up for lost surgeries during spring 2020.

What can you do?

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

Our Performance	Target *
38.8% ◆	<= 22.8%
Unit of Measure: Percent of surgeries waiting longer than 26 weeks	
Performance timeline: Apr-May 2020	BC Surgical Patient Registry
Data Source: FHA Internal	FHA Internal
* Target Source:	



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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?

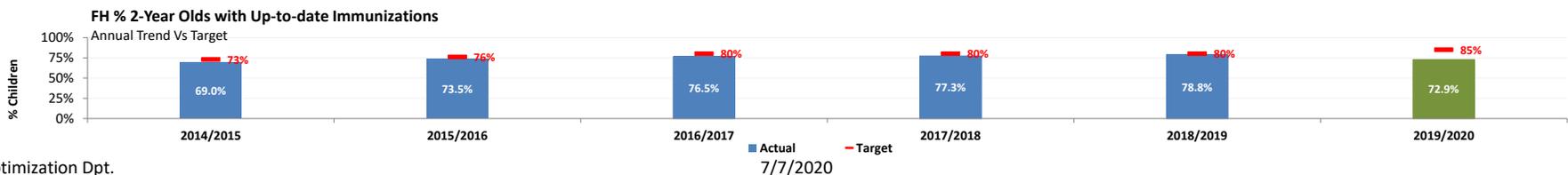
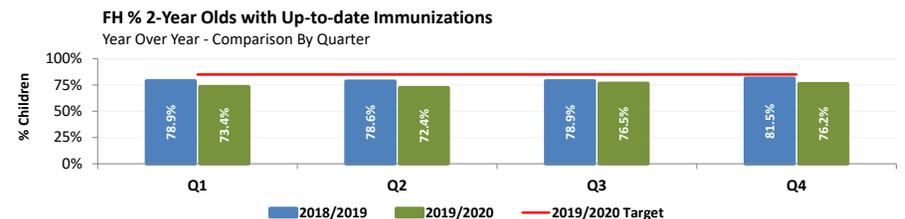
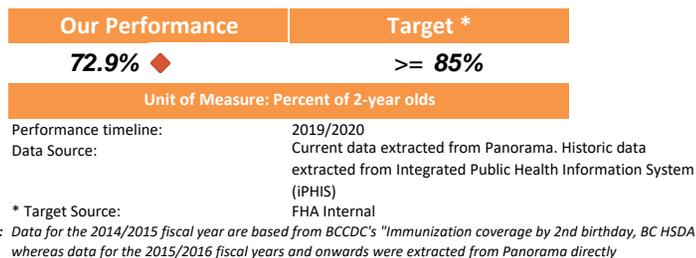
In Fiscal Quarter (FQ) 4 of Fiscal Year (FY) 2019/20 (January to March, 2020), 76.2% of 2-year-olds were up-to-date with their immunizations. This rate represents a 0.3 percentage point decrease with respect to the previous quarter (October to December 2019). Overall, during the FY 2019/2020 (April 2019 to March 2020) 72.9% of 2-year-olds were up-to-date with their immunizations. This value is 12.1 percentage points away from the target of 85%.

What are we doing?

To achieve our 85% 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 kindergarten 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. These actions have continued throughout our FH Covid-19 response. In January 2019, Population and Public Health received a grant from the Public Health Agency of Canada to explore the barriers parents and caregivers experience with ensuring their children are up to date with immunizations. Based on findings, strategies will be implemented such as immunization outreach clinics to mitigate these barriers to improve our up to date coverage rates. The pilot project is in Surrey and Chilliwack and will take place over 2.5 years and evaluated in 3 years. Due to Covid-19 our outreach partner sites suspended services starting in late March, as a result we have paused this project for now. Partnership Agreement with Telus Health Solutions, Surrey Hospital Foundation and Fraser Health to run a Mobile Health Clinic in Surrey and surrounding Fraser Valley communities. This initiative will allow us to address identified gaps in services including: scale-up of the provision of pre-exposure prophylaxis (PrEP) for HIV prevention and other sexual health services; immunization to targeted pre-school aged children attending Strong Start programs; and target vulnerable youth (up to 19 years old) to offer dental examinations, education, fluoride varnish applications, and client navigation for dental care funding opportunities. The official launch of the van took place on March 11, 2020 shortly after the clinic arrived in BC. Service delivery is planned to start in May 2020.

