

# Our Health Care Report Card

	Time Frame	Target	Year to Date	
<b>Convenient Health Care - Responsive care in the best setting: hospital, community or home</b>				
Emergency patients admitted to hospital within 10 hours	Apr 2018 - May 2019	>= 58.0 %	55.7 %	
Discharged long length of stay patient days	Apr 2019 - May 2019	<= 7,597	8,172	
Current long length of stay patient days	Apr 2018 - May 2019	<= 7,689	8,657	
Average inpatient days	Apr 2019 - May 2019	<= 2,043	2,073	
Scheduled surgeries waiting longer than 26 weeks	Apr 2019 - Apr 2019	<= 10.0 %	30.4 %	
Scheduled surgeries completed within 26 weeks	Apr 2019 - Apr 2019	>= 95.0 %	87.5 %	
<b>Exceptional Care - Wrapping care around the person for the best outcome</b>				
Completed multidisciplinary mortality reviews	Apr 2018 - Mar 2019	>= 297	142	
% of MHSU readmissions within 30 days – based on diagnosis code	Apr 2018 - Nov 2018	<= 13.0 %	14.9 %	
% of MHSU readmissions within 30 days – based on patient service	Apr 2018 - Mar 2019	<= 13.0 %	13.0 %	
<i>Clostridium difficile</i> infection rate	Apr 2018 - Feb 2019	<= 3.6	3.5	
Alternate level of care (ALC) stay days as a proportion of total stay days	Apr 2019 - May 2019	<= 6.2 %	6.8 %	
Hand hygiene compliance	Apr 2018 - Dec 2018	>= 85.0 %	83.4 %	
Care sensitive adverse events (per 1,000 inpatient cases)	Apr 2018 - Jan 2019	<= 31.4	28.3	
Average hospital days in the last 6 months of life for clients known to VCH community programs	Apr 2018 - Dec 2018	<= 13.98	16.50	
<b>Great Place to Work - Coming together to build a better workplace</b>				
Sick time rate	Apr 2019 - May 2019	<= 5.1 %	5.1 %	
Overtime rate	Apr 2019 - May 2019	<= 2.3 %	2.9 %	
Acute productive hours per patient day	Apr 2019 - May 2019	<= 7.0	5.9	



Within desirable target range



Within 10% of target



Outside desirable target range by more than 10%

# Our Health Care Report Card

## Emergency patients admitted to hospital within 10 hours

May 2019

### 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.

#### How are we doing?

In April 2019, 55.7% of ED patients were admitted to the hospital within 10 hours at VCH, which does not meet the target of 58%. All Communities of Care are performing worse than target with the exception of PHC where 67.3% of ED patients were admitted within 10 hours. With the exception of PHC which had a decrease in admissions by 8%, all other sites had an increase in admissions with Coastal Urban and Richmond seeing an increase of 6% in ED admissions compared to the same period last year.

#### 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.

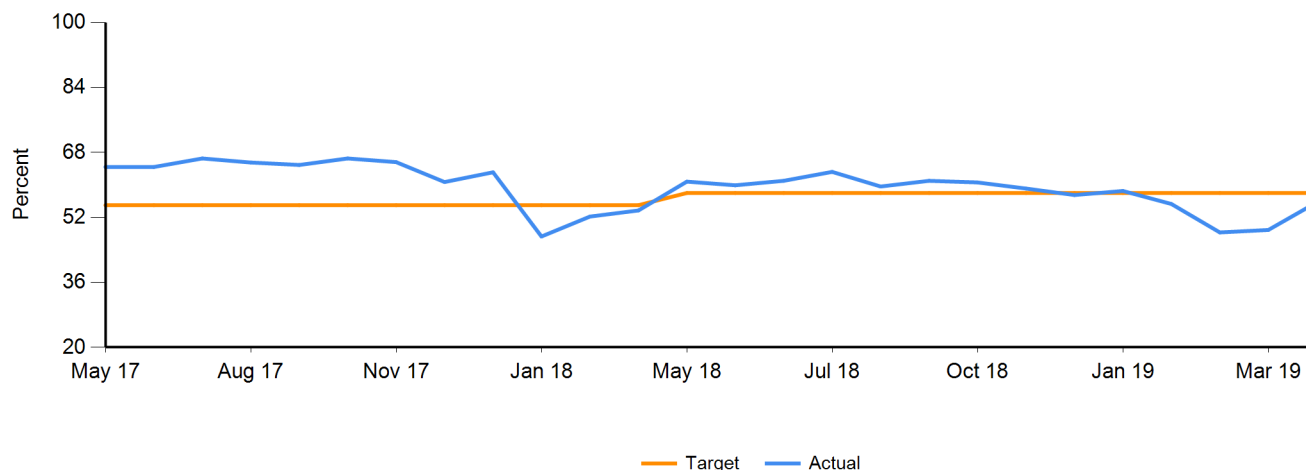
#### What can you do?

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](http://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 *
55.7 %	>= 58.0 %
of patients moved to an inpatient bed within 10 hours	

Year-to-date Timeline: Apr 2018 - May 2019

\*Our target was set by the Ministry of Health



# Our Health Care Report Card

May 2019

## Discharged long length of stay patient days

For all patients discharged from the hospital, how many days did they stay beyond 30 days?

### What are we measuring?

We are measuring the number of days that our patients stay in hospital past 30 days before they are discharged. When the number of days over 30 is greater than 180 days, we count the long length of stay as 180 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, there is a good chance that they could be better suited for a different setting, such as community, long term care, or a separate rehabilitation facility. Measuring our discharged patient days gives us the official view of each patient's full stay.

### How do we measure it?

We count the number of days greater than 30 that each patient stayed. Patients who reside outside of Vancouver Coastal Health (VCH) are excluded from this measure.

### How are we doing?

In April 2019, there were 8,172 long length of stay days for discharged patients at VCH. This indicator is performing worse than target for VCH overall. All Communities of Care are performing worse than target with the exception of Vancouver. At PHC, the largest percentage of LLOS patients are at the SPH site where regional t-cons continue weekly to assess each long stay patient without a plan. In Richmond, LLOS increases are a direct result of increased ALC days from December 2018 to March 2019.

### What are we doing?

We are identifying patients who have been staying with us longer than 30 days and working to discharge those patients when appropriate with the correct supports in place.

