Our Health Care Report Card

	Time Frame	Target	Year to Date	
System Health				
Acute productive hours per patient day	Apr to Sep 2022	<= 6.5	6.6	
Alternate level of care (ALC) stay days as a proportion of total stay days	Apr 2022 to Sep 2022	<= 7.5 %	9.1 %	
Exceptional Care				
Emergency patients admitted to hospital within 10 hours	April to September 2022	>= 58.0 %	39.9 %	
Scheduled surgeries waiting longer than 26 weeks	Apr 2022 to Sep 2022	<= 5.0 %	36.7 %	
Clostridium difficile infection rate	Apr 2022 to Jul 2022	<= 3.2	4.5	
% of MHSU readmissions within 30 days – based on diagnosis code	Apr 2021 to Mar 2022	<= 13.0 %	14.9 %	
Potentially Inappropriate Use of Antipsychotics in Long-Term Care (CIHI-Adjusted RAI-QI)	Apr 2022 to Jun 2022	<= 22.5 %	29.7 %	
% of overall hospital deaths for clients with a community referral (in last year)	Jul 2022 to Sep 2022	<= 37.6 %	36.4 %	
Hospital standardized mortality ratio (HSMR)	Apr 2022 to May 2022	<= 100	77	
Great Place to Work				
Overtime rate	Apr 2022 to Sep 2022	<= 4.3 %	6.3 %	
Relief Not Found	2021/22 P1-P13	<= 1.5 %	2.2 %	
WorkSafe BC Time Loss Claim Rate	Jan 2022 to Jun 2022	<= 5.28	6.06	

 Within desirable target range  Within 10% of target  Outside desirable target range by more than 10%

Report Generated on: Oct 20, 2022

Our Health Care Report Card

Acute productive hours per patient day

Oct 2022

Are we matching our nursing levels to patient need?

What are we measuring?

We measure the productivity of nursing staff who provide direct patient care, including registered nurses, licensed practical nurses and nursing care aides.

Why?

We are measuring productivity levels to help us do a better job of planning ahead for the number of patients we expect to care for. For example, if we know of a time of day, month or year when we see more patients than usual, we can plan for higher staffing levels. Also, some patients in the hospital, as in the intensive care unit, require 24 hours of nursing care per day. Other patients do not need as many direct nursing hours to receive quality care and ultimately to make a full recovery. It's about using our staff resources (labour) in the most efficient and effective way possible.

How do we measure it?

This measure divides the total number of nursing hours paid (labour) by the number of patient days (volume). As per the Ministry of Health definition, this measure includes Medical, Surgical, Medical/Surgical, Intensive Care Unit (ICU), Obstetrics, Pediatrics, Mental Health and Substance Use, Physical Rehab, and Palliative Nursing Units.

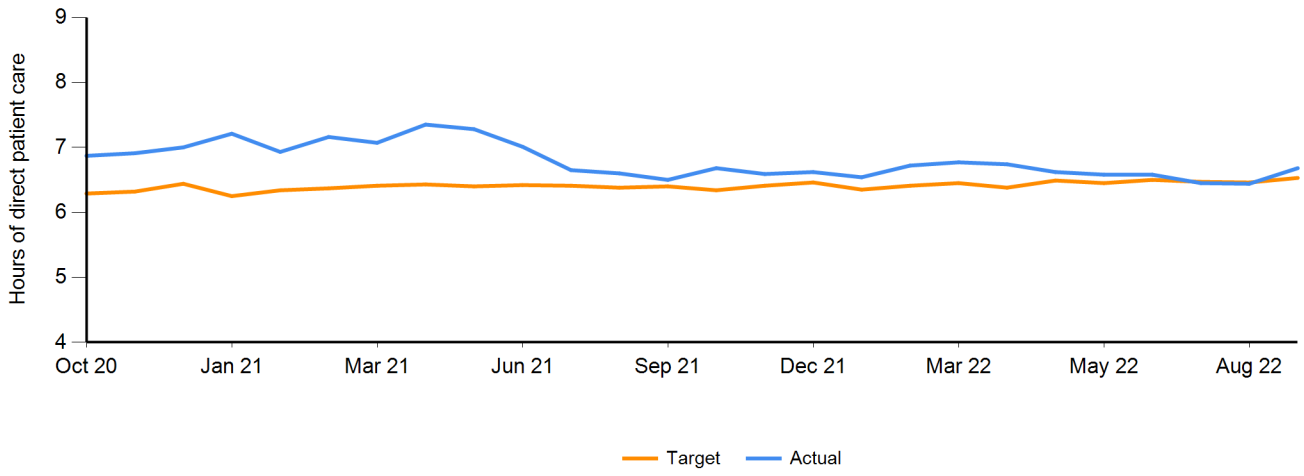
What are we doing?

All communities of care and Providence Health Care continue to use the Capacity Planning Tool (CapPlan) to access real-time information and managing paid hours reports for better management decision-making. We are also identifying improvement opportunities. For example, internal benchmarking.

Our performance	Target *
6.6	<= 6.5
hours of direct patient care per day	

Year-to-date Timeline: Apr to Sep 2022

*Our target is based on our performance of the last year to date.



Our Health Care Report Card

Alternate level of care (ALC) stay days as a proportion of total stay days

Oct 2022

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 to move a patient to ALC may relate to how responsive community services are to patients, how closely the teams work together, capacity for the right type of care, or the efficiency of the 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 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?

For FY2022/23 year-to-date, 9.1% of the inpatient days were ALC days for VCH overall, which is higher than the target of 7.5%. All Communities of Care with the exception of Richmond are performing worse than the previous periods.