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. You can check your child's status at <https://immunizebc.ca/vaccination-status-indicator> 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 www.fraserhealth.ca/immunizationform Immunizations for children aged 2 months - 6 years of age continue to be available during the FH Covid-19 response.



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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 98.7% in Fiscal Quarter (FQ) 3, 2019/20 (October to December, 2019) to 98.4% in FQ4, 2019/20 (January to March, 2020). Overall, during the fiscal year 2019/2020 (April 2019 to March 2020) the RPCWT was unchanged from previous fiscal year at 98.7% and remained above the fixed annual target of 95%.

What are we doing?

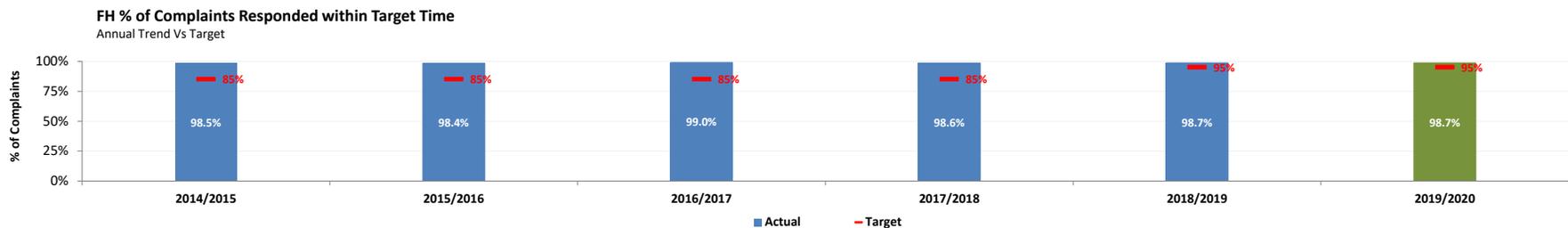
Health Protection staff receive public complaints via telephone, email or the FH Feedback system. Staff then assess the particulars of the complaint and respond as necessary to mitigate any health hazards that may be present. Often a site visit to the premises or affected area is conducted. Wherever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

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).



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: FP02, 2020/21 - Ending May 28, 2020

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) 4 of Fiscal Year (FY) 2019/20 (January to March, 2020), 67.4% of women who gave birth in FHA hospitals were registered with the Best Beginnings program during their pregnancy. This rate represents a 1.3 percentage point decrease with respect to the FQ3, 2019/20 (October to December, 2019) rate at 68.7%. The percentage of prenatal registrations in FY 2019/20 (April 2019 to March 2020) is 6.5 percentage points below the overall target of 75% at 68.5%.

What are we doing?

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

What can you do?

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

Our Performance	Target *
-----------------	----------

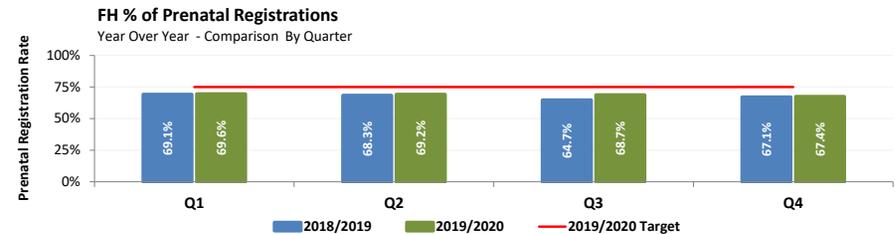
68.5% ▲

≥ 75%

Unit of Measure: Percent of women registered
--

Performance timeline:	2019/2020
Data Source:	PARIS System
* Target Source:	FHA Internal

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



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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.