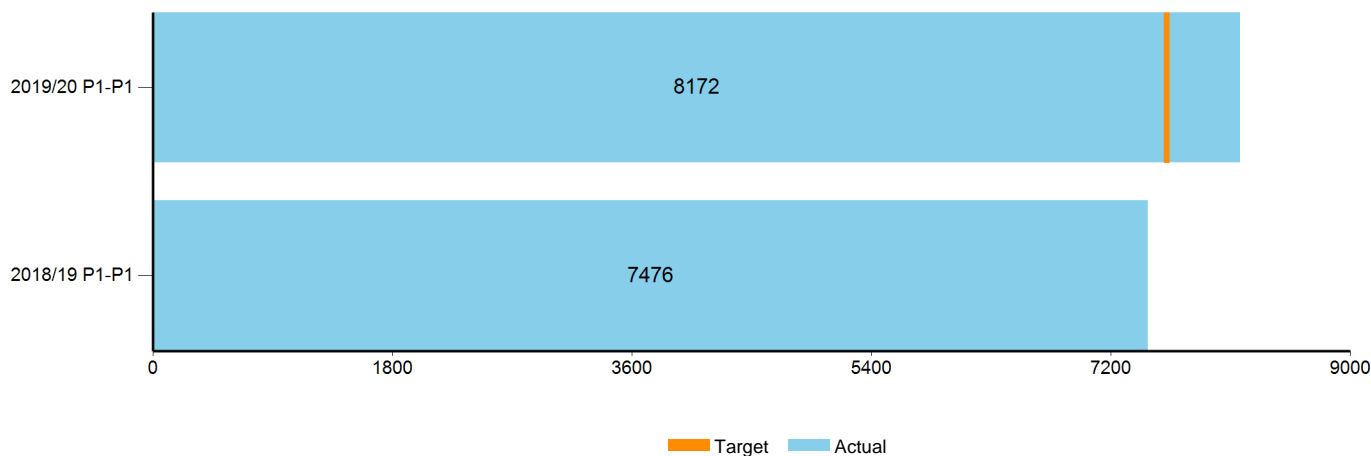
### What can you do?

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

Our performance	Target *
8,172	<= 7,597
stay days over 30	

Year-to-date Timeline: Apr 2019 - May 2019

\*Our target is to maintain the three-year historical average



# Our Health Care Report Card

## Current long length of stay patient days

May 2019

**For all patients currently in the hospital, how many days have they been there beyond 30 days?**

### What are we measuring?

We are measuring the number of days greater than 30 days that current patients have stayed so far in our hospitals. When the number of days over 30 is greater than 180 days, we count the long length of stay as 180 days.

### Why?

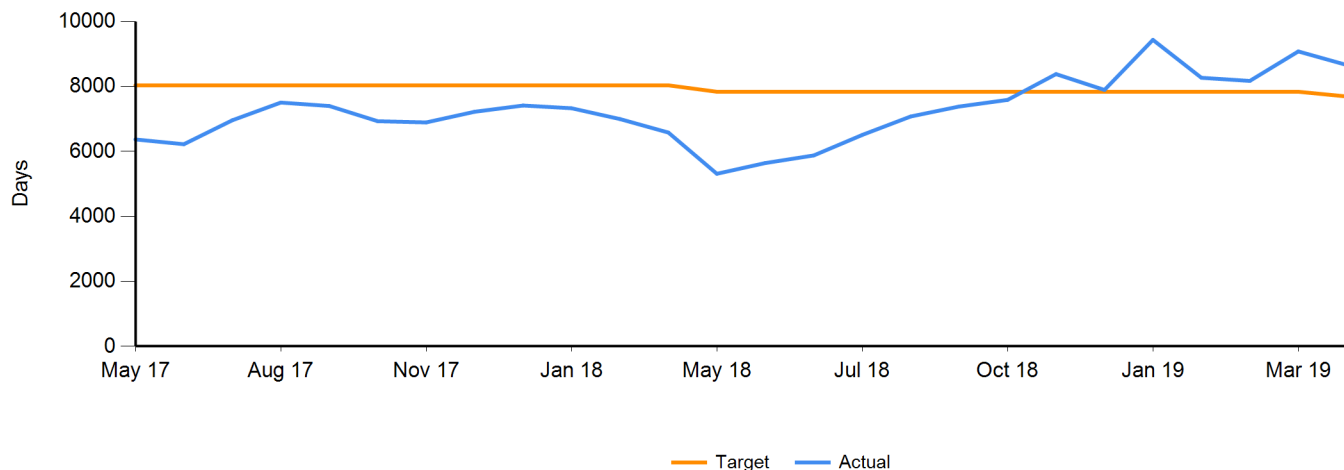
Our goal is to provide the best quality of care for our patients. When patients have stayed longer than 30 days in the hospital, there is a good chance that they could be better suited for a different setting, such as community, long term care, or a separate rehabilitation facility. Measuring the long length of stay days for current patient stays helps us identify patients who may be ready for discharge.

### How do we measure it?

At the end of each fiscal period, we count the number of days over 30 that current patients stayed in the hospital. We report the year-to-date average number of days that are greater than 30 for each patient. For example, if a patient has a current stay of 35 days, we would report five long length of stay days for them. Patients who reside outside of Vancouver Coastal Health (VCH) are excluded from this measure.

### How are we doing?

This is a leading indicator corresponding to the long stay days measure for discharged patients. This indicator is based on the long stay patients who are currently in the hospital. Richmond and Coastal are performing better than the target and we expect to see sustainment of the number of discharged long length of stay patient days at these Communities of Care in the coming month. Long length of stay days for current patients at Vancouver and Providence are worse than the target.



### What are we doing?

We are identifying patients who have been staying with us longer than 30 days and working to discharge those patients, when appropriate, with the correct supports in place.

### 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 *
8,657	$\leq 7,689$
year-to-date average stay days over 30	

Year-to-date Timeline: Apr 2018 - May 2019

\*Our target is to maintain the three-year historical average

# Our Health Care Report Card

May 2019

## Average inpatient days

On average, how many patients are in the hospital each day?

### What are we measuring?

We are measuring the total number of inpatient days in our hospitals divided by the number of days in the year to give us the average number of beds occupied per day.

### Why?

Our goal is to provide the best quality of care to our patients, and to improve their hospital experience. Sometimes it is more appropriate for patients to be cared for in their homes or in the community. Identifying these patients and connecting them with suitable community level resources will improve their overall experience and quality of care.

### How do we measure it?

We count the number of inpatients who have stayed at our hospitals each period, and the number of days that those patients stayed with us. This indicator is the total number of inpatient days divided by the number of calendar days in the month (fiscal period). This metric has been adjusted to remove Diagnostic Treatment Unit (DTU) patients discharged home. Newborns are excluded from the measure of inpatient days.

### How are we doing?

In April there were 2,073 average inpatient days at VCH. Current performance is worse than target at VCH overall. All Communities of Care, except PHC, are performing worse than target and worse in comparison to performance at this time last year. On average, there are 30 more beds when comparing with the same time frame from last year. At Richmond, the increased ALC days from December 2018 to March 2019 have led to increased inpatient days.

### What are we doing?

We are striving to make sure that are patients are not staying in hospital longer than they should be and are not being admitted to hospital when there is a more suitable option. We are working with community providers to make sure the continuum of care for our patients is seamless. By doing this we are able to provide a safe transition from acute care to community care.

