



# **Alberta Health Services Performance Report**

**June 2011**

**(New measures and measures with data updates only)**

Prepared by  
Data Integration, Measurement and Reporting

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## Introduction

Alberta Health Services is on a journey to become the best publicly-funded health-care system in Canada.

The start of this journey begins with knowledge and ambition: knowledge of how our services compare to the best, and ambition to improve the quality of our services and the health of Albertans.

In this report we are examining both. We are measuring our performance near the start of this journey, and we are measuring our progress towards the targets, which Alberta Health Services (AHS) established in partnership with Alberta Health and Wellness, and through consultation with clinical leaders and a review of national benchmarks.

The targets are intentionally ambitious. Setting goals for performance and monitoring our progress in reaching these goals are fundamental to transforming the health-care system.

The report also links performance targets to our five Transformational Improvement Programs to help us ensure we are making the right improvements and are putting our resources in the right places.

### **Reporting our performance: January 1 – March 31, 2011**

Designed to gauge performance and drive improvement, this report provides a snapshot in time and shows us where we are performing well and areas where we need to take action to improve.

A few areas where AHS has met or is on track to meeting the annual target include: patients admitted from ED within 8 hours (all sites), patient satisfaction rates in hospitals, access to radiation therapy (ready-to-treat status until first treatment), admissions for ambulatory care sensitive conditions, and number of Netcare users. In addition, while not meeting the 2010/11 performance targets, AHS has made significant improvement on the number of people waiting in acute/sub-acute beds for continuing care placement, as well as the percentage of Albertans enrolled in a Primary Care Network.

We are also responding to a number of priority areas with immediate and aggressive actions to improve performance. These areas include: emergency department lengths of stay, access to continuing care beds, as well as wait times for hip replacements, knee replacements, coronary artery bypass graft surgeries, and cataract surgeries.

#### ***Highlights of actions underway to improve performance in these priority areas:***

- Ongoing implementation of new Emergency Department (ED) surge capacity protocols to provide additional capacity when demands on Emergency and across the health system reach critical thresholds. When reached, the new protocols trigger immediate action to reduce wait times.
- Completing the addition of 360 new hospital beds by June 30, 2011 (323 beds were opened as of March 31, 2011). As well, an additional 40 hospital beds will be opened by March, 2012. More open hospital beds will reduce ED length of stay for many patients requiring admission.
- Informing Albertans about their care options. Many Albertans visit the ED for illness and injuries that could be treated by a family doctor, at a drop-in clinic or an urgent care centre.

- Adding 1,000 new continuing care beds in 2011/12, on top of the 1,166 beds added during the 2010/11 year. This additional capacity allows us to free up hospital beds currently occupied by Albertans whose health needs would be better met outside of the hospital. More open hospital beds will help improve ED length of stay for many patients requiring admission.
- Increasing home care spending in an effort to keep seniors safe, healthy and independent in their homes and reduce the number of avoidable ED visits.
- Implementing care pathways for patients requiring hip or knee replacement. This involves a central intake of referrals and offering a “next available surgeon and site” option to interested patients. The project is now underway in all 12 facilities performing hip and knee replacements.
- Increasing cataract surgeries: funding allocation to maintain increased volumes of cataract procedures in 2011/12 in order to reduce wait times.

In addition to these high priority areas, there are others that also require more attention and action. These are highlighted in the report and information on actions being taken can be found in the summary page for each measure.

In order to transform the way we deliver health services across the province, we need a vision for the future, transparent and accountable action plans, reliable measures, and specific targets. We need to know how well we are doing and where we need to improve. And, as we make improvements, we need an ongoing process to measure effectiveness.

More than just numbers, this report is a dynamic road map for the future and an essential tool to reach our goal of becoming the best publicly-funded health-care system in Canada.

With the release of each quarterly report, AHS reaffirms our commitment to provide timely and relevant information to the public. While the figures presented here measure our progress to date, the most important measure of our success in the future will be the health and satisfaction levels of Albertans.

For more information on actions we are taking and the programs we have in place to transform our health system, I encourage you to visit our website at [www.albertahealthservices.ca](http://www.albertahealthservices.ca).

*Dr. Chris Eagle, President & Chief Executive Officer, Alberta Health Services*

## What's being measured?

Alberta Health Services (AHS) delivers health services in five zones, each with different populations and geography. The measures presented here track our current and projected performance in a broad range of indicators that span the continuum of care. They include primary care, continuing care, population and public health, and acute (hospital-based) care. In addition, they touch upon various dimensions of quality such as timeliness, effectiveness, efficiency, satisfaction rates and others.

## How to read this report

This report is aligned with both the [2010-2015 Health Plan](#) and [Becoming the Best: Alberta's 5-Year Health Action Plan](#), as well as other AHS reports such as the Quality and Patient Safety Dashboard and the Human Resources Dashboard.

Information is at your fingertips in the “dashboard” which provides an at-a-glance view of all performance measures and allows you to see trends over time. The point-and-click drill-down features help you better understand the meaning of the data provided, and allows access to more detailed information by zone or site (as appropriate to the specific indicator).

You'll also have access to detailed definitions and one-page descriptions of each of indicator with comments on existing performance, actions being taken by AHS to improve performance, and other information.

The performance dashboard uses a “traffic light” method to show how AHS is performing relative to 2010-11 targets. Each indicator where quarterly updates are available has been compared to a prorated quarterly target as opposed to the year-end target. The prorated target simply allows us to see where we are this quarter relative to where we would expect to be. This “staggering” of targets throughout the year allows us to determine whether we are achieving the level of performance at the rate we expected.

A “green light” is used when actual performance is at or better than the prorated target; a “yellow light” represents performance within an acceptable range of the target (we are at least within 75 per cent of where we were expected to be), and a “red light” shows where performance is beyond an acceptable range. A green or yellow light can also be changed to red if the trends indicate there is risk of achieving our performance goals for the end of the year.




For indicators measured annually rather than quarterly, they are evaluated against the year-end target, where performance within 10 per cent is considered an acceptable range, resulting in a “yellow light.”


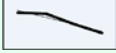









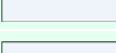







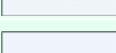



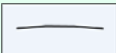





Data availability for quarterly updates varies due to data source differences. Most of the quarterly performance measures in this report are updated to the fourth quarter (January-March, 2011). For those indicators reporting Quarter 3 data, the following table explains why there is a one quarter reporting lag in each case.

<b>Quarterly Measures with a One Quarter Reporting Lag</b>	<b>Data Timeline Clarification</b>
<ul style="list-style-type: none"> <li data-bbox="191 453 618 483">Patient Satisfaction - Acute Care</li> </ul>	<p data-bbox="971 453 1419 686">For this survey, patients are called up to six weeks after they leave the hospital. Data are then prepared and analyzed for reporting. This means patient experience information for a particular quarter is available approximately 2 months after the end of a reporting period.</p>

Data included in this report come from Alberta Health Services, Alberta Health and Wellness, Health Quality Council of Alberta, and Statistics Canada.




# AHS Performance Dashboard






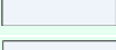

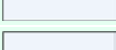

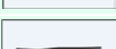



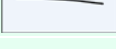

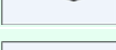






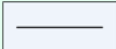
Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	Actual Performance	Year to Date Target	Status	Trend	Annual Target
<b>Staying Healthy / Improving Population Health</b>						
<a href="#">◇ Life Expectancy</a>	2010	81.6	na	na		na
<a href="#">◇ Potential Years of Life Lost (per 1,000 Population)</a>	2010	44.8	na	na		na
<b>Building a Primary Care Foundation</b>						
<a href="#">◇ Seniors (65+) Influenza Immunization Rate</a>	2010/11	59%	na			75%
<a href="#">◇ Children (6 to 23 Months) Influenza Immunization Rate</a>	2010/11	27% <sup>✓</sup>	na			75% <sup>^</sup>
<a href="#">Albertans Enrolled in a Primary Care Network (%)</a>	Apr 2011	72% <sup>✓</sup>	na			75%
<a href="#">◇ Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)</a>	Q4 2010/11	74 <sup>✓</sup>	76 (quarterly)			304 (annually)
<a href="#">◇ Family Practice Sensitive Conditions (% of ED visits)</a>	Q4 2010/11	28.0% <sup>✓</sup>	27.3%			27%
<a href="#">Health Link Wait Time ( % answered within 2 minutes)</a>	Q4 2010/11	71.7% <sup>✓</sup>	80%			80%
<a href="#">◇ Children Receiving Community Mental Health Treatment within 30 Days (%)</a>	Q4 2010/11	79% <sup>✓</sup>	85%			85%
<b>Improving Access, Reducing Wait Times</b>						
<a href="#">◇ Urgent CABG Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	2.2 <sup>✓</sup>	1.5			1.5
<a href="#">◇ Semi-urgent CABG Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	9.6 <sup>✓</sup>	5.0			5.0
<a href="#">◇ Scheduled CABG Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	19.9 <sup>✓</sup>	15			15.0
<a href="#">◇ Hip Replacement Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	36.6 <sup>✓</sup>	28.0			28
<a href="#">◇ Knee Replacement Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	48.0 <sup>✓</sup>	42.0			42
<a href="#">◇ Cataract Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	46.1 <sup>✓</sup>	36.0			36
<a href="#">◇ Other Scheduled Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	26.3 <sup>✓</sup>	tbd	na		tbd

◇ Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.  
 † Interim target pending confirmation. Status based on interim target.  
 \* Trend for these measures cannot be determined until subsequent data is available.  
 ^ Target under review.  
 ✓ Indicates data points that have been updated since the previous report.



Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	Actual Performance	Year to Date Target	Status	Trend	Annual Target
<a href="#">◇Radiation Therapy Access (referral to 1<sup>st</sup> consult) (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	5.5 ✓	4.0			4
<a href="#">◇Radiation Therapy Access (ready to treat to first therapy) (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	3.7 ✓	4.0			4
<a href="#">◇Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume EDs) £</a>	Q4 2010/11	65% ✓	70%			70%
<a href="#">◇Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £</a>	Q4 2010/11	78% ✓	82%			82%
<a href="#">◇Patients Admitted from ED within 8 hours (%) (15 Higher Volume EDs) £</a>	Q4 2010/11	44% ✓	45%			45%
<a href="#">◇Patients Admitted from ED within 8 hours (%) (All Sites) £</a>	Q4 2010/11	55% ✓	55%			55%
<b>Choice and Quality for Seniors</b>						
<a href="#">◇People Waiting in Acute/Sub-acute Beds for Continuing Care Placement</a>	Q4 2010/11	471 ✓	400			400
<a href="#">◇People Waiting in Community for Continuing Care Placement</a>	Q4 2010/11	1,110 ✓	975			975
<a href="#">◇Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)</a>	Q4 2010/11	47 ✓	tbd	na		tbd
<a href="#">◇Number of Home Care Clients</a>	Q4 2010/11	56,041 ✓	na	na	na*	tbd
<b>Enabling Our People / Enabling One Health System</b>						
<a href="#">◇Headcount to FTE Ratio</a>	Q4 2010/11	1.57 ✓	na			1.63
<a href="#">◇Registered Nurse Graduates Hired by AHS (%)</a>	Q4 2010/11	Total: 87% ✓ Non-Casual: 41% ✓	70%	Total  Non-Casual 	na	70% by year end
<a href="#">◇Disabling Injury Rate</a>	2010	3.19	na		na	2.41
<a href="#">Full-time to Part-time Clinical Worker Ratio</a>	Q4 2010/11	0.98 ✓	na	na		tbd
<a href="#">Employee Absenteeism Rate</a>	Q4 2010/11	12 ✓ days/FTE (annualized)	na	na		tbd




◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.






\* Trend for these measures cannot be determined until subsequent data is available.

✓Indicates data points that have been updated since the previous report.




£The Weekly ED Length of Stay (LOS) being [published](#) separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.












∞ Number of Home Care Clients – Q2 2010/11 data estimated for North Zone.

Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress




Performance Measure	Reporting Period	Actual Performance	Year to Date Target	Status	Trend	Annual Target
<a href="#">Overtime Hours to Paid Hours Ratio</a>	Q4 2010/11	2.17% ✓	na	na		tbd
◇ <a href="#">Number of Netcare Users</a>	Q4 2010/11	11,816 ✓	11,575			11,575
◇ <a href="#">On Budget: Year to Date</a>	2010/11	\$116M ✓	\$0		na	\$0
<b>Quality and Patient Safety</b>						
◇ <a href="#">Patient Satisfaction - Acute Care</a>	Q3 2010/11	82.2%	na		na*	80%
◇ Patient Satisfaction - Addictions and Mental Health (AHS)	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
<a href="#">Percentage of Patient Feedback as Commendations</a>	Q4 2010/11	9.12%	na	na	na	tbd
<a href="#">Percentage of Patient Concerns Escalated to Patient Concerns Officer</a>	Q4 2010/11	0.29%	na	na	na	tbd
Central Venous Catheter Bloodstream Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
◇ Hospital Acquired MRSA Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2011/12					
◇ Surgical Site Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13					
C-Difficile Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012					
Time to Resolve Patient Concerns	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012.					
Never (Adverse) Events	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Percent of patients diagnosed with diabetes with controlled blood sugar (haemoglobin A1c<8)	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Percent of patients diagnosed with hypertension with blood pressure control	Measurement proposed and being evaluated; no reporting strategy or start time available.					
Number of continuing care facility residents transferred to acute care for fall-related injury	Measurement proposed and being evaluated; no reporting strategy or start time available.					
◇ Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan. ✓ Indicates data points that have been updated since the previous report.						







# South Zone Performance Dashboard

Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target <sup>¥</sup>
<b>Staying Healthy / Improving Population Health</b>						
<a href="#">◇Life Expectancy</a>	2010	81.6	80.3	na	na	na
<a href="#">◇Potential Years of Life Lost (per 1,000 Population)</a>	2010	44.8	49.6	na	na	na
<b>Building a Primary Care Foundation</b>						
<a href="#">◇Seniors (65+) Influenza Immunization Rate</a>	2010/11	59%	59%	na		75%
<a href="#">◇Children (6 to 23 Months) Influenza Immunization Rate</a>	2010/11	27%	21%	na		75% <sup>^</sup>
<a href="#">Albertans Enrolled in a Primary Care Network (%)</a>	Apr 2011	72%	74%	na		75%
<a href="#">◇Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)</a>	Q4 2010/11	74	102	76		304 (annually)
<a href="#">◇Family Practice Sensitive Conditions (% of ED visits)</a>	Q4 2010/11	28.0%	30.2%	27%		27%
<a href="#">◇Children Receiving Community Mental Health Treatment within 30 Days (%)</a>	Q4 2010/11	79%	91%	82.8%		85%
<b>Improving Access, Reducing Wait Times</b>						
<a href="#">◇Hip Replacement Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	36.6	42.3	28		28
<a href="#">◇Knee Replacement Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	48.0	63.8	42		42
<a href="#">◇Cataract Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	46.1	41.1	36		36
<a href="#">◇Other Scheduled Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	26.3	23.3	tbd	na	tbd
<a href="#">◇Radiation Therapy Access (referral to 1<sup>st</sup> consult) (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	5.5	4.9	4		4
<a href="#">◇Radiation Therapy Access (ready to treat to first therapy) (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	3.7	1.6	4		4

<sup>¥</sup>Annual Targets as per Performance Agreements.  
 ◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.  
 † Interim target pending confirmation. Status based on interim target.  
 \* Trend for these measures cannot be determined until subsequent data is available.  
 ^ Target under review.

Status	
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	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target <sup>¥</sup>
<a href="#">◇Patients Discharged from ED or UCC within 4 hours (%) (Higher Volume EDs)</a> <sup>£</sup>	Q4 2010/11	65%	82%	70%		70%
<a href="#">◇Patients Discharged from ED or UCC within 4 hours (%) (All Sites)</a> <sup>£</sup>	Q4 2010/11	78%	88%	82%		82%
<a href="#">◇Patients Admitted from ED within 8 hours (%) (Higher Volume EDs)</a> <sup>£</sup>	Q4 2010/11	44%	88%	45%		45%
<a href="#">◇Patients Admitted from ED within 8 hours (%) (All Sites)</a> <sup>£</sup>	Q4 2010/11	55%	88%	55%		55%
<b>Choice and Quality for Seniors</b>						
<a href="#">◇People Waiting in Acute/Sub-acute Beds for Continuing Care Placement</a>	Q4 2010/11	471	22	25		25
<a href="#">◇People Waiting in Community for Continuing Care Placement</a>	Q4 2010/11	1,110	67	56		56
<a href="#">◇Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)</a>	Q4 2010/11	47	16	tbd	na	tbd
<a href="#">◇Number of Home Care Clients</a>	Q4 2010/11	56,041	5,587	tbd	na	tbd
<b>Enabling Our People / Enabling One Health System</b>						
<a href="#">◇Number of Netcare Users</a>	Q4 2010/11	11,816	na	na	na	na
<b>Quality and Patient Safety</b>						
<a href="#">◇Patient Satisfaction - Addictions and Mental Health (AHS)</a>	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
<a href="#">Percentage of Patient Feedback as Commendations</a>	Q4 2010/11	9.12%	7.01%	na	na	tbd
<a href="#">Percentage of Patient Concerns Escalated to Patient Concerns Officer</a>	Q4 2010/11	0.29%	0%	na	na	tbd




<sup>¥</sup>Annual Targets as per Performance Agreements.

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

\* Trend for these measures cannot be determined until subsequent data is available.

£The Weekly ED Length of Stay (LOS) being [published](#) separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.




∞ Number of Home Care Clients – Q2 2010/11 data estimated for North Zone.













Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target <sup>¶</sup>
Central Venous Catheter Bloodstream Infection Rate						
		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12				
◇Hospital Acquired MRSA Infection Rate						
		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2011/12				
◇Surgical Site Infection Rate						
		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13				
C-Difficile Infection Rate						
		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012				
Time to Resolve Patient Concerns						
		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012.				
Never (Adverse) Events						
		Measurement proposed and being evaluated; no reporting strategy or start time available.				
Percent of patients diagnosed with diabetes with controlled blood sugar (haemoglobin A1c<8)						
		Measurement proposed and being evaluated; no reporting strategy or start time available.				
Percent of patients diagnosed with hypertension with blood pressure control						
		Measurement proposed and being evaluated; no reporting strategy or start time available.				
Number of continuing care facility residents transferred to acute care for fall-related injury						
		Measurement proposed and being evaluated; no reporting strategy or start time available.				

<sup>¶</sup>Annual Targets as per Performance Agreements.  
◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

# Calgary Zone Performance Dashboard

Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target <sup>‡</sup>
<b>Staying Healthy / Improving Population Health</b>						
◇ <a href="#">Life Expectancy</a>	2010	81.6	82.9	na	na	na
◇ <a href="#">Potential Years of Life Lost (per 1,000 Population)</a>	2010	44.8	37	na	na	na
<b>Building a Primary Care Foundation</b>						
◇ <a href="#">Seniors (65+) Influenza Immunization Rate</a>	2010/11	59%	62%	na		75%
◇ <a href="#">Children (6 to 23 Months) Influenza Immunization Rate</a>	2010/11	27%	39%	na		75% <sup>†</sup>
<a href="#">Albertans Enrolled in a Primary Care Network (%)</a>	Apr 2011	72%	77%	na		75%
◇ <a href="#">Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)</a>	Q4 2010/11	74	56	76		304 (annually)
◇ <a href="#">Family Practice Sensitive Conditions (% of ED visits)</a>	Q4 2010/11	28.0%	22.1%	27.3%		27%
◇ <a href="#">Children Receiving Community Mental Health Treatment within 30 Days (%)</a>	Q4 2010/11	79%	80%	82.8%		85%
<b>Improving Access, Reducing Wait Times</b>						
◇ <a href="#">Urgent CABG Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	2.2	1.8	1.5		1.5
◇ <a href="#">Semi-urgent CABG Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	9.6	6.1	5.0		5.0
◇ <a href="#">Scheduled CABG Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	19.9	24.7	15.0		15.0
◇ <a href="#">Hip Replacement Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	36.6	29.8	28		28
◇ <a href="#">Knee Replacement Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	48.0	33.3	42		42
◇ <a href="#">Cataract Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	46.1	56.9	36		36
◇ <a href="#">Other Scheduled Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	26.3	27.7	tbd	na	tbd

<sup>‡</sup>Annual Targets as per Performance Agreements.




◇ Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.









† Interim target pending confirmation. Status based on interim target.

\* Trend for these measures cannot be determined until subsequent data is available.

^ Target under review.

**Status**

	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target <sup>¥</sup>
<a href="#">◇Radiation Therapy Access (referral to 1<sup>st</sup> consult) (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	5.5	6	4		4
<a href="#">◇Radiation Therapy Access (ready to treat to first therapy) (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	3.7	3.7	4		4
<a href="#">◇Patients Discharged from ED or UCC within 4 hours (%) (Higher Volume EDs) <sup>£</sup></a>	Q4 2010/11	65%	61%	70%		70%
<a href="#">◇Patients Discharged from ED or UCC within 4 hours (%) (All Sites) <sup>£</sup></a>	Q4 2010/11	78%	70%	82%		82%
<a href="#">◇Patients Admitted from ED within 8 hours (%) (Higher Volume EDs) <sup>£</sup></a>	Q4 2010/11	44%	42%	45%		45%
<a href="#">◇Patients Admitted from ED within 8 hours (%) (All Sites) <sup>£</sup></a>	Q4 2010/11	55%	43%	55%		55%
<b>Choice and Quality for Seniors</b>						
<a href="#">◇People Waiting in Acute/Sub-acute Beds for Continuing Care Placement</a>	Q4 2010/11	471	146	155		155
<a href="#">◇People Waiting in Community for Continuing Care Placement</a>	Q4 2010/11	1,110	504	437		437
<a href="#">◇Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)</a>	Q4 2010/11	47	47	tbd	na	tbd
<a href="#">◇Number of Home Care Clients</a>	Q4 2010/11	56,041	14,252	tbd	na	tbd
<b>Enabling Our People / Enabling One Health System</b>						
<a href="#">◇Number of Netcare Users</a>	Q4 2010/11	11,816	na	na	na	na
<b>Quality and Patient Safety</b>						
<a href="#">◇Patient Satisfaction - Addictions and Mental Health (AHS)</a>	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
<a href="#">Percentage of Patient Feedback as Commendations</a>	Q4 2010/11	9.12%	10.57%	na	na	tbd
<a href="#">Percentage of Patient Concerns Escalated to Patient Concerns Officer</a>	Q4 2010/11	0.29%	0.60%	na	na	tbd

<sup>¥</sup>Annual Targets as per Performance Agreements.

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

\* Trend for these measures cannot be determined until subsequent data is available.

<sup>£</sup>The Weekly ED Length of Stay (LOS) being [published](#) separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.




∞ Number of Home Care Clients – Q2 2010/11 data estimated for North Zone.










Status	
<span style="color: green;">■</span>	Performance is at or better than target, continue to monitor
<span style="color: yellow;">▲</span>	Performance is within acceptable range of target, monitor and take action as appropriate
<span style="color: red;">●</span>	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target <sup>‡</sup>
Central Venous Catheter Bloodstream Infection Rate		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12				
◇Hospital Acquired MRSA Infection Rate		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2011/12				
◇Surgical Site Infection Rate		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13				
C-Difficile Infection Rate		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012				
Time to Resolve Patient Concerns		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012.				
Never (Adverse) Events		Measurement proposed and being evaluated; no reporting strategy or start time available.				
Percent of patients diagnosed with diabetes with controlled blood sugar (haemoglobin A1c<8)		Measurement proposed and being evaluated; no reporting strategy or start time available.				
Percent of patients diagnosed with hypertension with blood pressure control		Measurement proposed and being evaluated; no reporting strategy or start time available.				
Number of continuing care facility residents transferred to acute care for fall-related injury		Measurement proposed and being evaluated; no reporting strategy or start time available.				
<sup>‡</sup> Annual Targets as per Performance Agreements. ◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.						



# Central Zone Performance Dashboard

Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target <sup>¥</sup>
<b>Staying Healthy / Improving Population Health</b>						
<a href="#">◇ Life Expectancy</a>	2010	81.6	80.7	na	na	na
<a href="#">◇ Potential Years of Life Lost (per 1,000 Population)</a>	2010	44.8	51.4	na	na	na
<b>Building a Primary Care Foundation</b>						
<a href="#">◇ Seniors (65+) Influenza Immunization Rate</a>	2010/11	59%	54%	na		75%
<a href="#">◇ Children (6 to 23 Months) Influenza Immunization Rate</a>	2010/11	27%	22%	na		75% <sup>‡</sup>
<a href="#">Albertans Enrolled in a Primary Care Network (%)</a>	Apr 2011	72%	66%	na		75%
<a href="#">◇ Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)</a>	Q4 2010/11	74	96	76		304 (annually)
<a href="#">◇ Family Practice Sensitive Conditions (% of ED visits)</a>	Q4 2010/11	28.0%	33.8%	27%		27%
<a href="#">◇ Children Receiving Community Mental Health Treatment within 30 Days (%)</a>	Q4 2010/11	79%	96%	82.8%		85%
<b>Improving Access, Reducing Wait Times</b>						
<a href="#">◇ Hip Replacement Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	36.6	27	28.0		28
<a href="#">◇ Knee Replacement Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	48.0	27.5	42.0		42
<a href="#">◇ Cataract Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	46.1	26.7	36.0		36
<a href="#">◇ Other Scheduled Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	26.3	25.1	tbd	na	tbd




<sup>¥</sup>Annual Targets as per Performance Agreement.







