## Provide the best care

### SYSTEM LEVEL

<table>
<thead>
<tr>
<th>Metric</th>
<th>Time Frame</th>
<th>Target</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Patient Experience</td>
<td>Apr 2012 to Jun 2012</td>
<td>&gt;= 90.0 %</td>
<td>89.1 %</td>
</tr>
<tr>
<td>Hospital Standardized Mortality Ratio</td>
<td>Apr 2012 to Jun 2012</td>
<td>&lt;= 100.0</td>
<td>83.0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Metric</th>
<th>Time Frame</th>
<th>Target</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA Rate</td>
<td>Apr 2012 to Sep 2012</td>
<td>&lt;= 4.2</td>
<td>6.5</td>
</tr>
<tr>
<td>Clostridium difficile Infection Rate</td>
<td>Apr 2012 to Sep 2012</td>
<td>&lt;= 8.0</td>
<td>9.7</td>
</tr>
<tr>
<td>Hand Hygiene Compliance</td>
<td>Apr 2012 to Sep 2012</td>
<td>100.0 %</td>
<td>68.8 %</td>
</tr>
</tbody>
</table>

### IMPROVE CLINICAL INTEGRATION AND QUALITY BY BUILDING REGIONAL PROGRAMS, DEPARTMENTS AND PROCESSES

<table>
<thead>
<tr>
<th>Metric</th>
<th>Time Frame</th>
<th>Target</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER Wait Time</td>
<td>Apr 2012 to Nov 2012</td>
<td>&lt;= 44.0</td>
<td>37.0</td>
</tr>
<tr>
<td>Surgery Wait Time</td>
<td>Apr 2012 to Nov 2012</td>
<td>&gt;= 75.0 %</td>
<td>74.3 %</td>
</tr>
<tr>
<td>Mental Health and Addiction Community Follow-up (Ages 15-64)</td>
<td>Apr 2011 to Sep 2011</td>
<td>&gt;= 88.0 %</td>
<td>84.0 %</td>
</tr>
<tr>
<td>Residential Care Wait Time</td>
<td>Apr 2012 to Oct 2012</td>
<td>&gt;= 80.0 %</td>
<td>74.3 %</td>
</tr>
</tbody>
</table>

## Promote better health for our communities

### SYSTEM LEVEL

<table>
<thead>
<tr>
<th>Metric</th>
<th>Time Frame</th>
<th>Target</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles, mumps and rubella (MMR) immunization coverage rates</td>
<td>Sep 2011 to Jun 2012</td>
<td>&gt;= 95.0 %</td>
<td>87.8 %</td>
</tr>
<tr>
<td>Alternate Level of Care Days</td>
<td>Apr 2012 to Nov 2012</td>
<td>&lt;= 7.0 %</td>
<td>7.4 %</td>
</tr>
</tbody>
</table>

### IMPLEMENT TARGETED HEALTH PROMOTION AND PREVENTION INITIATIVES TO REDUCE THE INCIDENCE OF CHRONIC DISEASE

<table>
<thead>
<tr>
<th>Metric</th>
<th>Year</th>
<th>Target</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Childhood Development Index</td>
<td>2009-2011</td>
<td>&lt;= 15.0 %</td>
<td>32.5 %</td>
</tr>
</tbody>
</table>

## REDUCE HEALTH INEQUITIES IN THE POPULATIONS WE SERVE

<table>
<thead>
<tr>
<th>Metric</th>
<th>Year</th>
<th>Disparity Ratio</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disparity Ratio for Life Expectancy</td>
<td>2006-2010</td>
<td>1.05</td>
<td>1.13</td>
</tr>
</tbody>
</table>

### COORDINATE CARE ACROSS THE CONTINUUM OF PRIMARY, COMMUNITY, HOME AND ACUTE CARE

<table>
<thead>
<tr>
<th>Metric</th>
<th>Year</th>
<th>Target</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care Sensitive Condition Rate (&lt;75 yrs)</td>
<td>2011/12</td>
<td>&lt;= 172</td>
<td>189</td>
</tr>
</tbody>
</table>

## Develop the best workforce

### SYSTEM LEVEL

<table>
<thead>
<tr>
<th>Metric</th>
<th>Time Frame</th>
<th>Target</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Safety Scores (PHC not included)</td>
<td>Apr 2011 to Mar 2013</td>
<td>&gt;= 3.7</td>
<td>3.7</td>
</tr>
<tr>
<td>Employee engagement</td>
<td>Apr 2011 to Mar 2013</td>
<td>&gt;= 3.5</td>
<td>3.5</td>
</tr>
<tr>
<td>Total Absence Rate</td>
<td>April 2012 - June 2012</td>
<td>&lt;= 14.4 %</td>
<td>13.7 %</td>
</tr>
</tbody>
</table>

### STRENGTHEN MANAGEMENT AND LEADERSHIP CAPACITY

<table>
<thead>
<tr>
<th>Metric</th>
<th>Time Frame</th>
<th>Target</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Management Staff with a Professional Development Plan</td>
<td>Apr 2012 to Sep 2012</td>
<td>&gt;= 80.0 %</td>
<td>50.3 %</td>
</tr>
</tbody>
</table>
### Innovate for sustainability