What are we doing?

We are working to prevent long hospital stays by providing high quality, integrated patient care and ensuring we have appropriate capacity in all of our community, rehabilitation and hospital services. We are also creating efficient processes to support patients transferring between services. Additionally, some hospitals are holding weekly meetings to focus on specific patients with a very long hospital stay.

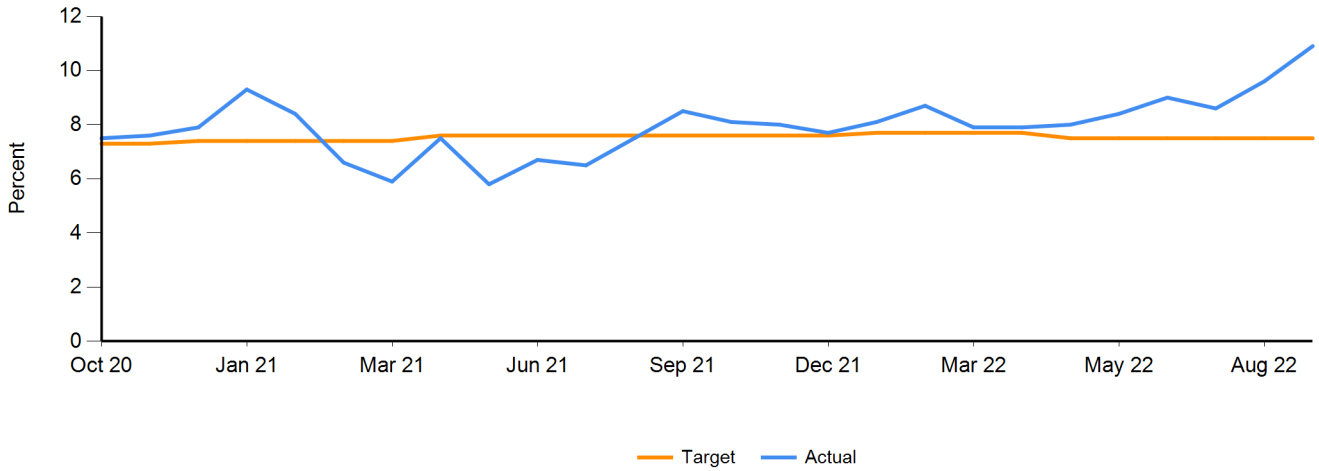
What can you do?

Talk to your health care provider or a family member about creating a discharge plan that will work best for you.

Our performance	Target *
9.1 %	<= 7.5 %
of hospital days are ALC days	

Year-to-date Timeline: Apr 2022 to Sep 2022

*Our target is set to match the financial budgets



Emergency patients admitted to hospital within 10 hours

Oct 2022

How quickly do emergency patients move to a hospital bed?

What are we measuring?

We are measuring the percentage of emergency patients who spend 10 hours or less in the Emergency Department (ED) waiting for a hospital bed.

Why?

Our EDs 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 longer term care, if needed, within 10 hours. This frees up beds in the ED for other patients waiting for treatment.

How do we measure it?

We track from the time patients arrive 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. ED wait time calculations exclude all time spent in the ABSU at St. Paul's Hospital.

What are we doing?

We are using new care units called diagnosis and treatment units in four of our urban hospitals. These units are located next to the EDs and allow us to observe patients receiving treatment for a longer period of time, with the goal to send them home rather than admit them to hospital. This promotes quality and safe care for patients and frees up space in the ED and hospital units for other ED patients.

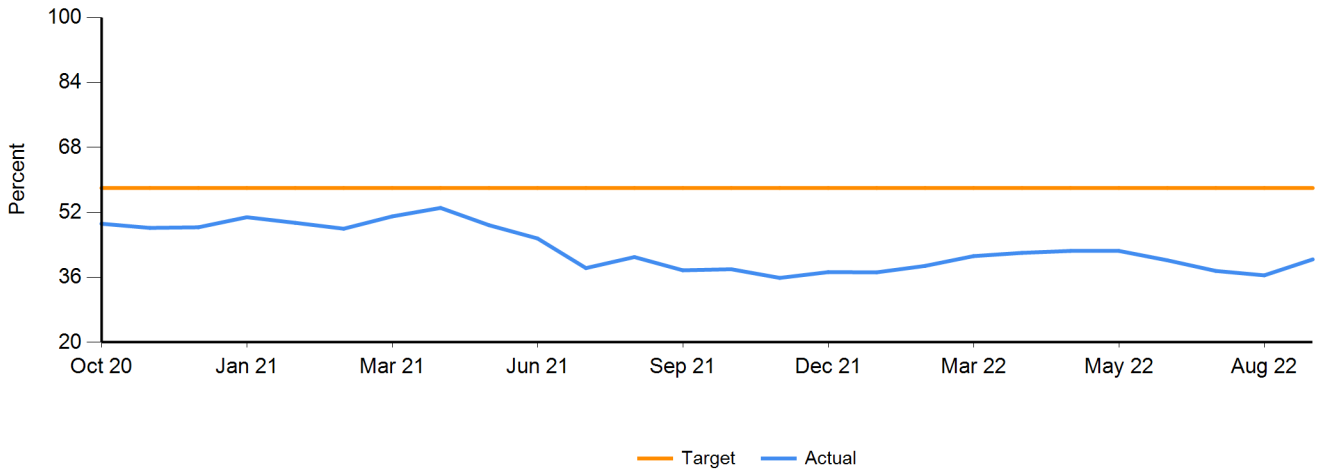
What can you do?