◇ Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

‡ Interim target pending confirmation. Status based on interim target.

\* Trend for these measures cannot be determined until subsequent data is available.

^ Target under review.

Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target <sup>¥</sup>
<a href="#">◇Patients Discharged from ED or UCC within 4 hours (%) (Higher Volume EDs) <sup>£</sup></a>	Q4 2010/11	65%	74%	70%		70%
<a href="#">◇Patients Discharged from ED or UCC within 4 hours (%) (All Sites) <sup>£</sup></a>	Q4 2010/11	78%	88%	82%		82%
<a href="#">◇Patients Admitted from ED within 8 hours (%) (Higher Volume EDs) <sup>£</sup></a>	Q4 2010/11	44%	54%	45%		45%
<a href="#">◇Patients Admitted from ED within 8 hours (%) (All Sites) <sup>£</sup></a>	Q4 2010/11	55%	76%	55%		55%
<b>Choice and Quality for Seniors</b>						
<a href="#">◇People Waiting in Acute/Sub-acute Beds for Continuing Care Placement</a>	Q4 2010/11	471	65	57		57
<a href="#">◇People Waiting in Community for Continuing Care Placement</a>	Q4 2010/11	1,110	128	128		128
<a href="#">◇Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)</a>	Q4 2010/11	47	37	tbd	na	tbd
<a href="#">◇Number of Home Care Clients</a>	Q4 2010/11	56,041	9,083*	tbd	na	tbd
<b>Enabling Our People / Enabling One Health System</b>						
<a href="#">◇Number of Netcare Users</a>	Q4 2010/11	11,816	na	na	na	na
<b>Quality and Patient Safety</b>						
<a href="#">◇Patient Satisfaction - Addictions and Mental Health (AHS)</a>	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
<a href="#">Percentage of Patient Feedback as Commendations</a>	Q4 2010/11	9.12%	3.59%	na	na	tbd
<a href="#">Percentage of Patient Concerns Escalated to Patient Concerns Officer</a>	Q4 2010/11	0.29%	0%	na	na	tbd

<sup>¥</sup>Annual Targets as per Performance Agreement.

<sup>◇</sup>Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

<sup>\*</sup>Trend for these measures cannot be determined until subsequent data is available.

<sup>£</sup>The Weekly ED Length of Stay (LOS) being [published](#) separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.

<sup>\*</sup> Q4 2010/11 estimated for Central Zone.




Status	
<span style="color: green;">■</span>	Performance is at or better than target, continue to monitor
<span style="color: yellow;">▲</span>	Performance is within acceptable range of target, monitor and take action as appropriate
<span style="color: red;">●</span>	Performance is outside acceptable range of target, take action and monitor progress













Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target <sup>‡</sup>
Central Venous Catheter Bloodstream Infection Rate		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12				
◇Hospital Acquired MRSA Infection Rate		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2011/12				
◇Surgical Site Infection Rate		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13				
C-Difficile Infection Rate		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012				
Time to Resolve Patient Concerns		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012.				
Never (Adverse) Events		Measurement proposed and being evaluated; no reporting strategy or start time available.				
Percent of patients diagnosed with diabetes with controlled blood sugar (haemoglobin A1c<8)		Measurement proposed and being evaluated; no reporting strategy or start time available.				
Percent of patients diagnosed with hypertension with blood pressure control		Measurement proposed and being evaluated; no reporting strategy or start time available.				
Number of continuing care facility residents transferred to acute care for fall-related injury		Measurement proposed and being evaluated; no reporting strategy or start time available.				

<sup>‡</sup>Annual Targets as per Performance Agreement.

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

# Edmonton Zone Performance Dashboard

Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target <sup>¥</sup>
<b>Staying Healthy / Improving Population Health</b>						
<a href="#">◇ Life Expectancy</a>	2010	81.6	81.8	na	na	na
<a href="#">◇ Potential Years of Life Lost (per 1,000 Population)</a>	2010	44.8	45.7	na	na	na
<b>Building a Primary Care Foundation</b>						
<a href="#">◇ Seniors (65+) Influenza Immunization Rate</a>	2010/11	59%	60%	na		75%
<a href="#">◇ Children (6 to 23 Months) Influenza Immunization Rate</a>	2010/11	27%	20%	na		75% <sup>^</sup>
<a href="#">Albertans Enrolled in a Primary Care Network (%)</a>	Apr 2011	72%	70%	na		75%
<a href="#">◇ Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)</a>	Q4 2010/11	74	60	76		304 (annually)
<a href="#">◇ Family Practice Sensitive Conditions (% of ED visits)</a>	Q4 2010/11	28.0%	16.9%	27.3%		27%
<a href="#">◇ Children Receiving Community Mental Health Treatment within 30 Days (%)</a>	Q4 2010/11	79%	45%	82.8%		85%
<b>Improving Access, Reducing Wait Times</b>						
<a href="#">◇ Urgent CABG Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	2.2	2.5	1.5		1.5
<a href="#">◇ Semi-urgent CABG Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	9.6	15.5	5.0		5.0
<a href="#">◇ Scheduled CABG Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	19.9	17.4	15.0		15.0
<a href="#">◇ Hip Replacement Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	36.6	49.8	28.0		28
<a href="#">◇ Knee Replacement Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	48.0	58.6	42.0		42
<a href="#">◇ Cataract Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	46.1	38	36.0		36
<a href="#">◇ Other Scheduled Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	26.3	26.1	tbd	na	tbd




<sup>¥</sup>Annual Targets as per Performance Agreements.









◇ Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

‡ Interim target pending confirmation. Status based on interim target.

\* Trend for these measures cannot be determined until subsequent data is available.

<sup>^</sup> Target under review.

Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target <sup>¥</sup>
<a href="#">◇Radiation Therapy Access (referral to 1<sup>st</sup> consult) (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	5.5	5.3	4.0		4
<a href="#">◇Radiation Therapy Access (ready to treat to first therapy) (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	3.7	3.9	4.0		4
<a href="#">◇Patients Discharged from ED or UCC within 4 hours (%) (Higher Volume EDs) <sup>£</sup></a>	Q4 2010/11	65%	57%	70%		70%
<a href="#">◇Patients Discharged from ED or UCC within 4 hours (%) (All Sites) <sup>£</sup></a>	Q4 2010/11	78%	64%	82%		82%
<a href="#">◇Patients Admitted from ED within 8 hours (%) (Higher Volume EDs) <sup>£</sup></a>	Q4 2010/11	44%	30%	45%		45%
<a href="#">◇Patients Admitted from ED within 8 hours (%) (All Sites) <sup>£</sup></a>	Q4 2010/11	55%	30%	55%		55%
<b>Choice and Quality for Seniors</b>						
<a href="#">◇People Waiting in Acute/Sub-acute Beds for Continuing Care Placement</a>	Q4 2010/11	471	151	129		129
<a href="#">◇People Waiting in Community for Continuing Care Placement</a>	Q4 2010/11	1,110	310	254		254
<a href="#">◇Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)</a>	Q4 2010/11	47	45	tbd	na	tbd
<a href="#">◇Number of Home Care Clients</a>	Q4 2010/11	56,041	20,205	tbd	na	tbd
<b>Enabling Our People / Enabling One Health System</b>						
<a href="#">◇Number of Netcare Users</a>	Q4 2010/11	11,816	na	na	na	na
<b>Quality and Patient Safety</b>						
<a href="#">◇Patient Satisfaction - Addictions and Mental Health (AHS)</a>	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
<a href="#">Percentage of Patient Feedback as Commendations</a>	Q4 2010/11	9.12%	9.66%	na	na	tbd
<a href="#">Percentage of Patient Concerns Escalated to Patient Concerns Officer</a>	Q4 2010/11	0.29%	0.12%	na	na	tbd




<sup>¥</sup>Annual Targets as per Performance Agreements.

◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

\* Trend for these measures cannot be determined until subsequent data is available.




£The Weekly ED Length of Stay (LOS) being [published](#) separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.










∞ Number of Home Care Clients – Q2 2010/11 data estimated for North Zone.

Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target <sup>‡</sup>
Central Venous Catheter Bloodstream Infection Rate						Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12
◇Hospital Acquired MRSA Infection Rate						Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2011/12
◇Surgical Site Infection Rate						Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13
C-Difficile Infection Rate						Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012
Time to Resolve Patient Concerns						Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012.
Never (Adverse) Events						Measurement proposed and being evaluated; no reporting strategy or start time available.
Percent of patients diagnosed with diabetes with controlled blood sugar (haemoglobin A1c<8)						Measurement proposed and being evaluated; no reporting strategy or start time available.
Percent of patients diagnosed with hypertension with blood pressure control						Measurement proposed and being evaluated; no reporting strategy or start time available.
Number of continuing care facility residents transferred to acute care for fall-related injury						Measurement proposed and being evaluated; no reporting strategy or start time available.
<sup>‡</sup> Annual Targets as per Performance Agreements. ◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan. ✓Indicates data points that have been updated since the previous report.						

# North Zone Performance Dashboard

Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target <sup>‡</sup>
<b>Staying Healthy / Improving Population Health</b>						
<a href="#">◇ Life Expectancy</a>	2010	81.6	79.8	na	na	na
<a href="#">◇ Potential Years of Life Lost (per 1,000 Population)</a>	2010	44.8	56.8	na	na	na
<b>Building a Primary Care Foundation</b>						
<a href="#">◇ Seniors (65+) Influenza Immunization Rate</a>	2010/11	59%	49%	na		75%
<a href="#">◇ Children (6 to 23 Months) Influenza Immunization Rate</a>	2010/11	27%	18%	na		75% <sup>^</sup>
<a href="#">Albertans Enrolled in a Primary Care Network (%)</a>	Apr 2011	72%	63%	na		75%
<a href="#">◇ Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)</a>	Q4 2010/11	74	125	76		304 (annually)
<a href="#">◇ Family Practice Sensitive Conditions (% of ED visits)</a>	Q4 2010/11	28.0%	38.8%	27.3%		27%
<a href="#">◇ Children Receiving Community Mental Health Treatment within 30 Days (%)</a>	Q4 2010/11	79%	79%	82.8%		85%
<b>Improving Access, Reducing Wait Times</b>						
<a href="#">◇ Hip Replacement Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	36.6	39.4	28.0		28
<a href="#">◇ Knee Replacement Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	48.0	43.1	42.0		42
<a href="#">◇ Cataract Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	46.1	47.1	36.0		36
<a href="#">◇ Other Scheduled Surgery Wait Time (90<sup>th</sup> percentile in weeks)</a>	Q4 2010/11	26.3	26.5	tbd	na	tbd




<sup>‡</sup>Annual Targets as per Performance Agreements.







◇ Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

‡ Interim target pending confirmation. Status based on interim target.

\* Trend for these measures cannot be determined until subsequent data is available.

<sup>^</sup> Target under review.

Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target*
<a href="#">◇Patients Discharged from ED or UCC within 4 hours (%) (Higher Volume EDs) £</a>	Q4 2010/11	65%	81%	70%		70%
<a href="#">◇Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £</a>	Q4 2010/11	78%	84%	82%		82%
<a href="#">◇Patients Admitted from ED within 8 hours (%) (Higher Volume EDs) £</a>	Q4 2010/11	44%	70%	45%		45%
<a href="#">◇Patients Admitted from ED within 8 hours (%) (All Sites) £</a>	Q4 2010/11	55%	84%	55%		55%
<b>Choice and Quality for Seniors</b>						
<a href="#">◇People Waiting in Acute/Sub-acute Beds for Continuing Care Placement</a>	Q4 2010/11	471	87	101		101
<a href="#">◇People Waiting in Community for Continuing Care Placement</a>	Q4 2010/11	1,110	101	100		100
<a href="#">◇Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)</a>	Q4 2010/11	47	119	tbd	na	tbd
<a href="#">◇Number of Home Care Clients</a>	Q4 2010/11	56,041	6,914	tbd	na	tbd
<b>Enabling Our People / Enabling One Health System</b>						
<a href="#">◇Number of Netcare Users</a>	Q4 2010/11	11,816	na	na	na	na
<b>Quality and Patient Safety</b>						
<a href="#">◇Patient Satisfaction - Addictions and Mental Health (AHS)</a>	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
<a href="#">Percentage of Patient Feedback as Commendations</a>	Q4 2010/11	9.12%	2.05%	na	na	tbd
<a href="#">Percentage of Patient Concerns Escalated to Patient Concerns Officer</a>	Q4 2010/11	0.29%	0%	na	na	tbd

¥Annual Targets as per Performance Agreements.




◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.

\* Trend for these measures cannot be determined until subsequent data is available.

£The Weekly ED Length of Stay (LOS) being [published](#) separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.

∞ Number of Home Care Clients – Q2 2010/11 data estimated for North Zone.



Status	
	Performance is at or better than target, continue to monitor
	Performance is within acceptable range of target, monitor and take action as appropriate
	Performance is outside acceptable range of target, take action and monitor progress

Performance Measure	Reporting Period	AHS Actual Performance	Zone Actual Performance	Zone Year to Date Target	Zone Status	Zone 2010/11 Target*
Central Venous Catheter Bloodstream Infection Rate		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12				
◇Hospital Acquired MRSA Infection Rate		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2011/12				
◇Surgical Site Infection Rate		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13				
C-Difficile Infection Rate		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012				
Time to Resolve Patient Concerns		Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/2012.				
Never (Adverse) Events		Measurement proposed and being evaluated; no reporting strategy or start time available.				
Percent of patients diagnosed with diabetes with controlled blood sugar (haemoglobin A1c<8)		Measurement proposed and being evaluated; no reporting strategy or start time available.				
Percent of patients diagnosed with hypertension with blood pressure control		Measurement proposed and being evaluated; no reporting strategy or start time available.				
Number of continuing care facility residents transferred to acute care for fall-related injury		Measurement proposed and being evaluated; no reporting strategy or start time available.				
†Annual Targets as per Performance Agreements. ◇Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.						

## Treatment Level Activity Report

Activity Measure	2008/09 Fiscal Year	2009/10 Q1	2009/10 Q2	2009/10 Q3	2009/10 Q4	2009/10 Fiscal Year	2010/11 Q1	2010/11 Q2	2010/11 Q3	2010/11 Q4	2010/11 Fiscal Year
Number of Hospital Discharges <sup>1</sup> ( <a href="#">by Site</a> )	357,392	92,920	89,642	89,683	90,069	362,314	92,634	89,129	89,957	92,301	364,021
Average Hospital Length of Stay (Days) <sup>1,2</sup> ( <a href="#">by Site</a> )	6.9	6.9	6.8	7.1	6.9	6.9	6.8	6.9	7.2	7.1	7.0
Per Cent of Alternate Level of Care (ALC) <sup>1,3</sup> Days	8.4%	8.2%	8.9%	10.9%	9.4%	9.4%	8.2%	9.9%	10.0%	8.0%	9.0%
Number of Hospital Births <sup>1</sup>	50,227	13,085	13,440	12,230	11,983	50,738	12,882	12,985	11,952	11,937	49,756
Number of Emergency Department Visits <sup>4</sup> ( <a href="#">by Site</a> )	1,921,151	501,685	494,297	482,639	474,182	1,952,803	491,908	491,130	472,001	486,759	1,941,798
Number of Urgent Care Service (UCS) Visits <sup>5</sup>	103,528	29,730	30,075	29,561	36,550	125,916	44,198	44,215	42,364	46,381	177,158
Number of Health Link Calls	864,240	205,649	190,883	433,586	200,074	1,030,192	175,319	167,602	203,281	212,769	758,971
Number of Total Primary Hip Replacements <sup>6</sup>	2,754	775	640	806	910	3,131	833	667	795	861	3,156
Number of Total Primary Knee Replacements <sup>6</sup>	3,811	1,079	871	1,060	1,118	4,128	1,225	897	1,132	1,141	4,395
Number of Cataract Surgeries	27,682	7,320	6,024	6,650	8,607	28,601	7,555	7,214	8,019	10,926	33,714
Number of MRI Exams <sup>7</sup>	157,724	41,302	40,432	38,960	45,254	165,948	45,008	43,369	40,389	48,656	177,422
Number of CT Exams <sup>8</sup>	418,373	91,584	88,972	84,801	85,424	350,781	88,727	87,485	77,670	79,281	333,163
Number of Lab Tests <sup>9</sup>	56,506,010	15,143,422	14,401,121	14,382,996	15,207,661	59,135,200	15,833,877	14,942,683	15,263,436	15,220,262	61,260,258

Notes: \* 2010/11 figures are preliminary, pending data verification.

N/A – These measures rely on abstracted data which is completed and available for reporting approximately 2-3 months post discharge.

1. The above figures exclude Grimshaw/Berwyn and District Community Health Centre as inpatient data abstracts are not submitted.

2. Average Hospital Length of Stay (Days) includes acute, subacute and Alternate Level of Care (ALC) days.

3. Alternate Level of Care (ALC) Days is the per cent of total hospital days. Use with caution as classification of ALC days is not standardized throughout the province.

4. Number of Emergency Department Visits excludes the following facilities: Breton Health Centre, Coaldale Health Centre, Rainbow Lake Health Centre, St. Mary's Health Care Centre (Trochu).

5. Number of Urgent Care Service (UCS) Visits: Figures are based on the certification effective dates below.

Airdrie Regional Health Centre 18-Dec-2009

Cochrane Community Health Centre 15-Feb-2011

Health First Strathcona 01-May-2008

Okotoks Health and Wellness Centre 17-Mar-2010

Sheldon M Chumir Centre 01-Apr-2008

South Calgary Health Centre 01-May-2008

6. Number of Total Primary Hip Replacements and Number of Total Primary Knee Replacements data source is inpatient data abstracts reported as of discharge date.

7. Number of MRI Exams: Figures include exams performed by Covenant Health DI sites. 2009/10 figures include outsourced exams.

8. Number of CT Exams: Figures include exams performed by Covenant Health DI sites. CT exam count converted to new (lower) exam values effective April 1, 2009 for all regions except former Capital Health; former Capital Health converted effective Oct 1, 2010.

9. Lab Tests: Volumes are not comparable to numbers reported in previous periods (prior to April 2009). Figures include tests performed in non-AHS facilities.

Data updated annually.  
Most current data is 2010.  
Next data update expected for Q4 2011/12.

## Life Expectancy

### WHAT IS BEING MEASURED?

Life expectancy is the number of years from birth a person would be expected to live based on mortality statistics.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

Life expectancy at birth is an indicator of the health of a population, measuring the number of years lived rather than the quality of life.

### WHAT IS THE TARGET?

Alberta Health Services (AHS) targets an increase in life expectancy in a manner consistent with the Canadian average, with the goal of being above the national average.

Over the next five years, there is an expectation that disparities in life expectancy throughout various AHS zones in the province will decrease, and that there will be an increase in life expectancy among First Nations populations.

### PERFORMANCE STATUS

Performance improvement observed since last reported period.  
Baseline 2008: 80.59 years

**TARGET:**  
Not Specific

**2010 ACTUAL:** 81.6 years

### HOW ARE WE DOING?

There is significant disparity in life expectancy between urban and rural zones. Life expectancy in the North is about two years less than for the average Albertan. As well, a child born in the Edmonton Zone can expect to live a year less than a child born in Calgary. Differences in health status and determinants of health are also evident between rural and urban areas.

### WHAT ACTIONS ARE WE TAKING?

Recent health promotion initiatives that have been piloted – and will be expanded in the future – include programs for community and family-based obesity prevention and weight management, as well as quitting smoking (e.g. promotion of an “Alberta quits” helpline and website, tobacco cessation training delivered to over 1,200 health professionals, and establishment of group cessation programs in communities). More broadly, AHS is working to improve population health through integrating health promotion and disease and injury prevention programs with other health care delivery services, and better coordination between health and other government and municipal sectors.

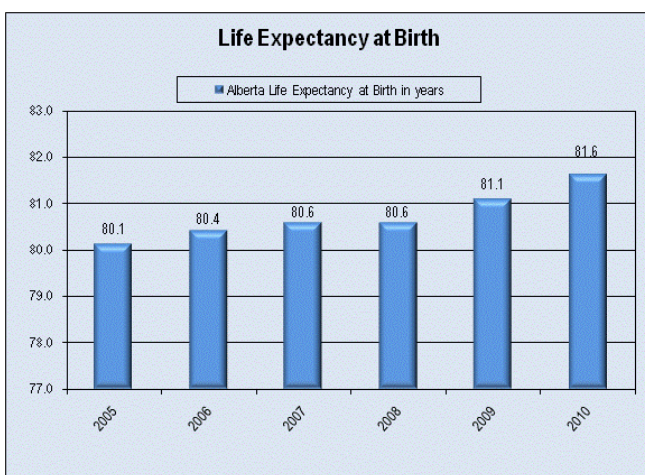
### WHAT ELSE DO WE KNOW?

The leading causes of death are cancer, ischemic heart diseases, cerebrovascular diseases (stroke), chronic lower respiratory diseases and accidents. Almost 60 per cent of the deaths in Alberta are due to cancer and circulatory diseases. These causes of death need to be carefully considered to determine opportunities to improve life expectancy.

Information is available by [zone](#) and [First Nations status](#).

### HOW DO WE COMPARE?

Using a similar definition, Alberta ranked fourth among the 10 provinces for life expectancy. Alberta = 80.5, Best Performing Province = 81.2 (British Columbia), Canada = 80.7 (Statistics Canada, 2005/2007)



Source: Alberta Health & Wellness

Data updated annually.  
Most current data is 2010.  
Next data update expected for Q4 2011/12.

### WHAT IS BEING MEASURED?

Potential years of life lost (PYLL) is the number of years of life “lost” per 1,000 population when a person dies from any cause before age 75. For example, if a person died at age 25, then 50 years of life has been lost. The total potential years of life lost is divided by the total population under age 75.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

PYLL is an indicator of premature mortality that gives greater weight to causes of death that occur at a younger age than to those at older ages. It emphasizes the loss of life at an early age and the causes of early deaths such as cancer, injury and cardiovascular disease. For example, the death of a person 40 years old contributes one death and 35 PYLL; whereas the death of a 70-year old contributes one death but only five years to PYLL.

### WHAT IS THE TARGET?

There is an expectation that PYLL will be monitored, and that improvements will be seen in PYLL over the next five years.

### PERFORMANCE STATUS

Performance improvement observed since last reported period.  
Baseline 2009: 47.3 years

**TARGET:**  
Not Specific

**2010 ACTUAL:**  
44.8 years

### HOW ARE WE DOING?

In 2010, there was an improvement in PYLL with a drop from 47.3 years per 1,000 population in 2009 to 44.8 years per 1,000 population in 2010.

### WHAT ACTIONS ARE WE TAKING?

Recent health promotion initiatives that have been piloted – and will be expanded in the future – include programs for community and family-based obesity prevention and weight management, as well as quitting smoking (e.g. promotion of an “Alberta quits” helpline and website, tobacco cessation training delivered to over 1,200 health professionals, and establishment of group cessation programs in communities). More broadly, AHS is working to improve population health through integrating health promotion and disease and injury prevention programs with other health care delivery services, and better coordination between health and other government and municipal sectors.

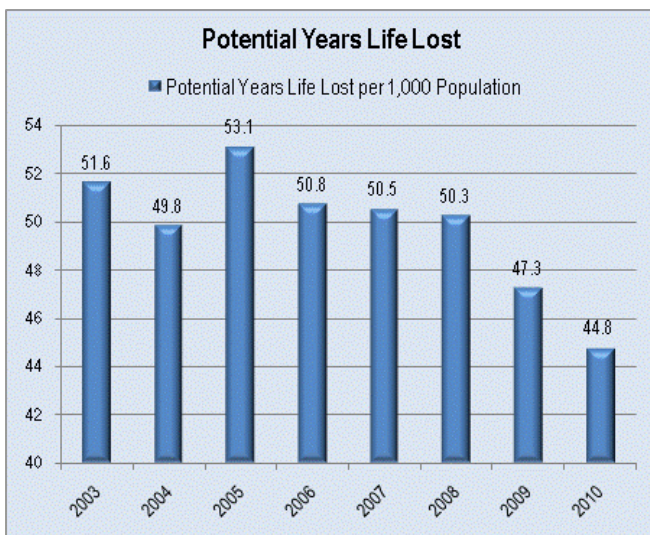
### WHAT ELSE DO WE KNOW?

PYLL rates for Alberta are calculated by cause of death as follows: all causes, cancer, colorectal cancer, lung cancer, diseases of the circulatory system, ischaemic heart diseases, cerebrovascular diseases (stroke), diseases of the respiratory system, external causes (injury), unintentional injury, land transport and intentional self-harm (suicide).