#### SYSTEM LEVEL

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Target Condition</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Productivity (in millions of dollars)</td>
<td>Apr 2011 to Mar 2012</td>
<td>&gt;= 125.0</td>
</tr>
<tr>
<td>Net Surplus or Deficit (in millions of dollars)</td>
<td>Apr 2012 to Nov 2012</td>
<td>&gt;= $0.0 M</td>
</tr>
</tbody>
</table>

#### OPTIMIZE CAPACITY, RESOURCE UTILIZATION AND PRODUCTIVITY

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Target Condition</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Productive Hours per Patient Day</td>
<td>Apr 2012 to Nov 2012</td>
<td>&lt;= 6.8</td>
</tr>
</tbody>
</table>

- **Within desirable target range**
- **Within 10% of target**
- **Outside desirable target range by more than 10%**
Emergency Patient Experience

Are patients happy with our emergency department services?

What are we measuring?

We measure the percentage of emergency department patients who rate the care they received at the hospital positively. Are patients happy with our services?

Why?

Our patient experience surveys provide us with valuable information about the way patients feel about our services. We use the feedback to identify areas for improvement so that we can continue to provide high-quality health care.

How do we measure it?

We take the total number of responses that answered “good”, “very good” or “excellent” to the overall quality of care question and divide by the total number of non-blank responses to the overall quality of care questions.

How are we doing?

Our latest result is near the target of 90%. For Q1, Coastal Rural sites and Urgent Care centers are included but affiliate sites in Bella Coola and Bella Bella excluded due to low volumes. Satisfaction with services may go down at times when there are more patients in the emergency department and the hospital is congested. Domains targeted for improvement with regional initiatives include coordination of care, communication, and physical comfort/pain management. For most sites, satisfaction has been constant despite a more than 20% increase in ED volumes since surveys started in 2007.

What we are doing?

1. Reviewing the results on a regular basis to identify issues and opportunities for improvement. 2. Focusing on initiatives to speed up the time it takes for patients to be seen and treated. 3. Developing a public “dashboard” to see wait times for our hospital’s Emergency Departments. 4. Researching opportunities for marginalized populations (e.g. homeless, elderly, new immigrants) to evaluate their care in the Emergency Department. 5. Creating a brochure to explain what patients can expect during their emergency department visit.

What can you do?

1. Call HealthLinkBC at 8-1-1 to speak to a nurse about your non-emergency health concerns, discuss your symptoms and get advice on whether you should see a health professional. You can also visit www.HealthLinkBC.ca. 2. Visit www.vch.ca to find out how to submit a compliment or complaint about the care you received.

Our performance | Target *
---|---
89.1 % | >= 90.0 %

of patients rate their care positively

Year-to-date Timeline: Apr 2012 to Jun 2012

* Our target is set by the B.C. Ministry of Health
Hospital Standardized Mortality Ratio

What is our mortality rate compared to other Canadian hospitals?

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

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

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.

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

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 2009/10.

How are we doing?
VCH continues to maintain a rate better than the national average. Multiple initiatives are underway to continue to reduce this ratio.

Our performance | Target *
--- | ---
83.0 | <= 100.0

ratio of observed to expected deaths

Year-to-date Timeline: Apr 2012 to Jun 2012

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

How many patients get Methicillin-Resistant Staphylococcus aureus from a hospital stay?

What are we measuring?
We monitor the number of patients who get Methicillin-Resistant Staphylococcus aureus (MRSA) as a result of a stay in hospital.

What we are doing?
1. Encouraging staff (doctors, nurses and others) to work hand cleaning into their practice routines. 2. Providing nursing units with monthly reports on their hand hygiene compliance. 3. Providing nursing units with weekly reports that show the number of cases acquired on their units to help them evaluate their improvement efforts. Our infection control team works with nursing units to identify opportunities for improvement.

Why?
Staphylococcus aureus is a bacterium that normally lives on skin and noses. Many people are carriers of Staphylococcus aureus and never have symptoms. Others may develop an infection, usually involving the skin. Sometimes it can cause more serious problems 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 can you do?
1. If you are MRSA positive, be sure to tell anyone who treats you. 2. Clean your hands regularly to prevent the spread of germs to others. Do not be shy about politely reminding everyone to clean his or her hands. 3. Follow doctors’ and nurses’ instructions on wound care.

How do we measure it?
We take the total number of new MRSA cases identified every three months and divide that by the total number of patient days for the same time period. We multiply that number by 10,000 to arrive at a case rate per 10,000 patient days. Comparisons prior to Q1 2013 should be used with caution as PHC data was not included in the VCH total.

How are we doing?
The regional year to date rate is 6.5 compared to 5.7 in quarter one. These rates are worse than our 2012/13 target of 4.2 per 10,000 patient days. The increase in MRSA quarterly rates correlates with a decrease in hand hygiene compliance. VCH is introducing a “refresh” of the hand hygiene program with the aim to further reduce MRSA rates. However, additional multidisciplinary intervention will be required to decrease the rate of MRSA.