You can seek alternative ways to get treatment before going to the ED such as going to see your family doctor, going to a walk-in clinic and using other community resources. Use our Emergency Department Dashboard at www.edwaittimes.ca to learn what options you have for a shorter wait time and when the ED may be less busy.

Our performance	Target *
39.9 %	>= 58.0 %
of patients moved to an inpatient bed within 10 hours	

Year-to-date Timeline: April to September 2022

*Our target was set by the Ministry of Health



Our Health Care Report Card

Scheduled surgeries waiting longer than 26 weeks

Oct 2022

How long are patients waiting for scheduled elective surgeries?

What are we measuring?

We measure the percentage of patients who have been waiting longer than 26 weeks for a scheduled elective surgery out of the total number of patients who are waiting for a scheduled elective surgery.

Why?

Our goal is to provide the best care for our patients. Elective surgery can be scheduled in advance because it does not involve a medical emergency. We want to exceed the Ministry of Health (MoH)'s target that no patients are waiting more than 26 weeks for surgery by continuing to shorten the time for our longest waiting patients.

How do we measure it?

We take the number of patients waiting longer than 26 weeks for a scheduled elective surgery and divide it by the total number of patients on the scheduled elective surgery waiting list as of the last day of the period. The wait time starts when the hospital receives the booking package from the surgeon's office. Dates that patients are unavailable for surgery are excluded from the wait time calculation. Pediatric patients waiting for procedures with a benchmark wait time of 52 weeks are excluded from this measure.

How are we doing?

September 2022 remained worse than target at 36.7%. Most sites have fully resumed surgical activity following seasonal closures, however, several sites continue to experience reductions in surgical activity due to staffing challenges. Scheduled surgical activity is focused on urgent and delayed surgeries, including patients who were postponed due to COVID or waiting more than twice their clinical benchmark. As a result, some non-urgent patients may be waiting longer for their surgery.

What are we doing?

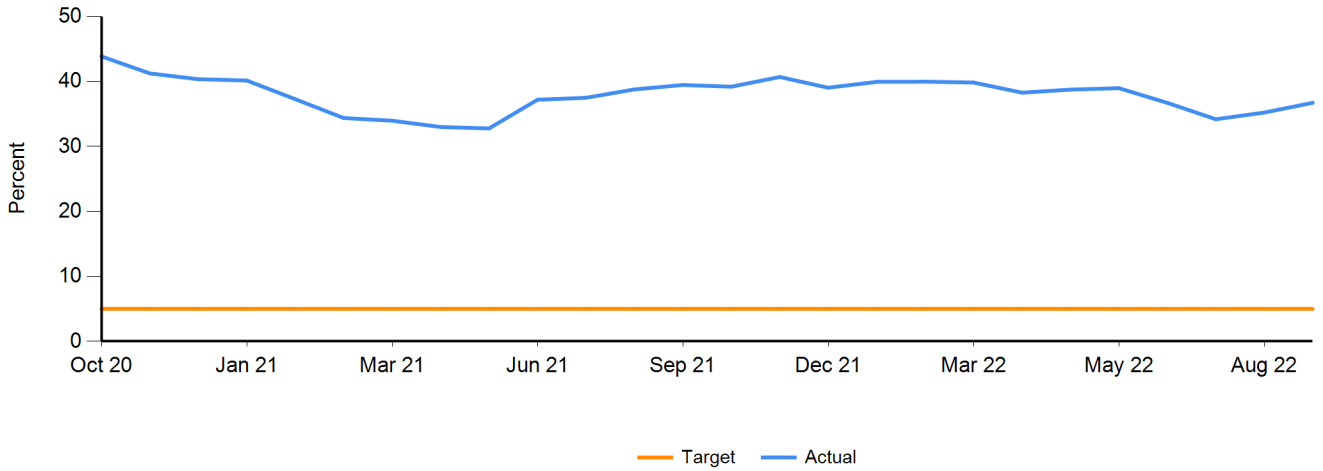
We are providing surgeon offices with regular reports that show, which patients are waiting the longest. This makes it easier for them to book patients, according to the wait time target. We are giving additional Operating Room time to surgeons to specifically treat patients who have been waiting more than 26 weeks and we are also purchasing additional equipment and implants so that surgery isn't limited by a shortage of necessary equipment or implants. Where a shortage of specialty trained staff might be the reason for the long wait, we are planning the necessary recruitment, training or other required action with our partners in physician recruitment, employee engagement, and education. Furthermore, we are piloting new models for referral and delivery of service to shorten the wait for consulting and treatment.

What can you do?

Use the surgical wait times website at www.health.gov.bc.ca/swt to look at the typical waiting times for surgeons performing your surgery. Talk to your family doctor about seeing a surgeon with a shorter wait time. It is also important to let your surgeon know if you're not yet ready, willing and able to have surgery and to let your surgeon know if you're going to be temporarily away or unavailable for surgery because of vacation or other personal reasons.

Our performance	Target *
36.7 %	<= 5.0 %

Year-to-date Timeline: Apr 2022 to Sep 2022



Clostridium difficile infection rate

Oct 2022

How many patients get this bacterial infection from a hospital stay?

What are we measuring?

We monitor the number of patients who get sick with the bacterium *Clostridium difficile* (*C. difficile*) as a result of a stay in hospital.

Why?

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

How do we measure it?