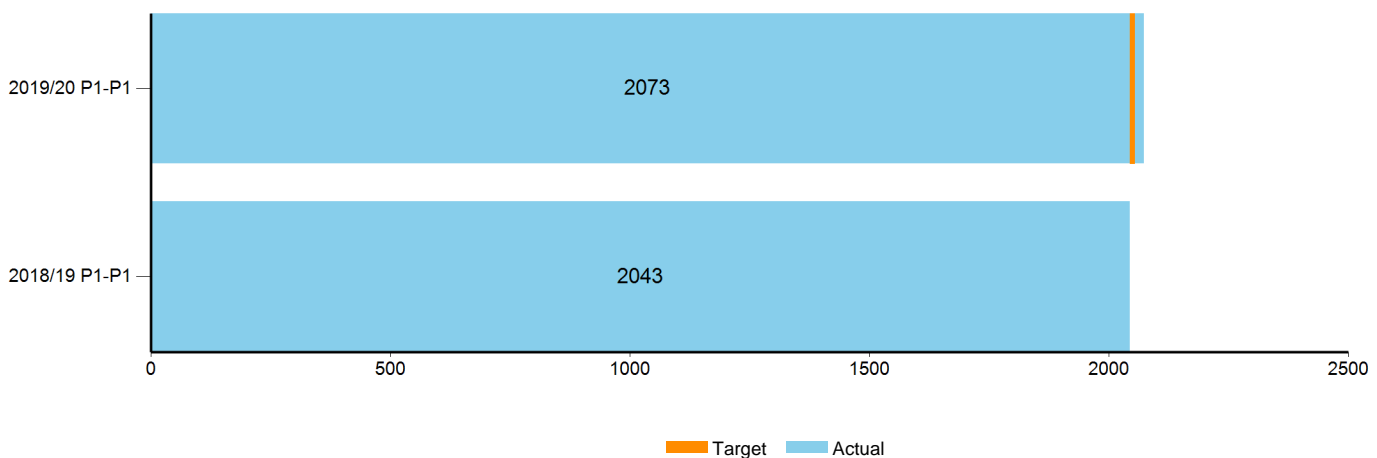
### What can you do?

Make sure that you understand your discharge plan when you are leaving the hospital. If you have any questions, do not hesitate to ask your care provider before you leave. Also, if you don't have a family doctor, try to find one who matches your needs at: [https://www.cpsbc.ca/physician\\_search](https://www.cpsbc.ca/physician_search)

Our performance	Target *
2,073	<= 2,043
average stay days	

Year-to-date Timeline: Apr 2019 - May 2019

\*Our target is to improve on the two-year historical average



# Our Health Care Report Card

May 2019

## Scheduled surgeries waiting longer than 26 weeks

### 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. To measure the wait time, we track the date hospitals receive the booking package from the surgeon's office to the date the patient has the surgery. 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?

Overall results remain significantly worse than target at 30.4%. This indicator is impacted by continued OR nurse and anesthesiologist shortages at multiple hospital sites. With reduced and insufficient OR capacity to meet demand, surgeons are providing care for the most urgent patients first and patients with less urgent conditions are waiting longer. VCH continues to work on turning this around through a comprehensive health human resource strategy, shifting services to make use of staffed and available OR capacity, including private facilities, and by increasing effort by all sites to work with offices on booking patients First in, First out (FIFO) within each wait time category as clinically appropriate.

#### What are we doing?

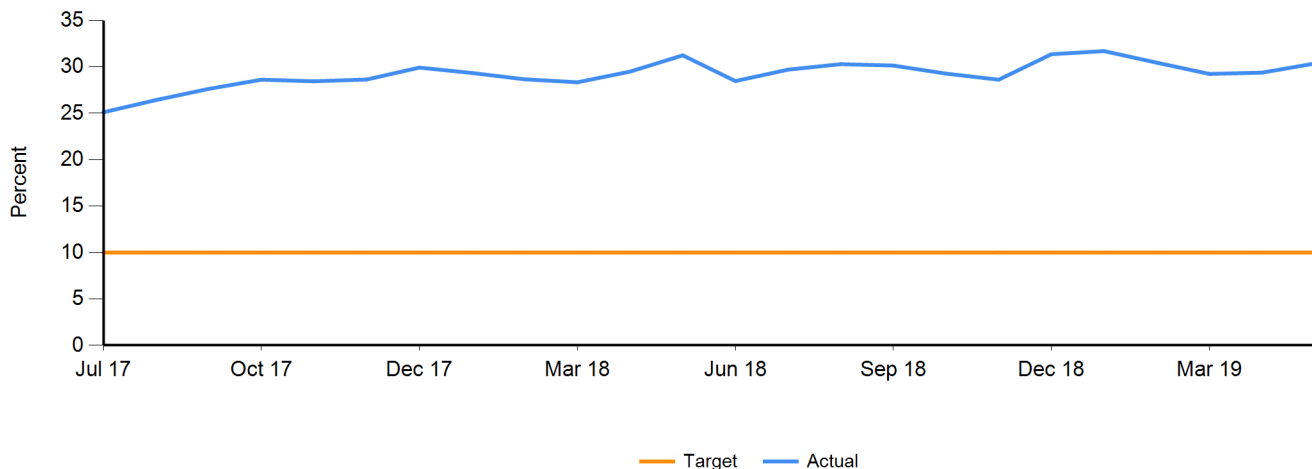
We are providing surgeon offices with regular reports that show, which patients are waiting the longest. This makes it easier for them to book patients, according to the wait time target. We are giving additional Operating Room time to surgeons to specifically treat patients who have been waiting more 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](http://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 *
30.4 %	<= 10.0 %

Year-to-date Timeline: Apr 2019 - Apr 2019





# Our Health Care Report Card

## Scheduled surgeries completed within 26 weeks

### How quickly are scheduled elective surgeries completed?

#### What are we measuring?

We measure the percentage of scheduled elective surgeries that were completed within 26 weeks out of the total number of completed scheduled elective surgeries.

#### 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. Many factors that affect wait time, including availability of resources, efficiency, volumes, patient choices, and treatment complexity. Information about wait times for completed surgeries can be used to help understand access to care and identify opportunities to decrease wait times.

#### How do we measure it?

We take the number of scheduled elective surgeries completed within 26 weeks and divide it by the total number of scheduled elective surgeries that are completed. To measure the wait time, we track the date hospitals receive the booking package from the surgeon's office to the date the patient has the surgery. Dates that patients are unavailable for surgery are excluded from the wait time calculation.

#### How are we doing?

Results are improving, but remain worse than target at 87.5%. Efforts continue to be focused on resolving the health human resource shortages, providing sufficient incremental operating room and bed capacity (including shifting resources and services where needed), and ensuring offices are booking patients First in, First out (FIFO) within each wait time category as clinically appropriate. In partnership with surgeons and surgeon offices, VCH is also working to improve waitlist management and accurate assignment of diagnosis codes. Additionally, we are improving OR efficiency to maximize the use of the current OR time available by improving the first case start time, reducing turnaround time, decreasing the number of early finishes and reducing seasonal closures.