Our performance | Target *
--- | ---
6.5 | <= 4.2

Year-to-date Timeline: Apr 2012 to Sep 2012

*Our target for 2012/13 is to decrease our regional annual rate by 10%.
Clostridium difficile Infection Rate

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

What are we measuring?
We monitor the number of patients who get sick with the bacterium Clostridium difficile (C. difficile) as a result of a stay in hospital.

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

What do we measure?
We take the total number of C. difficile infection cases identified every three months and divide it by the total number of patient days for the same time period. We multiply that number by 10,000 to arrive at a case rate per 10,000 patient days.

How are we doing?
The year to date rate for C. difficile infection acquired in hospital is 9.7 compared to 9.0 in quarter one. These rates are worse than our 2012/13 target of 8.0 per 10,000 patient days. Multidisciplinary interventions aimed at reducing hospital-acquired C. difficile infection are being strengthened.

What can you do?
1. If you have C. difficile infection, be sure to tell anyone who treats you. 2. Wash your hands regularly with soap and water to prevent the spread of the bacterium to others. Do not be shy about politely reminding everyone to wash his or her hands. 3. Use antibiotics only when necessary for serious infections. Be sure to take the full course of antibiotics, even after you start to feel better.

Target:
9.7 <= 8.0 cases of C. difficile per 10,000 patient days

Year-to-date Timeline: Apr 2012 to Sep 2012

*Our target for 2012/13 is to decrease our regional annual rate by 15%.
Hand Hygiene Compliance

Do hospital staff clean their hands often enough?

What are we measuring?

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

Why?

Clean hands are the single most effective way to stop the spread of infection or prevent patients from getting infections. Every health care-acquired infection adds $10,000 to $24,000 in treatment cost per patient. One third of health care-acquired infections are preventable by appropriate hand hygiene.

How do we measure it?

Every month we observe a sample of staff working at VCH hospitals. At PHC, we observe a sample of staff every three months. The percentage score reflects how often staff clean their hands when there is an opportunity to do so.

How are we doing?

The 2012-2013 annual target for hand cleaning is 100%. The VCH results show that the percent of observed hand cleaning has plateaued at approximately 70%. Efforts to revitalize the hand hygiene program are underway. As of November 1, hand hygiene auditors within VCH (excluding PHC) began handing out instant feedback cards. VCH hospital units receive their compliance reports on a monthly basis (PHC quarterly) and these are posted publicly.

What we are doing?

1. Installing new hand sanitizer dispensers in convenient locations. 2. Conducting more compliance audits to reinforce that hand cleaning is important. 3. Determining what staff groups and sites need help to improve their compliance. 4. Encouraging staff to work hand cleaning into their practice routines.

What can you do?

1. Politely ask health care workers if they have cleaned their hands before they examine or treat you. 2. Clean your own hands thoroughly and often.

Our performance

<table>
<thead>
<tr>
<th>Year-to-date</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 2012 to Sep 2012</td>
<td>68.8 %</td>
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</tbody>
</table>

Target *

<table>
<thead>
<tr>
<th>Year-to-date</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 2012 to Sep 2012</td>
<td>100.0 %</td>
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</table>

*Our target is set by the Vancouver Coastal Health Board of Directors.

Year-to-date Timeline: Apr 2012 to Sep 2012
ER Wait Time

What is the mid-point of the time in minutes that patients wait to be seen in Emergency?

What are we measuring?

We measure the mid-point of the time it takes for patients who register for care in the emergency department to be seen by a physician (half of the patients wait longer, half shorter). This number is used to indicate the delay before the patient receives a diagnosis and starts the recommended treatment.

Why?

We are at target overall. This is significant because our regional performance is holding even in the face of increasing regional ED volumes. The inexorable increase in ED volumes without coincident increase in physician manpower means that performance in this GLE indicator is likely to decrease during this fiscal year without additional intervention. A review of workforce resources and ED modeling is beginning.

How do we measure it?

We count the minutes from the patient’s start of triage registration to when a physician assigns themselves to that patient. Visit start times vary from site to site because of differences in emergency department information systems and variability in flow patterns caused by surges of patients at various times of the day.

How are we doing?

We have changed the target to be more realistic as VCH is achieving the best times in the Country in most sites. While the new target still provides us with the challenge, it allows for recognizing successes as well. In spite of excellent performance, we continue to strive to reduce wait times and improve overall regional efficiency. Pay for performance strategies have improved this measure. With the recent implementation of NACRS, our ability to review physician workload and patient population will be enhanced further allowing us to breakdown processes for quality improvement.

What we are doing?

Over the past 12 months, Vancouver General Hospital and Richmond Hospital have redesigned their triage processes to improve patient flow and access to care. St. Paul’s Hospital has started a review of how Fast Track patients get registered. A regional emergency department dashboard is being created to help emergency departments, the ambulance and the public understand when emergency departments in the region are busy. This should increase capacity by shifting patients to less busy sites.

What can you do?