We take the total number of healthcare associated *C. difficile* infection cases identified every three months and divide it by the total number of patient days for the same time period to calculate a rate for the fiscal period. To calculate the cumulative year to date rate each iteration of this report, we sum all the new healthcare associated *C. difficile* infections over the time period we are reporting on, and divide it by the total number of patient days for the same time period. We multiply that number by 10,000 to arrive at a case rate per 10,000 patient days.

How are we doing?

Our *C. difficile* infection rate for April 1, 2022 to July 21, 2022 is 4.5 per 10,000 inpatient days, which is higher than the target of 3.2 per 10,000 inpatient days and higher than the top end of our target range of 2.7 to 3.9 per 10,000 inpatient days. The target range is being used especially with our smaller sites that see fewer patients, and where slight changes in small numbers of *C. difficile* cases can lead to greater fluctuation in *C. difficile* rates. We are working on approaches to reduce the higher rates in our facilities that have seen an increase in healthcare associated *C. difficile* in the most recent months. We also continue to work to further drive improvements among all our facilities.

What are we doing?

We are improving our ability to quickly identify cases of *C. difficile* infection and working with the hospital pharmacy to promote appropriate treatment. We are also providing additional cleaning of hospital isolation rooms and equipment. All rooms with patients known or suspected of having *C. difficile* are cleaned twice a day. Furthermore, we are providing nursing units with regular reports (weekly Vancouver Coastal Health, monthly Providence Health Care) that show the number of cases associated with their unit to help them evaluate their improvement efforts. Our infection control team is working with all nursing units to identify opportunities for improvement.

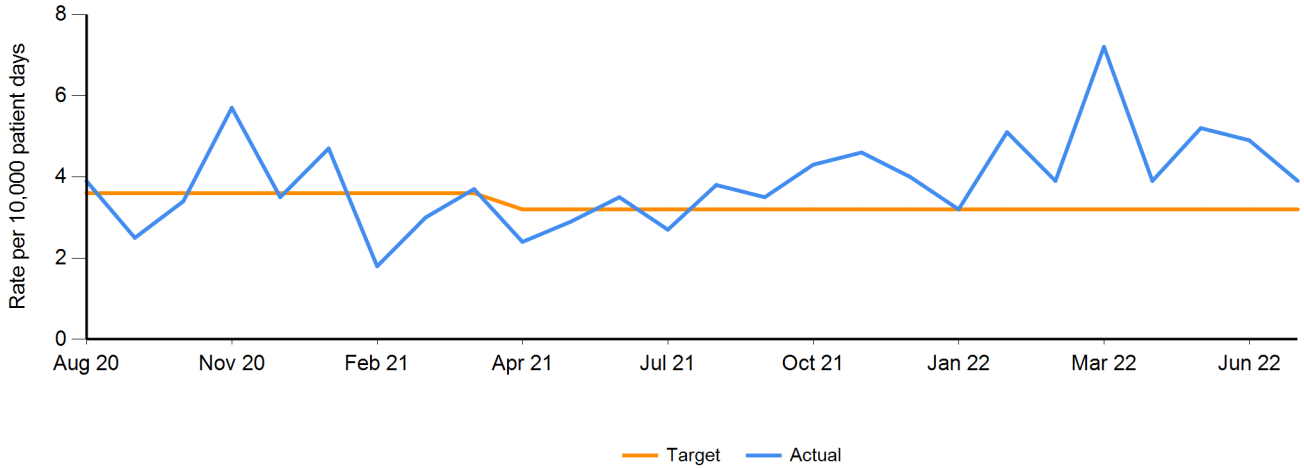
What can you do?

If you have *C. difficile* infection, be sure to tell anyone who treats you and wash your hands regularly with soap and water to prevent the spread of the bacterium to others. Do not be shy about politely reminding everyone to wash his or her hands. It is important to also only use antibiotics when necessary. Be sure to take the full course of antibiotics, even after you start to feel better.

Our performance	Target *
4.5	<= 3.2
cases of *C. difficile* per 10,000 patient days	

Year-to-date Timeline: Apr 2022 to Jul 2022

*Our target is set by VCH QPS using historical data from VCH (3.2 (95%: 2.7-3.9))



% of MHSU readmissions within 30 days – based on diagnosis code

Oct 2022

How many of our mental health and substance use (MHSU) patients return within 30 days?

What are we measuring?

We measure the percentage of readmissions to an inpatient unit at any of our hospitals for a MHSU condition, within 30 days. This indicator identifies MHSU patients using hospital discharge diagnosis codes and is considered the gold standard; it is based on the definition used by the Canadian Institute for Health Information. We have an additional indicator that uses hospital admissions data to identify readmissions as it allows for more up-to-date reporting with ~95% accuracy.

Why?

Reducing the MHSU readmission rate has moved to the top of the priority list for the Regional MHSU program. Ensuring continuity of care by providing appropriate care in the community after hospital discharge is one of the most important safeguards against hospital readmission. Tracking our readmission rate helps us to understand the effectiveness of our hospital care and how well we support patients after they leave the hospital.

How do we measure it?

We divide the number of readmissions to any of our hospitals for a MHSU condition occurring within 30 days of discharge (excluding patients discharged home from a Diagnostic and Treatment Unit), by the total number of all MHSU episodes of care, for patients who are 15 years or older at the time of their first admission. Readmissions are attributed to the last hospital that discharged the patient before he/she was readmitted. MHSU patients are identified based on the most responsible diagnosis code in the Discharge Abstract Database.

How are we doing?

