Our Health Care Report Card

Fraser Health

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

No	Measure Name	Reporting Period	Target	Actual	Status	Preferred Direction
	QUALITY AND SAFETY					
1	In-Hospital *Clostridioides Difficile* Infection (CDI) Incidence	Apr 1, 2024 - Jan 02, 2025	*3.3*	*2.3*	●	↓
2	In-Hospital Methicillin-Resistant *Staphylococcus aureus* (MRSA) Incidence	Apr 1, 2024 - Jan 02, 2025	*3.8*	*3.9*	▲	↓
3	Hand Hygiene Compliance	Apr 1, 2024 - Jan 02, 2025	*80%*	*83.1%*	●	↑
4	In-Hospital Sepsis Rate	Apr 1 - Oct 10, 2024	*3.8*	*3.9*	▲	↓
5	In-Hospital Acquired Delirium	Apr 1 - Oct 10, 2024	*7.3*	*11.2*	◆	↓
6	In-Hospital Acquired Non-Aspiration Pneumonia	Apr 1 - Oct 10, 2024	*7.3*	*10.2*	◆	↓
7	In-Hospital Acquired Urinary Tract Infection	Apr 1 - Oct 10, 2024	*10.0*	*21.3*	◆	↓
8	Hospital Standardized Mortality Ratio	Apr 1 - Jun 30, 2024	*93*	*91*	●	↓
9	Worsened Pressure Ulcer in Long Term Care Community	Apr 1 - Sep 30, 2024	*1.6%*	*2.1%*	◆	↓
	CAPACITY AND CARE ACROSS ALL SECTORS					
10	Emergency Patients Admitted to Hospital Within 10 Hours	Apr 1, 2024 - Jan 02, 2025	*65.0%*	*18.3%*	◆	↑
11	Admitted Patients Waiting for Inpatient Bed Placement	Apr 1, 2024 - Jan 02, 2025	*130*	*242.3*	◆	↓
12	Patients Length of Stay Relative to Expected Length of Stay	2023/2024	*0.95*	*1.07*	◆	↓
13	Long Stay Patients	Apr 1, 2024 - Jan 02, 2025	*455*	*632.7*	◆	↓
14	Alternate Level of Care (ALC) Days	Apr 1 - Oct 10, 2024	*12.9%*	*14.1%*	▲	↓
15	Hospitalization Rates for Residents (Age 70+)	2023/2024	*213.7*	*227.1*	▲	↓
16	Overall Readmission Rates to Hospitals within 30 Days	2023/2024	*10.0*	*9.9*	●	↓
17	Mental Health & Substance Use Patients Hospital Readmission Rate (Age 15+)	2023/2024	*13.3%*	*13.1%*	●	↓
18	Patients with Chronic Conditions Admitted to Hospital (Age 75+)	2023/2024	*3,448*	*2,287*	●	↓
19	Low Acuity Emergency Visits by Community	Apr 1, 2024 - Jan 02, 2025	*100.0*	*103.7*	▲	↓
20	Home Health Services Provided Within Benchmark Time	Apr 1, 2024 - Jan 02, 2025	*50.0%*	*53.2%*	●	↑
21	Wait Time for Home Health Assessment (RAI-HC)	Apr 1, 2024 - Jan 02, 2025	*30.0*	*14.0*	●	↓
22	Admissions to Long Term Care within 30 Days	Apr 1, 2024 - Jan 02, 2025	*75.0%*	*55.8%*	◆	↑
23	Emergency Visits by Home Health Clients	Dec2023-Nov2024	*75.8*	*81.4*	▲	↓
24	Emergency Visits by Long Term Care Residents	Dec2023-Nov2024	*30.0*	*44.2*	◆	↓
25	Non-emergency Surgeries Completed Within 26 Weeks	Apr 1, 2024 - Jan 02, 2025	*95%*	*89.6%*	▲	↑
26	Non-Emergency Surgeries Waiting Longer Than 26 Weeks	Apr 1, 2024 - Jan 02, 2025	*22.8%*	*21.9%*	●	↓
	POPULATION & PUBLIC HEALTH MEASURES					
27	Percent of 2-Year Olds with Up-To-Date Immunizations	Apr 1 - Dec 31, 2024	*80%*	*71.4%*	◆	↑
28	Health Protection Program Response Time to Public Complaints	Apr 1 - Dec 31, 2024	*95%*	*97.7%*	●	↑
29	Prenatal Registrations	Apr 1 - Dec 31, 2024	*75%*	*56.5%*	◆	↑
	STAFF					
30	Nursing and Allied Professional Sick Time	Apr 1, 2024 - Jan 02, 2025	*5.8%*	*6.4%*	▲	↓
31	Nursing and Allied Professional Overtime	Apr 1, 2024 - Jan 02, 2025	*3.9%*	*9.1%*	◆	↓
32	Lost Time Claims Rate	Apr 1 - Sep 30, 2024	*5.3*	*8.2*	◆	↓
33	Long Term Disability Claims Rate	Jan 1 - Sep 30, 2024	*2.25*	*1.70*	●	↓
34	Turnover Rate In The First Year Of Service	Apr 1 - Dec 31, 2024	*2.5%*	*3.3%*	◆	↓
	BUDGET ACCOUNTABILITY					
35	Budget Performance Ratio	Apr 1, 2024 - Jan 02, 2025	*1.000*	*1.010*	▲	↓

Notes:

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

KPI Count By Status

Meeting Target	●	11
Within 10% of Target	▲	9
Not Meeting Target	◆	15

Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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 CDI new cases/reinfections attributed to the same facility where a patient was admitted and identified as a CDI case. Rates are presented per 10,000 patient days, within a specified time frame (e.g. fiscal period, year-to-date, fiscal year).

Why?

Clostridioides difficile is the most common cause of healthcare-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?

([Number of CDI new cases/reinfections attributed to the same facility where patient was admitted and identified as a CDI case] / [Total number of patient days for a particular site or FH overall] * 10,000) for a specified reporting period

How are we doing?

Fraser Health's CDI incidence rate, which is the number of new acute care cases per population-at-risk, is 2.3 in 2024/25 year-to-date, which is meeting the current FHA internal target of ≤ 3.3 cases per 10,000 patient days. In previous fiscal years from 2018/19 to 2023/24, 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. The Infection Prevention and Control (IPC) Practitioners conduct detailed reviews of each CDI case to understand the factors that may have contributed to the infection. This information helps staff develop quality improvement action plans to reduce CDI transmissions.
The IPC program works with Environmental Services to ensure that all rooms of patients with suspected or known CDI are cleaned twice a day with a sporicidal agent, and also collaborates with acute care sites to implement ultra-violet germicidal irradiation technology and quality improvement action plans to reduce healthcare-associated CDI. In addition, hand hygiene practices of healthcare providers are monitored across FH to support IPC best practices.

What can you do?

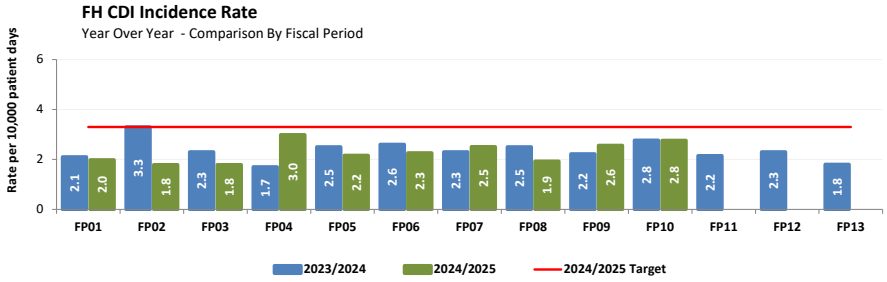
One of the most important things you can do is to clean your hands when entering and exiting a facility or patient room, and support your family or loved ones to clean their hands as frequently as possible. When visiting, please follow all instructions and signs posted on the unit to decrease the chance of spreading germs.

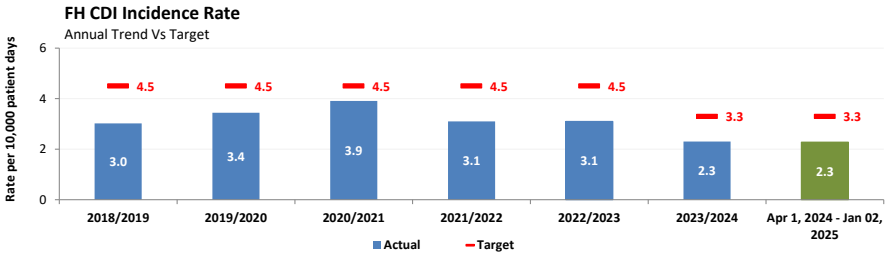
Our Performance	Target *
2.3	<= 3.3

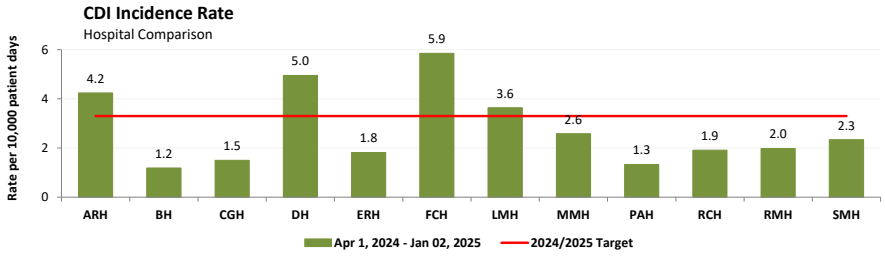
Unit of Measure: Number of infections / 10,000 patient days

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
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)
3) As of FP04 of 2023/24, the data source for patient days has changed. As a result, there may be a light discrepancy in previously reported rates







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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 MRSA cases attributed to the same facility where patient was admitted and identified as MRSA positive. Rates are presented per 10,000 patient days, within a specified time frame (e.g. fiscal period, year-to-date, fiscal year).

How are we doing?

Fraser Health's MRSA incidence rate, which is the number of new acute care cases per population-at-risk, has decreased from 5.3 in 2018/19 to 3.9 in 2024/25 year-to-date, which is slightly above the current FHA internal target of ≤ 3.8 cases per 10,000 patient days. In previous fiscal years from 2018/19 to 2023/24, the rate of MRSA remained below the FHA internal target set for each respective year. Please see figures below.

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.

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).

How do we measure it?

([Number of new MRSA cases attributed to the same facility where patient was admitted and identified as MRSA positive] / [Total number of patient days for a particular site or FH overall] * 10,000) for a specified reporting period

What can you do?

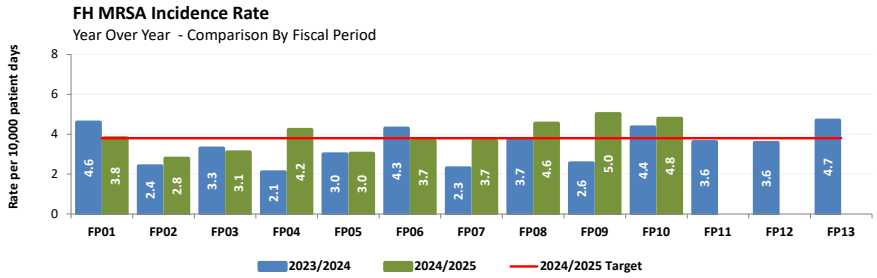
One of the most important things you can do is to clean your hands when entering and exiting a facility or patient room, and support your family or loved ones to clean their hands as frequently as possible. When visiting, please follow all instructions and signs posted on the unit to decrease the chance of spreading germs.

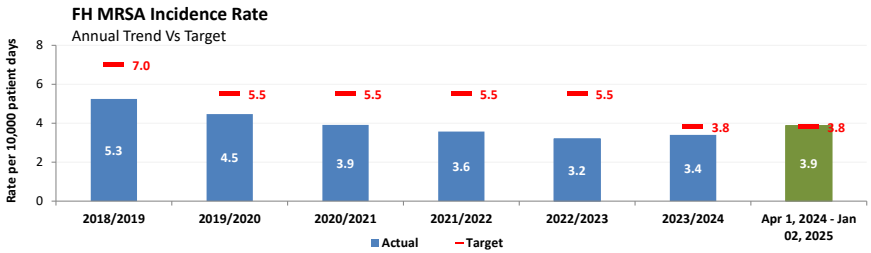
Our Performance	Target *
3.9 ▲	<= 3.8

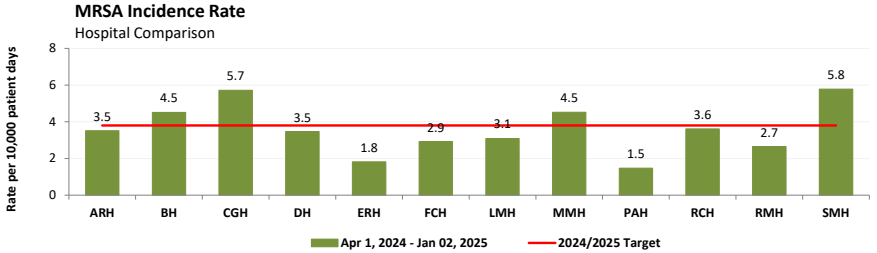
Unit of Measure: Number of infections / 10,000 patient days

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
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)
3) As of FP04 of 2023/24, the data source for patient days has changed. As a result, there may be a light discrepancy in previously reported rates







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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.

How are we doing?

Fraser Health's overall hand hygiene compliance improved over the years from 79.6% in 2018/19 to 83.1% in 2024/25 year-to-date. Based on the currently available results, Fraser Health is meeting the provincial target of >=80%.

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.

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.

How do we measure it?

([Number of times healthcare providers correctly performed hand hygiene while providing direct patient care] / [Total number of times that hand hygiene should have been performed by those same healthcare providers] * 100) for a specified reporting period

What can you do?

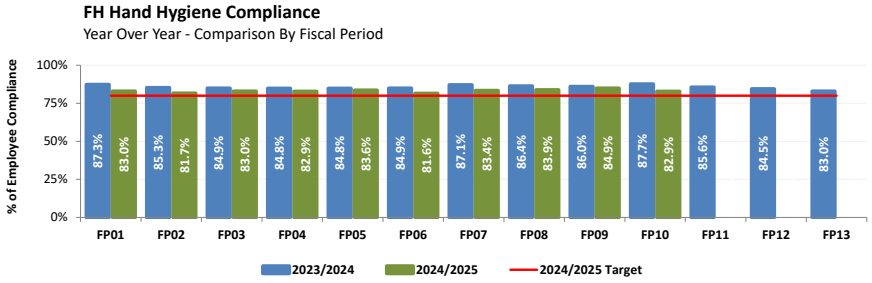
One of the most important things you can do is to clean your hands when entering and exiting a facility or patient room, and support your family or loved ones to clean their hands as frequently as possible.

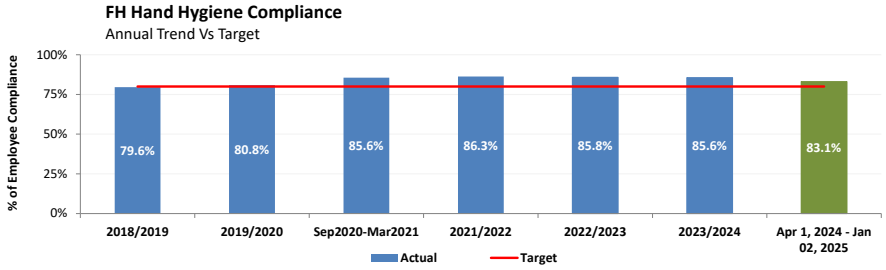
Our Performance	Target *
83.1%	***>= 80%***

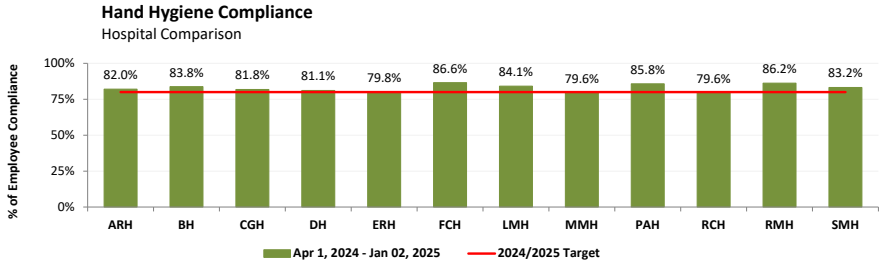
Unit of Measure: Percent of compliant employees

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
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)
4) The regional hand hygiene audit program was suspended in April 2020 due to the COVID-19 pandemic, and resumed in September 2020.