#### What are we doing?

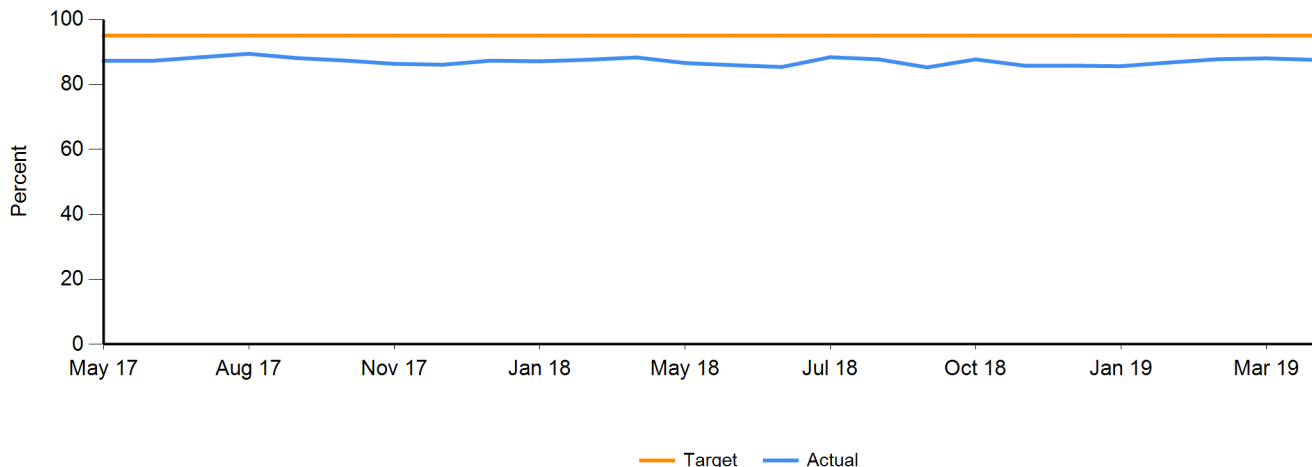
We are providing surgeon offices with regular reports that show, which patients are waiting the longest. This makes it easier for them to book patients, according to the wait time target. We are giving additional Operating Room time to surgeons to specifically treat patients who have been waiting more 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](http://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 *
87.5 %	>= 95.0 %

Year-to-date Timeline: Apr 2019 - Apr 2019



# Our Health Care Report Card

May 2019

## Completed multidisciplinary mortality reviews

### How many mortality cases have been reviewed to identify areas to improvement?

#### What are we measuring?

We measure the number of completed multidisciplinary mortality cases reviewed utilizing the Honey Badger Safety Learning System (HBSLS) methods and tools.

#### Why?

Regularly reviewing in-hospital mortalities has been found to help identify opportunities to improve patient care and drive future quality improvement activities. The multidisciplinary approach to the mortality review process used in the HBSLS promotes the inclusion of multiple perspectives on the patient journey and focuses on the processes of care with a systems lens to drive actionable outcomes.

#### How do we measure it?

When two clinical staff members (one nurse and one physician) have independently completed a mortality review and reported it in the HBSLS database, we count it as one completed case.

#### How are we doing?

The intent behind implementing this new method of chart review across VCH and PHC was to create a meaningful mechanism to identify system level opportunities for improvement. While simple in concept, and with a general agreement amongst healthcare leadership that this is the right thing to do, a significant amount of work was required to ensure staff were engaged in this new process and provided with the education/tools they required for this work to be successful. PHC is focusing on mortality as their first "convenience" sample, but each of the COC's is determining what cohort of patients to review for maximal learning. Although the target of 99 reviews has only been completed at PHC, each COC within VCH has been set up now to ensure success of the program ongoing.

#### What are we doing?

We are enabling opportunities for staff to learn about and use a systems lens as a basis for driving quality improvement across VCH and PHC. Through the HBSLS process, we are building teams to support a positive patient safety culture. We are also creating a system whereby care-based learning is shared across the organization to help drive change. Furthermore, we are establishing a learning culture that promotes quality improvement on both a local and regional scale.

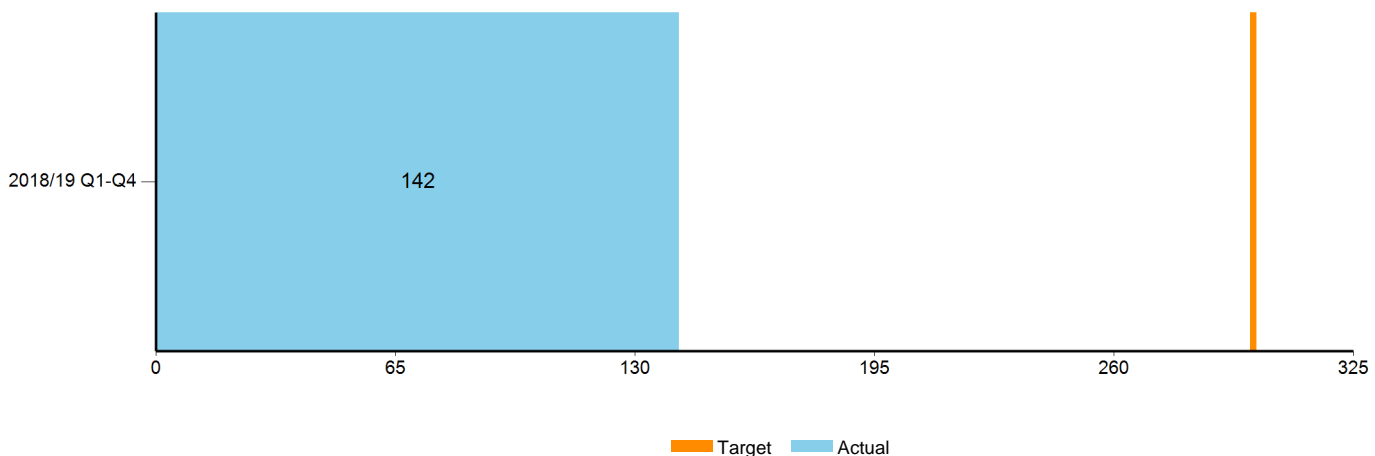
#### What can you do?

If you or a family member have ideas or comments about your visit at VCH or PHC, please share them with a healthcare provider. We value your input about how we can improve the care we provide.

Our performance	Target *
142	>= 297
YTD completed mortality reviews	

Year-to-date Timeline: Apr 2018 - Mar 2019

\*Our target was approved by the Senior Executive Team





# Our Health Care Report Card

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

May 2019

### 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?

To address the indicator's poor performance, the MHSU program has created a Regional Steering Committee with the purpose of meeting the 13% readmission rate target. Work to date includes 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). The leading indicator (based on patient service) indicates that MHSU readmission rates have improved over the last six months.