The mental health and substance use readmission rate has moved to the top of the priority list for the Regional MHSU program. To address this, the MHSU program has created a Regional Steering Committee with the purpose of supporting each Community of Care (CoC) towards the 13% readmission rate target. Work to date includes increasing compliance of the 'When I leave the Hospital' form process; creating a standard process across the region for reviewing each MHSU readmission; and identifying the first CoC to implement the 'Psychosis Treatment Optimization Program' (Vancouver). Second quarter results will be available once the internal Discharge Abstract Data for October 2021 is available.

What are we doing?

The MHSU program has created a working group with the purpose of supporting each Community of Care (CoC) towards a 12% readmission rate target. Ongoing work includes: 1) Increasing uptake and compliance of the 'When I leave the Hospital' form, which is used to ensure that patients have a community appointment booked following hospital discharge within 28 days (target= 95%) and that health care providers have communicated the follow-up plan to the patient, family members, and other supports; 2) Creating a standard process across the region for reviewing each MHSU readmission; 3) Increasing services and connections between programs, such as connecting emergency departments and MHSU community services, increasing the number of community outreach teams, and more.

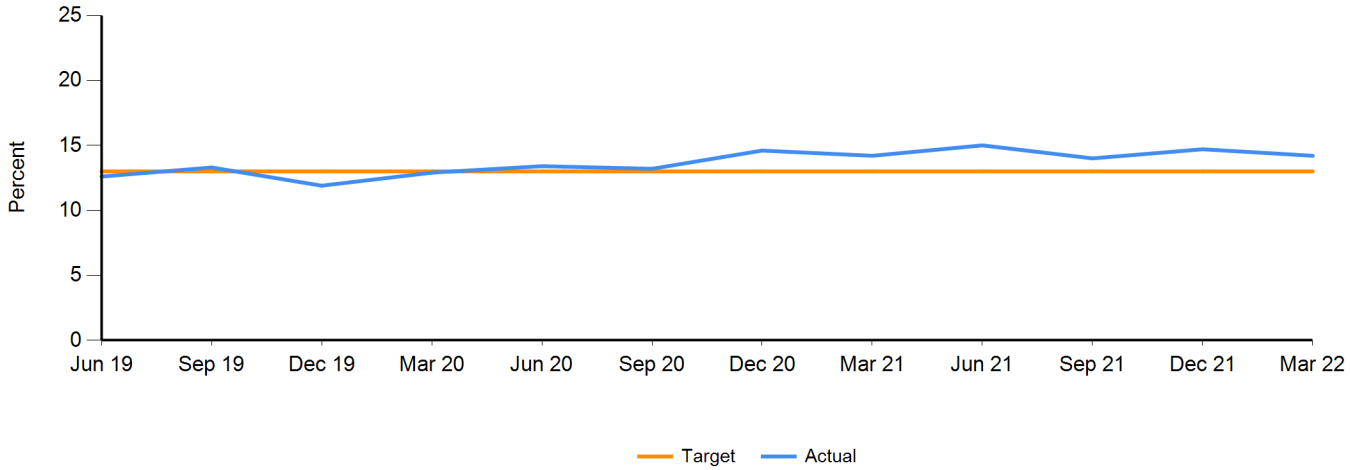
What can you do?

If you or a family member or friend needs to stay in one of our hospitals, work with our health care providers to understand the discharge plan before going home. The plan could include information on the community services needed, activities that might help with recovery, medications or equipment. Let a health care provider know as soon as possible if you have any questions or concerns.

Our performance	Target *
14.9 %	<= 13.0 %
of MHSU patients readmitted to any VCH/PHC site	

Year-to-date Timeline: Apr 2021 to Mar 2022

*Our target was determined in consultation with regional MHSU program



Potentially Inappropriate Use of Antipsychotics in Long-Term Care (CIHI-Adjusted RAI-QI)

Oct 2022

Why?

Antipsychotic medications are often prescribed to address symptoms of aggression and agitation in residents with dementia. However, not all symptoms respond well to antipsychotic medications. As a result, a careful balance must be struck between possible benefits and potential risks for cerebrovascular and cardiovascular side effects of stroke, confusion or dizziness including increased chance of death (BC MOH, 2011, Government of Canada, 2005).

How do we measure it?

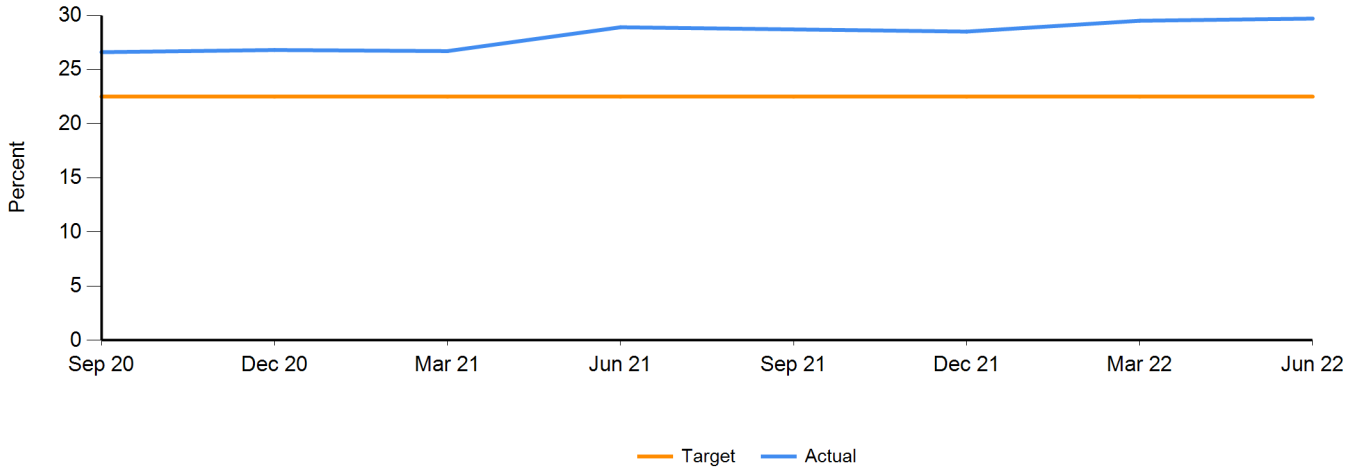
The number of residents who received antipsychotic medication on their target assessment divided by the number of all residents with valid assessments [InterRAI] within the applicable time period.