How are we doing?

Burnaby and Hope remain the Local Health Authorities (LHAs) with the highest and lowest Average Life Expectancy at Birth (ALEB) in Fraser Health, respectively. The ALEB across LHAs in 2013-2017 ranged from a high of 84.1 years in Burnaby to a low of 75.4 years in Hope. Although the ALEB disparity between Burnaby and Hope increased with respect to the 2012-2016 period (7.3), the current disparity (8.7 years) is similar to the difference in ALEB observed during the 2011-2015 period (8.6 years).

What are we doing?

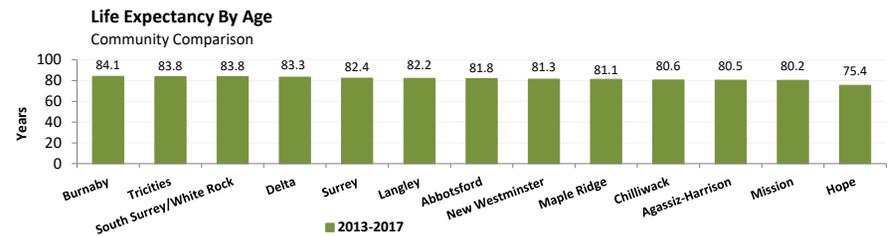
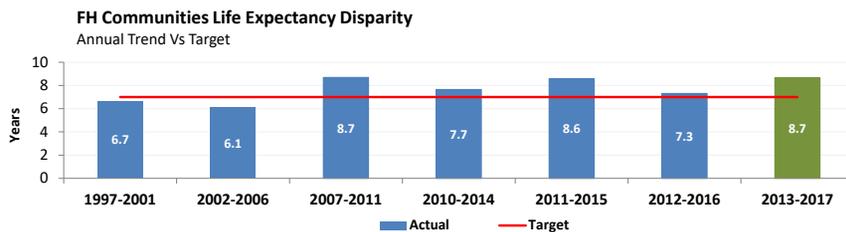
Population and Public Health (PPH) activities in health promotion, community engagement and community development contribute to improving Life Expectancy (LE) across the region; focused efforts in these areas can reduce health disparities and improve life expectancy in geographic areas and populations 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 the 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 properties. Health Equity Assessment Training across PPH staff ensure our programs and services include 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 equal chance for health.

Our Performance	Target *
8.7 ◆	<= 7.0
Unit of Measure: Number of years different in life expectancy	
Performance timeline:	2013-2017
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



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

Nursing and Allied Professional Sick Time

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

What are we measuring?

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

Why?

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

How 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?