There are regular peaks in arrival volumes each and every day in our Emergency Departments that makes it difficult to see all patients in a timely fashion. By avoiding peak periods such as noon to 9:00 PM you can help reduce the time to physician. As well, having a family physician is important for preventative care. Remember the BC Healthlink number: 8-1-1 if you are looking for advice.

Our performance | Target *
-----------------|---------
37.0             | <= 44.0

mid-point of minutes for ED patients to be seen by a physician

Year-to-date Timeline: Apr 2012 to Nov 2012
*The target is based on continued improvement from 2011/12 rather than on an external comparator, because VCH performance already exceeds the lowest other Canadian hospital in the NACRS database at 44 minutes.
Surgery Wait Time

Are patients waiting too long for non-emergency surgeries?

What are we measuring?
We monitor the percentage of elective (non-emergency) surgeries we complete within the target wait time assigned by a patient’s surgeon.

Why?
So patients have timely access to surgery and do not wait beyond the maximum medically acceptable wait times.

How do we measure it?
According to their patient’s diagnosis, surgeons assign their patients one of five provincially agreed upon target wait time levels for elective surgery: 2, 4, 6, 12 or 26 weeks. Cataract surgery is an exception, with a federally mandated wait time target of 16 weeks. We then measure the number of elective patients whose surgery is completed within the target time frame.

How are we doing?
Overall performance has slipped since the beginning of the fiscal year 2011/12 from 77 to 74% of patients within target.

What we are doing?
1. Adjusting access to operating rooms so that we can treat patients who are waiting beyond their target wait times more quickly. 2. Using special funding from the Ministry of Health to provide additional operating room time for selected procedures. 3. Educating surgeon’s offices on wait list management and ensuring patients are correctly booked according to the target wait time for their diagnosis.

What can you do?
1. Go to the Ministry of Health website on BC surgical wait times (http://www.health.gov.bc.ca/swt/) and compare the wait times by hospital and surgeon. 2. Talk to your family physician if you want to be referred to a surgeon with a shorter wait time for surgery. 3. Be sure to let your surgeon know if there is a change in your symptoms, for better or for worse, and let your surgeon know if you will be unavailable for surgery for some time or no longer wish to proceed.

Our performance | Target *
--- | ---
74.3 % | >= 75.0 %

of surgery patients waited less than target time.

Year-to-date Timeline: Apr 2012 to Nov 2012

*We have a series of targets, beginning at 75% for this fiscal year and improving to 80% and 85% in 2013/14 and 2014/15.
Mental Health and Addiction Community Follow-up (Ages 15-64)

How well do we bridge mental health and addiction patients from hospital to community?

What are we measuring?

We measure how many patients, aged 15 to 64, admitted to hospital with a Mental Health and Addiction diagnosis received follow-up in the community within 30 days of discharge. This follow-up can be with a family doctor, community mental health and addiction service provider or a psychiatrist. We do not count patients aged 65 and older because it’s more likely that they have other health conditions that would require follow-up after they leave the hospital.

Why?

Follow-up care within 30 days of discharge from hospital for mental illness and/or addiction issues helps the patient’s return to the community from hospital, improves outcomes and may reduce re-hospitalization for some individuals, or help readmission happen before individuals reach a crisis stage.

How do we measure it?

We compare the date that the Mental Health and Addiction patient was discharged from the hospital to the date that they had a visit with their family doctor, a community mental health and addiction service provider or a psychiatrist.

How are we doing?

Our current performance under-represents our true community follow-up because we are not able to count when patients follow-up with our contracted partners. Additionally, some patients may miss scheduled appointments which could also lower our performance. No new data available from MOH SharePoint.

What we are doing?

We have multidisciplinary rounds on our inpatient units where the care team focuses on discharge planning and ensures that community supports are arranged for post-discharge follow-up. We are introducing new evidence-based community programs that support integrated coordinated care across hospital and community such as acute home based treatment (AHBT) and Assertive Community Treatment (ACT) teams. We are introducing programs to better connect primary care physicians with tools that support timely information sharing to improve care planning.

What can you do?

Advise your care team that you would like to be an active participant in planning for your discharge and community follow-up. Prior to leaving hospital, ensure you are provided with a discharge resource list that includes your community follow up plans, a current list of medication and a list of resources to call in the event you require immediate support. Ensure your family and/or supports are aware of your community follow up plan and can help you transition back to community.

Our performance | Target *
---|---
84.0 % | >= 88.0 %

of mental health and addiction patients had community follow-up within 30 days

Year-to-date Timeline: Apr 2011 to Sep 2011

*Our target was set by the Regional Mental Health and Addiction Program
Residential Care Wait Time

How long does it take for clients to get a residential care bed?

What are we measuring?

We track how long individuals wait before being placed in a residential care home. What percent of people receive a bed within 30 days?

What we are doing?

1. Working on strategies to ensure an adequate number of residential care beds are available for providing complex care. 2. Focusing on internal processes for moving patients from hospital or community settings to residential care in a timely way. This includes matching the needs of clients to the type of bed available, up to date assessment and medical information for clients waiting for residential care, and timely notification when a bed becomes available.