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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 2024/25 year-to-date performance for hospital sepsis is 3.88 and is performing slight above the target of 3.8. Our hospitals' results show that five sites (Chilliwack General, Delta, Langley Memorial, Mission Memorial, and Royal Columbian) are meeting their internal targets. There was an increase in hospital acquired sepsis with patients who acquired COVID-19.

What are we doing?

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 is focused on prevention of all hospital acquired infections, treatment of infections and early recognition and treatment of sepsis. All levels of leadership monitor sepsis results and actively support reducing hospital acquired sepsis rates by highlighting and sustaining best practices already in place throughout FH acute care sites.

What can you do?

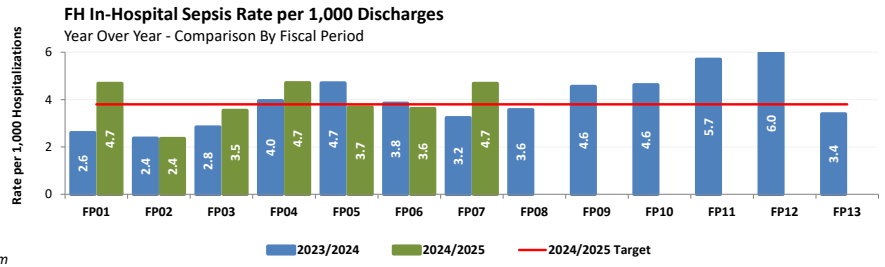
You are encouraged to get vaccinated against COVID-19, the flu, pneumonia, and any other infections that could lead to sepsis. Practice of good hygiene (e.g. brushing your teeth, hand washing, bathing regularly) is especially important while in the hospital and insuring adequate nutrition and hydration. 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 phamplet 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.

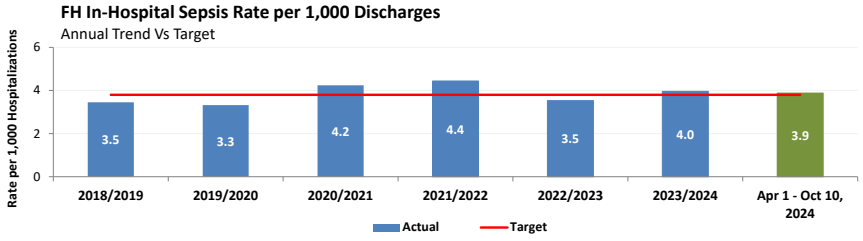
Our Performance	Target *
3.88 △	*<= 3.8*

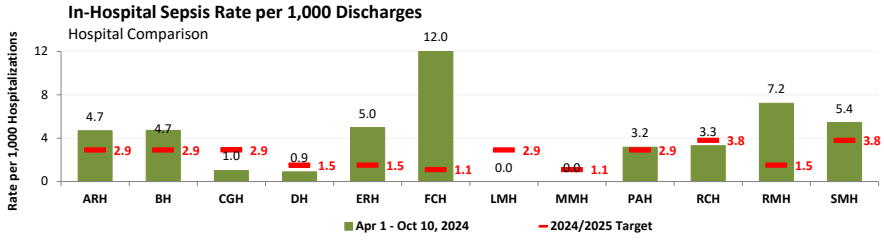
Unit of Measure: Infections per 1,000 Discharges

Performance timeline:	Apr 1 - Oct 10, 2024
Data Source:	Med2020 Abstracting and Coding system
* 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: FP10, 2024/25 - Ending Jan 02, 2025

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 2024/25 year-to-date performance for in-hospital acquired delirium is 11.2. Fraser Canyon is currently meeting the target. 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. Due to improvement work focused on regular in-hospital screening and early identification of hospital acquired delirium, we anticipate an increase in our delirium rates.

What are we doing?

Hospital acquired delirium is a 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.

Fraser Health is focused on an interprofessional, multi-faceted approach for delirium. This approach includes: education and the implementation and sustainment of revised clinical practice tools and guidelines. The regional Delirium Steering Committee is testing upstream identification of patients at increased risk of delirium; improved documentation/charting/coding; and enhancing delirium prevention and recognition in the community ("pre-admission"). We anticipate a continued increase in hospital acquired delirium as quality improvement efforts in delirium recognition and charting/coding reflects more accurate delirium prevalence data.

What can you do?

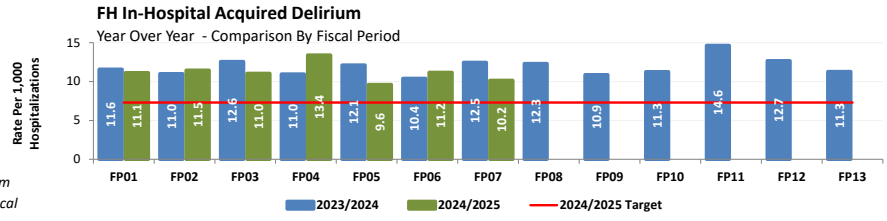
As a family member, you know your family member best. Please tell staff if you see any unusual change in behaviour. You can help by visiting and bringing in familiar items from home, such as favorite music and pictures. Ask your family member to use their walking aid, hearing aids, dentures, and glasses. 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

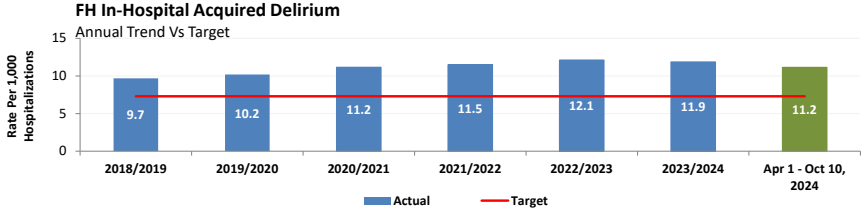
Our Performance	Target *
11.2 ◆	<= 7.3

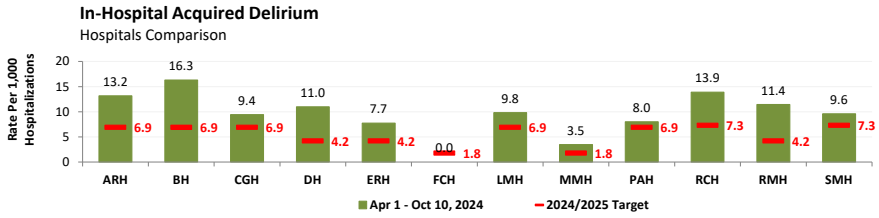
Unit of Measure: Infections per 1,000 Discharges

Performance timeline:	Apr 1 - Oct 10, 2024
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: FP10, 2024/25 - Ending Jan 02, 2025

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.

How are we doing?

Fraser Health's 2024/25 year-to-date performance for in-hospital acquired UTI is 21.3. All sites are currently above target. We will continue to work with our sites and programs to address opportunities for reducing this infection, which can impact a patient's length of stay in our facilities.

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.

What are we doing?

Hospital acquired urinary tract infection is a 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. The unit-based quality improvement teams (together QI) will continue to monitor trends over time and work with our sites and programs to sustain gains in reducing HAUTIs. The regional early mobilization strategy will contribute to reducing HAUTIs.

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.

What can you do?

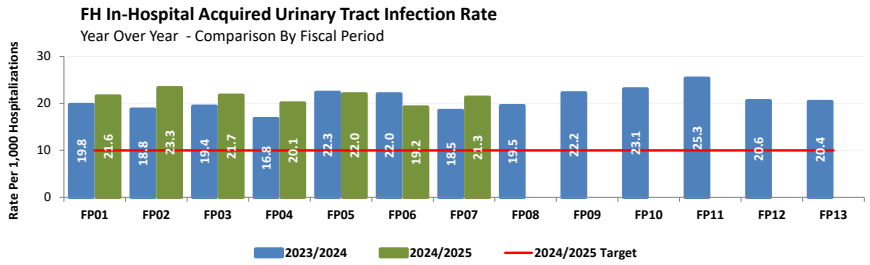
It is important to mobilize, hydrate, maintain adequate nutrition and empty your bladder every few hours to reduce the risk of acquiring a urinary tract infection. Together, we can help to reduce the risk of acquiring an infection or injury during your hospital stay.

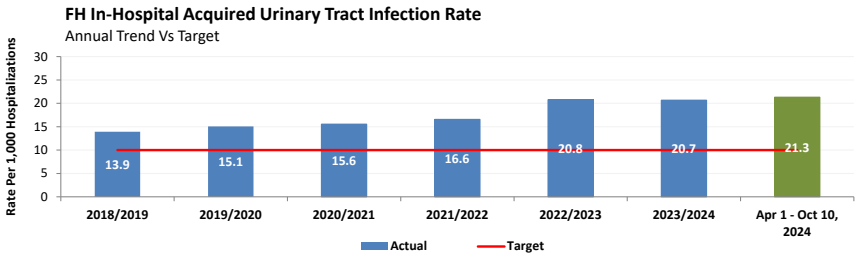
Our Performance	Target *
21.3 ◆	<= 10.0

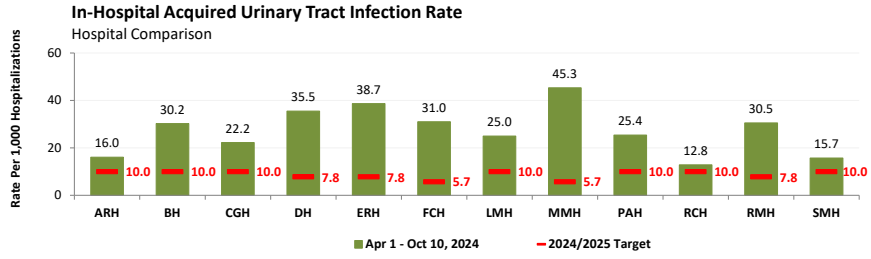
Unit of Measure: Infections per 1,000 Discharges

Performance timeline:	Apr 1 - Oct 10, 2024
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: FP10, 2024/25 - Ending Jan 02, 2025

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 2024/25 year-to-date performance for hospital acquired non-aspiration pneumonia is 10.2. Two sites (Chilliwack General 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. COVID-19, as well as the beginning of respiratory season, has negatively influenced our hospital acquired pneumonia numbers as patients on outbreak units who acquired COVID-19, and subsequently pneumonia, are included in the increase in numbers.

What are we doing?

Hospital acquired pneumonia is an infection in the lungs. It 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. This includes enhanced communication with patients and families as to their role in health promotion and prevention during a hospital admission. Mobilization is seen as integral to pneumonia prevention. Early mobilization is one of the 4 high impact strategies being introduced regionally as part of an improvement collaborative.

What can you do?

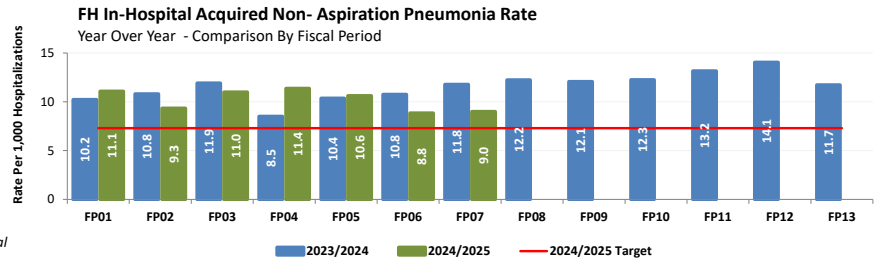
Pre-hospitalization vaccinations for flu, pneumococcal and RSV are recommended for these who meet the eligibility requirements. You are encouraged to mobilize if able, take deep breaths and cough every hour to reduce the risk of acquiring pneumonia. Maintaining adequate nutrition and hydration is key. 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.

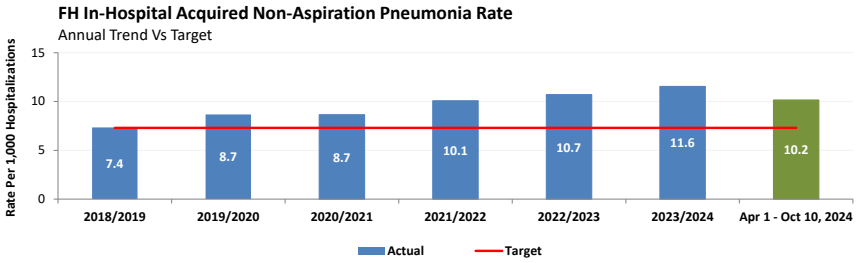
Our Performance	Target *
10.2 ◆	<= 7.3

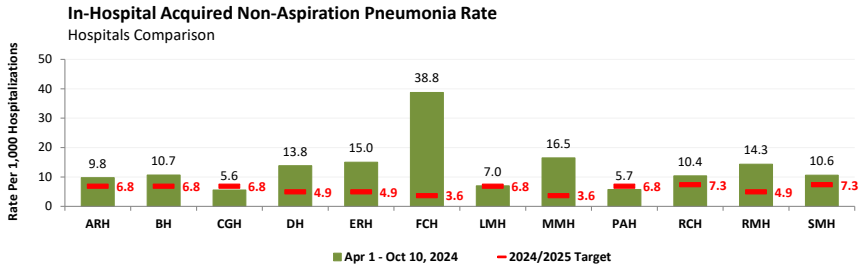
Unit of Measure: Infections per 1,000 Discharges

Performance timeline:	Apr 1 - Oct 10, 2024
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: FP10, 2024/25 - Ending Jan 02, 2025

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 2024/25 year-to-date HSMR rate of 91 is meeting the target of 93. At the hospital level, seven sites are performing below the target (Delta, Eagle Ridge, Langley Memorial, Mission Memorial, Peace Arch, Royal Columbian and Ridge Meadows). Chilliwack General is performing close to the target. All Fraser Health sites 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 of at risk patients, 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. Quality improvement work continues with our electronic health record implementation to build in quality prompts, screening and alerts in an effort to continue to improve care to reduce harm and HSMR.

What can you do?

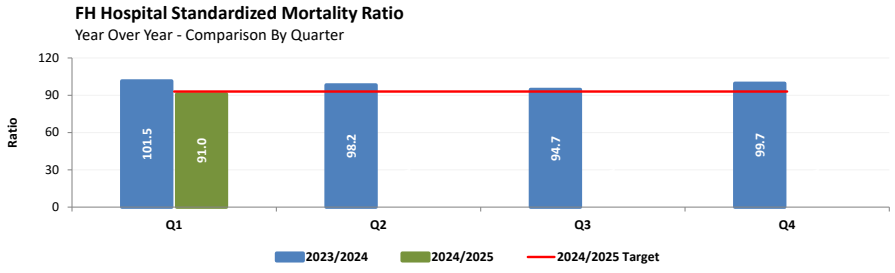
No matter what stage of life or health you are at, communication with your healthcare team regarding what you or your family are seeing or experiencing is vital to ensure appropriate treatment and levels of intervention. If you are a patient, we encourage you to participate as much as possible in setting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

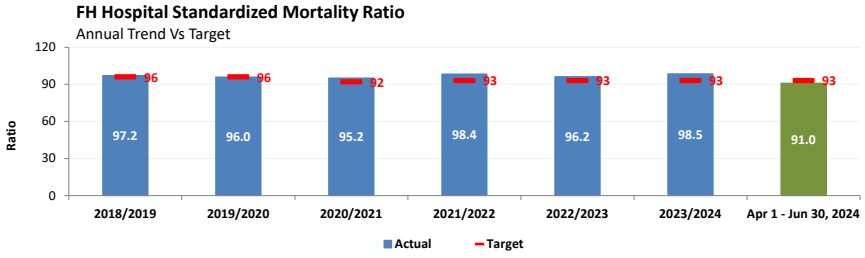
Our Performance	Target *
91.0	<= 93

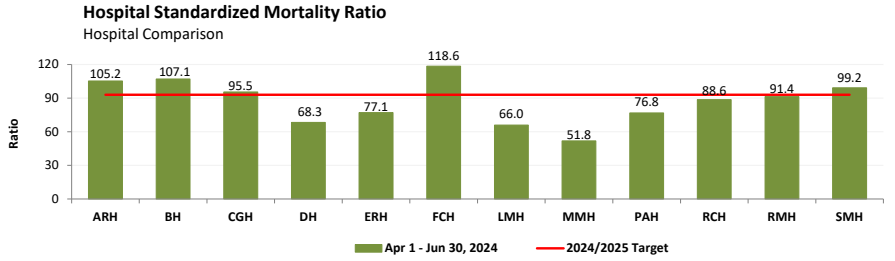
Unit of Measure: Hospital Mortality Ratio

Performance timeline:	Apr 1 - Jun 30, 2024
Data Source:	Canadian Institute for Health Information (CIHI)
* Target Source:	FHA Internal
BC Average (2020/21)	93
BC Average Source:	CIHI - Your Health System

Notes: *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-calculates with the new methodology (using 2015-2016 to 2017/2018 data)*







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

Worsened Pressure Ulcer in Long Term Care Community

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

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 Community 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?