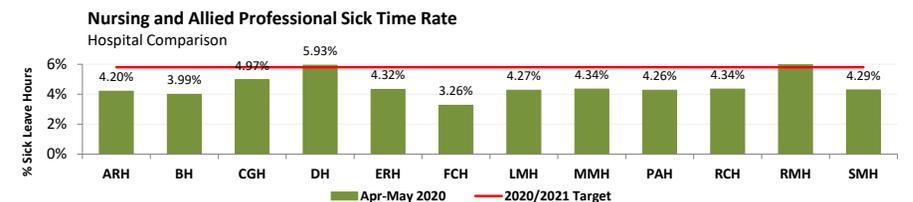
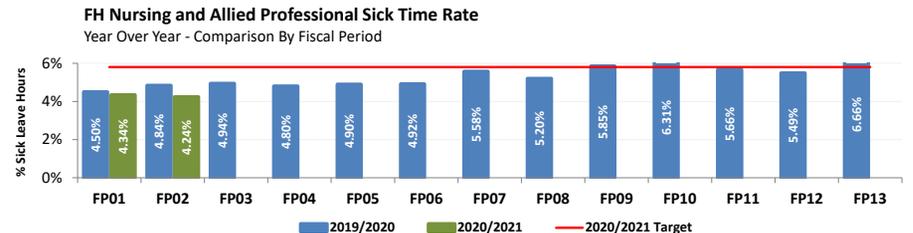
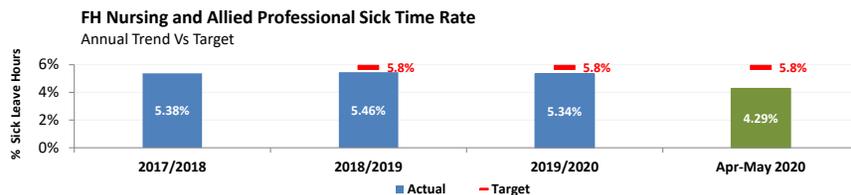
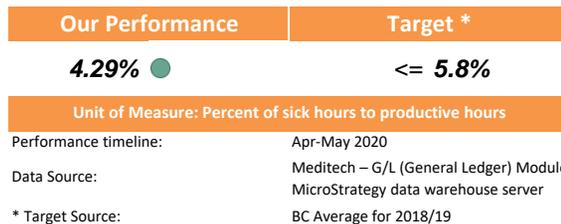
The 2020/21 year-to-date performance of 4.29% remains well below our target of 5.8% for Nurses and Allied Health professionals. Ten of our hospitals are performing well and remain below the set target. Unfortunately the impact of COVID-19 can be seen in 2019/20 FP13, where the sick rate spikes to 6.66%. Some of the increased sick time usage is due to the initial self-isolation mandate for staff after a potential exposure to COVID-19 or return from travel. Instructions have changed over the course of managing the outbreak which will influence the amount of sick time taken. Additionally, staff that are immunocompromised that could not be redeployed safely were able to utilize their sick time and other banks prior to going onto unpaid COVID-19 leave.

What are we doing?

The successful attendance support mandate launched in February 2019 that focused on informing and educating the organization on the importance of maintaining a healthy sick bank as the Short Term Disability benefit was suspended in early March with the onset of COVID-19. Key messaging has always been "if you are sick do not come to work", and that message is even more important in the current state. The inform-educate-offer letter campaign that provided staff with quarterly updates on their sick time usage have been discontinued temporarily. Supportive resources remain available to all staff who may be impacted negatively due to present health conditions or fear or anxiety related to the pandemic. Employees that are immunocompromised and potentially at higher risk for contracting the illness or developing more dire symptoms, and work in high risk areas, are supported through efforts to redeploy them to more appropriate work in an environment with reduced risk. In the event they are unable to be redeployed successfully, staff are supported through the use of their sick and other banks, prior to moving to COVID-19 leave. During this time their benefits continue to be employer-paid. The Starling Minds Mental Fitness online CBT support program has been extended for an additional 6 months. This program uses online cognitive behavioural therapy and is available to support employees in building resiliency to stress, anxiety and depression. Special modules having been created by the developers to address increased anxiety related to COVID-19 specifically. The additional supportive resources available through the Absence and Disability Management program at Fraser Health continue to be available, with many of the mental health resources moving to a virtual platform successfully.

What can you do?

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



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

Nursing and Allied Professional Overtime

How often do our staff work overtime?

What are we measuring?

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

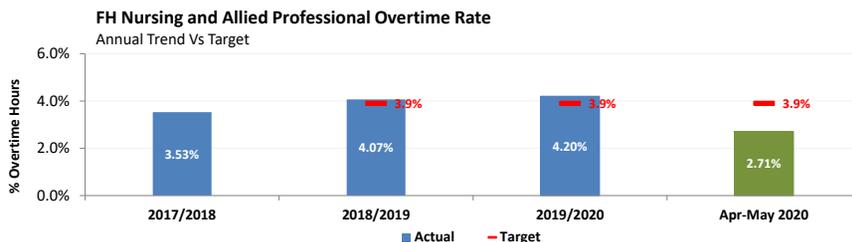
Why?

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

How do we measure it?