Information is available by [zone](#) and [sex](#).

### HOW DO WE COMPARE?

Using a similar definition, Alberta ranked third among the 10 provinces for PYLL. Alberta = 49.9, Best Performing Province = 44.4 (Ontario), Canada = 49.0 (Statistics Canada, 2005/2007)



Source: Alberta Health & Wellness



Data updated annually.  
Most current data is 2010/11.  
Next data update expected for Q4 2011/12.

## Seniors (65+) Influenza Immunization Rate

### WHAT IS BEING MEASURED?

The percentage of seniors aged 65 and older who have received the seasonal influenza vaccine during the previous influenza season (Oct 2010 through Apr 2011).

Data on immunizations comes from AHS Zones and the First Nations and Inuit Health (FNIH), Health Canada, Alberta Region. Seniors in Lloydminster primarily receive immunizations from Saskatchewan Health and are likely missing from the numerator count; as such the Lloydminster population has been removed from the denominator.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

A high rate of seasonal influenza immunization among seniors will reduce the incidence of complications and death associated with influenza disease in this population.

Providing influenza immunization to eligible Albertans is a major activity of the public health system. A high rate of coverage will reduce the impact of disease on the healthcare system.

### WHAT IS THE TARGET?

The Alberta Health and Wellness (AHW) target is for 75 per cent of seniors 65 years of age and older to have received one dose of seasonal influenza vaccine.

### PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.

Baseline 2008/09: 60%

2010/11 TARGET:  
75%

2010/11 ACTUAL:  
59%

### HOW ARE WE DOING?

The 2010/11 seasonal influenza immunization rate for seniors aged 65 and older is 59 per cent. The rate is below the target of 75 per cent.

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A number of steps were taken to enhance immunization coverage for the seniors population during the 2010/11 influenza season, including the engagement of a range of community partners who offered the vaccine (pharmacies and physician offices), the establishment of targeted clinics for seniors, as well as the administration of vaccine for home-bound seniors. In addition, the first in a series of planning meetings for the 2011/12 season was held in February 2011 with representatives from AHS and Alberta Health and Wellness, along with physicians, pharmacists and other health care providers to discuss strategies to optimize immunization coverage next season.

Subsequent actions planned: Development of the 2011/12 seasonal influenza immunization campaign will continue over the coming months under Steering Committee leadership.

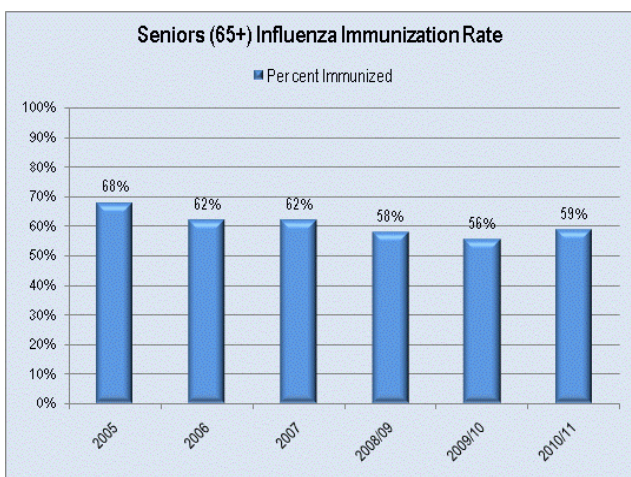
### WHAT ELSE DO WE KNOW?

A high rate of coverage will reduce the impact of disease on the healthcare system during influenza season, including physician and emergency department visits, and hospitalizations. The lower immunization rate for 2009/10 may be due to seniors choosing the pandemic H1N1 vaccine component because it was known to be the circulating strain.

Information is available by [zone](#).

### HOW DO WE COMPARE?

Using a similar definition, Alberta ranked fifth among the 10 provinces for self-reported influenza immunization. Alberta = 63.9 per cent, Best Performing Province = 72.8 per cent (Nova Scotia), Canada = 66.5 per cent (Statistics Canada, 2009)



Source: Alberta Health & Wellness; figures are preliminary calculations from AHS.

Data updated annually.  
Most current data is 2010/11.  
Next data update expected for Q4 2011/12.

## Children (6 to 23 Months) Influenza Immunization Rate

### WHAT IS BEING MEASURED?

The percentage of children between the ages of six and 23 months who have received the recommended doses of seasonal influenza vaccine is measured.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

A high rate of seasonal influenza immunization among children reduces the incidence of complications and death associated with influenza disease and reduces the spread of disease to older age groups during the influenza season.


Providing influenza immunizations to eligible Albertans is a major activity of the public health system. A high rate of coverage will reduce the impact of disease on the healthcare system.

### WHAT IS THE TARGET?

The Alberta Health and Wellness (AHW) target is for 75 per cent of children aged six to 23 months to have received the recommended doses of seasonal influenza vaccine.

### HOW ARE WE DOING?

The influenza immunization rate for children between the ages of 6-23 months was 27 per cent for 2010/11, well below target.

 <b>PERFORMANCE STATUS</b> Performance is outside acceptable range, take action and monitor progress.	<b>2010/11 TARGET:</b> 75%
	<b>2010/11 ACTUAL:</b> 27%

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A number of steps were taken to enhance child immunization coverage during the 2010/11 influenza season, including the administration of vaccine when children presented for routine immunizations in child health clinics. In addition, the first in a series of planning meetings for the 2011/12 season was held in February 2011 with representatives from AHS and AHW, along with physicians, pharmacists and other health care providers to discuss strategies to optimize immunization coverage next season.

Subsequent actions planned: Development of the 2011/12 seasonal influenza immunization campaign will continue over the coming months under Steering Committee leadership.

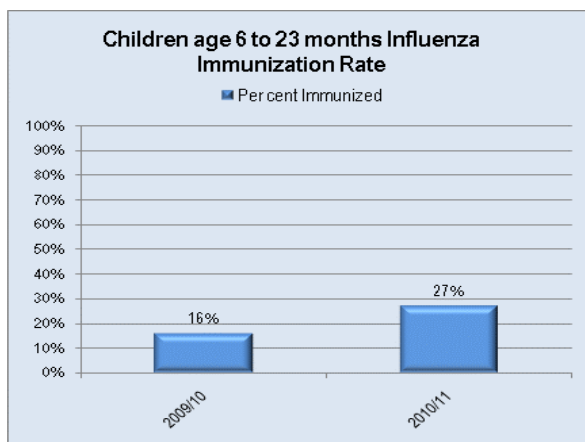
### WHAT ELSE DO WE KNOW?

Children receiving influenza vaccine for the first time require two doses. Poor uptake for the needed second dose is common. The 2009/10 rate is believed to be lower than previous years as many parents chose to have their children receive only the pandemic H1N1 vaccine. Methods of data collection have been inconsistent in previous years and rates are not directly comparable. AHS is working with AHW to standardize data collection and reporting of this indicator.

Information is available by [zone](#).

### HOW DO WE COMPARE?

Limited comparable data is available.



Source: Alberta Health & Wellness and Alberta Health Services; figures are preliminary calculations from AHS.

Notes for 2009/10: Immunization data is representative of four Alberta Health Services (AHS) Zones (South, Calgary, Central and Edmonton). Data is not complete due to issues with the Immunization coverage rate reporting system (MediTech) in parts of the province. Data is also not available from First Nations and Inuit Health (FNIH), Health Canada, Alberta Region. Methodology was corrected 2009/10 forward to reflect children requiring two doses for immunity.

Data updated twice yearly.  
Most current data is April 2011.  
Next data update expected for Q3 2011/12.

## Albertans Enrolled in a Primary Care Network (%)

### WHAT IS BEING MEASURED?

The percentage of Albertans enrolled in a Primary Care Network (PCN) measures the proportion of Albertans who are attached to a physician working within a PCN.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

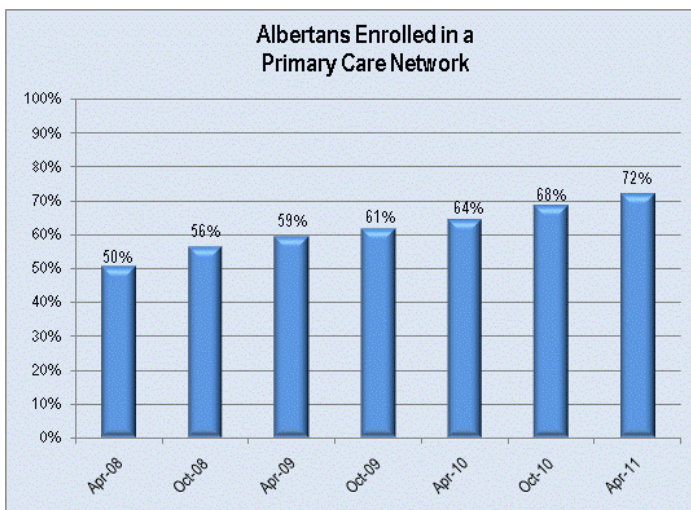
A PCN is an arrangement between a group of family physicians and Alberta Health Services (AHS) to provide and coordinate a comprehensive set of primary health care services to patients. Primary Care is the care individuals receive at the first point of contact with the healthcare system. Patients receive care for their everyday health needs, including prevention, diagnosis and treatment of health conditions, as well as health promotion.

### WHAT IS THE TARGET?

AHS has established a target of 75 per cent of Albertans enrolled in a PCN for 2010/11.

### HOW ARE WE DOING?

The percentage of Albertans enrolled in a PCN is 72 per cent as of April 2011, which is below the 2010/11 target of 75 per cent.



Source: Alberta Health & Wellness; Apr 2010 figure is a preliminary calculation from AHS.



### PERFORMANCE STATUS

Performance is within acceptable range, monitor and take action as appropriate.  
Baseline Apr 2009: 59%

**2010/11 TARGET:**  
75%

**ACTUAL: 72%**  
April 2011

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: AHS Zones are actively recruiting new physicians to form PCNs or to join existing PCNs. New PCNs have also been established recently in Grande Prairie (Oct/2010), Lloydminster (Jan/2011) and Wainwright (Apr/2011), with five more prospective PCNs currently at the Letter of Intent stage. In addition, work is ongoing to increase enrolment of specific populations (e.g. palliative patients and new mothers with babies).

Subsequent actions planned: AHS and its partners will continue to create new PCNs and also recruit new and existing physicians to PCNs currently in operation. Work is also ongoing to recruit patients not yet attached to a physician. Lastly, all partners will continue to work collaboratively to improve efficiency, patient and provider satisfaction, and increased PCN participation within the framework of a primary care model that supports physicians, teams and best practice.

### WHAT ELSE DO WE KNOW?

Alberta Health Services is working to apply and advance a patient-focused model of primary health care that offers care in the community, and provides a team-based health care provider approach.

Information is available by [zone](#).

Reference: Primary Care Initiative Program Office

### HOW DO WE COMPARE?

Alberta ranked ninth among the 10 provinces for self-reports of having a regular medical doctor. Alberta = 80.6 per cent, Best Performing Province = 92.8 per cent (Nova Scotia), Canada = 84.9 per cent (Statistics Canada, 2009). Alberta ranked fifth among the 10 provinces in terms of number of family physicians per 100,000 population. Alberta = 112, Best Performing Province = 119 (Nova Scotia), Canada = 101 (Canadian Institute for Health Information, 2008)



Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

## Admissions for Ambulatory Care Sensitive Conditions

### WHAT IS BEING MEASURED?

Admissions for Ambulatory Care Sensitive Conditions (ACSCs) measures the acute care hospitalization rate for Albertans younger than age 75 years, per 100,000 population, presenting with one or more of the following seven chronic conditions: angina, asthma, chronic obstructive pulmonary disease (COPD), diabetes, epilepsy, heart failure and pulmonary edema, and hypertension.

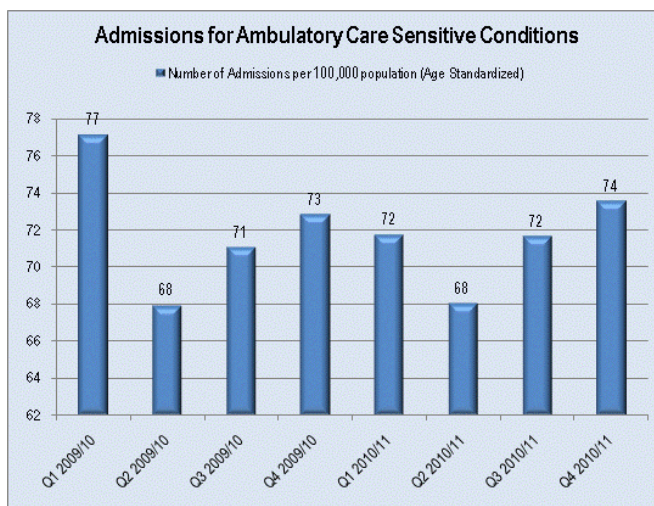
Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?