Why?

When a person is eligible for residential care, it means they may be unable to continue to live safely in their own home or community setting without additional support. They have complex health care needs and require 24-hour nursing care in a supervised and secure environment. We want to ensure timely access to a residential care home so they get the quality of care they need.

How do we measure it?

We divide the number of patients placed within the target time of 30 days, by the total number of patients admitted to residential care.

How are we doing?

Overall VCH is tracking very close to the Ministry target of 80% of residents admitted within 30 days. Initiatives that support clients to remain at home, with enhanced supports, continue in all Communities of Care. The Coastal Community of Care is challenged primarily due to a few clients with very specialized care needs that cannot be met within the usual residential care service. VCH is working on a framework and implementation plan for meeting the needs of clients who have specialized care and housing needs.

Our performance | Target *
---|---
74.3 % | >= 80.0 %

of clients are placed within 30 days

Year-to-date Timeline: Apr 2012 to Oct 2012

* Our target is set by the B.C. Ministry of Health
Measles, mumps and rubella (MMR) immunization coverage rates

Are our kindergarten children protected against vaccine preventable illness?

What are we measuring?
We measure the percentage of kindergarten children who are up to date for immunization against measles, mumps and rubella by the end of each school year.

What we are doing?
We are trying to coordinate immunization programs across the region as well as trying to address local discrepancies in coverage rates.

Why?
To ensure children are protected against diseases easily preventable by vaccine.

What can you do?
Make sure your children receive all their shots on time.

How do we measure it?
We measure the number of students enrolled in kindergarten (ages 4-6) who have received two doses of measles-containing vaccine by the end of the school year. To be counted, doses must be given on or after the first birthday with at least 28 days between doses.

How are we doing?
Our coverage target of 95% represents an immunization level where the spread of these diseases in our community is almost impossible. Vancouver Coastal Health Authority is below target at 87.8%. There are some pockets in our communities where vaccination coverage is low.

<table>
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<tr>
<th>Our performance</th>
<th>Target *</th>
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</thead>
<tbody>
<tr>
<td>87.8 %</td>
<td>&gt;= 95.0 %</td>
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Our performance is calculated as the percentage of kindergarten children who are fully vaccinated for MMR.

Year-to-date Timeline: Sep 2011 to Jun 2012

* Our target is the level of coverage at which spread of the disease in the community is almost impossible.
Alternate Level of Care 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, mental health and addiction services are to patients, how closely the teams work together, a lack of capacity for the right type of care, or inefficient processes for transferring a patient.

How do we measure it?

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

How are we doing?

Overall VCH is slightly worse than our target of 7%. All Communities of Care are having success with initiatives that support patients with complex health needs to go home from hospital with added supports earlier. In addition, in all Communities of Care, patients with long lengths of stay in the hospital are monitored weekly by teams that include both hospital and community providers, to plan for discharges that are safe and appropriate.

What we are doing?

1. Working to prevent long hospital stays by providing high quality, integrated patient care. 2. Ensuring we have appropriate capacity in all of our community, rehabilitation and hospital services. 3. Creating efficient processes to support patients transferring between services. 4. As a short-term action, some hospitals are holding weekly meetings with clinical leadership and health care workers to focus on specific patients with a very long hospital stay.

Our performance Target *
7.4 % <= 7.0 %
of hospital days are ALC days

Year-to-date Timeline: Apr 2012 to Nov 2012
* Our target is set to maintain our 2009/10 levels
Early Childhood Development Index

How ready are the children in our communities for school?

**What are we measuring?**
We use a tool called the Early Childhood Development Index (EDI) to measure how ready kindergarten children are for elementary school.

**Why?**
We use the EDI to measure children’s early development and predict any future health and social problems that they may have. This helps us plan for health programs in our communities.

**How do we measure it?**
The EDI is a questionnaire designed to measure children’s development in kindergarten. The EDI is a checklist that teachers complete for each child after knowing them for about 6 months. The questionnaire has 104 questions and measures 5 main areas of child development: physical, social, emotional, language and communication. These are good predictors of adult health, education and social outcomes.

**How are we doing?**
There is definite room for improvement to decrease vulnerability among kindergarten children right across all Vancouver Coastal Health communities. Improvements in this measure are needed in both low and high income communities. New data may become available in late fall 2012.

**What we are doing?**
We are working with the BC Ministry of Health on the Healthy Families BC initiative which will respond to some of the province’s early childhood development issues. We are also working with partners outside the health care system to address the social determinants of health. Improvement in this area will require larger investment in early childhood development programs, fiscal policy which supports families with young children and more accessible, high-quality childcare resources.

**What can you do?**
Take advantage of the programs in your community that provide stimulation and activities for parents with babies, toddlers, and pre-school children, like community centres, public health offices, libraries or other community groups.