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

Our Performance	Target *
2.71% ●	<= 3.9%
Unit of Measure: Percent of overtime hours to productive hours	
Performance timeline:	Apr-May 2020
Data Source:	Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server
* Target Source:	BC Ministry of Health

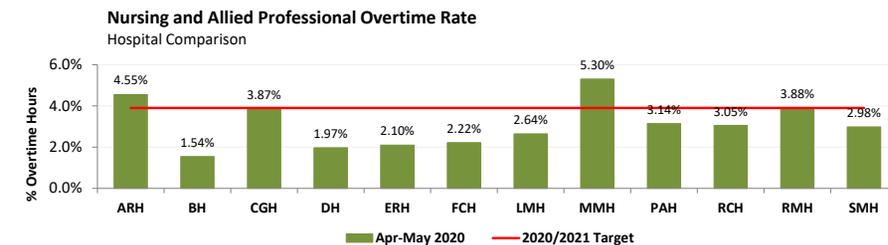
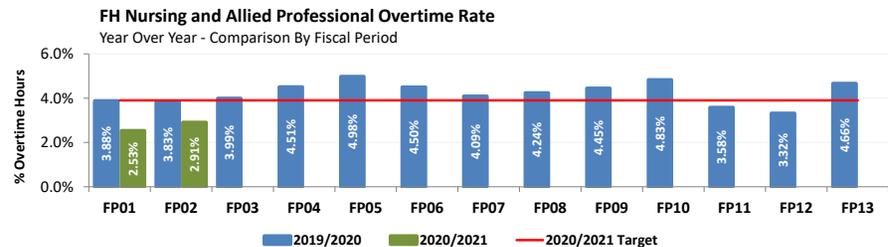


How are we doing?

As the reporting of overtime now focuses on Nursing and Allied Health, the target was increased to 3.9%. The year-to-date (up to financial period 02), overtime rate for Nursing and Allied Health was 2.71%, which is well below the new target. As overtime is cyclical throughout the year, it is important to compare overtime for the same period year by year. The initial interpretation of the reduction in overtime is due to the COVID-19 pandemic, reduction in elective surgeries and decrease in patient volumes. In the first two fiscal periods, Fraser Health's overall overtime rate was lower compared to the same periods last year. Of the 12 hospitals, 10 met the new target.

What are we doing?

- Strategic HR continues to proactively meet and targets sites with high overtime, workload and/or sick time to develop mitigation strategies.
- Overtime is reported bi-weekly to the executive for review. Additional strategies are under consideration including: new staffing strategies for nursing, promotion of regular relief pools and targeted recruitment.
- A regional overtime mitigation plan is in place and being implemented.
- Discussions are underway with clinical operations to determine opportunities to increase the number of casual employees in order to meet our relief needs.



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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?

Our 2019/20 year-to-date performance of 6.55 is not meeting the target of 5.3. The year over year chart shows that Q3 claims rate is higher than the same quarter last year. At the hospital level, five are achieving the target (CGH, FCH, MMH, PAH and RCH).