#### 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.

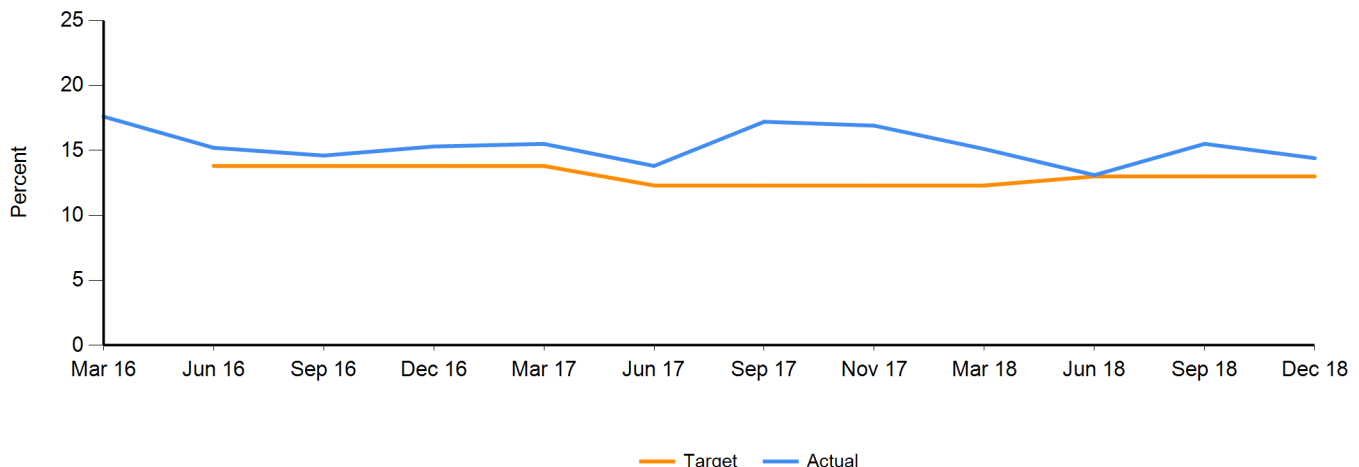
#### What can you do?

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 2018 - Nov 2018

\*Our target was determined in consultation with regional MHSU program



# Our Health Care Report Card

## % of MHSU readmissions within 30 days – based on patient service

May 2019

### 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 a MHSU-inpatient unit at any of our hospitals, within 30 days. This indicator is based on admissions that have been assigned to a psychiatric patient service. We have an additional indicator that uses hospital discharge diagnosis codes to identify readmissions. Using admissions data allows for more up-to-date reporting (1 week vs 3 month delay) 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 MHSU readmissions to any of our hospitals 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 admissions are identified based on the patient service in which they are placed.

#### How are we doing?

To address the indicator's poor performance, the MHSU program has created a Regional Steering Committee with the purpose of meeting the 13% readmission rate target. Work to date includes 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). This leading indicator shows a slight improvement in performance up to March indicating possible improved performance in the coming months for the other readmission indicator (which is only current to December).

#### 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.

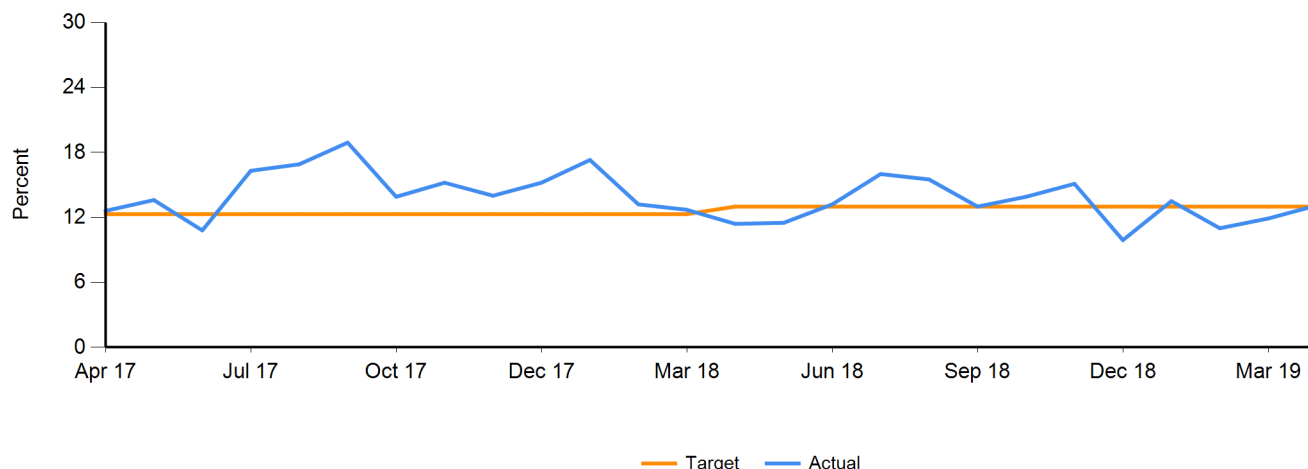
#### What can you do?

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 *
13.0 %	<= 13.0 %
of mental health and substance use patients readmitted to any VCH/PHC site	

Year-to-date Timeline: Apr 2018 - Mar 2019

\*Our target was determined in consultation with regional MHSU program



## Clostridium difficile infection rate

May 2019

### 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. 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 in February 2019 is 3.5 per 10,000 inpatient days, which is lower than the target of 3.6 per 10,000 inpatient days, and falling within the target range of 2.9 to 4.3 per 10,000 inpatient days. The target range is being used especially with our smaller sites, where slight changes in small numbers of *C. difficile* infection cases can lead to greater fluctuation in *C. difficile* infection rates. We continue to work to further drive improvements.

#### 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.

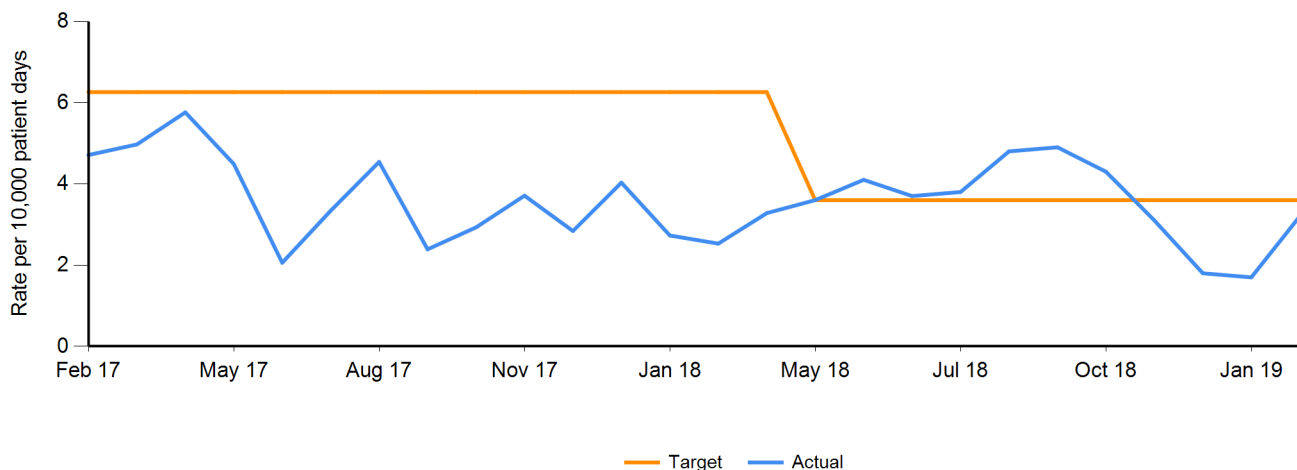
#### What can you do?