Hospitalization of a person with an ACSC is considered a measure of access to primary health care services. A disproportionately high ACSC rate is presumed to reflect problems accessing appropriate care in the community. It is assumed that appropriate care could prevent the onset of this type of illness or condition, control an acute illness or condition, or manage a chronic disease or condition, preventing an avoidable admission to an acute care facility.

### WHAT IS THE TARGET?

An annual target of 304 (76 per quarter) ACSC admissions per 100,000 population under age 75 years, has been established for 2010/11. As large variations exist in the rate of hospitalization for these conditions across Canada, the "right" target is not yet known ([CIHI Health Indicators 2009](#)).



Source: AHS Discharge Abstract Database

 <b>PERFORMANCE STATUS</b> Performance is at or better than target, continue to monitor. Baseline 2007-09: 309 annually	<b>2010/11 TARGET: 304</b> admissions per 100,000 <b>Q4 TARGET: 76</b>
	<b>Q4 ACTUAL: 74</b> admissions per 100,000

### HOW ARE WE DOING?

While there has been a slight increase in overall ACSC admissions in the most recent quarter, performance remains better than target. The annual ACSC rate for the 2010/11 fiscal year is 281 per 100,000 of population under age 75 years.

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A business case has been submitted for additional staffing support within the South, Central and North Zones (where targets are not being met) to enhance self-management supports and patient participation in community based programming. As well, a provincial Diabetes Working Group was established in early 2011 to identify care gaps, prioritize opportunities and establish short-term action plans for improvement.

Subsequent actions planned: AHS and Patient Care Networks (PCNs) continue to work on decreasing hospital admissions by focusing on chronic disease management and prevention, maximizing the use of inter-professional teams (e.g. social workers and mental health providers), and also ensuring that hospital flow and transitions with the community are appropriate. Also, a provincial case management model will be developed for patients with chronic disease (initial focus on diabetes and obesity).

### WHAT ELSE DO WE KNOW?

Participation from PCNs in provincial quality improvement programs is expected to reduce wait times and increase access to primary care.

Information is available by [zone](#).

### HOW DO WE COMPARE?

Using a similar definition, Alberta ranked third among the 10 provinces for lowest admissions for ambulatory care sensitive conditions. Alberta = 308, Best Performing Province = 279 (British Columbia), Canada = 320 (CIHI 2008/09)



Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

# Performance Measure Update

## Family Practice Sensitive Conditions

### WHAT IS BEING MEASURED?

Family practice sensitive conditions report the per cent of emergency department (ED) and urgent care visits for health conditions that may be appropriately managed at a family physician's office. Examples of included conditions are: conjunctivitis and migraine. See the detailed indicator definition (currently pending approval) for full list of included conditions.

Detailed indicator [definition](#) is available.


Further information on this indicator is available from the Health Quality Council of Alberta (HCQA) [Measuring & Monitoring for Success](#) report.

### WHY IS THIS IMPORTANT?

Treatment when appropriate at family physician offices allows for proper follow up and better patient outcomes. The expectation is that more effective provision of primary care services would result in improvement in this measure.

### WHAT IS THE TARGET?

Alberta Health Services has established the target for family practice sensitive conditions at 27 per cent of ED or urgent care visits.

 <b>PERFORMANCE STATUS</b> Performance is outside acceptable range, take action and monitor progress. Baseline 2008/09: 28%	<b>2010/11 TARGET: 27%</b> of ED/UCC visits <b>Q4 TARGET: 27%</b>
	<b>Q4 ACTUAL: 28.0%</b> of ED/UCC visits

### HOW ARE WE DOING?

The percentage of family practice sensitive conditions is slightly above the AHS target of 27 per cent of ED or urgent care visits for the most recent quarter.

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Work continues on a primary care model that redirects patients from Emergency to primary care, including local level plans to enhance primary care within identified communities. A pilot "train the trainer" project on system-wide case management skills has also been initiated with Home Care staff to evaluate the impact of a case management approach on: (1) improving access to the health system; (2) eliminating gaps in service when transitioning between healthcare providers; and (3) coordinating services across health sectors. In addition, a radio campaign promoting the services of HealthLink Alberta took place in the Fall and Winter months.

Subsequent actions planned: Developments on the system-wide case management model will continue over the long-term, as will collaborations with Patient Care Networks to balance after-hours service delivery with physician recruitment and retention. In addition, a provincial public education campaign on Urgent Care services will be developed.

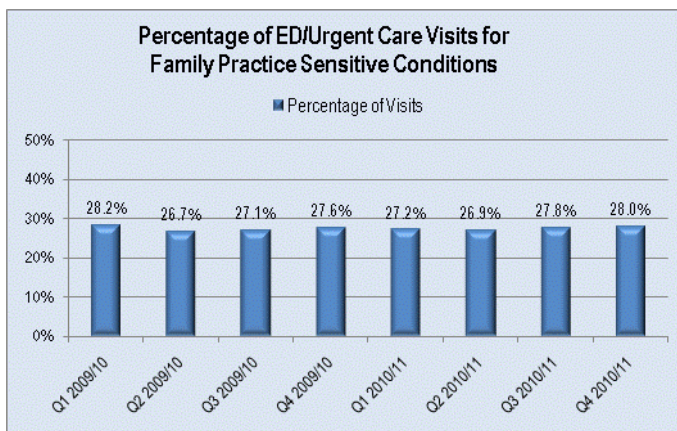
### WHAT ELSE DO WE KNOW?

This indicator may be affected by access and continuity of primary care. See indicator: Albertans Enrolled in a Primary Care Network. Also see: Admissions for Ambulatory Care Sensitive Conditions.

Information is available by [zone](#).

### HOW DO WE COMPARE?

National benchmark comparisons are not available.



Source: Provincial Ambulatory (ED/Urgent Care) Abstract Data

## Health Link Alberta Service Level (% answered within 2 minutes)

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

Health Link Alberta Service Level measures the percentage of calls to Health Link Alberta that are answered within two minutes.

### WHY IS THIS IMPORTANT?

One of Health Link Alberta's goals is to help people make informed decisions about their health situation and about the care that is appropriate for their symptoms. Slow response times would discourage some callers.

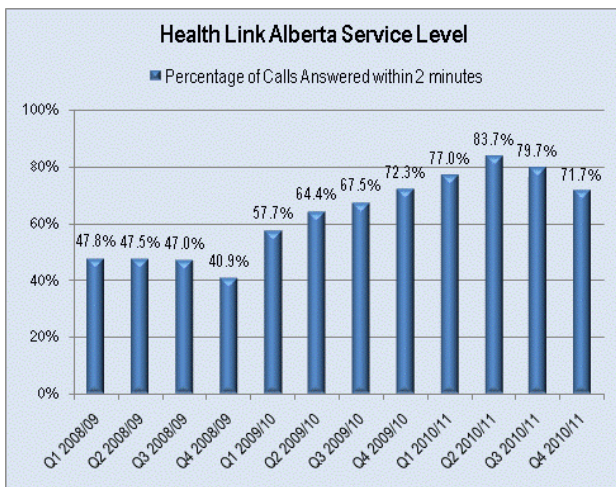
Detailed indicator [definition](#) is available.

### WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a 2010/11 annual target of 80 per cent of calls to be answered within two minutes.

### HOW ARE WE DOING?

The percentage of Health Link Alberta calls answered within two minutes was 71.7 per cent for Q4 2010/11.



Source: Health Link Alberta, Nortel Contact Centre Management 6.0



### PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.  
Baseline 2009/10: 65%

2010/11 TARGET: 80%  
Q4 TARGET: 80%

Q4 ACTUAL: 71.7%

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A review of the volume and types of calls placed to Health Link Alberta was completed. As a result, a new schedule for Nursing and Information & Referral has been implemented to better match call presentation patterns. A radio campaign promoting the services of Health Link Alberta took place in the Fall and Winter months. As well, e-mail distributions to new parents were initiated with over 14,000 new subscribers signed up year to date.

Subsequent actions planned: A plan for technology upgrades continues its development to assist with improving the Health Link Alberta wait time target. As well, a comprehensive Five-year plan for Health Link Alberta will be developed in 2011.

### WHAT ELSE DO WE KNOW?

Historically, callers perceive the wait time as very good to excellent when the targeted average of two minutes is met.

### HOW DO WE COMPARE?

National benchmark comparisons are not available.

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

## Children Receiving Community Mental Health Treatment within 30 Days (%)

### WHAT IS BEING MEASURED?

The percentage of children receiving community mental health treatment within 30 days measures the per cent of children under the age of 18 referred for mental health services who received face-to-face assessment with a mental health therapist within a 30 day period.

The data includes all scheduled, urgent and emergent cases and is limited to children enrolled in programs at community mental health clinics across Alberta.

These results exclude some enrolments that have not been completed within the selected time period.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?


Wait times for access to community mental health treatment services are used as an indicator of patient access to the health care system and reflect the efficient use of resources.

### WHAT IS THE TARGET?

The 2010/11 target for children receiving community mental health treatment within 30 days is 85 per cent. Provincial wait-time standards reflect the maximum time children should wait to receive mental health services in Alberta.

### HOW ARE WE DOING?

Currently, AHS is not meeting the 85 per cent target of referred children receiving a face-to-face assessment within 30 days. Results are anticipated to improve with the implementation of subsequent years of the Children's Mental Health Plan for Alberta: Three-Year Action Plan (2008/11).

 <b>PERFORMANCE STATUS</b> Performance is within acceptable range, monitor and take action as appropriate.	2010/11 TARGET: 85% Q4 TARGET: 85%
	Q4 ACTUAL: 79%

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Efforts have been focused at those sites which remain below target. Specific examples include:

- Implementation of coordinated regional intake and redevelopment of intake processes to ensure screening assessments take place within 2-3 working days (Edmonton).
- Increase in mental health therapy positions to reduce wait times (Edmonton and North Zones).
- Installation of a triage nurse in the Pediatric Behavioural Developmental Clinic to streamline referrals to the appropriate discipline (Calgary).
- Change in business processes to reduce the time between receipt of referral and assignment to the receiving clinic (Calgary).

Subsequent actions planned: Again, efforts are being focused at those sites which remain below target. Specific examples include:

- Improve processes to follow-up with clients who do not attend initial appointments (Edmonton).
- Complete recruitment of vacant mental health therapist positions (Edmonton and North Zones).
- Launch pilot project to allow patients/families to access discipline specific assessments as early in the care continuum as possible to prevent the need for more intensive services (Calgary).

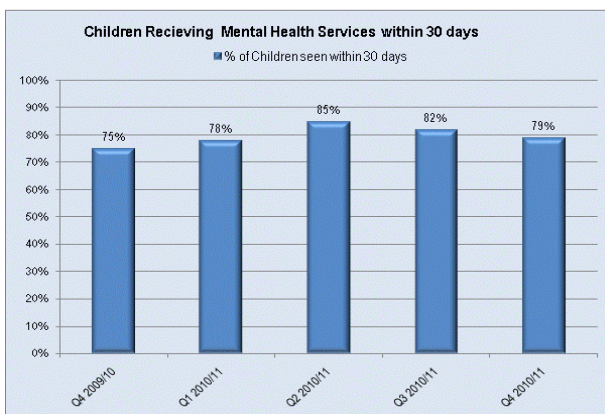
### WHAT ELSE DO WE KNOW?

There appears to be some seasonal and geographic variation in the results reported for this measure. Further analysis may inform these differences.

Information is available by [zone](#).

### HOW DO WE COMPARE?

Currently, Alberta is the only province with access standards for children's mental health, as such, there is no comparable information from other provinces regarding the wait times for children to receive community mental health treatment.



Source: AHS Mental Health Services



Data updated quarterly.  
 Most current data is Q4 2010/11.  
 Next data update expected for Q1 2011/12.

## Coronary Artery Bypass Graft (CABG) Wait Time for Urgent Category (Urgency Level I)

### WHAT IS BEING MEASURED?

Coronary artery bypass graft (CABG) wait time is calculated as the time from the date of cardiac catheterization to the date surgery was completed. If a cardiac catheterization was not performed, the wait time is calculated from the date of alternate imaging, or from the date of cardiology referral to surgery.