Overall FH rate of 2.1% in 2024/25 year-to-date did not meet the target of < 1.6%. However, percentages are showing a reduction from previous time period due to organizational focus on reduction of worsening pressure ulcers for the last two years. Agassiz-Harrison, Burnaby, Hope, Mission and South Surrey/White Rock are exceeding target with rates under 1.6%.

What are we doing?

Care providers are aware of the many factors that contribute to the optimal health of residents living in long-term care. Fraser Health partners with care communities on an annual basis to review each care community's policies and practices related to maintaining healthy skin, wound prevention and management, and provides on-site consultation, education, coaching and mentorship. In addition, a tracking system is in place with data monitored on an ongoing basis to identify areas of strength and improvement. Fraser Health has initiated the Save Our Skin (S.O.S.) Pressure Injury Prevention Collaborative Sept 2023 across the region to improve outcomes for residents by reducing pressure related injuries. All of the education for SOS has been completed, and quality improvement initiatives are progressing. Currently in 2024 and continuing in to 2025, Fraser Health will be focusing on increasing the knowledge, skill and competency around basic and complex wound care for the frontline staff in long-term care through numerous education initiatives.

What can you do?

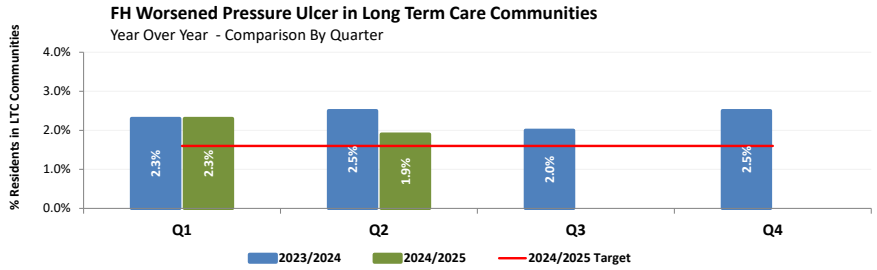
As always, family members are an important part of long term care team. If you have a loved one who resides in a long term care community, please encourage and support them to receive adequate nutrition and hydration since it has an important impact on "skin health" and healing of ulcers. If you observe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

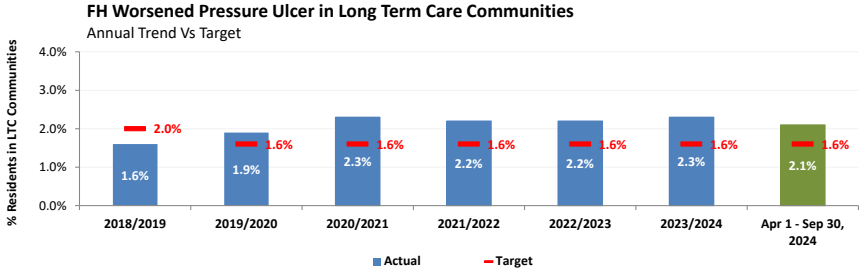
Our Performance	Target *
2.1% ◆	<= 1.6%

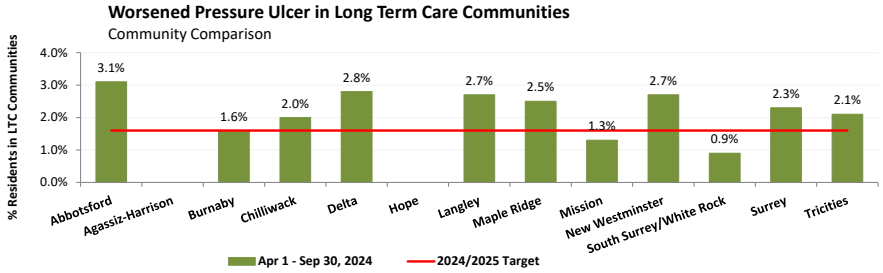
Unit of Measure: Percent of long term care residents

Performance timeline:	Apr 1 - Sep 30, 2024
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: FP10, 2024/25 - Ending Jan 02, 2025

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. Target was increased from 46% in 2019/20 to 65% in 2020/21. Fraser Health's current performance of 18.3% is not meeting our new internal target. We are experiencing unprecedented levels of congestion with higher ED visit volumes than before Covid. We 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, we are taking a patient-centered care and discharge planning approach by focusing on reducing unnecessary transfer delays and Long Lengths of Stay which will help create inpatient capacity to support the timely movement of patients from the emergency department. We are taking a focused and deliberate approach in strengthening our partnerships between acute and community teams and working on improving communication between health care teams, patients and families. In addition, we continue to reinforce the 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.

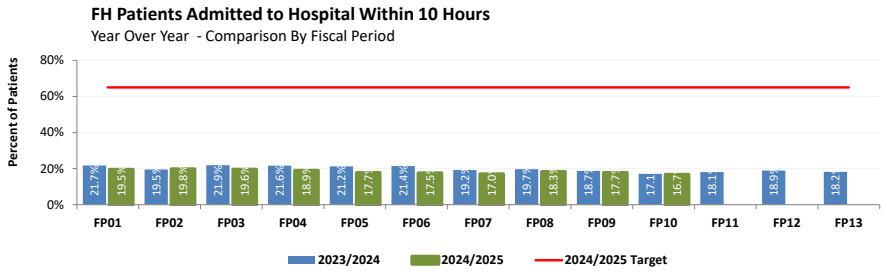
What can you do?

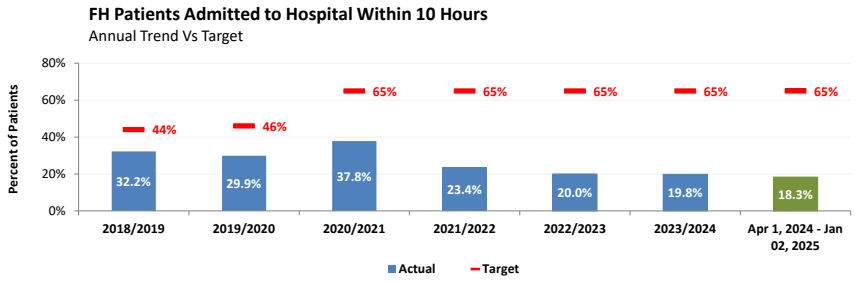
Fraser Health is committed to working with the communities that we serve to place more emphasis on the promotion of health and on preventing or delaying chronic diseases, disabilities, and injuries. Doing this will improve quality of life while reducing disparities and the impact these conditions have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

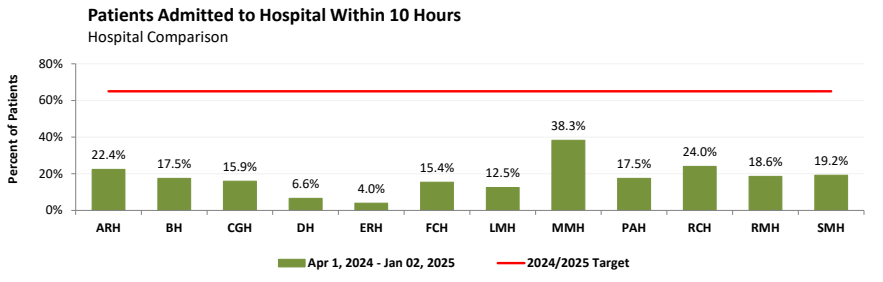
Our Performance	Target *
18.3% ◆	>= 65.0%

Unit of Measure: Percent of patients admitted within 10 hours

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
Data Source:	NACRS as measured by FHA
* Target Source:	BC Ministry of Health







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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.

How are we doing?

Fraser Health strives for continuous improvement. 2021/22 target is decreased from 160 in 2020/21 to 130. Our 2024/25 year-to-date performance of 242.3 is not meeting our new internal target. We are seeing lower volume in admitted patients across our EDs from FP03 to FP06 in 2023/24. We have seen a rise in occupancy in recent periods as our overall site occupancy has risen. We continue to strive for incremental, improvements in the number of admitted patients being held in our EDs.

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

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. Creation of a Regional Access and Flow Coordination Centre has brought new focus to creating capacity throughout the system and moving patients to the right place at the right time.

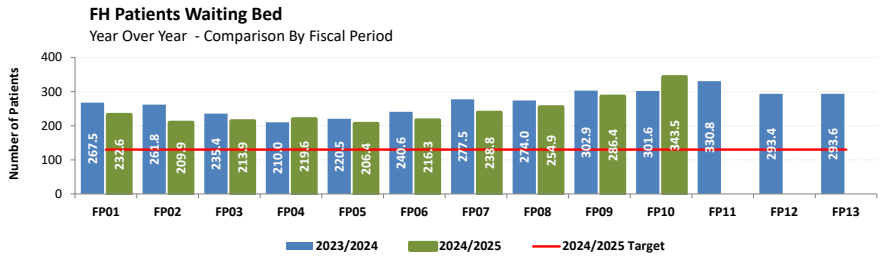
How do we measure it?

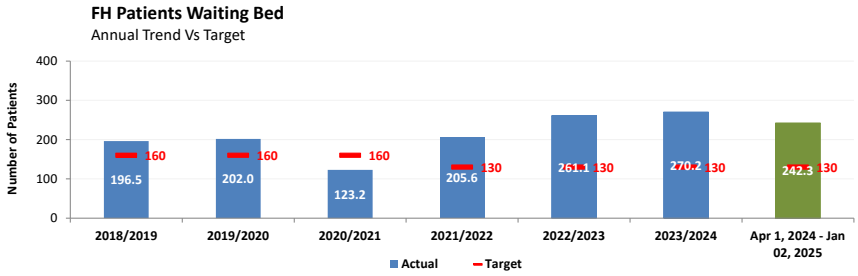
Every day at 2pm, we count the number of inpatients in our hospitals that are in locations that are not typically designated for clinical care (including Emergency Departments). We then take the average for all days for the reporting period.

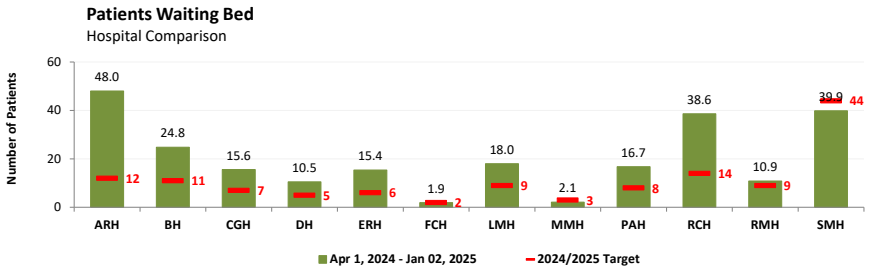
Our Performance	Target *
242.3 ◆	<= 130

Unit of Measure: Number of patients waiting for Inpatient bed

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
Data Source:	Meditech Client Server (Admissions), Master Bed Map spreadsheet (Clinical Capacity Optimization and Finance)
* Target Source:	FHA Internal







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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.

How are we doing?

Fraser Health patients' actual length of stay relative to expected length of stay is above our internal target; Chilliwack General and Fraser Canyon hospitals are meeting the target for this indicator. Royal Columbian hospital is performing close to the target. We are experiencing longer lengths of stay as we move into our annual respiratory season.

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.

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.

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.

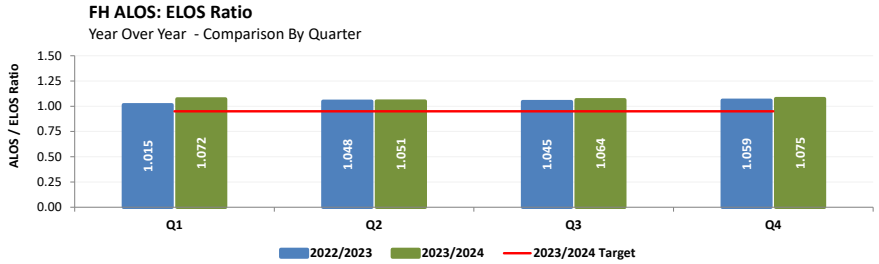
What can you do?

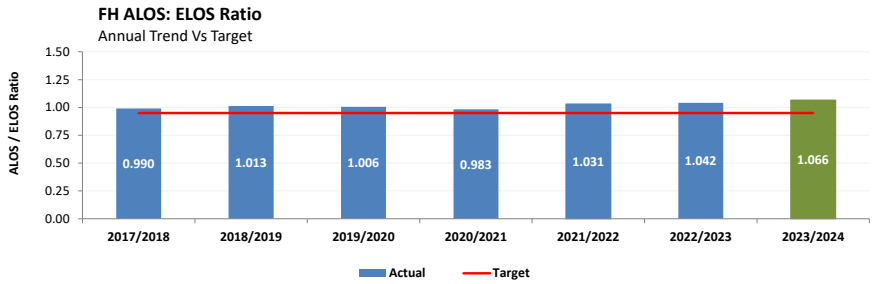
Take an active role in your plan of care. Ask questions about your medical condition and participate in setting your goals for care. Inform your care providers about what we need to know about you so we can give you the best care possible and feel confident when you leave the hospital.

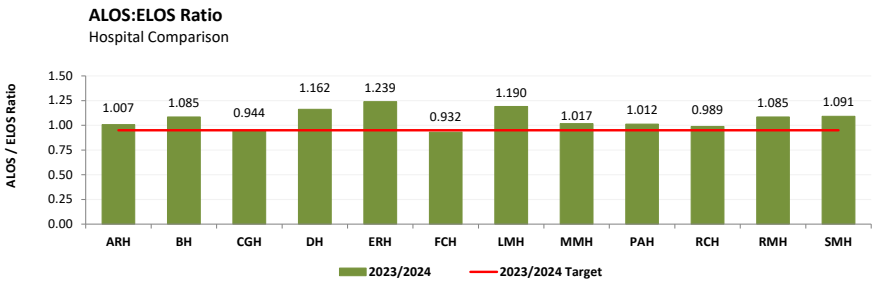
Our Performance	Target *
1.066 ◆	<= 0.95

Unit of Measure: Ratio of Actual to Expected Length of Stay

Performance timeline:	2023/2024
Data Source	MOH Measurement SharePoint
* Target Source:	FHA Internal







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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.

How are we doing?

Fraser Health's 2024/25 year-to-date performance of 632.7 is not meeting our internal target of 455. In 2020/21, we saw a significant improvement in the long length of stay as we navigated the early stages of the COVID-19 situation. However, since period 4 of 2022/23, long length of stay is performing over the target. We continue to work with our sites and programs to improve length of stay.

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.

What are we doing?

Fraser Health has patient care rounds at multiple levels that focus specifically on patients with complex needs to coordinate their care and identify resources that they might need. 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 established a regional structure within the organization to promote collaboration and provide real time, 7 day a week oversight and monitoring of patient transitions while facilitating real times decisions concerning patient movement both within sites and across our system. With strong and sustained involvement from our community partners we have been able to make progress towards transitioning patients to the correct care locations in a more timely manner.

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.

What can you do?

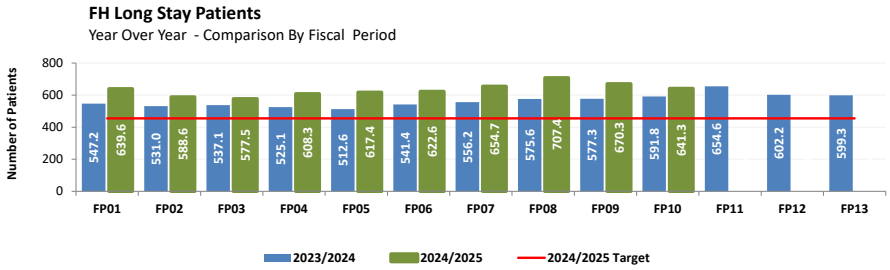
You are encouraged to talk with your health care team early in your stay about when you are likely to be discharged and what supports you may need to return home.