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 *
3.5	≤ 3.6
cases of <i>C. difficile</i> per 10,000 patient days	

Year-to-date Timeline: Apr 2018 - Feb 2019

\*Our target is based on recommendations made by the PICNet Surveillance Steering Committee (3.6 (95%: 2.9-4.3))



# Our Health Care Report Card

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

May 2019

### 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?

In April, 6.8% of inpatient days were ALC days for VCH overall, which is worse than the target of 6.2%. PHC is not included in VCH overall, as PHC data is not available for this period. Vancouver and Coastal are performing worse than target while Richmond is performing better than target. Due to volume demands from acute services, VCH has purchased services for 4 residential care beds for Vancouver residents in Fraser Health to increase the supply of residential care beds in addition to the 13 OCP beds already in use in Vancouver.

#### 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.

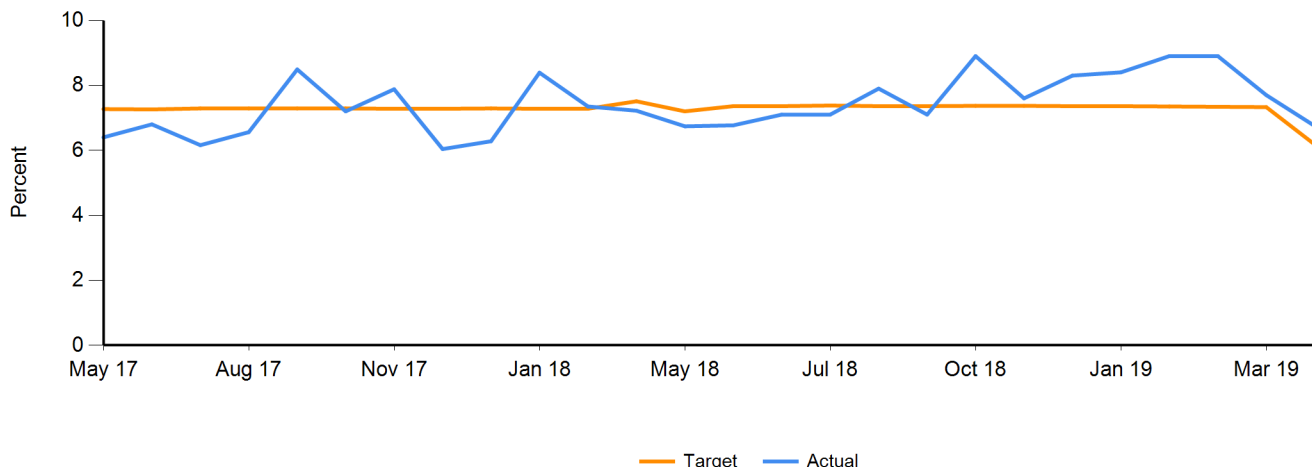
#### What can you do?

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

Our performance	Target *
6.8 %	<= 6.2 %
of hospital days are ALC days	

Year-to-date Timeline: Apr 2019 - May 2019

\*Our target is set to match the financial budgets



# Our Health Care Report Card

May 2019

## Hand hygiene compliance

### Do hospital staff clean their hands often enough?

#### What are we measuring?

We observe how often health care workers clean their hands before and after they come in contact with patients or their environment.

#### Why?

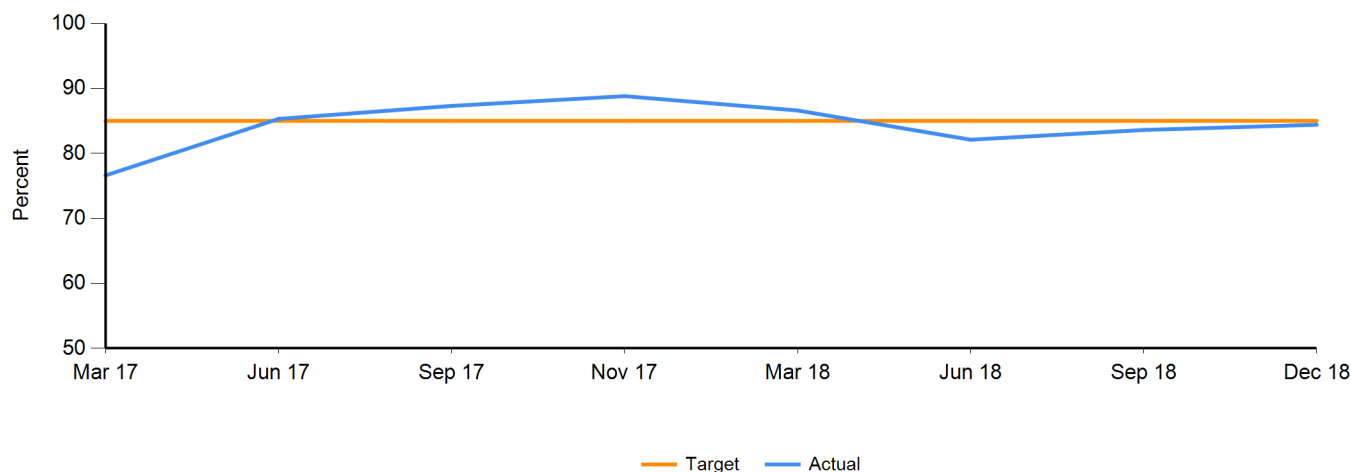
Clean hands are the single most effective way to stop the spread of infection or prevent patients from getting infections. Every health care associated infection adds \$10,000 to \$24,000 in treatment cost per patient.

#### How do we measure it?

Every month we observe a sample of staff working in Vancouver Coastal Health (VCH) hospitals. At Providence Health Care (PHC), we observe a sample of staff every three months. The percentage score reflects how often staff, clean their hands when there is an observed opportunity to do so.

#### How are we doing?

Hand hygiene percent compliance for 2018/19 September to December is 83.4%, which meets the Provincial Hand Hygiene Working Group target of 80.0% (set by the Ministry of Health) but is worse than the VCH/PHC target of 85.0%. Current performance is also worse than the overall hand hygiene percent compliance for 2017/18 of 86.9%. Coastal hand hygiene compliance may have been affected by CST/Cerner roll out that took place from April to June 2018.



#### What are we doing?

Improvement is contingent on staff increasing hand hygiene compliance before coming into contact with patients, which is consistently lower than after patient contact. Both PHC and VCH are targeting educational interventions to improve compliance before patient contact.

#### What can you do?

You can politely ask health care workers if they have cleaned their hands before they examine or treat you. You can also clean your own hands thoroughly and often, especially before and after eating and after going to the washroom.

Our performance	Target *
83.4 %	>= 85.0 %
of hand cleaning opportunities taken	

Year-to-date Timeline: Apr 2018 - Dec 2018

\*Our target is set to encourage incremental improvements with the ultimate goal of 100% compliance.