**Our performance**

<table>
<thead>
<tr>
<th>Year</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-11</td>
<td>32.5 %</td>
</tr>
<tr>
<td>2007-09</td>
<td></td>
</tr>
<tr>
<td>2003-06</td>
<td></td>
</tr>
<tr>
<td>2000-03</td>
<td></td>
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</tbody>
</table>

**Target**

<table>
<thead>
<tr>
<th>Year</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-11</td>
<td>&lt;= 15.0 %</td>
</tr>
<tr>
<td>2007-09</td>
<td></td>
</tr>
<tr>
<td>2003-06</td>
<td></td>
</tr>
<tr>
<td>2000-03</td>
<td></td>
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</tbody>
</table>

Year-to-date Timeline: 2009-2011

*Our target was set by the Government of BC and is hoped to be achieved by 2015*
Disparity Ratio for Life Expectancy

Are there inequalities in life expectancy across Vancouver Coastal Health?

What are we measuring?
We calculate, by community, how much longer people with the longest life expectancy can expect to live as compared to those with the shortest life expectancy.

What we are doing?
We are addressing causes of early death including causes like motor vehicle injuries or drug overdoses. We also have targeted specific communities to decrease early death. For example, harm reduction services in the Downtown Eastside community have significantly improved life expectancy in that area over the past decade. We are also working with partners outside the health care system to improve social factors that can lead to poor health and early death.

Why?
The disparity ratio for life expectancy measures the inequity in health between communities. Reducing these inequities by raising life expectancy is one of the main goals of Vancouver Coastal Health’s work in its communities.

What can you do?
Lead a healthy life and reduce risky behaviours that might contribute to injury or early death.

How do measure it?
Life expectancy is calculated by the British Columbia Vital Statistics Agency in areas they call “Local Health Areas”. The disparity ratio for life expectancy is calculated by dividing the life expectancy in the Local Health Area with the longest life expectancy by the life expectancy of the Local Health Area with the shortest life expectancy.

How are we doing?
The people in the best performing Local Health Area, Richmond, are expected to live 13% longer than those in the worst performing Local Health Area, the Central Coast. The life expectancy in Richmond during the 2007-2011 timeframe was 85.5 years.

Our performance | Target *
--- | ---
1.13 | 1.05

ratio of highest life expectancy to lowest life expectancy in VCH

Year-to-date Timeline: 2006-2010
*Our target of 1.05 reflects equal life expectancy across all of VCH
Ambulatory Care Sensitive Condition Rate (<75 yrs)

How many hospital stays could be avoided by using outpatient clinics instead?

What are we measuring?

Ambulatory care sensitive conditions (ACSC) is related to hospitalization and 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 are often referred to as avoidable hospitalizations and is a measure of the primary care system performance.

Why?

The rate of admissions to hospital for ACSC is used as a measure of patient access to appropriate primary health care. A very low rate of ACSC could indicate that there is good access to appropriate primary care and other outpatient care. However, we still expect some ACSC because not all hospital admissions with these conditions are avoidable.

How do we measure it?

The Hospital admission case rate for ambulatory care sensitive conditions per 100,000 population < 75 yrs is within target parameters but as always there is a potential to improve. We are continuing with the implementation of the integrated primary and community care initiative and will be striving to improve further.

How are we doing?

VCH has the best rates in BC and among the best in Canada for this metric, but not quite at our target level. We have physicians, other healthcare staff and patients looking at their communities and determining where they need to focus. We are looking at the reasons patients go to ER "unnecessarily" and starting to introduce change to respond to local need.

What we are doing?

We have started an initiative to redesign how patients with complex health issues receive care in the community. This is a 5 year project and we are in our second year. This project is being approached community by community. We are shifting resources to support the creation of a robust relationship between a GP, their patients and other care providers in the community. We have patients on all of the planning groups for this work. We are integrating and partnering with all projects that support working to keep people out of emergency and the hospital.

What can you do?

Build a relationship with your GP and partner with your doctor in keeping yourself well. Exercise if you can, eat a healthy diet and try to maintain a healthy weight.

Our performance

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate per 100,000 population</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>189</td>
<td>&lt;= 172</td>
</tr>
</tbody>
</table>

* Our target is based on consistent patient volumes from 2009/10 adjusted for population growth.
Staff Safety Scores (PHC not included)

Does our staff see Vancouver Coastal Health as safe?

What are we measuring?
We measure our staff's opinion of Vancouver Coastal Health’s (VCH) commitment to staff and patient safety.

Why?
The public expects to receive safe, quality care from VCH. We know ensuring the safety of our staff is inseparably linked with the provision of safe, quality care for our patients, clients and residents. Valuing the health and safety of everyone is foundational to the People First commitment.

How do we measure it?
Starting this year, employees at VCH were asked a series of survey questions regarding their perceptions of safety at VCH.

How are we doing?
This is VCH’s first year measuring how our staff see safety in their workplace. This result will provide the target for future years. The staff survey also included 12 questions designed to measure employee engagement—how involved with, committed to, and satisfied an employee is with their work. The data from these questions has shown a strong link between how engaged employees are and how positively they see the safety of their workplace.

What we are doing?
We expect that the overall score for Safety and Engagement will improve next year as we address the safety concerns identified by the survey. Action planning is occurring throughout VCH to improve safety and engagement across the organization. These plans are a required part in every VCH manager’s performance plan starting in 2012. Our goal is continuous improvement.