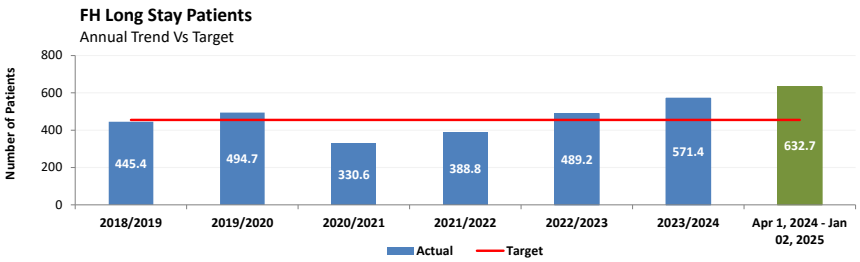
Our Performance	Target *
632.7 ◆	<= 455

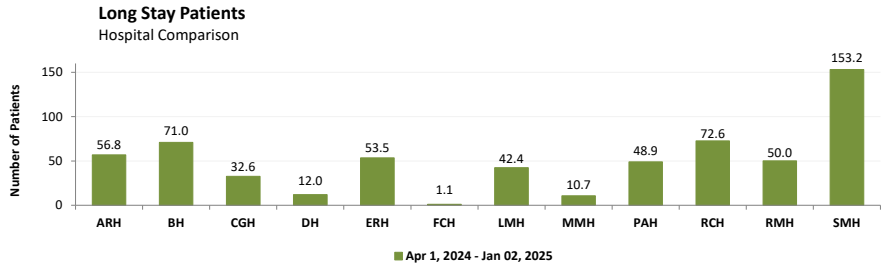
Unit of Measure: Number of patients staying longer than 30 days

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
Data Source:	Meditech
* Target Source:	FHA Internal

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







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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 are we doing?

Fraser Health’s 2024/25 year-to-date performance of 14.1% is performing above the target for this indicator. Six hospitals are meeting the target (Abbotsford Regional, Delta, Fraser Canyon, Royal Columbian, Ridge Meadows and Surrey Memorial). We have seen significant improvement in ALC occupancy and long length of stay for our inpatients in acute care. The volume of patients awaiting placement into Long Term Care Beds has also been significantly reduced as we continue to work on ensuring the right patient receives the right care in the right location.

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.

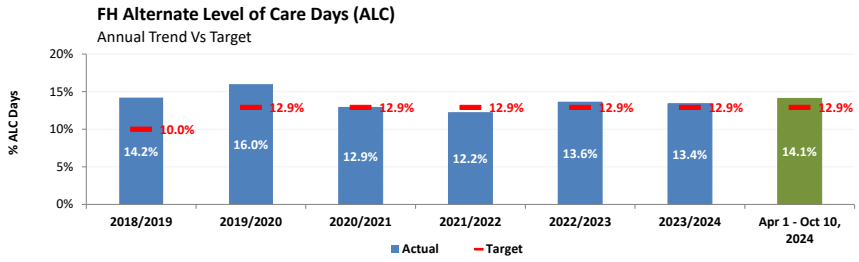
How do we measure it?

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.

Our Performance	Target *
14.1% △	*<= 12.9%*

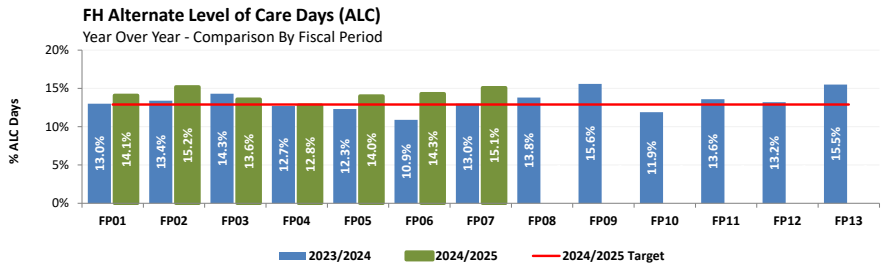
Unit of Measure: Percent of ALC days to total days

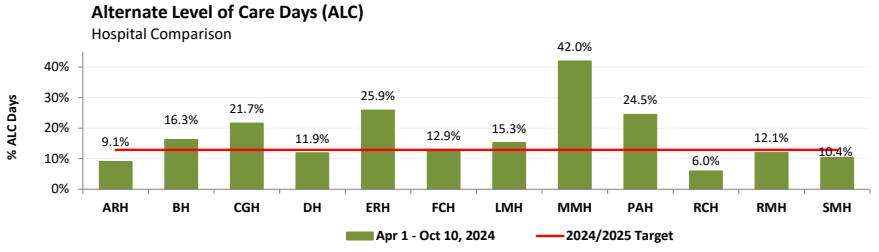
Performance timeline:	Apr 1 - Oct 10, 2024
Data Source:	Med2020 Abstracting and Coding System
* Target Source:	BC Ministry of Health



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 Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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

How are we doing?

The standardized hospitalization rate for seniors has been in steady decline over the last seven years. The 2023/24 regional rate of 227.1 is slightly higher than the targeted rate of 213.7 hospitalizations per 1,000 seniors. Rates vary by community. In Burnaby and South Surrey/White Rock communities, rates are lower than the target. In the Fraser East/Fraser Rural part of the region (Mission, Abbotsford, Chilliwack, Agassiz-Harrison and Hope) higher hospitalization rates for residents aged 70+ years are demonstrated in comparison with many urban communities.

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.

What are we doing?

We are seeking to reduce unnecessary hospitalizations by ensuring people aged 70 and older have access to a family doctor or nurse practitioner through Primary Care Networks. Most communities in the Fraser region now have Primary Care Networks. Primary Care Networks aim 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. Urgent and Primary Care Centres (UPCCs) are also attaching those complex patients that do not have a regular primary care provider.

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).

What can you do?

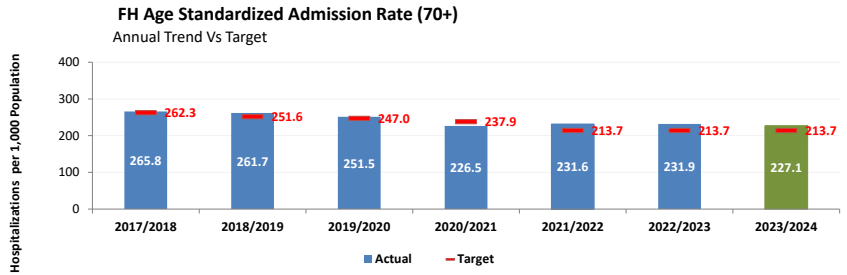
Ensure that you have a family doctor, and/or nurse practitioner. Use the available community based services and programs to meet your health and social care needs. Ask your family doctor and health care team to help you learn how you can best manage your chronic conditions as well as help you know early 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. Utilize preventative measures if you can such as exercise, eating a healthy diet and maintaining a healthy weight. For additional support for advice of how to meet your health care needs call HealthLink BC (dial 8-1-1) which is available 24 hours,7 days a week to speak to a Registered Nurse or call Fraser Health's Virtual Care Service to get you connected to health services in your communities for non-urgent or emergent care needs and is available seven days a week from 10 AM to 10 PM at 1-800-314-0999.

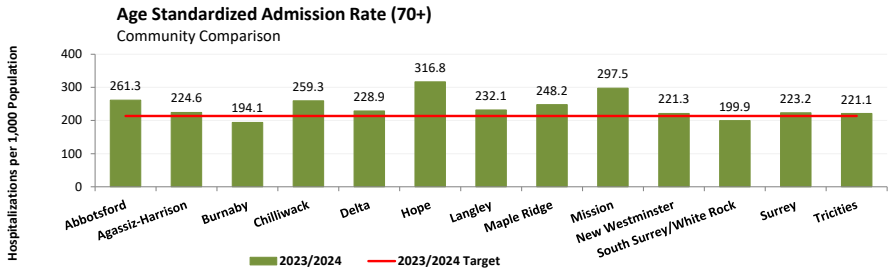
Our Performance	Target *
227.1 △	<= 213.7

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

Performance timeline:	2023/2024
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 Canada 2011; Based on BC Hospital Discharge Data; Population data provided by BC STATS (P.E.O.P.L.E. 2024);*
2) In the most recent update, MOH updated the report by using P.E.O.P.L.E. 2024 instead of P.E.O.P.L.E. 2021. Previously reported numbers have been restated.





Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

Overall Readmission Rates to Hospitals within 30 Days

How many patients are readmitted to FHA hospitals within 30 days of discharge

What are we measuring?

This indicator measures the rate of unplanned hospital readmissions within 30 days of discharge from an episode of care, expressed per 100 episodes. While not all readmissions are preventable, they may occur at any acute care facility and are not limited to the site of the original care episode. Readmissions are attributed to the place of service, not the patient's place of residence.

An episode of care includes all inpatient services provided within a specific timeframe across the continuum of care. This measure accounts for episodes related to obstetric, pediatric, surgical, and medical care, with Mental Health and Substance Use (MHSU) cases excluded.

How are we doing?

Fraser Health's 2023/24 hospital readmission rate of 9.9 meets our internal target of 10 and is trending in the desired direction. Six of our hospitals (Abbotsford Regional, Burnaby, Langley Memorial, Peace Arch, Royal Columbian, and Surrey Memorial) are achieving their internal targets. The remaining hospitals are actively working toward improving performance on this indicator.

Why?

Urgent, unexpected, or unplanned returns to hospital lead to poor patient experience and outcomes and add to health system costs. Such unexpected readmissions indicate a need for better coordination and quality of care within the hospital. Monitoring this indicator can potentially help improve effectiveness of hospital care and planning for patient support after discharge.

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.

How do we measure it?

We take the number of urgent or emergent readmissions to an FHA acute care hospital within 30 days of an episode of care, and divide it by the total number of inpatient episodes of care during a defined time period. The result expressed as a rate per 100 episodes.

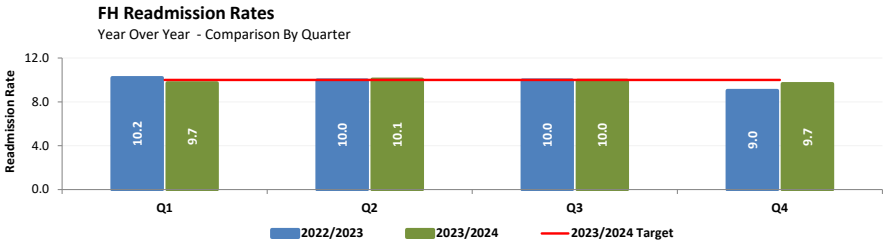
What can you do?

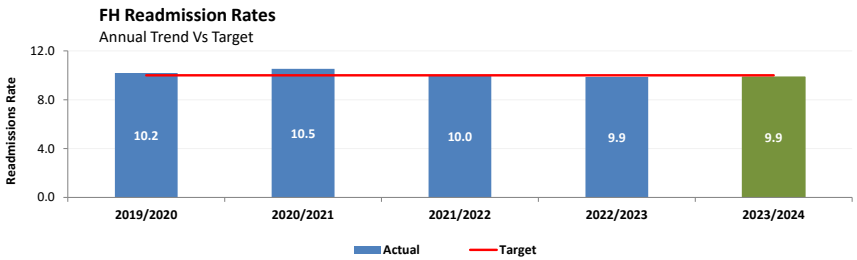
If you or your loved one needs to stay in one of our hospitals, discuss with our healthcare providers the discharge plan at the beginning of the stay. The plan could include information about the type of care required, activities that will help with the recovery, medications, diet and/or equipment. Let 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.

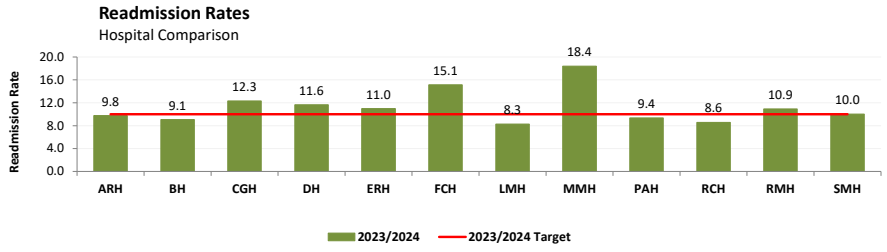
Our Performance	Target *
9.9	<= 10.0

Unit of Measure: Readmissions per 100 episodes of care

Performance timeline:	2023/2024
Data Source:	BC Ministry of Health
* Target Source:	FHA Internal
BC Average (2023/24)	10.2
BC Average Source:	BC Ministry of Health







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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 MHSU readmission rate for Q4 of 2023/24 is 12.8%, meeting the target of 13.3%. This reflects a slight increase from the Q3 2023/24 rate of 11.6%, but a 2.2% decrease from the Q2 2023/24 rate of 15.0%. The rate of 12.8% is also lower than 13.4% rate in the same quarter of 2022/23 .

When comparing the annual readmission rate for this fiscal year to the previous fiscal years, this is the first time since 2018/19 that we have met the target of 13.3%. Additionally, the rate of 13.1% for 2023/24 indicates a significant decrease from 14.5% in 2022/23.

Readmission rates for the first three quarters of the 2023/24 fiscal year vary across the 13 Fraser Health communities, ranging from 9.9% in New Westminster to 19.0% in Chilliwack. Nine communities successfully met the target during this period, with rates ranging from 9.9% in New Westminster to 13.2% in Surrey. The readmission rate for Tricities was 13.5%, slightly missing the target of 13.3%. However, the remaining three communities had significantly higher rates: 15.3% in South Surrey/White Rock, 18.8% in Hope and 19.0% in Chilliwack.

What are we doing?

MHSU has taken several actions to reduce readmission rates. These actions will continue to ensure ongoing improvement. The Surrey Adult Mental Health Centre was expanded to increase hours of operations including psychiatry services. This has allowed for improved access so individuals get attached to the appropriate services sooner. As well, two other programs added include the child and youth Emergency Response Team and Transition Team. These programs are ensuring youth discharged from acute care are being supported while they transition to community-based services ensuring that there are not gaps in support. HSU has established a team of substance use clinicians and staff to support, coordinate, and facilitate access to Substance Use Services. Several Rehabilitation and Recovery services such as occupational therapy, recreation therapy, exercise therapy, vocational counselling, and family support, are now being provided virtually. Additional, Adult Mental Health services such as individual counselling, group therapy services, and reproductive mental health services are offered virtually. The change in service delivery has provided us with the opportunity to evaluate the impact of virtual health services with 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 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 in Surrey and has resulted in decreased readmission rates. The Regional Substance Use Services Access Team (SUSAT) 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 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.

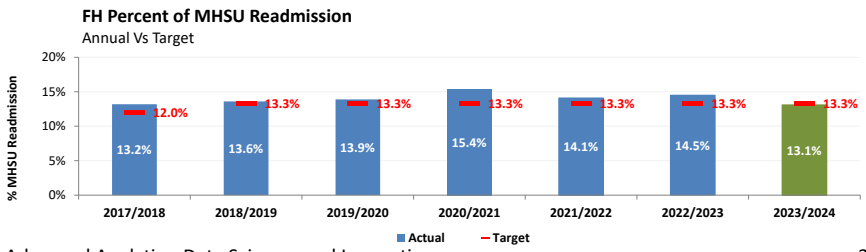
Our Performance	Target *
13.1%	***<= 13.3%***

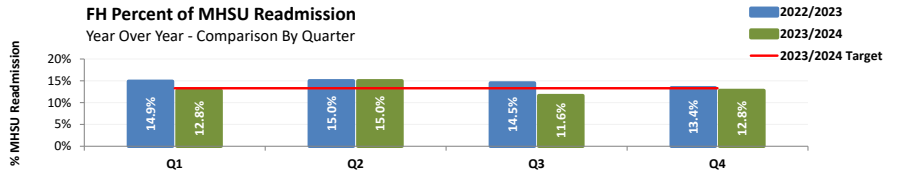
Unit of Measure: Percent of patients readmitted

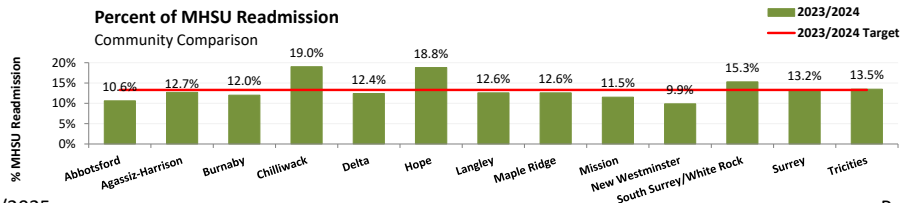
Performance timeline:	2023/2024
Data Source:	MOH Measurement SharePoint
* Target Source:	BC Ministry of Health

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 Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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 are we doing?