# Our Health Care Report Card

## Care sensitive adverse events (per 1,000 inpatient cases)

May 2019

### Are our patients getting high quality nursing care?

#### What are we measuring?

Vancouver Coastal Health (VCH) is measuring the rate of care sensitive adverse events (CSAE) for all medical and surgical patients 55 years of age or older. An adverse event happens when a patient is unintentionally harmed as a result of medical treatment. The events included in this measure are urinary tract infections (UTI), pressure ulcers, in-hospital bone fractures and pneumonia.

#### Why?

Our goal is to provide the best care to our patients. Our patients will have better health outcomes, and a better recovery, if there is a greater quality of nursing care.

#### How do we measure it?

We take the number of patients who have one or more care sensitive adverse events while in hospital and divide it by the total number of medical and surgical patients aged 55 and older. The rate we report is per 1,000 patient discharges.

#### How are we doing?

Continued partnership has been developed between Health Information Management (HIM) and Quality and Patient Safety (QPS) to help increase reliability in measurement. Based upon provided rates, multiple unit level initiatives to decrease high rates of CSAE events have been initiated throughout the organization utilizing Team Based Quality Improvement teams whose aim is to focus on the solution that is right for their area. Findings should continue to be interpreted with caution at this time, and be viewed alongside individual CSAE component metrics.

#### What are we doing?

We are implementing a number of projects across the organization that focus on reducing the risk of developing urinary tract infections and pneumonia during a hospital stay.

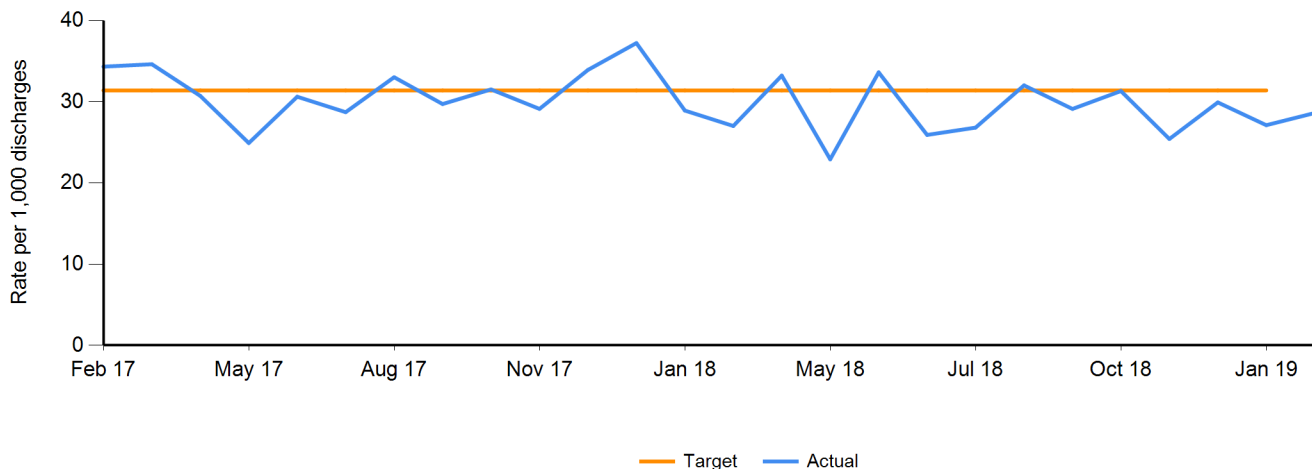
#### What can you do?

To reduce your risk of developing pneumonia if you are staying in the hospital, work with your nurse and physiotherapist to move around as much as possible and to take deep breaths. To reduce your risk of getting a urinary tract infection, work with your nurse to make sure you are getting proper nutrition and that your catheter (if you have one) is kept clean, with the catheter bag hanging at a level below your waist.

Our performance	Target *
28.3	<= 31.4
per 1,000 discharges	

Year-to-date Timeline: Apr 2018 - Jan 2019

\*Our target is based on historical peer group performance





# Our Health Care Report Card

## Average hospital days in the last 6 months of life for clients known to VCH community programs

May 2019

### What are we measuring?

We are measuring the intensity of care by capturing the number of days that patients spend in the hospital during final six months of their life among patients who have previously received care and supports through a Vancouver Coastal Health (VCH) community program. It is an inverse indicator of our success in providing appropriate care to clients in their homes.

### Why?

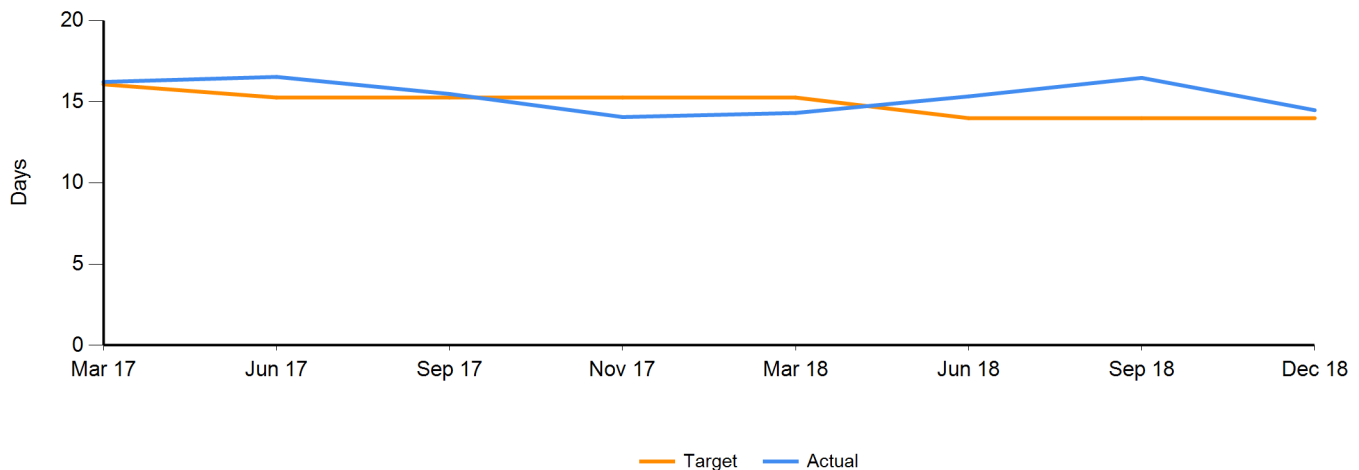
Planning care and supporting patients well in community settings during this stage of life improves quality of life and experience of care for patients and families. Increasing support for patients in their home setting reduces the need for a crisis admission to hospital. Hospital days in the final six months of life is one of the Institute for Health Improvement (IHI)'s Whole System Measures for quality care.

### How do we measure it?

For each fiscal quarter, we count all inpatient days in VCH and Providence Health Care hospitals in the last 180 days of life by adults whose death was recorded during the fiscal quarter and divide it by the number of deaths. We exclude anyone who is not a resident of the VCH region and anyone with no record of receiving care from our community programs. The Community of Care-level indicators are determined by residence, not location of death.

### How are we doing?

Results have improved in December 2019 resulting in performance of 14.5 days in hospital in the last 6 months of life. This is above the VCH target of 14 days, but Richmond and Coastal Rural are currently below target for this measure, and Vancouver is within 10% of target. End-of-Life indicator targets are based on continuous improvement, so improved performance over the course of the year is an expected trend.