Only scheduled CABG surgeries on adults 18 years of age and older are included in this measure; emergency procedures are not included. Urgency levels for patients are determined during peer-reviewed physician rounds in Edmonton, and by guidelines reviewed by surgeons in Calgary. Patients whose urgency level changed are excluded.

The 90<sup>th</sup> percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery. Median wait time is the point at which 50 per cent of patients have had their surgery.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

### WHAT IS THE TARGET?

The provincial/territorial benchmark for Urgency I CABG surgeries is within two weeks. The AHS target for 2010/11 is one and a half weeks for Urgent CABG surgeries.

<b>PERFORMANCE STATUS</b> Performance is outside acceptable range, take action and monitor progress. Baseline 2009/10: 2.4 weeks	2010/11 TARGET: 1.5 Q4 TARGET: 1.5 weeks
	Q4 ACTUAL: 2.2 weeks

### HOW ARE WE DOING?

The wait time for urgent CABG surgery is longer than the previous three quarters and remains longer than target.

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A computerized “flagging” system was implemented to identify patients who are close to exceeding the allowable wait time in their applicable urgency category. A clinical assessment is then made to ensure patient safety. As well, a process was implemented for daily triage of urgent and semi-urgent cases based on patient needs and operating room availability.

Subsequent actions planned: A three-year plan for cardiac surgery to meet AHS targets will be completed by Fall 2011. Both Calgary and Edmonton are working on refining the booking process and continuing with a central intake/wait list for urgent and semi-urgent patients. As well, we are refining the development and implementation of a process to increase surgeon awareness of patients on the waiting list and length of time waiting- alerts for patients nearing access benchmarks. In this process we are ensuring that patients requiring other types of cardiovascular surgeries are not impacted.

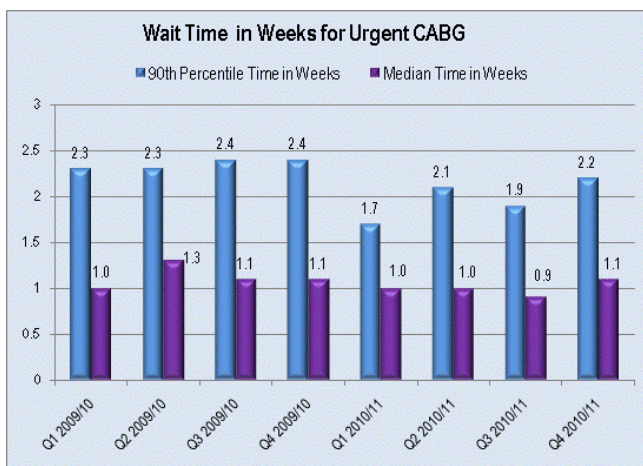
### WHAT ELSE DO WE KNOW?

All patient conditions are carefully reviewed to ensure patients are assigned a wait time that matches the seriousness of their condition. Patients are given an earlier date should their condition change while awaiting their previously assigned surgical date.

Information is available for [sites](#) performing this surgery.

### HOW DO WE COMPARE?

Relevant national comparisons will be included when available. Currently work is being undertaken to establish comparable interprovincial definitions.



Source: AHS Open Heart Waitlist Database (Edmonton), VELOS, APPROACH and OR data from ORIS (Calgary)

## Coronary Artery Bypass Graft (CABG) Wait Time for Semi-Urgent Category (Urgency II)

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

Coronary artery bypass graft (CABG) wait time is calculated as the time from the date of cardiac catheterization to the date surgery was completed. If a cardiac catheterization was not performed, the wait time is calculated from the date of alternate imaging, or from the date of cardiology referral to surgery.

Only scheduled CABG surgeries on adults 18 years of age and older are included in this measure; emergency procedures are not included. Urgency levels for patients are determined during peer-reviewed physician rounds in Edmonton, and by guidelines reviewed by surgeons in Calgary. Patients whose urgency level changed are excluded.

The 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery. Median wait time is the point at which 50 per cent of patients have had their surgery.

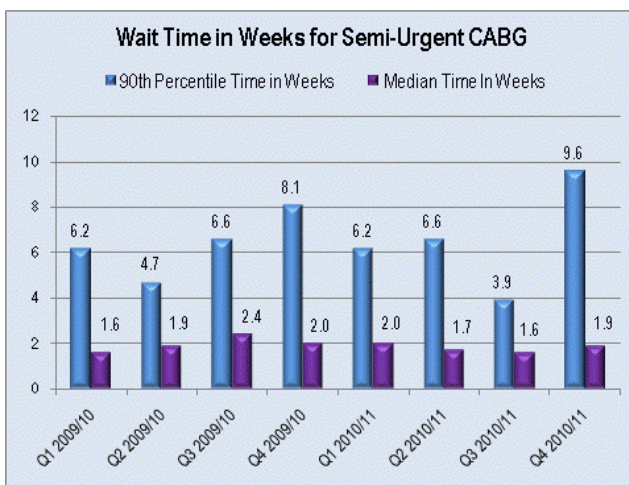
Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?


Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

### WHAT IS THE TARGET?

The provincial/territorial benchmark for Urgency II CABG surgeries is within six weeks. The Alberta Health Services (AHS) target for 2010/11 is five weeks for semi-urgent CABG surgeries.



Source: AHS Open Heart Waitlist Database (Edmonton), VELOS, APPROACH and OR data from ORIS, the OR database (Calgary)



**PERFORMANCE STATUS**

2010/11 TARGET: 5.0  
Q4 TARGET: 5.0  
weeks

Performance is outside acceptable range, take action and monitor progress.  
Baseline 2009/10: 7 weeks

Q4 ACTUAL: 9.6  
weeks

### HOW ARE WE DOING?

While the median wait time for semi-urgent CABG surgery has remained consistent, Q4 saw a large increase in 90<sup>th</sup> percentile wait time which is attributed to longer waits for a small group of patients (as the lowest volume category, this group can be susceptible to large swings in performance).

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A computerized “flagging” system was implemented to identify patients who are close to exceeding the allowable wait time in their applicable urgency category. A clinical assessment is then made to ensure patient safety. As well, a process was implemented for daily triage of urgent and semi-urgent cases based on patient needs and operating room availability.

Subsequent actions planned: A three-year plan for cardiac surgery to meet AHS targets will be completed by Fall 2011. Both Calgary and Edmonton are working on refining the booking process and continuing with a central intake/wait list for urgent and semi-urgent patients. As well, we are refining the development and implementation of a process to increase surgeon awareness of patients on the waiting list and length of time waiting- alerts for patients nearing access benchmarks. In this process we are ensuring that patients requiring other types of cardiovascular surgeries are not impacted.

### WHAT ELSE DO WE KNOW?

All patient conditions are carefully reviewed to ensure that patients are assigned a wait time that matches the seriousness of their condition. Patients are given an earlier date if their condition changes while awaiting the previously assigned surgical date.

Information is available for [sites](#) performing this surgery.

### HOW DO WE COMPARE?

Relevant national comparisons will be included when available. Currently work is being undertaken to establish comparable interprovincial definitions.

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

## Coronary Artery Bypass Graft (CABG) Wait Time for Scheduled Category (Urgency III)

### WHAT IS BEING MEASURED?

Coronary artery bypass graft (CABG) wait time is calculated as the time from the date of cardiac catheterization to the date surgery was completed. If a cardiac catheterization was not performed, the wait time is calculated from the date of alternate imaging, or from the date of cardiology referral to surgery.

Only scheduled CABG surgeries on adults 18 years of age and older are included in this measure; emergency procedures are not included. Urgency levels for patients are determined during peer-reviewed physician rounds in Edmonton, and by guidelines reviewed by surgeons in Calgary. Patients whose urgency level changed are excluded.

The 90<sup>th</sup> percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery. Median wait time is the point at which 50 per cent of patients have had their surgery.

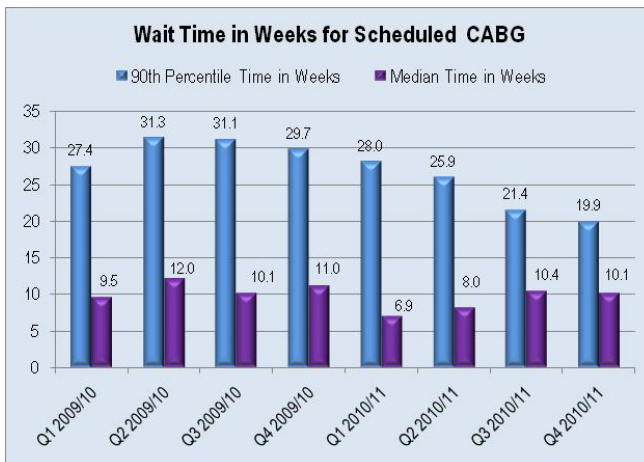
Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

### WHAT IS THE TARGET?

The provincial/territorial benchmark for Urgency III CABG surgeries is within 26 weeks. The 2010/11 Alberta Health Services (AHS) target is 15 weeks.



Source: AHS Open Heart Waitlist Database (Edmonton), VELOS, APPROACH and OR data from ORIS, the OR database (Calgary)

### PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.  
Baseline 2009/10: 31 weeks

20010/11 TARGET:  
15.0  
Q4 TARGET: 15.0

Q4 ACTUAL:  
19.9 weeks

### HOW ARE WE DOING?

Although the wait time for scheduled CABG surgery has improved over the last year, it is still significantly longer than target.

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A computerized "flagging" system was implemented to identify patients who are close to exceeding the allowable wait time in their applicable urgency category. A clinical assessment is then made to ensure patient safety.

Subsequent actions planned: In addition to the actions noted for urgent/semi-urgent patients, Edmonton is beginning a Cardiovascular Process Improvement project planned to review each part of the patient journey. In Calgary, the referral and triage process for non-urgent patients will be re-engineered to reduce wait times. Both cities are examining existing OR capacity and efficiencies.

### WHAT ELSE DO WE KNOW?

All patient conditions are carefully reviewed to ensure that patients are assigned a wait time that matches the seriousness of their condition. Patients are given an earlier date should their condition change while they are awaiting their previously assigned surgical date.

Information is available for [sites](#) performing this surgery.

### HOW DO WE COMPARE?

Relevant national comparisons will be included when available. Currently work is being undertaken to establish comparable interprovincial definitions.



Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

Hip replacement wait time is the time from the date the patient and clinician agreed to hip replacement (arthroplasty) surgery as the treatment option of choice, to the date surgery was completed. Only scheduled, elective hip replacements are included in this measure. Emergency cases are not included in the calculation. The 90<sup>th</sup> percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery.

Detailed indicator [definition](#) is available. Definition will be revised for future reporting.

### WHY IS THIS IMPORTANT?

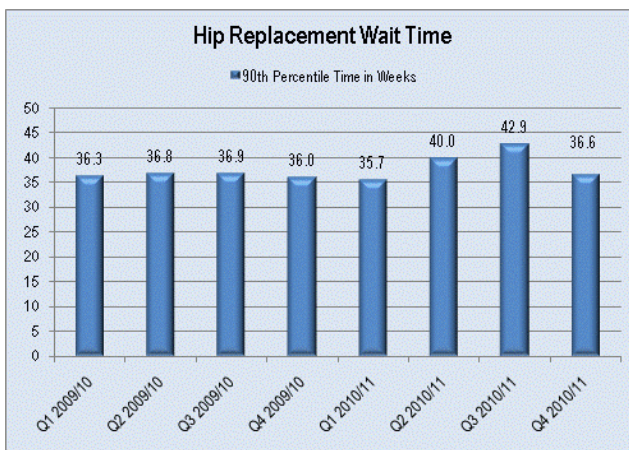
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

### WHAT IS THE TARGET?

The provincial/territorial benchmark for hip replacement surgeries is within 26 weeks. The Alberta target for 2010/11 is 28 weeks.

### HOW ARE WE DOING?

The wait time for hip replacement surgery is significantly longer than the target. As there is variation across the province in how definitions of urgency are applied and data is collected, the actual wait time may be less than reported. Alberta Health Services (AHS) is developing standard definitions for measurement of wait times, to improve the accuracy of the measure for future reports.



Source: AHS; DIMR from Site Surgery Wait List and Surgical Databases



### PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.  
Baseline 2009/10: 37.1 weeks

2010/11 TARGET: 28.0  
Q4 TARGET: 28.0  
weeks

Q4 ACTUAL: 36.6  
weeks

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A new central intake process has been established in all five zones. A new 56 bed, four operating room orthopedic surgery centre was opened in Edmonton. The provincial Hip and Knee Replacement Transformational Improvement Program (TIP) continues with a view to reducing wait times and length of stay. A provincial plan to achieve the 14 week wait time targets by 2014/15 for hip and knee replacement has been developed.

