Vancouver Coastal Health
Balanced Scorecard

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Mark Chase
Executive Director Decision Support
Vision and Strategy

Financial/Stewardship
"Financial Performance"

Customer/Stakeholder
"Satisfaction"

Internal Business Process
"Efficiency"

Organizational Capacity
"Knowledge and Innovation"

Strategic Objectives
Strategy Map
Performance Measures & Targets
Strategic Initiatives
Development

• Metrics selected from:
  – VCH True North strategies
  – MoH strategic priorities
  – reviews of comparative and descriptive system metrics
• Same metrics are reported to SET and Board
• With Board encouragement, VCH began reporting publically in 2011 – the first HA to do so
Publicly accessible

• Located on the VCH website www.vch.ca
  ➢ About Us
  ➢ Accountability

• Published every two months
  – Two summary pages with metrics, values and performance “traffic lights”
  – Linked to VCH Goals and Objectives
  – Each metric has a detailed description with graph and explanations
**Our Health Care Report Card**

### Pay for Performance - Live Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Time Frame</th>
<th>Target</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency patients admitted to hospital within 10 hours</td>
<td>Apr 2015 to Dec 2015</td>
<td>&gt;= 55.4 %</td>
<td>53.4 %</td>
</tr>
<tr>
<td>Surgery wait time longer than 52 weeks</td>
<td>Dec 31, 2015</td>
<td>&lt;= 2.0 %</td>
<td>1.2 %</td>
</tr>
<tr>
<td>Percent of hip fracture fixations completed within 48 hours</td>
<td>Mar 2015 to Nov 2015</td>
<td>&gt;= 90.0 %</td>
<td>93.8 %</td>
</tr>
<tr>
<td>Care sensitive adverse events (per 1,000 inpatient cases)</td>
<td>Jan 2015 to Oct 2015</td>
<td>&lt;= 34.5</td>
<td>35.6</td>
</tr>
<tr>
<td>Discharged long length of stay patients - ADTC based</td>
<td>Apr 2015 to Dec 2015</td>
<td>&lt;= 75,286</td>
<td>69,262</td>
</tr>
<tr>
<td>Current long length of stay days</td>
<td>Apr 2015 to Dec 2015</td>
<td>&lt;= 9,030</td>
<td>7,867</td>
</tr>
<tr>
<td>Average census bed days</td>
<td>Apr 2015 to Dec 2015</td>
<td>&lt;= 2,074</td>
<td>2,074</td>
</tr>
</tbody>
</table>

**Provide the best care**

**SYSTEM LEVEL**

<table>
<thead>
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<th>Measure</th>
<th>Time Frame</th>
<th>Target</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency patient experience</td>
<td>Apr 2014 to Mar 2015</td>
<td>&gt;= 90.0 %</td>
<td>86.2 %</td>
</tr>
<tr>
<td>Hospital standardized mortality ratio (HSMR)</td>
<td>Apr 2015 to Sept 2015</td>
<td>&lt;= 100.0 %</td>
<td>86.0</td>
</tr>
</tbody>
</table>

**REDUCE UNNECESSARY VARIATION IN CARE BY USING EVIDENCE BASED PROTOCOLS**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Time Frame</th>
<th>Target</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clostridium difficile infection rate</td>
<td>Apr 2015 to Sept 2015</td>
<td>&lt;= 7.50</td>
<td>7.40</td>
</tr>
<tr>
<td>Hand hygiene compliance</td>
<td>Apr 2015 to Dec 2015</td>
<td>&gt;= 85.0 %</td>
<td>78.9 %</td>
</tr>
</tbody>
</table>

**IMPROVE CLINICAL INTEGRATION AND QUALITY BY BUILDING REGIONAL PROGRAMS, DEPARTMENTS AND PROCESSES**
Our health care report card

How do we measure quality care in our hospitals and communities?
Our health care report card

How do we measure quality care in our hospitals and communities?

1. Discharged long length of stay patients
2. Clostridium difficile infection rate
3. Hospital standardized mortality ratio
4. Communities with healthy living plans
1. Discharged long length of stay patients
The number of days patients stay, beyond 30 days.

13% improvement
Target is 5% improvement

Apr – Dec 2014
79,248 days

Apr – Dec 2015
69,262 days

Target: <= 75,286

April to December 2015
2. Clostridium difficile infection rate

The number of patients who get the bacterial infection from a hospital stay.

Target: <= 7.5

Below target, but infection rate has slightly increased in 2015/16.

April to September 2015

Dec 13
6.5

Jun 14
4.8

Dec 14
4.1

Jun 15
7.4

Sept 15
7.4
3. Hospital standardized mortality ratio (HSMR)

Patient mortality rate compared to other Canadian hospitals.