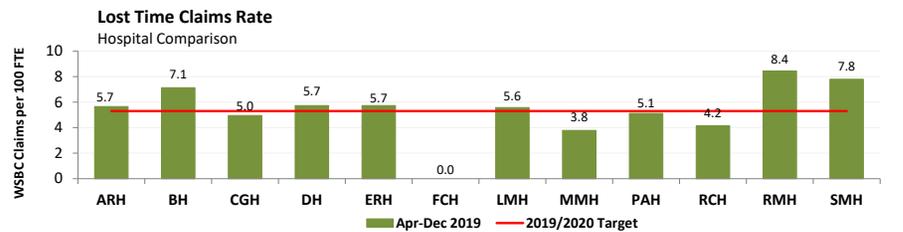
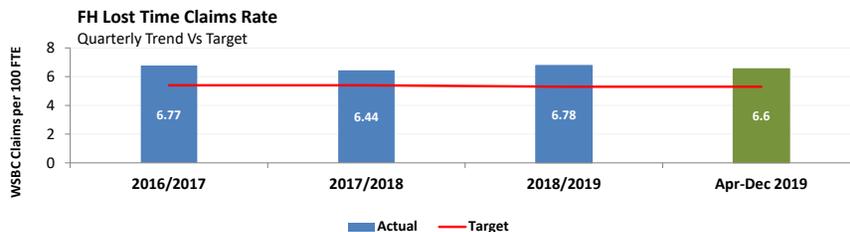
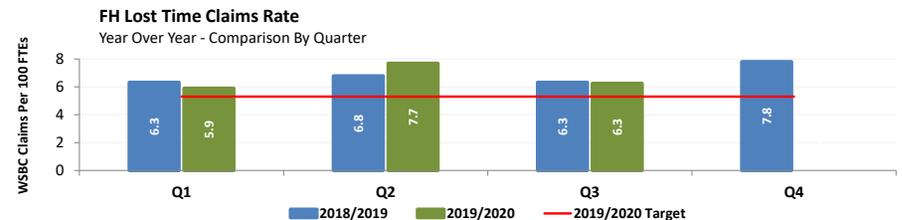
What are we doing?

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, slips trips and falls and violence. Managers and Directors are being held to key sets of KPIs in their safety management systems - through their performance plans and through planned activities with Health and Safety. Prevention plans include a focus on high priority units with an integrated prevention focus that includes bringing units up to standards for compliance, injury prevention/reduction plans and a series of planned management meetings to engage and make managers aware as to issues in their units.

What can you do?

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

Our Performance	Target *
6.55 ◆	<= 5.3
Unit of Measure: Number of WSBC accepted claims / 100 FTEs	
Performance timeline:	Apr-Dec 2019
Data source:	FHA Workplace Health
* Target Source:	BC Ministry of Health



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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?

Our 2019 performance of 1.98 is meeting our target of 2.25. The new LTD Claims rate decreased over the course of 2019. The Workplace Health Absence and Disability Management Team continues to close more claims that are being opened, resulting in a decrease of the total LTD claim volume.

What are we doing?

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

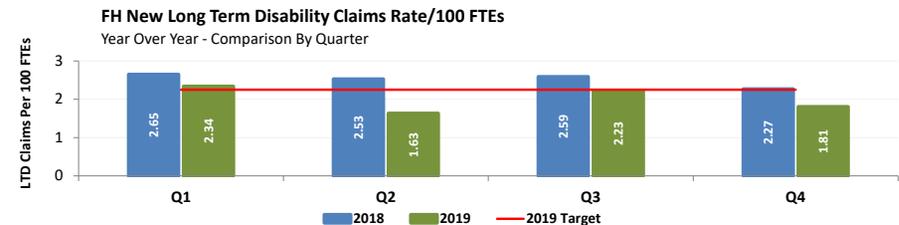
What can you do?

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 *
1.98 ●	<= 2.25
Unit of Measure: Number of LTD claims / 100 FTEs	

Performance timeline: 2019
 Data source: FHA Workplace Health White Database and FHA Meditech System
 * Target Source: FHA Internal

Note: Data refreshed on November 4, 2019



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

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

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.

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.

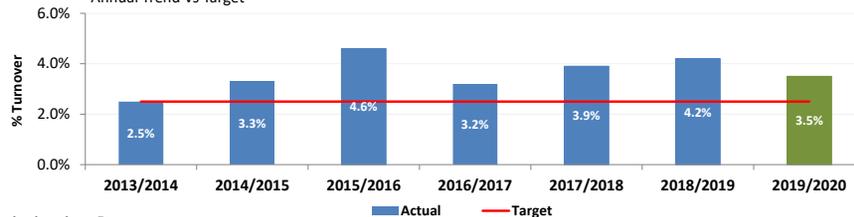


Performance timeline: 2019/2020
 Data Source: Meditech
 * Target Source: FHA Internal

Notes: Due to implementation of new employee 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



How are we doing?