How are we doing?

Due to an access issue with CIHI data, the Q3-2021/22 update is based on internal VCH RAI-LTC data, with an estimated risk-adjustment. The performance for VCH has decreased moderately to 28.5% in Q3-2021/22, but is still well above the expected target of 22.5%. Of note, completed RAI-LTC assessments in Q3-2021/22 were 79.6%, which is well under the assessment completion target of 90.0% and may have impacted the reported values. This indicator data will be updated with CIHI risk-adjusted data when it is available.

Our performance	Target *
29.7 %	<= 22.5 %

Year-to-date Timeline: Apr 2022 to Jun 2022



% of overall hospital deaths for clients with a community referral (in last year)

Oct 2022

What are we measuring?

We are measuring the percentage of deaths that occur in hospital for adults living in our region who are connected to our community programs in their last year of life.

Why?

Planning end of life care and supporting patients well in community settings improves quality of life and the experience of care for patients and families. Increasing support for patients in their home setting reduces the need for crisis admission to hospital.

How do we measure it?

Every three months, we count the number of deaths at a Vancouver Coastal Health (VCH) or Providence Health Care hospital and divide that by the total number of deaths recorded for adults who had a referral to a community program in the last year of their lives. This includes referrals for 'Home & Community Care', 'Mental Health & Addictions', and 'Primary Care', but excludes 'Public Health' referrals. Anyone who is not a resident of the VCH region is also excluded from this indicator.

How are we doing?

Between April 2022 and June 2022, more people receiving community palliative care were able to die outside of hospital in their preferred setting: home, Long Term Care or Hospice. Among clients who were known to community health services in their last year of life, 35.3 % of them died in hospital which is 2.3 % better than our goal of 37.6% and consistent in performance with the previous three months.

What are we doing?

Healthcare providers in all care settings (hospital, community, Long Term Care) have conversations with patients and loved ones about their goals of care, i.e. the type of care they want to receive at different stages of life. These conversations help us to plan better with clients for their care needs now and in the future. We are working to improve the way we share that information with care providers when clients transition from one care setting to another to ensure that care aligns with what matters most to the people we serve. This approach allows us to provide well-coordinated care aligned with clients' wishes near the end of life and, when required, timely access to any palliative resources.

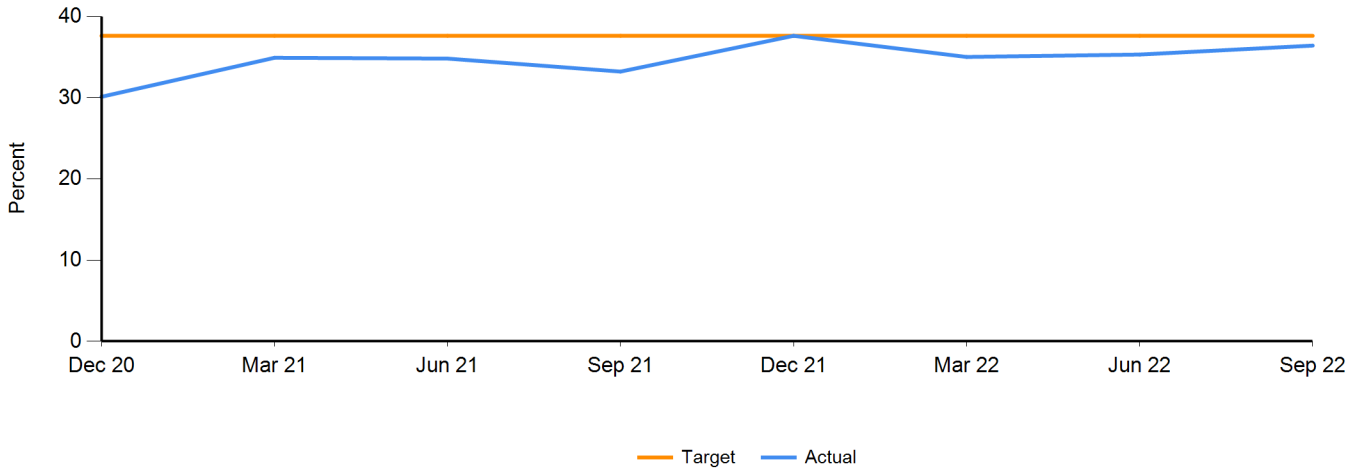
What can you do?

Ensure your healthcare providers, family and loved ones know what matters most to you for your care if ever you are unable to speak for yourself. If you have one ore more serious health conditions, the 'What Matters Most to Me' worksheet (tinyurl.com/WhatMattersMostToMe) can help you think about what's important to you. Creating an Advance Care Plan can also be a great way to communicate your wishes.