Target is = 100

We continue to maintain rates that are well below the national average.

April to September 2015
4. Communities with healthy living plans
The percentage of communities that have a written agreement to promote healthy living.

- **Current Year (2014/2015):** 57%
- **Target:** >= 36%
- **Agreements cover 88% of our region’s population.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/2015</td>
<td>57%</td>
</tr>
<tr>
<td>2013/2014</td>
<td>29%</td>
</tr>
<tr>
<td>2012/2013</td>
<td>21.4%</td>
</tr>
</tbody>
</table>

April 2014 – March 2015
Domains in the US National Healthcare Quality and Disparity Report, 2014

- Access to Health Care
- Patient Safety
- Person- and Family-Centered Care
- Care Coordination
- Effective Treatment
- Healthy Living
- Care Affordability
- Priority Populations

H Burstin et al
# BC Health Quality Matrix

## Dimensions of Quality

<table>
<thead>
<tr>
<th>Acceptability</th>
<th>Appropriateness</th>
<th>Accessibility</th>
<th>Safety</th>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care that is respectful to patient and family needs, preferences, and values</td>
<td>Care provided is evidence based and specific to individual clinical needs</td>
<td>Ease with which health services are reached</td>
<td>Avoiding harm resulting from care</td>
<td>Care that is known to achieve intended outcomes</td>
</tr>
</tbody>
</table>

## Areas of Care

### Staying Healthy
- Preventing injuries, illness, and disabilities

### Getting Better
- Care for acute illness or injury

### Living with Illness or Disability
- Care and support for chronic illness and/or disability

### Coping with End of Life
- Planning, care and support for life-limiting illness and bereavement

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### Equity
- Distribution of health care and its benefits fairly according to population need

### Efficiency
- Optimal use of resources to yield maximum benefits and results

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4 Descriptor reflects direction of the Ministry of Health and input from the Provincial End of Life Standing Committee.

In 2008, the BC Health Quality Matrix was developed in collaboration with the members of the Health Quality Network which included BC’s Health Authorities, Ministry of Health Services, academic institutions and provincial quality improvement groups and organizations.

[bcpsqc.ca](http://www.bcpsqc.ca)
National Quality Forum measure evaluation criteria

• Importance to measure and report (1st must-pass)
  – What is the level of evidence for the measures?
  – Is there an opportunity for improvement?

• Scientific acceptability of the measurement properties (2nd must-pass)
  – What is the reliability and validity of the measure?

• Usability and Use
  – Can potential audiences use performance results for both accountability and performance improvement?

• Feasibility
  – Can the measure be implemented without undue burden, capture with electronic data/electronic health records?

• Assess related and competing measures

H Burstin et al
US National Quality Strategy

Priorities

1. Making care safer by reducing harm caused during the delivery of care (e.g. central line associated bloodstream infections);
2. Ensuring that all persons, and their family, are engaged as partners in their care (e.g. advanced care planning);
3. Promoting effective communication and coordination of care (e.g. patient experience of care);
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality (e.g. primary percutaneous coronary intervention within 90 min of hospital arrival);
5. Working with communities to promote widespread use of best practices to enable healthy living (e.g. avoidable hospitalization for asthma);
6. Making quality care more affordable for individuals, families, employers and governments by developing and spreading new healthcare delivery models (e.g. total cost of care).

Priorities of the National Quality Strategy (NQS), introduced in 2011 by the Agency for Healthcare Research and Quality on behalf of the US Department of Health and Human Services, as cited in H Burstin et al, “The evolution of healthcare quality measurement in the United States”, in the Journal of Internal Medicine, Vol. 279, Issue 2
## 20% Transformational Change: VCH Strategic Planning Framework

### Access to Primary and Community Care
- Implement Seniors Prototype Models of Care
- Create new spaces for VCH Addiction, Treatment and Prevention Service (500 substance use spaces across BC)
- Transform MH&A Services; implement ICM teams, ACT team and PHC Hub
- Expand Hospice capacity and develop end of life guidelines, education and resources
- Implement plan for Residential Care Rejuvenation
- Expand Residential Care Capacity in Richmond
- SPH Redevelopment
- Complete DTES Redesign
- Continue GP for ME

### Access to Surgical Services
- Address Health Human Resource Gaps
- Meet incremental volume commitments for surgery and colonoscopy
- Address long waiting surgical patients
- Improve the number of patients treated within target
- Increase MRI access to enable surgical access

### Rural Health Services
- Implement pool of travelling urban specialists
- Provide outreach clinics
- Expand Telehealth
- Develop Physician recruitment and retention strategies
- Partner in Joint Project Board initiatives
- Initiate Sustainable Rural Practice Communities Project