### What are we doing?

Clinicians are having discussions around goals of care with patients and their families. We are working on providing well-coordinated care in the community for clients nearing the end of life and, when required, timely access to hospice. We are also supporting the palliative approach in Residential Care and developing strategies to better identify the population that need palliative care.

### What can you do?

Ensure your family and loved ones know what you would want for your care if ever you are unable to speak for yourself. Have a discussion with your care team around your wishes.

Our performance	Target *
16.50	<= 13.98
Average hospital days in the last 6 months of life	

Year-to-date Timeline: Apr 2018 - Dec 2018

\*Our target was set by the palliative program

# Our Health Care Report Card

## Sick time rate

May 2019

### How often are staff away from work due to an illness?

#### What are we measuring?

We track the amount of time our employees are away from work due to illness.

#### 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 coworkers, and allows us to reinvest in patient care.

#### How do we measure it?

We track the number of hours lost to sickness 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?

In April 2019, sick time for VCH was 5.1%, which meets the target of 5.1%. PHC is not included in VCH overall, as PHC data is not yet available for April 2019. Vancouver and Coastal are performing better than target. Although Richmond is performing worse than target, their performance is better than last year at this time but their target is more aggressive. Compared to last year at this time, performance at all CoCs has improved.

#### What are we doing?

We have an attendance and wellness program to help staff who have frequent, sporadic absences from work improve their attendance. It does not apply to employees with one long absence or a documented chronic disability. We hold meetings with staff who have above-average sick time to proactively identify any issues that may be contributing to their sick time and offer appropriate support.

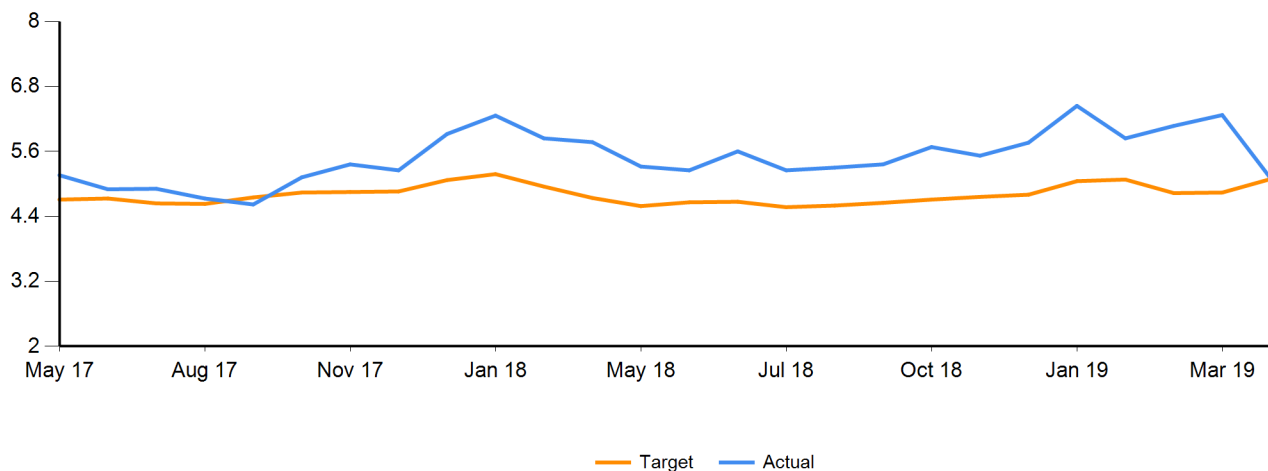
#### What can you do?

Abide with all our infection-control measures; this includes hand washing and staying away from our facilities if you're sick to protect both our patients and our staff. Get a flu shot; anyone who has contact with our patients is eligible for a free flu shot available from your physician, local pharmacy or public health centre.

Our performance	Target *
5.1 %	<= 5.1 %
of total productive hours were sick hours	

Year-to-date Timeline: Apr 2019 - May 2019

\*The target is the budget for sick time and is determined by VCH's finance department



# Our Health Care Report Card

## Overtime rate

May 2019

### 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 generally 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.

#### How are we doing?

In April 2019, the overtime percentage at VCH overall is 2.9%, which is slightly higher than last year-to-date period 1 of 2.8% and higher than the budget target of 2.3%. PHC is not included in VCH overall, as PHC data is not yet available for April 2019.

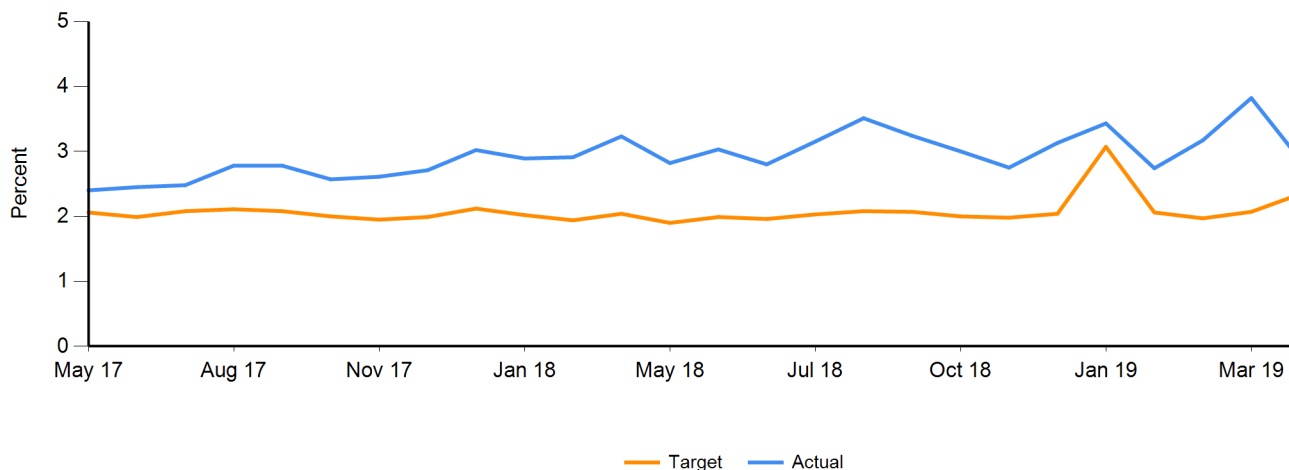
#### What are we doing?

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 *
2.9 %	<= 2.3 %
of total productive hours were overtime hours	

Year-to-date Timeline: Apr 2019 - May 2019

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



# Our Health Care Report Card

May 2019

## Acute productive hours per patient day

### 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 patient care and 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.

#### How are we doing?

The acute productive hours per patient day for April 2019 is at 5.9, which meets the VCH overall target of 7.0. PHC is not included in VCH overall, as PHC data is not yet available for April 2019.

#### 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 *
5.9	$\leq 7.0$
hours of direct patient care per day	

Year-to-date Timeline: Apr 2019 - May 2019

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