Overall FH % First Year of Service Turnover has gone down by 0.6% for Q4 with 3.5% (43 terminations within the 1217 new hires) compared to last quarter 4.1% (45 terminations within the 1108 new hires). When comparing to the last year Q4, the % has decreased by 0.3% at 4.2% (44 terminations within the 1036 new hires). The numbers in Q3 19/20 to Q4 19/20 have been adjusted to take into consideration the large repatriation numbers in the Community Health Workers.

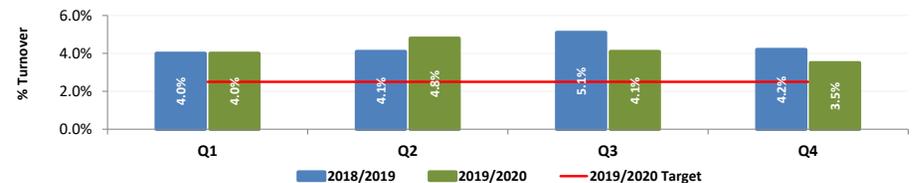
When the numbers are segregated by Designated Group, it is best to consider the numbers of Turnover as well as the %, as the counts become very small. When comparing Q4 2019/20 to Q4 2018/19, there have been varying changes. Excluded shows the largest change in Turnover with 11 Turnovers (25.6% of all Turnovers) in 2019/20 from 20 Turnovers (45.5% of all Turnovers) in 2018/19. Community shows a decrease in Turnover %; Community have 9 Turnovers (20.9% of all Turnovers) in 2019/20 from 10 Turnovers (22.7% of all Turnover in 2018/19). Nurses have 7 Turnovers (16.3% of all Turnovers) in 2019/20 from 3 Turnover (6.8% of all Turnovers) in 2018/19. Paramedics have 8 Turnovers (18.6% of all Turnovers) in 2019/20 from 3 Turnovers (6.8% of all Turnovers) in 2018/19. Facilities decreased by 1 with 7 Turnovers (16.3% of all Turnovers) in 2019/20 from 8 Turnovers (18.2% of all Turnovers) in 2018/19. Nurses-LPN have increased from 0 to 1.-LPN have increased from 0 to 1.

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.

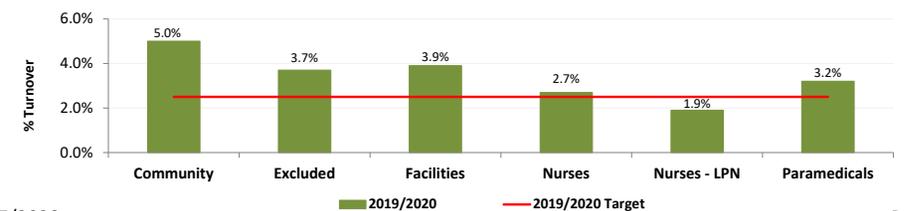
FH % Turnover In The First Year Of Service

Year Over Year - Comparison By Quarter



% Turnover In The First Year Of Service

Designated Group Comparison



Our Health Care Report Card

Fiscal Period: FP02, 2020/21 - Ending May 28, 2020

Budget Performance Ratio

How well are we performing compared to our budgeted plan?

What are we measuring?

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

How are we doing?

The second period ended with a deficit of \$10.7 million which included significant expenditures related to the COVID-19 pandemic response. Fraser Health continues to implement a number of ongoing mitigation strategies which continue to improve productivity, moderate spend against budget, transition care to the appropriate level and help allow Fraser Health to meet its overall financial commitments to the Ministry.

Why?

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

What are we doing?

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

How do we measure it?

Budgeted expenditures less net variance to budget over budgeted expenditures.

Our Performance	Target *
1.030 ▲	≤ 1.000
Unit of Measure: Actual to budget ratio	
Performance timeline: Data Source:	Apr-May 2020 Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server FHA Internal
* Target Source:	