Fraser Health's performance has remained relatively stable the past several years and continued trending in the desired direction. The 2023/24 admission rate of 2,287 is below our target of 3,448. Comparing 2022/23 and 2023/24 data by each quarter, the number of patients with chronic conditions admitted to hospital aged 75+ are relatively similar, and below target. The 2023/24 year-to-date admission rate is the lowest rate reported since 2017/18. Most FHA communities are below the target. We continue to examine opportunities to improve access to care in the Fraser East/Fraser Rural part of the region to help with reducing hospital admissions for this patient population.

What are we doing?

Fraser Health (FH) continues to work in partnership with community providers (family physicians and nurse practitioners) 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 attachment, access to primary care and chronic disease management services, and care for seniors and individuals with medical complexity. New initiatives have been locally planned and implemented to ensure the needs of the local population needs are being addressed.
All communities within FH have now commenced activities that aim to optimize access to primary and community care services through the planning and implementation phases of Primary Care Networks (PCNs). Fraser Health is currently establishing Urgent and Primary Care Centres and working in partnership with the PCNs over the next 3-years, which will improve access to primary care and reduce the need for emergency department visits. Initiatives to explore chronic disease management pathways for specific conditions are underway (heart failure, COPD).

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.

What can you do?

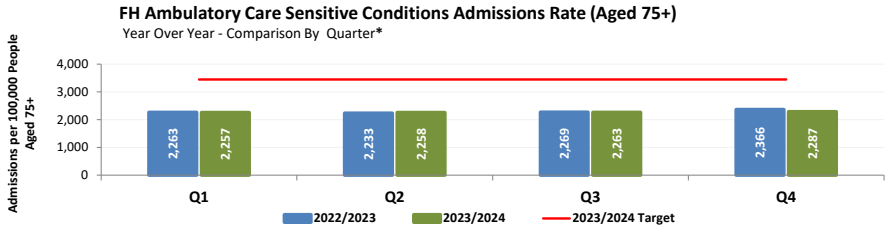
Fraser Health is committed to working with individuals, families, and communities to help people maintain as much health and independence as possible through prevention, early detection, and management of chronic conditions in their homes and communities. Ask your healthcare providers to help you learn how to manage your chronic condition before going to the Emergency Department.

Our Performance	Target *
2,287	**<= 3,448**

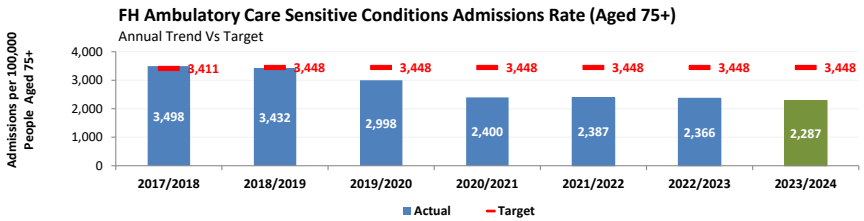
Unit of Measure: Number of patients admitted / 100,000 Population

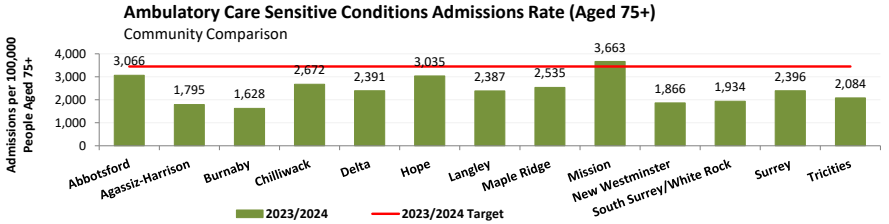
Performance timeline:	2023/2024
Data Source:	MOH Measurement SharePoint
* Target Source:	BC Ministry of Health

Notes: *1. All rates are standardized using the direct method; All rates are per 100,000 population; The standard population used is Census 2021; Population data provided by BC STATS (P.E.O.P.L.E. 2024);*
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: FP10, 2024/25 - Ending Jan 02, 2025

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?

2024/25 year-to-date visit volumes of 103.7 are higher than the target of 100. Low-acuity visit volumes have decreased since FP04 this year and are lower compared to the same periods last year. In particular, since FP07, the rate has fallen below the target of 100. In many urban areas, low-acuity CTAS 4 and 5 ER visits are less frequent. However, in smaller, more rural communities in Fraser East, CTAS 4 and 5 ED visit volumes are higher in many communities. Hope, in particular, has had current and historically high volumes of CTAS 4 and 5 ED visits.

What are we doing?

Several Urgent and Primary Care Centres (UPCCs) are located Fraser East communities such as Abbotsford, Mission and Chilliwack. UPCCs provide care options for patients with urgent health care needs requiring medical attention in 12-24 hours. In addition, select communities have been reviewing the CTAS 4 and 5 presentations for their population specifically and engaging in dialogue between community providers and ERs to support care for patients in the right place including determining how low acuity patients could be re-directed to appropriate levels of care. Facilitating attachment to family physicians and nurse practitioners continues to help reduce low acuity ER visits. Virtual health services are also available across Fraser Health (FH) improving access to health care services and teams including strong connections with the Urgent and Primary Care Centres (UPCCs) to book in-person visits.

What can you do?

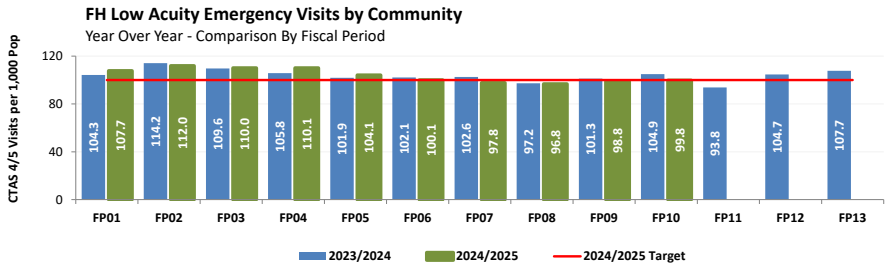
You can attend any of the ten Urgent & Primary Care Centres (UPCCs) in Fraser Health to access a provider and the health care team to meet your urgent primary care needs. For more information, visit: https://www.fraserhealth.ca/Service-Directory/Services/primary-care-services/urgent-and-primary-care-centre. 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. Pharmacists can also provide prescriptions for 21 minor ailments and contraception. Additionally, you can call HealthLinkBC (8-1-1) to speak to a Registered Nurse to provide advice to help you manage your health care needs. Fraser Health's Virtual Care service gets you connected to health services in your communities for non-urgent or emergent care needs and is available seven days a week from 10 AM to 10 PM at 1-800-314-0999.

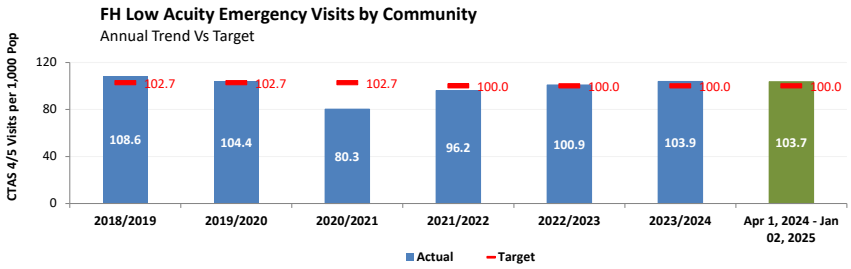
Our Performance	Target *
103.7 △	<= 100.0

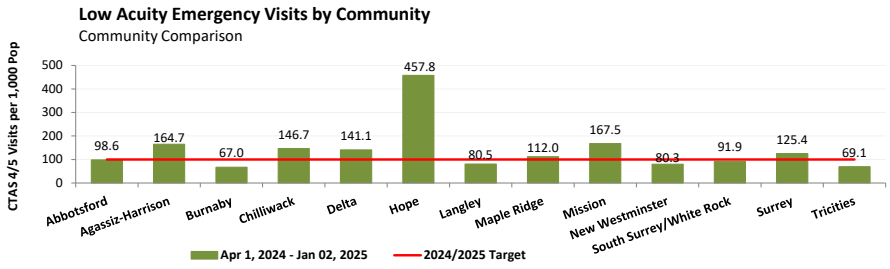
Unit of Measure: Number of CTAS 4 and 5 ER Visits /1,000 Population

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
Data Source:	Amcare and Meditech for the numerator and P.E.O.P.L.E.2015 (BC Stats) for the denominator
* Target Source:	FHA Internal

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







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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 is prioritized based on the identified risks to the health and safety of client/caregiver if 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, and Community Health Professionals.

How are we doing?

By implementing team based care, and coordination of services by a most responsible community health professional, clients and caregivers access to the home health care teams is improving. The percentage of home health services that are provided within benchmark time is currently over our target at 53.2% and remains stable. We will continue to work with our programs to identify gaps and improve this indicator.

Why?

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

What are we doing?

The Home and Community Care team continues to monitor progress towards the goal and adjust activities as appropriate based on learnings. Use of technology is embedded into standard work flows for assessments, follow up care and improved collaboration. Work continues across all communities to close gaps in staffing levels.

How do we measure it?

We take the number of clients starting a specific home health service whose wait time from referral to service start is within the recommended wait time limit and divide by the total number of clients who began service . All calculations match the same time period.

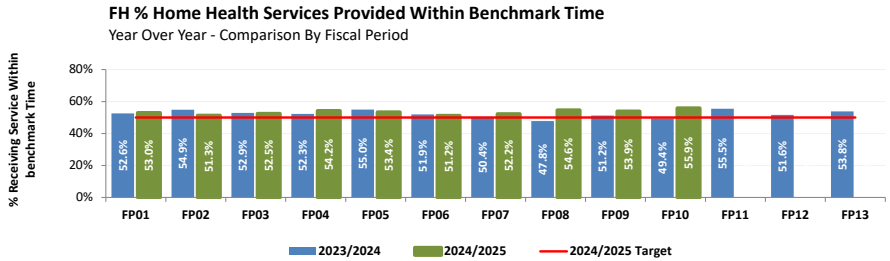
What can you do?

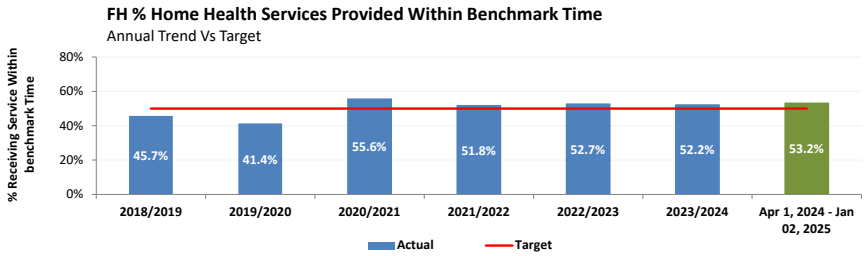
If you have not been contacted by Home Health to set up the services you need please call your local office. Alternately, you can ask your Doctor or Nurse Practitioner to help you connect with Home health through their Community Health Nurse contact. If you do not have a primary care provider call the Home Health Services Line to request assistance at 1-855-412-2121.

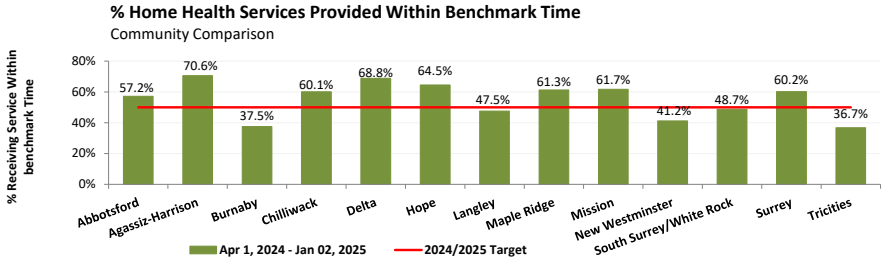
Our Performance	Target *
53.2%	>= 50.0%

Unit of Measure: Percent of Services provided within benchmark

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
Data Source:	PARIS System
* Target Source:	FHA Internal







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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.

How are we doing?

Fraser Health's 2024/25 year-to-date performance of 14.0 is meeting our internally set target of less than 30 days and is trending in a desired direction. All communities except Hope have achieved client wait times below the 30 day target.

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.

What are we doing?

Wait time information sources and scheduled work cycles are currently under review. Our aim is for continuous improvement and to accurately reflect the work done by our Community Health Nurse teams in each community.

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.

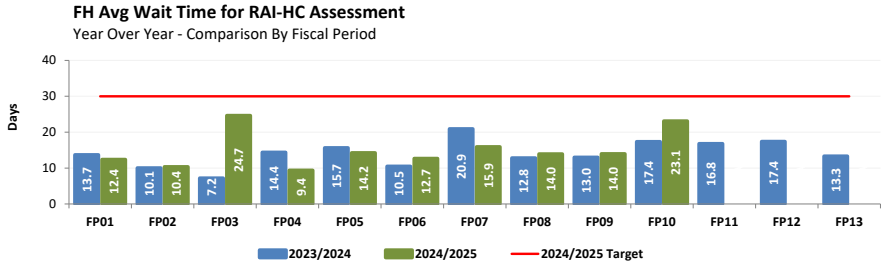
What can you do?

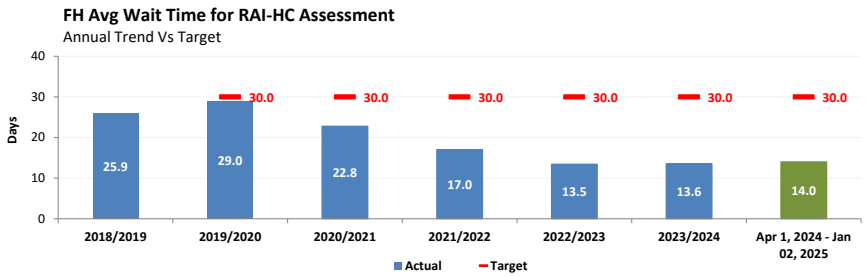
If you have not been contacted by your local home health office to update your assessments or schedule the services you expect please call your local home health office. Clients and families can call the Home Health Service Line on 1-855-412-2121 to ensure your contact information is up to date and connect with your local home health office should you need assistance.

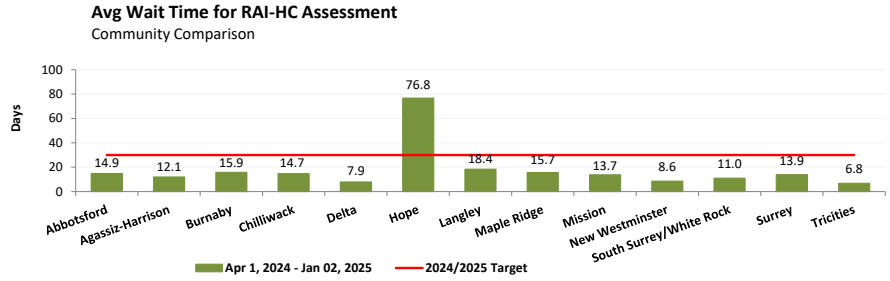
Our Performance	Target *
14.0	<= 30.0

Unit of Measure: Number of days clients waiting for Assessment

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
Data Source:	GoldCare System
* Target Source:	FHA Internal







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

Admissions to Long Term Care within 30 Days

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

What are we measuring?

Percentage of new Long Term Care residents admitted to a LTC care community within 30 days of being assessed and approved for services.

How are we doing?

In 2024/25 year-to-date, 55.8% of Fraser Health residents were admitted to long term care (LTC) within 30 days of being assessed and approved for LTC services. Annual admission rates, to date, show a similar pattern since fiscal year 2022/23 and is attributed to the surge in demand for LTC across the region. Demand for LTC continues to be high this year.

Why?

Our goal is to provide the best quality of care for our residents. 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.

What are we doing?

Fraser Health has structures, processes and resources in place to support clients who can safely live at home. Placement to LTC is done in accordance with Ministry of Health policy. Various initiatives are underway to optimize timely transitions to LTC across Fraser Health.

How do we measure it?

We take the number of residents placed in Long Term Care with a wait time of 30 days or less and divide by the total number of residents placed in the same period. These figures exclude residents 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.