Our performance	Target *
36.4 %	<= 37.6 %
of overall hospital deaths of patients from VCH community programs	

Year-to-date Timeline: Jul 2022 to Sep 2022

*Our target was set by the palliative program



Hospital standardized mortality ratio (HSMR)

Oct 2022

What is our mortality rate compared to other Canadian hospitals?

What are we measuring?

We are measuring the number of patient deaths in our hospitals, compared to the average Canadian experience.

Why?

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.

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 only looks at patients with one of the diagnosis groups that account for about 80% of in-hospital deaths, after excluding patients with palliative care. It takes into account factors that may affect mortality rates, such as the age, sex, length of stay, other diagnoses and the admission status of patients. It uses the national baseline average from 2015/16 to 2017/18.

How are we doing?

Hospital Standardized Mortality Ratio (HSMR) is still performing much better than target at 83. Overall, VCH continues to perform better than the provincial average.

What are we doing?

Comprehensive reviews are done on all deaths within Vancouver Coastal Health to ensure that safe, high quality care was delivered to the patient.

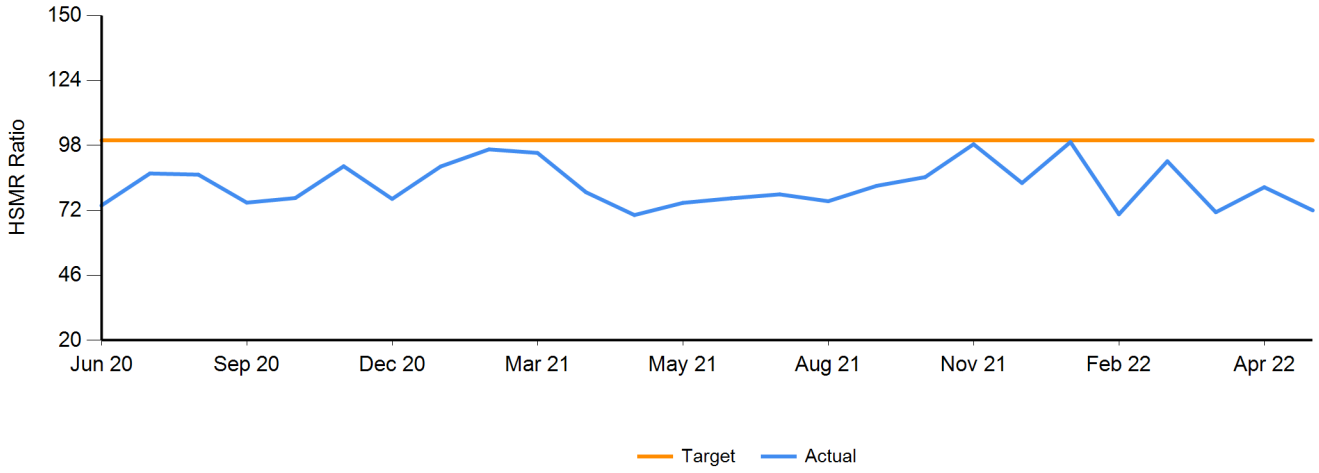
What can you do?

1. Keep in mind that HSMR is not a perfect measure. Hospital care is complicated and depends on many factors, not all of which are reflected or accounted for by the HSMR.
2. You should not use the information to pick where to seek care.

Our performance	Target *
77	<= 100
ratio of observed to expected deaths	

Year-to-date Timeline: Apr 2022 to May 2022

*Our target is the national standard set by the Canadian Institute for Health Information.



Overtime rate

Oct 2022

How often do our staff work overtime?

What are we measuring?

We are measuring the amount of overtime hours our staff work, as an indicator of their workload.

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 more expensive than providing the same care at regular wage rates. Overtime also puts workload stress on individual employees and can negatively impact their health. Overtime is an indicator that can prompt a deeper dive to explore contributing factors and identify corrective action which could include regularization of staff or a staffing model review.

How do we measure it?

Total overtime hours divided by total productive (working) hours. All Corporate and Lower Mainland Consolidation (LMC) overtime is included only in the overall VCH figure and not in each Community of Care or PHC.

How are we doing?

Overtime rates continue to be high (worse than target) particularly at the Coastal Community of Care at 9.4% and has been trending up for last year. Difficult to recruit vacancies and increased absenteeism will drive higher OT usage.

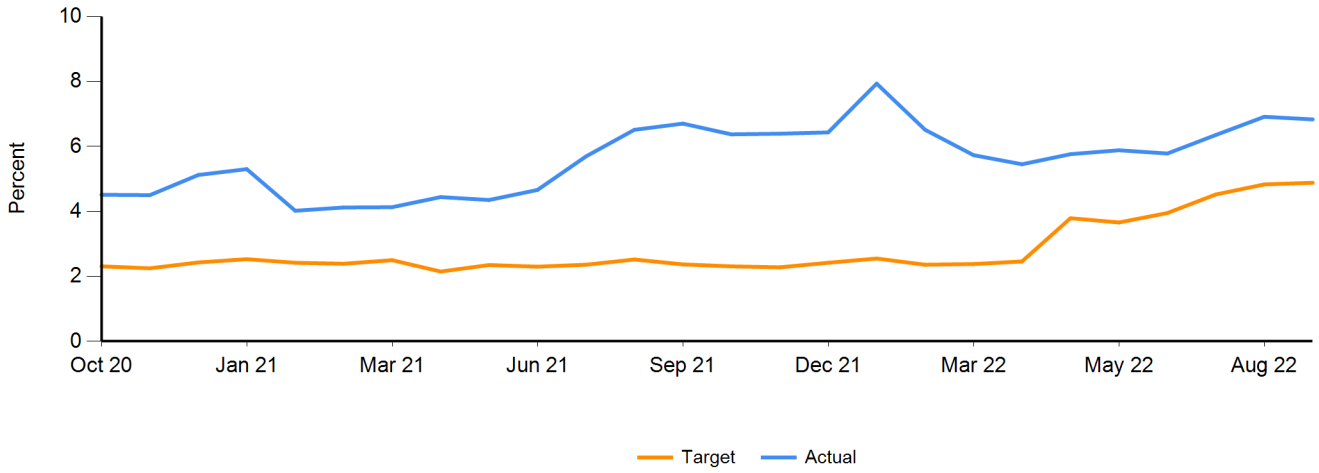
What are we doing?