What can you do?
If you or your family sees something that is unsafe please let us know right away. We value your contributions to improving the safety for everyone in contact with the health care system.

<table>
<thead>
<tr>
<th>Our performance</th>
<th>Target *</th>
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</thead>
<tbody>
<tr>
<td>3.7</td>
<td>&gt;= 3.7</td>
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</table>

out of a 5 point safety scale

Year-to-date Timeline: Apr 2011 to Mar 2013
Survey completed in Spring 2011. Next survey will be in April 2013.
Employee engagement

Staff and patient safety scores: Employee Engagement Score

What are we measuring?
A measure of an employee's psychological commitment to their job.

Why?
The public expects to receive safe, quality care from VCH. We know that engaged employees are safer, more likely to stay, be more productive and are more patient centred. Employee engagement is a strong driver for organizational performance. Valuing our staff and their contribution to the organization is foundational to the People First commitment.

How do we measure it?
The overall mean score of all 12 Gallup engagement questions

How are we doing?
The engagement mean score for VCH was the highest mean score for any BC Health Authority’s first time doing the Gallup survey. VCH data has demonstrated the strong linkage between employee engagement and safety. This is VCH’s first year assessing engagement in this manner so this result provides a benchmark. We expect that the overall score for Safety and Engagement to improve as each manager addresses key issues in their departments.

What we are doing?
Action planning on two items is occurring throughout VCH to improve engagement and safety across the organization. These plans are a required element in every VCH manager’s performance plan starting in 2012. Our goal is continuous improvement and building great work environments.

What can you do?
A part of engagement is recognition for a job well done. Appreciating good care with a thank you or a kind word goes a long way to supporting our staff in their efforts to deliver on the VCH vision of supporting healthy lives in healthy communities. If you or your family experience something that denotes a work area that does not show caring or commitment to you and the quality of care you receive, please let us know right away. We value your contributions to creating and sustaining great workplace environments for you, for our staff and for everyone in contact with the health care system.

Our performance | Target *
---|---
3.5 | >= 3.5

Year-to-date Timeline: Apr 2011 to Mar 2013
Survey completed in Spring 2011. Next survey will be in April 2013.
Total Absence Rate

What percentage of staff time is lost to illness or injury?

**What are we measuring?**

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

**Why?**

To take care of our patients we need to be healthy and well. And, to be accountable to the taxpayers of British Columbia we need to minimize the amount we pay in overtime and other extra coverage for illness or injury. By tracking the health and safety of our workforce we can have the most staff onsite and the least amount of people working overtime to cover for their coworkers.

**How do we measure it?**

Total Absence Rate is calculated by dividing the time lost due to illness and injury by the total amount of productive time.

**How are we doing?**

Total Absence Rate has been improving over the past three years due to concerted efforts of the Attendance and Wellness Promotion Program which focuses on keeping staff at work (reducing sick time), as well as the Healthy Workplace Project which focuses on returning people back to work, effectively reducing Long Term Disability (LTD) and WorkSafeBC (WSBC) time.

**What can you do?**

Remember to care for those giving you care. Follow their instructions to help reduce the risk of passing your illness onto your caretaker.

**What we are doing?**

We are supporting our employees to stay at work if it is safe or return to work as quickly as possible. The Total Absence Rate at VCH has been shrinking over the past three years in part due to our Attendance and Wellness Promotion Program, which focuses on keeping staff at work (reducing sick time), as well as the Healthy Workplace Project, which focuses on returning people back to work, effectively reducing Long Term Disability (LTD) and WorkSafeBC (WSBC) time.

**Our performance**

<table>
<thead>
<tr>
<th>Our performance</th>
<th>Target *</th>
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<tbody>
<tr>
<td>13.7 %</td>
<td>&lt;= 14.4%</td>
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</table>

Our performance is the percentage of staff time lost to illness or injury. Target is the percentage we aim to achieve.

Year-to-date Timeline: April 2012 - June 2012

* Our target is based on our performance of the last year to date, quarter 2
% of Management Staff with a Professional Development Plan

Percentage of management staff with a Professional Development Plan

What are we measuring?
We are measuring the percentage of our management staff that has a plan to conduct professional development activities.

What we are doing?
We are educating our management staff on how to utilize the PerformanceLink system through face to face training sessions and online video vignettes. We are conducting 360 assessments with all managers and directors and educating them on the importance of professional development plans.

Why?
Healthcare is a complex and adaptive environment and our managers must stay current in leading practices to ensure care is delivered at a high quality in a cost effective manner. It is essential that VCH’s management staff has the skills, knowledge and abilities to be effective leaders in healthcare. Developing the competencies to lead in a healthcare environment and to ensure the resources to do so are used effectively requires deliberate and thoughtful professional development planning. To ensure VCH continues to have the right skill mix throughout the organization VCH must promote the professional development of its management staff.

How do we measure it?
We divide the total number of staff in PerformanceLink that have created a professional development plan in PerformanceLink by the total number of staff in the PerformanceLink system and multiply it by one hundred percent.