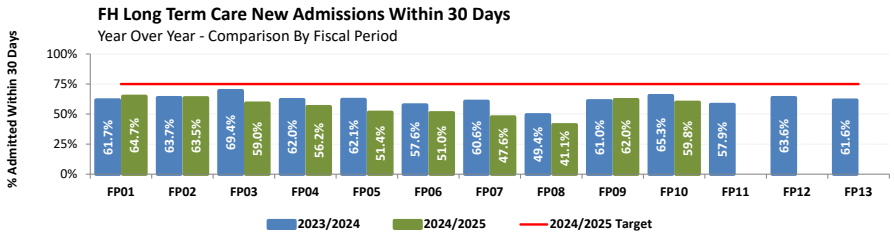
What can you do?

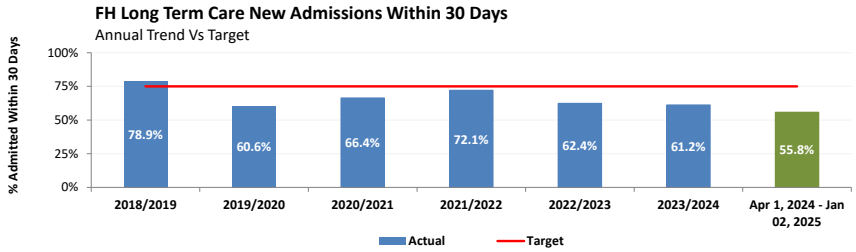
If you are a healthy senior, consider making choices now to keep yourself healthy so you may remain at home as long as possible. For those needing support to live at home, Fraser Health's community support services are here to help and LTC communities are here to support those who need them.

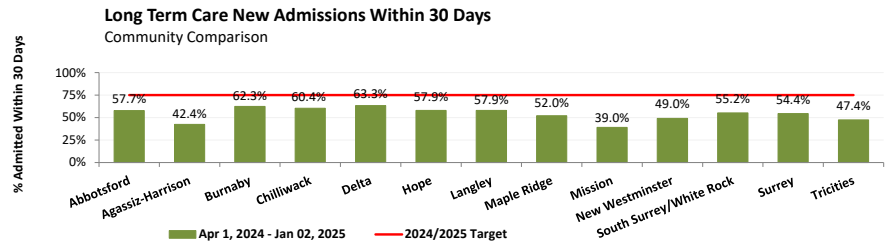
Our Performance	Target *
55.8% ◆	>= 75%

Unit of Measure: Percent of residents admitted within 30 days

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
Data Source:	Strata Health Pathway
* Target Source:	FHA Internal







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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 Emergency Department(ED) visits that were not for IV therapy, Imaging, or scheduled physician consultations.

How are we doing?

Home Health clients' use of the Emergency Department (ED) is stable but remains higher than the benchmark

Why?

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

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. We have implemented emergent visit response service tracking for known home health clients in all Fraser Health communities. Emergent visits focus on responding to clients within 24 hours for non-medical needs that can be met in their home.

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 are 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 Community Health Nurse 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.

What can you do?

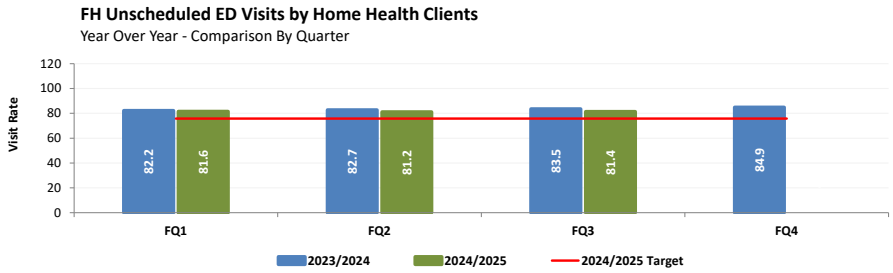
If you are receiving Home Health services and need additional support to keep you safely at home connect with your home health office or your community health nurse to assist you access the care and services you need.

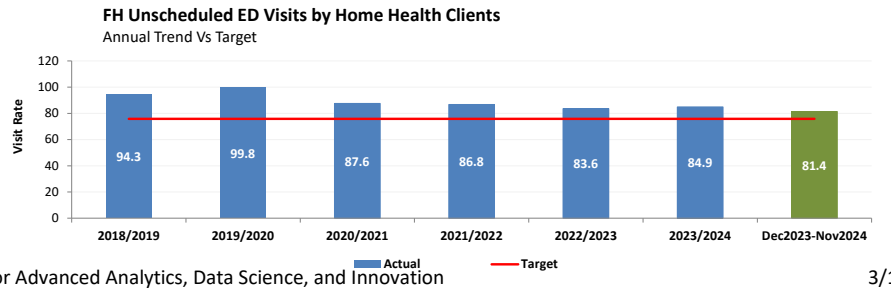
Our Performance	Target *
81.4 △	<= 75.8

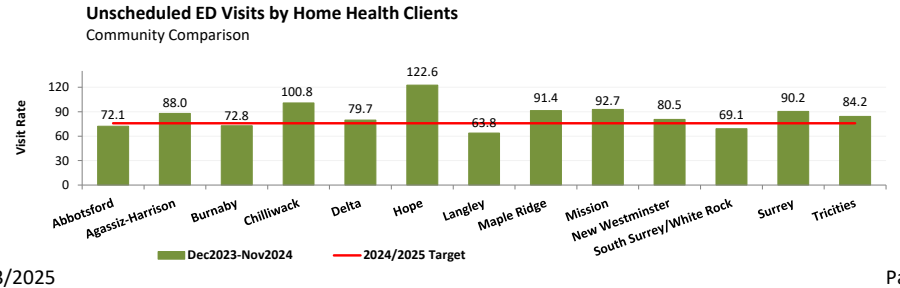
Unit of Measure: Number of ER visits / 100 Home Health Clients

Performance timeline:	Dec2023-Nov2024
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: FP10, 2024/25 - Ending Jan 02, 2025

Emergency Visits by Long Term Care Residents

What is the rate of Long Term Care (LTC) residents 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 residents to Fraser Health emergency departments, as a proportion of the total number of Long Term Care residents 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 residents 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 community. 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 community 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 and 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 staff, and family/residents who make informed decisions about goals of care.

How are we doing?

The number of ED visits by LTC residents has reduced compared to the previous time frame. While Chilliwack is meeting the FH target, other communities are actively working to reduce unscheduled ED visits by LTC residents (see details below).

What are we doing?

Fraser Health continues to focus on best practice expectations for long-term care physicians including 24/7 availability, on-site attendance when required, proactive visits to residents and meaningful medication reviews which support a reduction in avoidable transfers to acute care. Fraser Health also has several quality improvement initiatives underway including new virtual physician services to provide temporary medical care at long-term care communities impacted by physician shortages. Also, education on advance care planning conversations and documentation of goals of care is in progress. Fraser Health also supports local initiatives that focus on enhancing communication as people transition between acute care and long term care to ensure a safe return home after an acute care visit. Each care community also receives a quarterly report of their performance (relative to the target of 7.5 per 100 residents) to raise awareness and provide opportunity to develop local quality improvement action plans.

How do we measure it?

We take the number of ED visits by Long Term Care residents in a given period and divide by the average number of residents 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.

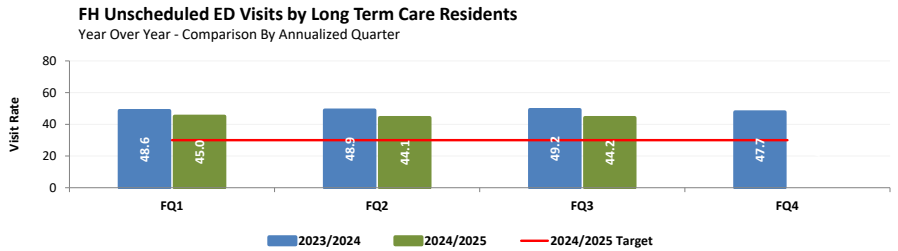
What can you do?

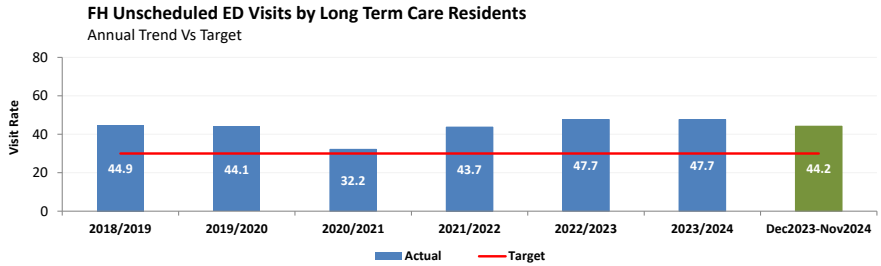
Learn about what care is available in long-term care, who is part of the health care team in long-term care, and how you can plan ahead to ensure care meets your needs. Visit the Fraser Health website and search for Long-Term Care, or use the link https://www.fraserhealth.ca/health-topics-a-to-z/long-term-care to watch the videos.

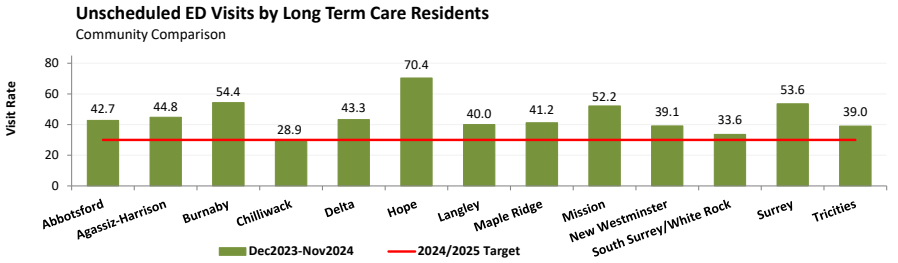
Our Performance	Target *
44.2 ◆	<= 30.0

Unit of Measure: Number of ER visits/100 residents

Performance timeline:	Dec2023-Nov2024
Data Source:	PARIS System, Meditech and NACRS
* Target Source:	FHA Internal







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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.

How are we doing?

The proportion of non-emergency surgeries completed within 26 weeks decreased to 88.9% in the most recent period vs 89.2% in the previous period.

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.

What are we doing?

Fraser Health is following the Surgical Renewal plan to extend capacity to exceed pre-pandemic surgeries. This includes HHR efforts to add nurses, physicians and support staff, as well as capital investments at our sites to expand our physical surgical capacity.

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.

What can you do?

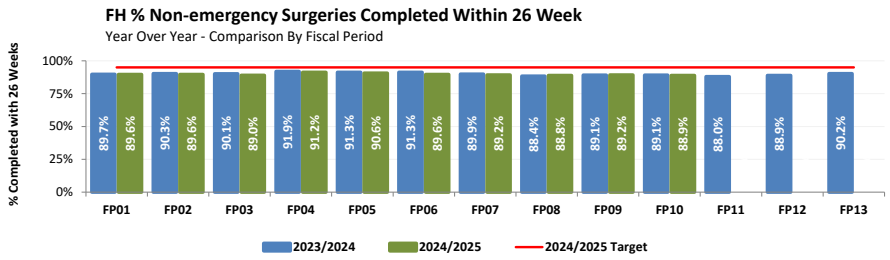
Review the Fraser Health Choosing a Surgeon website (https://www.fraserhealth.ca/health-topics-a-to-z/surgery/choosing-a-surgeon) and the Ministry of Health Surgical Wait Times website (https://www2.gov.bc.ca/gov/content/health/accessing-health-care/surgical-wait-times) to check for surgeons who may 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.

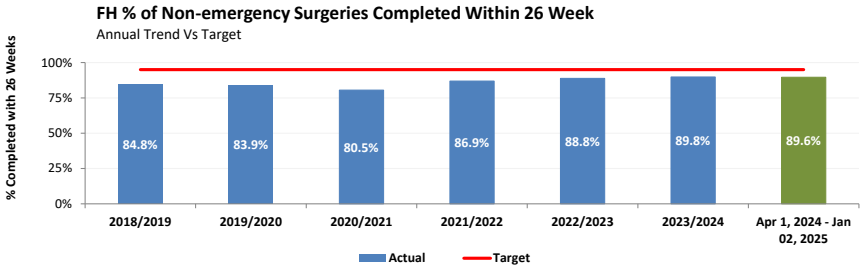
Our Performance	Target *
89.6% △	>= 95%

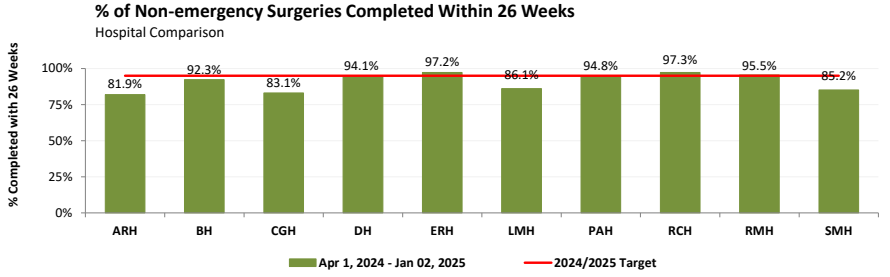
Unit of Measure: Percent of surgeries completed within 26 weeks

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
Data Source:	BC Surgical Patient Registry
* Target Source:	BC Ministry of Health

Notes: *Target is based on the current MOH service plan.*







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

Non-Emergency Surgeries Waiting Longer Than 26 Weeks

How many patients on the waitlist for non-emergency surgery have waited longer that 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 from 19.4% to 21.9% in the most recent period. The target of 22.8% has been met now since FY2022/23 FP08 (approx. 25 months).

What are we doing?

Fraser Health is following the Surgical Renewal plan to extend capacity to exceed pre-pandemic surgeries. This includes HHR efforts to add nurses, physicians and support staff, as well as capital investments at our sites to expand our physical surgical capacity.

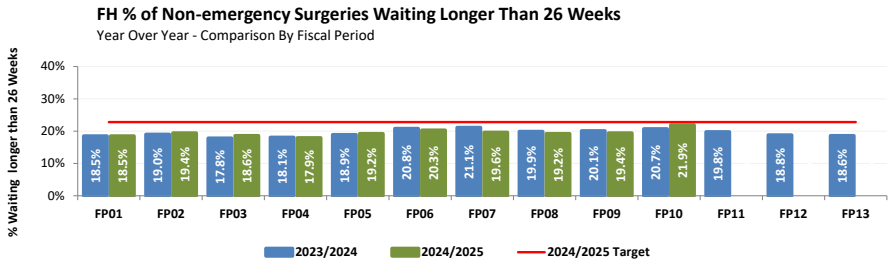
What can you do?

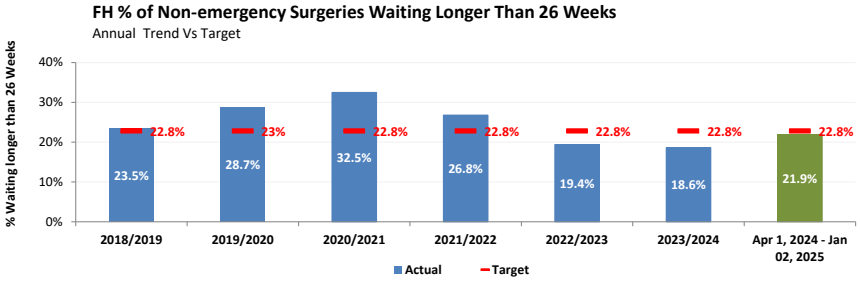
Review the Fraser Health Choosing a Surgeon website (https://www.fraserhealth.ca/health-topics-a-to-z/surgery/choosing-a-surgeon) and the Ministry of Health Surgical Wait Times website (https://www2.gov.bc.ca/gov/content/health/accessing-health-care/surgical-wait-times) to check for surgeons who may 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.

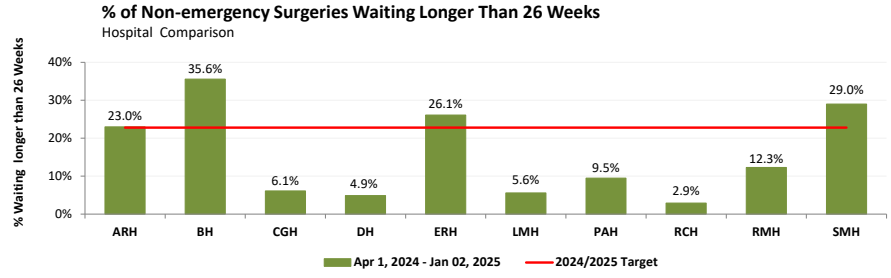
Our Performance	Target *
21.9%	<= 22.8%

Unit of Measure: Percent of surgeries waiting Longer than 26 weeks

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
Data Source:	BC Surgical Patient Registry
* Target Source:	FHA Internal







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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?