Our Human Resources team has helped hire staff for vacation relief positions to avoid staff working overtime to cover their coworkers' shifts. We also have an attendance and wellness promotion program that helps staff working on a casual basis to cover short-notice events, such as sick calls, at regular wage rates.

Our performance	Target *
6.3 %	<= 4.3 %
of total productive hours were overtime hours	

Year-to-date Timeline: Apr 2022 to Sep 2022

*The target is the budget for overtime and is determined by finance.



Relief Not Found

Oct 2022

How often are staff absent and we are not able to backfill their shift?

What are we measuring?

We are measuring the number of times staff are absent and require replacement, or additional staff are required, but we are unable to bring anyone in.

Why?

Tracking Relief Not Found (RNF) aligns to the Great Place to Work strategic priority, as one of our goals is to ensure departments are not working short staffed. We want to provide the best patient care by ensuring there is sufficient staffing coverage for unexpected staff absences. Providing care when there are not enough staff members compromises patient care and potentially creates unsafe conditions for the workforce. Reducing the number of times relief is not found will ensure uninterrupted staffing coverage and result in better patient care.

How do we measure it?

Number of RNF hours divided by the number of productive hours plus RNF hours.

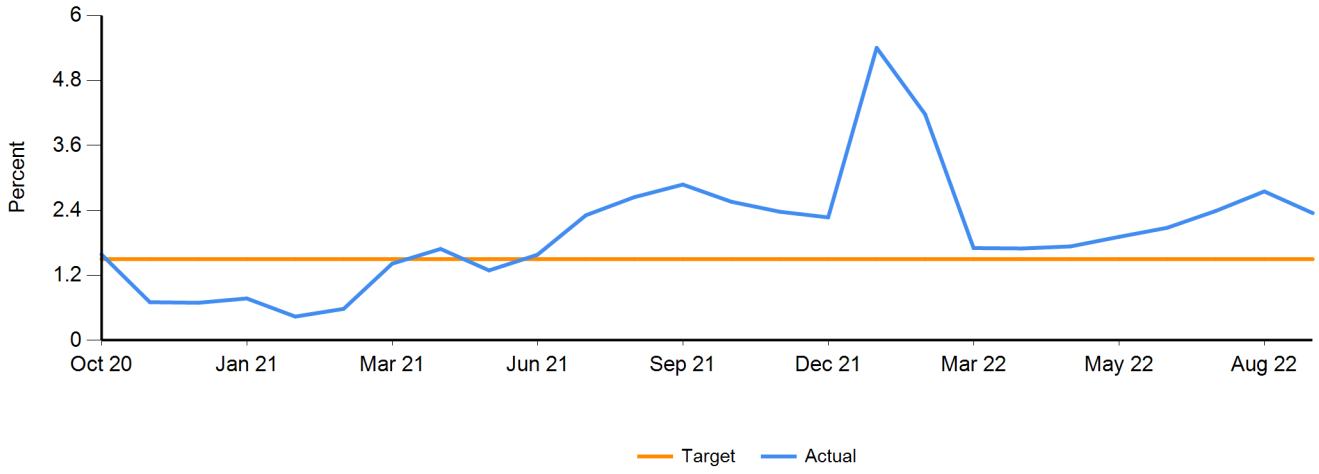
What are we doing?

Senior leaders, managers, and Employee Engagement teams are either already running or developing projects to understand causes of RNF and reduce it across Vancouver Coastal Health (VCH), focusing on areas that are above desired target. VCH regularly assesses opportunities to regularize relief needs to free up contingent staff to work during peak demand times. VCH has developed RNF dashboards for each Community of Care which the Chief Operating Officer's use to monitor unit progress each fiscal period.

Our performance	Target *
2.2 %	<= 1.5 %

Year-to-date Timeline: 2021/22 P1-P13

*Our target was set by the Clinical Strategy and Innovation Committee.



WorkSafe BC Time Loss Claim Rate

Oct 2022

Why?

The WorkSafe BC Time Loss Claim Rate provides insight to the prevalence of workplace injuries. One of our goals is to ensure a safe working environment for our staff. A high rate would indicate we have had an increase in lost work hours which would also manifest in higher sick rate and possibly an increase in long term disabilities (LTD) for serious injuries. Absences from work can result in increased relief not found (with impacts on patient care and staff burnout) and/or increase related costs of overtime and the working short premium.

How do we measure it?

Number of WorkSafe BC (WSBC) Timeloss claims divided by productive hours and multiplied by 80% to exclude non-productive hours. It displays the number of WSBC TimeLoss Claims per 100 FTE in each year.

How are we doing?

VCH has continued to perform better than most health authorities. The time loss rate has been steady and we will continue to monitor as post-COVID safety programs continue to be implemented.

Our performance	Target *
6.06	<= 5.28

Year-to-date Timeline: Jan 2022 to Jun 2022