How are we doing?
More managers and directors are utilizing PerformanceLink to capture their operational plan than their professional development plan so there is opportunity for improvement. Overall, we have observed an increase in this indicator from 37.3% in Q4 of 2011/12 to 51.2% during Q2 of 2012/13.

Our performance | Target *
--- | ---
50.3 % | >= 80.0 %

of management staff have a professional development plan

Year-to-date Timeline: Apr 2012 to Sep 2012
Research Productivity (in millions of dollars)

How successful are we at getting research funding?

What are we measuring?
We track how many dollars in research funding that VCH and PHC researchers get each year.

Why?
Being successful at getting research funding attracts top researchers and students to come to BC and then to stay here. Having researchers doing research locally also means that we will benefit from the results of their health related research faster.

How do we measure it?
We track all the research funding (in dollars) that our researchers receive, and for each fiscal year we calculate the total amount of research dollars that were had at any point in that year.

How are we doing?
Of the 7 main research institutes affiliated with UBC, Vancouver Coastal Health Research Institute (VCHRI) holds the most funding (38.24%), and Providence Health Care Research Institute (PHCRI) holds 13.81% for a total of 52.05% for VCHA in fiscal year 2011-2012. Overall the total research funding is very similar to the previous year’s figures with the exception of about a $17M increase in Infrastructure funding for VCHRI. Most of this infrastructure funding is received for the Centre for Brain Health.

What we are doing?
1. Provide assistance to researchers in their applications to obtain funding
2. Work with foundations to partner on funding research projects as well as the buildings and other resources needed to do research
3. Share the amazing research that is being done at VCH and PHC with the public and show how it can have positive impacts locally
4. Assist researchers to connect with those in other fields of work and organizations to work together on new and innovative projects
5. VCHRI and PHCRI have been proactive in the recruitment of clinicians and personnel, and in supporting the development of provincial research networks e.g. the BC Clinical Research Infrastructure Network (BCCRIN).

What can you do?
Advocate for the importance of health research funding in general and the importance of supporting it to be done locally. Participate in research studies when appropriate and relevant to their health.

Our performance | Target *
--- | ---
134.3 | >= 125.0

millions of dollars in total research funding for VCH and PHC in the 2010/11 fiscal year.

Year-to-date Timeline: Apr 2011 to Mar 2012

*This is a combined VCHRI and PHCRI target
Net Surplus or Deficit (in millions of dollars)

How are we managing our money?

What are we measuring?

We are measuring how much money we spend to provide health care services to over 25% of British Columbians. When most people think about health care, the first thing they think of is hospitals. While many of our services are offered in the 13 hospitals we operate, we also offer a number of other services including primary care, community-based residential and home health care, mental health, addiction, public health and research.

Why?

Our $2.8 billion in annual funding comes from your tax dollars. We have a responsibility to you to manage our finances, make the most of the funding to provide quality patient care, and ensure our health care system is sustainable.

How do we measure it?

We track the dollars we spend every month and compare it to our budget.

How are we doing?

Vancouver Coastal Health reports a $0.9 million surplus for year-to-date ending November 8, 2012. A balanced budget is expected for the year.

What we are doing?

1. Looking for innovative ways to provide quality health care services that are cost effective. 2. Focusing on strategies to optimize our workforce of health care providers. This includes improving productivity, reducing overtime and reducing sick time. 3. Joining Fraser Health, Providence Health Care, the Provincial Health Services Authority and the B.C. Ministry of Health in a Lower Mainland Consolidation initiative. It improves efficiency and reduces costs across health organizations by consolidating several corporate, back-office and clinical support services.

<table>
<thead>
<tr>
<th>Our performance</th>
<th>Target *</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 0.9 M</td>
<td>&gt;= $ 0.0 M</td>
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</table>

million dollars under budget (surplus)

Year-to-date Timeline: Apr 2012 to Nov 2012

* Our target is established by the B.C. Ministry of Health
Acute Productive Hours per Patient Day

Are we matching our nursing levels to patient need?

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

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

How do we measure it?
This measure divides the total number of nursing hours paid (labour) by the number of patient days (volume).

How are we doing?
Productive hours per patient day is worse than budget due to increased patient acuity and reduction of the less acute ALC days. The staff forecasting tool is being rolled out to all sites and all programs. Early successes have been experienced in key units. Further improvement on staffing is expected as the process matures.

What we are doing?
1. Implementing a new forecasting technology to plan ahead for patient demand and match nursing levels to volumes. 2. Implementing electronic scheduling and timekeeping to reduce clinical time spent on scheduling nurses. 3. Improving access to real-time information and reports for better management decision-making. 4. Vancouver directors and managers hold “bed” meetings twice a day to review the patient demand on each service area to better match patients, beds and staff.

<table>
<thead>
<tr>
<th>Our performance</th>
<th>Target *</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.0</td>
<td>≤ 6.8</td>
</tr>
<tr>
<td>hours of direct patient care per day</td>
<td></td>
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</table>

Year-to-date Timeline: Apr 2012 to Nov 2012

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