Between birth and 2 years of age, British Columbians are offered free vaccines that protect them against 14 different diseases. The percentage of 2-year olds with up-to-date immunizations tells us what percentage of children have received all recommended vaccines to protect our communities from potentially serious vaccine preventable diseases.□
To be considered up-to-date for their immunizations, a child should have received:□
- 4 doses of a diphtheria/tetanus/pertussis vaccine□
- 3 doses of a hepatitis B vaccine□
- 1 dose of a measles/mumps/rubella vaccine□
- 3 doses of a polio vaccine□
- 1 dose of a varicella vaccine (or recorded exemption for varicella due to previous disease or protective antibody levels) □
- be up-to-date for Haemophilus influenzae type b, as defined by age at first dose□
- be up-to-date for pneumococcal conjugate, as defined by age at first dose□
- be up-to-date for meningococcal C conjugate, as defined by age at first dose

How are we doing?

In Fiscal Quarter (FQ) 3 2024/25 (October to December, 2024), 72.1% of 2-year-olds were up-to-date with their immunizations. This rate represents a 0.1% decrease with respect to the FQ2 2024/25 (July to September, 2024). The FQ3 immunization rate is 7.9 percentage points below the Fraser Health target of 80%.

Why?

Immunization is the most effective preventive health measure to protect children and adults from vaccine-preventable disease. Previous outbreaks among children in the Fraser Health Authority (FHA) and current outbreaks around the world remind us of the need to be vigilant in maintaining high immunization coverage rates. Young children are the most vulnerable to vaccine-preventable diseases and most immunizations in an individual's life are received before the age of two. As a result, 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.

What are we doing?

We have increased the number of childhood immunization appointments offered at our Public Health Units each month. We are also offering immunizations appointments in community settings, such as recreation centres, community schools, and local service agencies.

In addition to expanding service, we are reaching out more frequently to help families stay on-schedule with their child's immunizations. We send out reminder letters or text messages to families whose children are coming due for immunizations and we make phone calls to families whose children have fallen behind on immunizations to help them book an appointment to catch up.

How do we measure it?

Percentage of 2-year olds with up-to-date immunizations 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.

What can you do?

The most important thing you can do is immunize your children on time with all the vaccines they need. If you have questions or are unsure about the immunizations that are recommended for your child, speak to a healthcare provider for more information. Immunizations for children aged 2 months - 6 years of age remain the most effective way to protect children from vaccine-preventable diseases. Parents can sign up for free text reminders at immunizebc.ca/reminders. Visit www.fraserhealth.ca/immunization to find out how to get immunized.

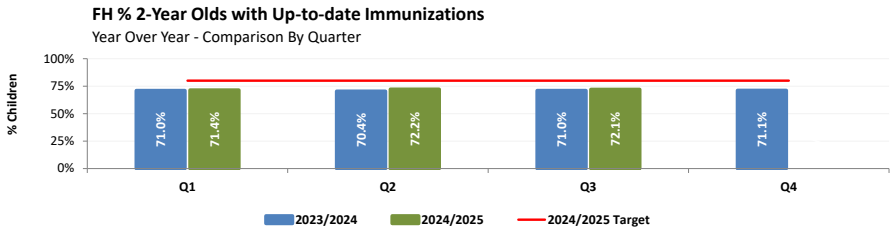
Parents should also make sure that their child's immunizations are documented with public health. You can check your child's immunization history and see which immunizations they still need at www.healthgateway.gov.bc.ca. If children are immunized by a primary care provider or receive their immunizations from another health authority (e.g., Vancouver Coastal Health), parents should report their child's immunizations to Fraser Health by submitting records online at www.fraserhealth.ca/immunizationform or calling the local health unit.

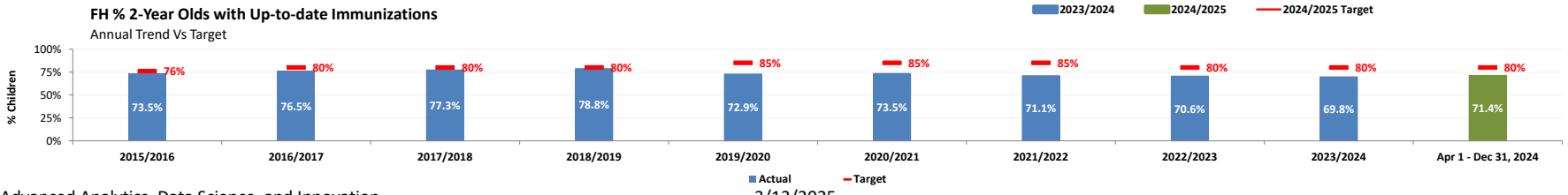
Our Performance	Target *
71.4% ◆	*>= 80%*

Unit of Measure: Percent of 2-year olds

Performance timeline:	Apr 1 - Dec 31, 2024
Data Source:	Panorama 2 year old immunization coverage reports (based on data entered in PARIS as of June 23, 2019)
* Target Source:	FHA Internal

Notes: *Data for the 2014/2015 fiscal year are based from BCCDC's "Immunization coverage by 2nd birthday, BC HSDA" quarterly reports whereas data for the 2015/2016 fiscal years and onwards were based off of Panorama 2 year old immunization coverage reports.*





Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

Health Protection Program Response Time to Public Complaints

Is the public receiving a timely response to complaints regarding environmental health and community care facility licensing issues?

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.

How are we doing?

In Fiscal Quarter (FQ) 3 2024/25(October to December 2024) the rate of Responding to Public Complaints Within Targets (RPCWT) was 97.9%, which is 2.9 percentage points above its target of 95.0%. This indicator has consistently met its target since 2014 and only fell short during 2021/22 FQ3 (October to December, 2022).

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.

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.

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).

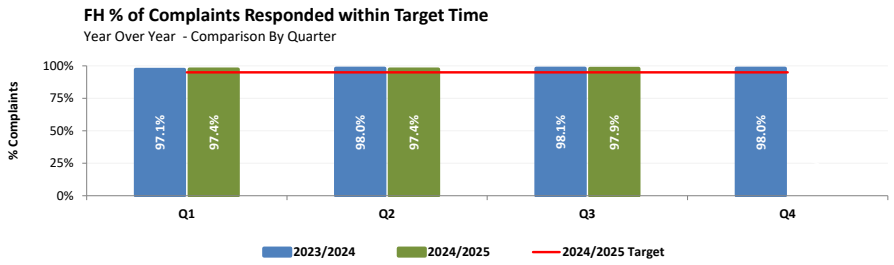
What can you do?

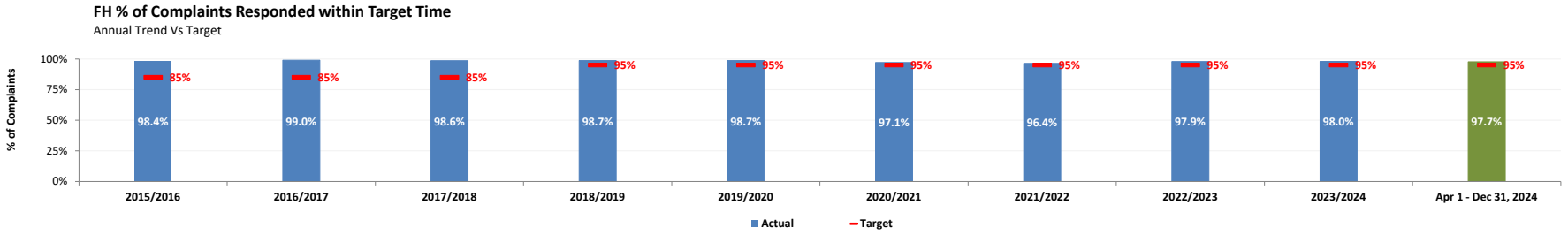
The public can notify their local Health Protection office to report a complaint. Licensing Officers follow up on concerns in licensed care facilities (day cares and residential care). Environmental Health Officers follow up on community environmental complaints (food safety, recreational water safety,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

Our Performance	Target *
97.7%	>= 95.0%
Unit of Measure: Percent of complaints	

Performance timeline:	Apr 1 - Dec 31, 2024
Data Source:	HealthSpace
* Target Source:	FHA Internal

Notes: *1) New indicator target of 95% is based on previous years average performance across the 6 programs areas.*
2) YTD average percentage can be higher or lower than quarterly data percentages due to complaints and/or reportable incidents being:
- started in the respective quarters but not completed until much later in a different quarter and/or
- entered after quarter end for the previous quarter(s).





Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

Prenatal Registrations

What percentage of birthing people/individuals 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 birthing people/individuals 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 offers expectant parents with access to nursing services designed to support their pregnancy. This is especially important for vulnerable birthing people, such as teen parents or those with high-risk pregnancies, who can benefit from enhanced programs like the Nurse-Family Partnership and Enhanced Family Home visiting. The rate of prenatal registration reflects the acceptability and accessibility of the broader Best Beginnings program for these individuals.

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) 3 2024/25 (October to December 2024), 56.7% of individuals who gave birth in FH hospitals were registered with the Best Beginnings program during their pregnancy. This rate represents a 0.6 percentage point increase from the previous quarter (July to September 2024). The FQ3 2024/25 rate was 18 percentage points below the Fraser Health target of 75%. Despite not meeting the target of 75%, we are seeing an increase in the number of eligible clients accepting home visiting services through the Enhanced Family Visiting and Nurse Family Partnership programs.

What are we doing?

Our updated online registration form launched in October 2024. This new form has several design changes and multiple translations to better serve diverse populations. We are closely monitoring registration rates using the new form and are planning additional outreach and engagement for populations that are less likely to complete prenatal registration. A broader promotion and communication strategy is being planned for 2025/26.

Population and Public Health (PPH) continues to collaborate with key stakeholders, including GPs, maternity clinics, and community partners, to promote early registration and raise awareness of the program. As we develop new promotional materials, PPH will visit GP offices, maternity clinics and birthing hospitals to ensure that multi-language posters with QR codes and hardcopies of the registration form, are available for all pregnant people who attend a clinic during their pregnancy. We are also working closely with our birthing hospitals to ensure that the information is available to assist with hospital admissions and service planning.

What can you do?

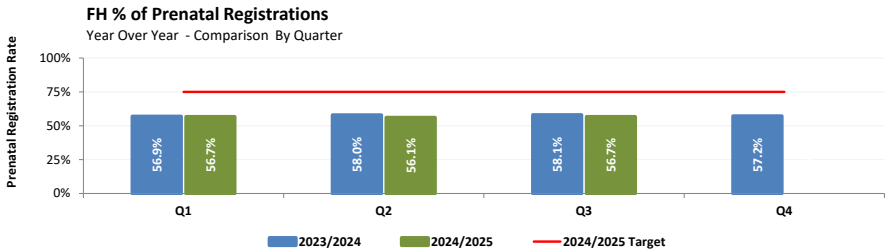
If you are a pregnant person in Fraser Health region, you should register with Public Health's Best Beginnings program early in your pregnancy. You can register online at bestbeginnings.fraserhealth.ca or with your local public health unit. You can also share this information with pregnant people you know to encourage them to register. Community and health service workers can promote the program to their clients/patients and help them with registration, if needed.

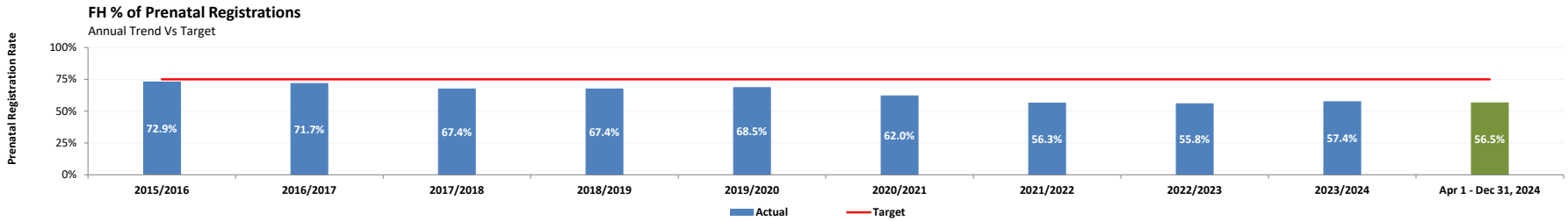
Our Performance	Target *
56.5% ◆	>= 75%

Unit of Measure: Percent of women registered

Performance timeline:	Apr 1 - Dec 31, 2024
Data Source:	PARIS System
* Target Source:	FHA Internal

Notes: *Query updated for data extraction from Paris (<=0.5 percentage point difference). Q2 and Q3 of 2023/24 updated. Fraser Health transitioned from Panorama to Paris in FY 2019/20. Therefore, from Q2 of FY 2019/20 on, the quarterly and YTD prenatal registration rates are calculated with PARIS data. Prior to that Panorama data was used.*





Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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 2024-25 year-to-date performance for the FH Nursing and Allied Professional Sick Time Rate is higher than the target of 5.8%, currently tracking at 6.37%. Although this metric remains above target, there is positive trending the demonstrates a recovery from the pandemic sick leave rate high of 6.89% in 2022-23. Ten of the twelve hospitals continue to demonstrate sick leave rates above 6% with Fraser Canyon at the highest rate-year to-date at 7.5%. Peace Arch hospital is successfully achieving the target of 5.8%.

What are we doing?

The goal of Attendance Support is to ensure all staff are aware that supportive resources are available to assist them if they are struggling with a medical issue. The relaunch of Attendance Support by the Absence and DM team at Fraser Health in October 2022 has successfully reduced the overall absence rate (sick = unpaid sick time/productive hours) from 8.25% to 7.12% presently.

The Attendance Support team continues to reach out to those employees demonstrating absence rates of greater than 20% to offer supportive resources in the event of chronic and/or ongoing medical issues impacting their regular attendance at work. Additionally, information letters are being provided to staff informing them of their current absence rates, educating them on the role of their sick bank as their short-term disability coverage in the event of a lengthy illness/injury, and offering supportive resources should the employee be in need of assistance to manage or recover from an ongoing or chronic illness.

Of the Nursing and Allied Health professionals engaged in Attendance Support since the restart, 72% of Nurses and 78% of Allied Health Professionals demonstrated improvement after just one connection, with 36% and 42% decreasing their absence rates to below their peer group average respectively.

Supportive resources remain available to all staff who may be impacted negatively due to present health conditions. The Starling Minds Mental Fitness online CBT support program will be renewed with a 2-year contract (April 2023 – March 2025) to provide staff access to online cognitive behavioural therapy to support employees in building resiliency to stress, anxiety and depression. Fraser Health had launched the MyHealth APP, designed to be a one-stop shop for all staff for Health, Well-being and Safety tools, resources and information.

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.

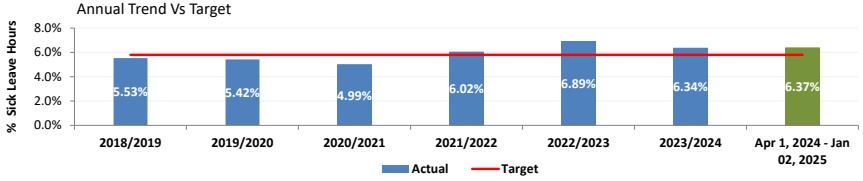
Our Performance	Target *
6.37% △	<= 5.8%

Unit of Measure: Percent of sick hours to productive hours

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
Data Source:	Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server
* Target Source:	BC Average for 2018/19

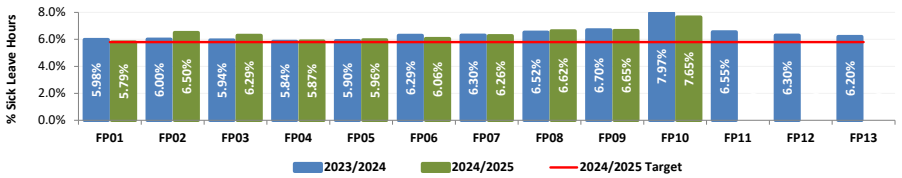
FH Nursing and Allied Professional Sick Time Rate

Annual Trend Vs Target



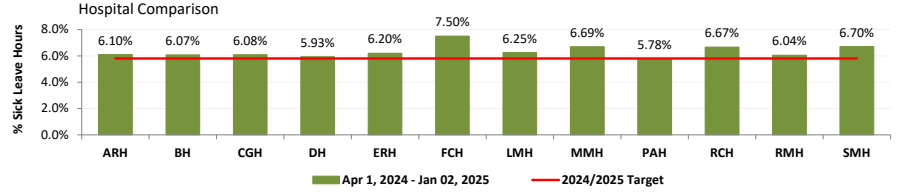
FH Nursing and Allied Professional Sick Time Rate

Year Over Year - Comparison By Fiscal Period



Nursing and Allied Professional Sick Time Rate

Hospital Comparison



Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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.

How are we doing?

The reporting of overtime focuses on Nursing and Allied Health, the target is currently 3.9% that was set in 2020. The overtime rate for 2024/25 year-to-date for Nursing and Allied Health is 9.11%, which is above the target. Drivers of OT includes vacancies, sick calls and ongoing pressure in Emergency room visits and bed capacity across the region compared to previous years. Workload, short notice replacement needs and staff vacancies are the primary drivers of overtime.

Why?

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

What are we doing?

• Overtime is reported via a dashboard to the executive and is reviewed daily. The majority of overtime continues to be utilized by our Emergency units. Overtime is driven by workload needs, short notice absences and existing staff vacancies.
• To address vacancies in Fraser Health, recruitment incentives are currently being offered for difficult to fill vacancies and rural remote vacancies. Additionally, recruitment of Internationally Educated Nurses and Allied Health staff has significantly increased. ER and Critical Care areas have formed working groups to look at opportunities to redesign workflows and staffing models.

How do we measure it?

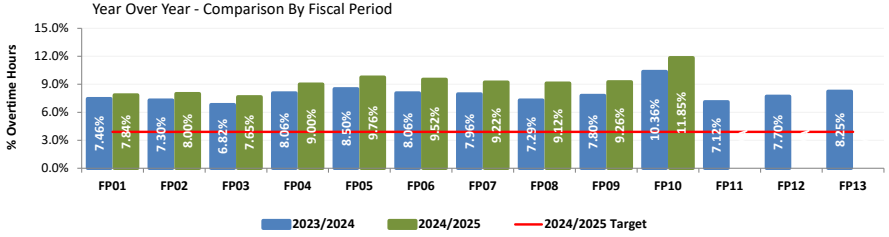
We take the total overtime hours and divide by total productive (working) hours.

Our Performance	Target *
9.11% ◆	*<= 3.9%*

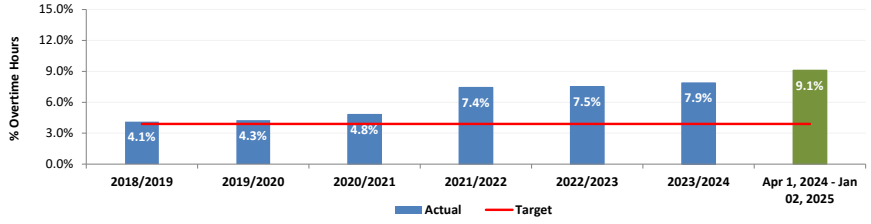
Unit of Measure: Percent of overtime hours to productive hours

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
Data Source:	Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server
* Target Source:	BC Ministry of Health

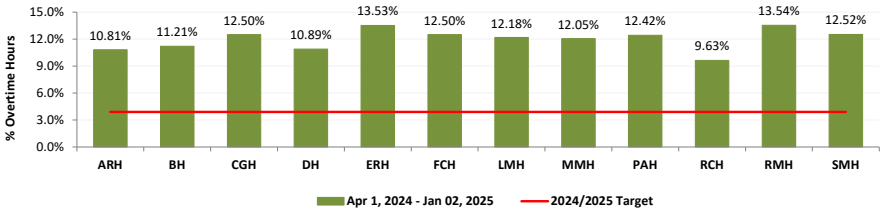
FH Nursing and Allied Professional Overtime Rate
Year Over Year - Comparison By Fiscal Period



FH Nursing and Allied Professional Overtime Rate
Annual Trend Vs Target



Nursing and Allied Professional Overtime Rate
Hospital Comparison



Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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.

How are we doing?

Our 2024/25 year-to-date performance of 8.2 is not meeting the target of 5.3. However, our lost time rate has been steadily decreasing from a high off 11.2 in 2021/2022 and is at the lowest level in the past 5 years. This has occurred despite the addition of several programs and occupations with a substantially high risk of occupational injury. Claims resulting from a psychological health component have increased steadily and are often combined with other types of incidents (e.g. primarily violence). Claims rate decreases have been seen for certain hazards (e.g. violence) again this year.

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.

What are we doing?

Prevention activities continue across Fraser Health, including ongoing proactive work at eliminating/reducing risk. This is occurring through focuses efforts on the built environment, provision of appropriate equipment, work procedures, training, and adoption and utilization. An integrated organizational approach to psychological health and safety has been established through the Well-being Collaborative. This Collaborative has developed and is aiming to launch a new organizational-wide survey to collect information from staff allowing insight into issues of concern and allowing for focused interventions and actions. A number of departments and programs with higher incidents and claims rates have been identified and initiatives are being undertaken in those areas to address causal factors in order to reduce risk and resulting potential for incidents and claims.

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.

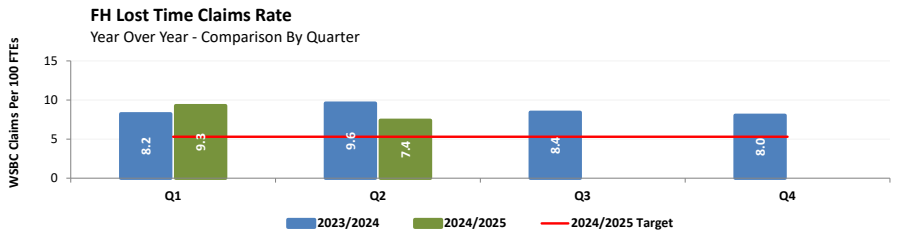
What can you do?

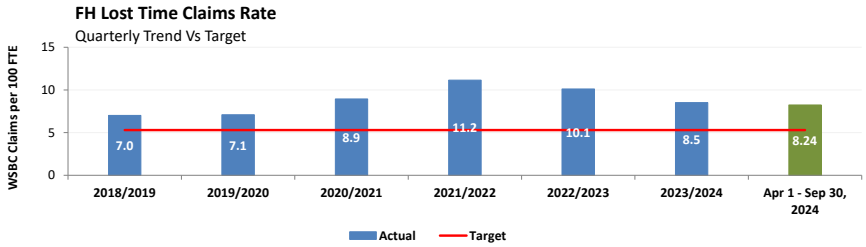
Ensure that all staff have completed required prevention activities such as education and training, including violence prevention, hazardous drugs, and fit-testing. Compliance in these areas requires improvement. Ensure monthly department inspections are occurring within the required timelines. Ensure that all reported hazards and investigations are investigated in an effective manner and that all associated actions are completed.

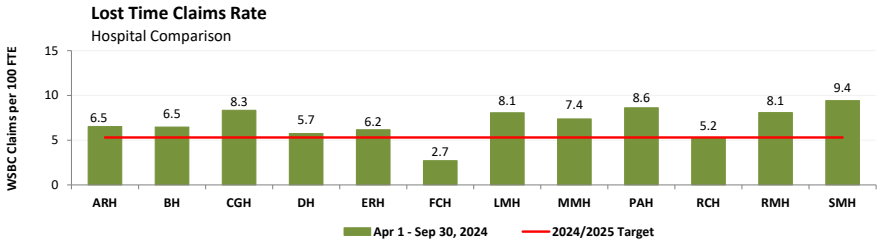
Our Performance	Target *
8.2 ◆	<= 5.3

Unit of Measure: Number of WSBC accepted claims / 100 FTEs

Performance timeline:	Apr 1 - Sep 30, 2024
Data source:	FHA Workplace Health
* Target Source:	BC Ministry of Health







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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)

How are we doing?

The 2024 year-to-date NEW LTD rate continues to trend at it's lowest rate since 2015, currently tracking at 1.7. This is in part due to the growth of the organization over this timeframe, but is also largely due to the continuing success that the Absence and Disability Management (ADM) team is having with returning employees to productive work prior to an LTD claim becoming necessary.
The changes implemented in ADM in early 2019 continue to realize an improvement of close to 20% in cases that return to work prior to LTD (2019 baseline = 54%; 2024 = 71.7%), positively impacting the new LTD claims rate. The top four causes of new LTD claims remain consistent: 1) Mental Health; 2) Chronic MSI/Connective Tissue - i.e. Rheumatoid arthritis, etc. 3) Accident/Injury -i.e. MVA; 4) Cancer. Fraser Health started 2024 with 1555 open LTD claims. As of December 2024, Fraser Health had 1564 open claims, a change of only 9 claims overall despite the continuing growth of the organization (11.4% increase from Jan to Dec 2024). The ADM team continues to successfully close LTD claims at a slightly higher rate than new claims being accepted overall as evidenced by the New/Closed LTD Claim ratio of 0.80.

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.

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.
Direct Referral services supporting employees with Musculo-skeletal injuries and mental issues health continue to 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.

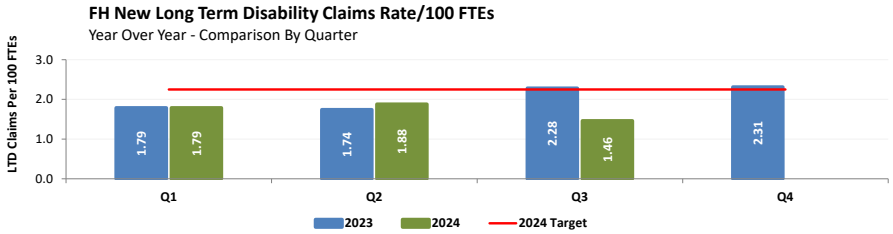
How do we measure it?

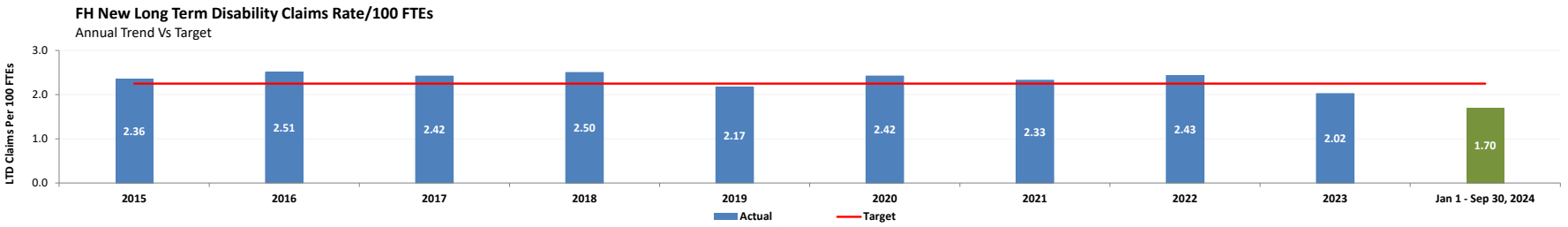
We divide the number of New LTD Claims starting benefits in the quarter by the Total number of Productive Hours (Regular hours + Overtime hours + Other Productive Hours)*195000 hours (80% of total working hours per 100 employee in the year)

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 *
1.70	<= 2.25
Unit of Measure: Number of LTD claims / 100 FTEs	
Performance timeline:	Jan 1 - Sep 30, 2024
Data source:	FHA Workplace Health White Database and FHA Meditch System
* Target Source:	FHA Internal





Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

Turnover Rate In The First Year Of Service

What is the percentage of employees hired within the past year that have been terminated.

What are we measuring?

Percent of Regular Status Employees who left Fraser Health Authority (Voluntary or Involuntary) within their first year of service

How are we doing?

Overall FH % First Year of Service Turnover has gone up by 0.3% for Q3 with 3.3% (138 terminations within the 4162 new hires) compared to last quarter with 3.0% (127 terminations within the 4276 new hires). In comparing to the last year Q3, the % has decreased by 1.2% to 3.3% from 4.5%.

When the numbers are segregated by Designated Group, the counts become very small. It is best to consider the numbers of Turnover as well as the %. In comparing Q3 2024/25 to Q2 2024/25, there have been varying changes. Community holds the largest % this quarter with 34 Turnovers (24.6% of all Turnovers) followed by Facilities with 33 Turnovers (23.9% of all Turnovers). Excluded has risen with 32 Turnovers (23.2% of all Turnovers). The Nurses group has increased with 22 Turnovers (15.9% of all Turnovers). Paramedicals decreased to 9 Turnovers (6.5% of all Turnovers). LPN Turnovers were the lowest with 8 Turnovers (5.8% of all Turnovers).

Why?

Retention of individuals has a large impact on Fraser Health operations and staff. Measuring the percentage of employees with less than one year of service is one indicator of quality of hire and the quality of the work environment. A high percentage may signal a misalignment between employee and employer expectations, how effective the individuals are integrating into the organization and ensuring we are hiring the right fit.

What are we doing?

FH has several strategies in place to ensure we hire the right individuals and retain them within FH. New Hire Survey will continue to be sent out to all the new hires of FH within the 6 months of their hires. FH will be reviewing departments that have high numbers and will be following with the corresponding directors for further insight. Exit Survey are also completed when an employee's decide to leave FH.

How do we measure it?

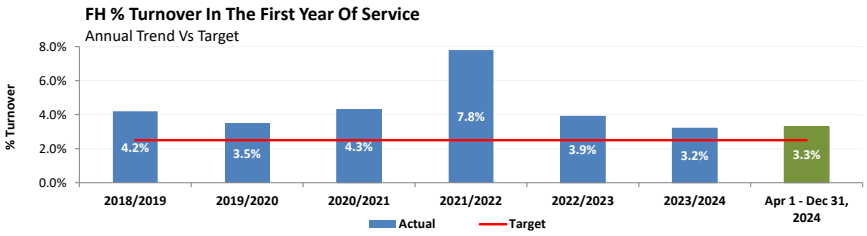
Divide employees who have been hired and terminated within the year over the employees who have been hired within the year. Termination includes voluntary and involuntary turnover. Termination due to retirement, transfers/mitigation as part of an organizational change or employees who pass away are not included. Only considered Regular Status employees.

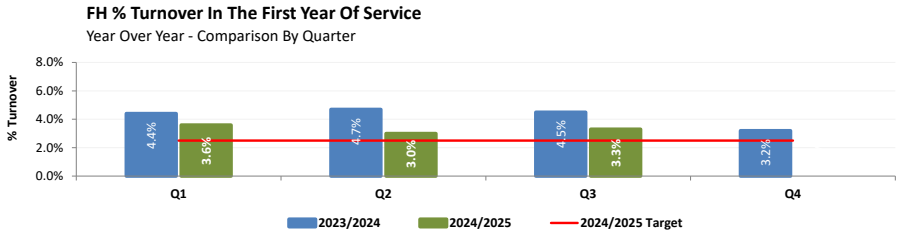
Our Performance	Target *
3.3% ◆	<= 2.5%

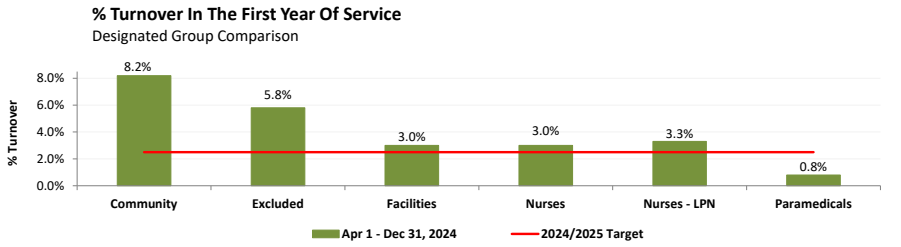
Unit of Measure: Percent of employees turnover

Performance timeline:	Apr 1 - Dec 31, 2024
Data Source:	Meditech
* Target Source:	FHA Internal

Notes: *Due to implementation of new employees types in our HR systems, employees were reassigned into the new types which resulted in change in numbers for the specific groups and some minor adjustments to the over all numbers at Fraser health level. All numbers were restated for consistency and accuracy of trending and comparison over time.*







Our Health Care Report Card

Fiscal Period: FP10, 2024/25 - Ending Jan 02, 2025

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 10th period ended with a year to date deficit of $49.5 million. 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. Fraser Health is also working with the Ministry to mitigate the financial impacts of the ongoing pandemic recovery and clinical service needs.

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 *
1.010 △	<= *1.000*

Unit of Measure: Actual to budget ratio

Performance timeline:	Apr 1, 2024 - Jan 02, 2025
Data Source:	Meditech – G/L (General Ledger) Module data stored on a MicroStrategy data warehouse server
* Target Source:	FHA Internal