Subsequent actions planned: Funding for year one of the five-year provincial hip and knee replacement plan will increase knee replacement volumes starting in Summer 2011, once staff/physician resources are in place. These increased volumes, along with ongoing improvement work to eliminate inefficient processes and use of inpatient and sub-acute bed days, will help to achieve wait time targets. Variation in central intake processes across the province will also be addressed. As well, better linkage of primary health care providers to medical and surgical specialists will occur through a standardized approach for assessing, referring and booking patients with specialists (cancer, cardiac, hip/knee, and cataract), to be developed by early 2012.

### WHAT ELSE DO WE KNOW?

Currently this measure reports on the wait time from decision date to surgical date. Provincial wait time definitions from primary care referral to surgical date have been approved by the Bone & Joint Clinical Network, for implementation across the Province.

Information is available by [site](#).

### HOW DO WE COMPARE?

Using a similar measure in 2010, Alberta ranked sixth among the 10 provinces for hip replacement surgery wait times. Alberta = 38.3 weeks, Best Performing Province = 24.6 weeks (Ontario) (CIHI, 2010)

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

Knee replacement wait time is the time from the date the patient and clinician agreed to knee replacement (arthroplasty) surgery as the treatment option of choice, to the date surgery was completed.

Only scheduled, elective knee replacements are included in this measure. Emergency cases are not included in the calculation.

The 90<sup>th</sup> percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery.

Detailed indicator [definition](#) is available. Definition will be revised for future reporting.

### WHY IS THIS IMPORTANT?


Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

### WHAT IS THE TARGET?

The provincial/territorial benchmark for knee replacement surgeries is within 26 weeks. The Alberta target for 2010/11 is 42 weeks.

### HOW ARE WE DOING?

The wait time for knee replacement surgery is longer than the target. As there is variation across the province in how definitions of urgency are applied and data is collected, the actual wait time may be less than reported. Alberta Health Services (AHS) is developing standard definitions for measurement of wait times, to improve the accuracy of the measure for future reports.



**PERFORMANCE STATUS**

Performance is outside acceptable range, take action and monitor progress.  
Baseline 2009/10: 51.1 weeks

2010/11 TARGET: 42.0  
Q4 TARGET: 42.0  
weeks

Q4 ACTUAL: 48.0  
weeks

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A new central intake process has been established in all five zones. A new 56 bed, four operating room orthopedic surgery centre was opened in Edmonton. The provincial Hip and Knee Replacement Transformational Improvement Program (TIP) continues with a view to reducing wait times and length of stay. A provincial plan to achieve the 14 week wait time targets by 2014/15 for hip and knee replacement has been developed.

Subsequent actions planned: Funding for year one of the five-year provincial hip and knee replacement plan will increase knee replacement volumes starting in Summer 2011, once staff/physician resources are in place. These increased volumes, along with ongoing TIP work to eliminate inefficient processes and use of inpatient and sub-acute bed days, will help to achieve wait time targets. Variation in central intake processes across the province will also be addressed. As well, better linkage of primary health care providers to medical and surgical specialists will occur through a standardized approach for assessing, referring and booking patients with specialists (cancer, cardiac, hip/knee, and cataract), to be developed by early 2012.

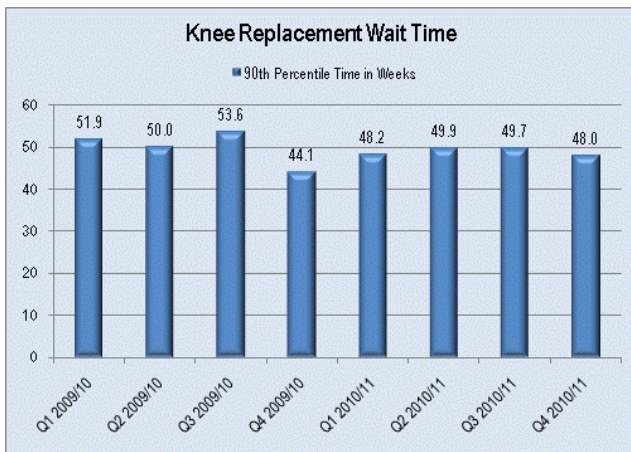
### WHAT ELSE DO WE KNOW?

Currently this measure reports on the wait time from decision date to surgical date, Provincial waiting time definitions from primary care referral to surgical date have been approved by the Bone & Joint Clinical Network for implementation across the Province.

Information is available by [site](#).

### HOW DO WE COMPARE?

Using a similar measure in 2010, Alberta ranked sixth among the 10 provinces for knee replacement surgery wait times. Alberta = 49.1 weeks, Best Performing Province = 27.1 weeks (Ontario) (CIHI, 2010)



Source: AHS, DIMR from Site Surgery Wait List and Surgical Databases



Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

Cataract surgery wait time is defined as the time from the date when the patient and clinician agreed to cataract surgery as the treatment option of choice, to the date the surgery was completed.

Only the first eye cataract surgery is included in the measure. Patients who voluntarily delayed their procedure, those who had a scheduled follow-up procedure, and those that received emergency care are excluded from the measure. Calgary cataract wait times include patients who voluntarily delay their procedure.

The 90<sup>th</sup> percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

### WHAT IS THE TARGET?

The provincial/territorial benchmark for high risk cataract surgeries is within 16 weeks. The Alberta target for 2010/11 is 36 weeks.

### HOW ARE WE DOING?

The preliminary result for 90<sup>th</sup> percentile wait time for Cataract Surgery for Q4 2010/11 was 46.1 weeks which exceeds the target time of 36 weeks.



### PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.  
Baseline 2009/10: 41 weeks

2010/11 TARGET:  
36 weeks  
Q4 TARGET: 36.0

Q4 ACTUAL:  
46.1 weeks

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Cataract volumes for the 2010/11 year increased to 12,180 in Calgary and 13,961 in Edmonton, an increase of 2,889 and 2,136 cases from the previous year, respectively. Of all the Zones, Calgary continues to have the highest backlog of cases, yet this was reduced from 9,500 people waiting in October 2010 to 6,050 people waiting in April, 2011. As well, the average wait time in Calgary also decreased from 28 (April 2010) to 24 weeks (April 2011).

Subsequent actions planned: Contract extensions with non-hospital surgical facilities in Edmonton and Calgary have been negotiated. Calgary and Edmonton cataract activity will continue into the 2011/12 fiscal year with increased volumes allocated as in 2010/11. In addition, a 3-year plan for meeting long-term wait time targets is scheduled for completion in Fall 2011.

Plans are underway to manage the waitlist by ensuring that all patients who need to be waitlisted are.

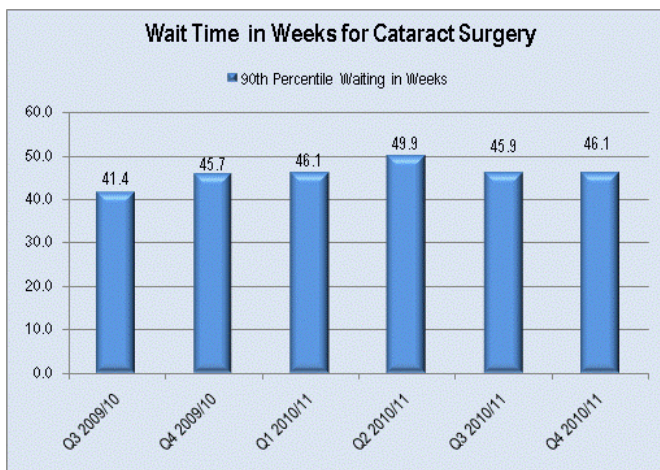
### WHAT ELSE DO WE KNOW?

Cataract surgery wait times are significantly longer in Calgary than elsewhere within the province.

Information is available by [zone](#).

### HOW DO WE COMPARE?

Using a similar measure, Alberta ranked 10th among the 10 provinces for cataract surgery wait times. Alberta = 47.3 weeks, Best Performing Province = 17.0 weeks (New Brunswick) (CIHI, 2010)



Source: Alberta Health & Wellness

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

Wait time for other scheduled surgery is defined as the time from the date when the patient and clinician agreed to surgery as the treatment option of choice, to the date the surgery was completed.

Only scheduled surgeries are included in this measure. Patients who voluntarily delayed their procedure, those who had a scheduled follow-up procedure, and those that received emergency care are excluded from the measure.

All other scheduled surgeries exclude Coronary Artery Bypass Graft (CABG), hip replacement, knee replacement and cataract surgeries.

The 90<sup>th</sup> percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

### WHAT IS THE TARGET?

No wait time target for other scheduled surgeries has been defined for 2010/11. Targets will be set in 2011/12.

### PERFORMANCE STATUS

Performance target for 2010/11 is not yet established for comparison.

2010/11 TARGET:  
TBD

Q4 ACTUAL: 26.3  
weeks

### HOW ARE WE DOING?

Using latest developed measurement methodology (under review) 90<sup>th</sup> percentile wait times for other surgeries was 26.3 weeks for Q4 2010/11.

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Wait time targets for cancer surgery have been developed. As well, a Surgical Services Health Plan Working Group (SSHPWG) was established to develop a coordinated and comprehensive set of projects that will deliver a sustainable surgical service delivery model for Albertans.

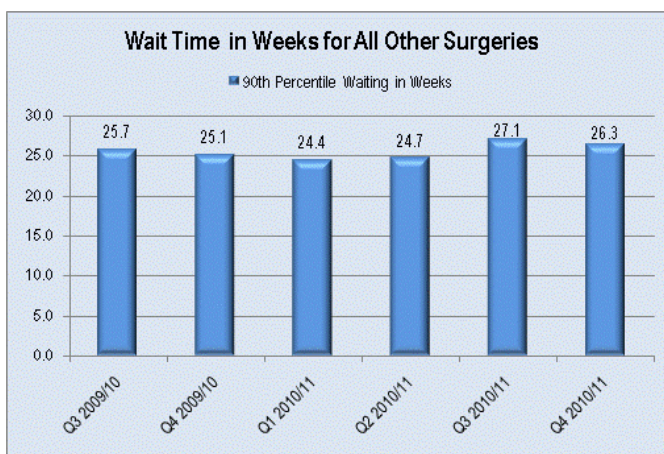
Subsequent actions planned: New surgical volume investments will be made for spinal implants, cancer surgery and other general surgeries. The SSHPWG will complete a comprehensive plan by Fall 2011 to: (1) measure and manage wait times from referral to discharge; (2) maintain and improve patient outcomes in line with industry best practice; and (3) establish provincial surgical efficiency targets (e.g. on time starts, turnaround times, percent overruns, etc.). In addition, a plan to further implement a Safe Surgery Checklist in all operating rooms across Alberta will be developed by Fall 2011.

### WHAT ELSE DO WE KNOW?

Information is available by [zone](#).

### HOW DO WE COMPARE?

National benchmark comparisons are not available.



Source: Alberta Health & Wellness

Note: Q3 2010/11 figures include incomplete contracted surgical facilities data; figures will be revised as data becomes available.

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

# Performance Measure Update

## Radiation Therapy Wait Time Referral to First Consultation (Radiation Oncologist)

### WHAT IS BEING MEASURED?

Referral to consultation by radiation oncologist wait time is the time from the date that a referral was received from a physician outside a cancer facility to the date that the first consult with a radiation oncologist occurred.

Currently this data is collected on patients referred to a tertiary cancer facility (Cross Cancer Institute in Edmonton, Tom Baker Cancer Centre or Holy Cross in Calgary). As of Q3 2010/11, data is also reported on patients referred to Jack Ady Cancer Centre in Lethbridge. There is a project underway to collect these data at three additional cancer centres that provide consultations to patients in Medicine Hat, Red Deer, and Grande Prairie.

The 90<sup>th</sup> percentile is the time it takes in weeks for 90 per cent of patients to have had their first consult.


Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

Wait times are an important measure of how quickly people are getting access to cancer care. They reflect the ability of Alberta Health Services (AHS) to meet the needs of cancer patients.

### WHAT IS THE TARGET?

The Alberta target for referral to radiation oncologist consultation is four weeks for 90 per cent of patients.

 <b>PERFORMANCE STATUS</b> Performance is outside acceptable range, take action and monitor progress. Baseline 2009/10: 7.4 weeks	2010/11 TARGET: 4 Q4 TARGET: 4 weeks
	Q4 Actual: 5.5 weeks
	(Empty space)

### HOW ARE WE DOING?

Wait times from cancer referral to consultation by radiation oncologists are outside the target. However, in the majority of tumour groups, patients are seen within the target timeline. The wait time is 5.5 weeks in Q4 2010/11.

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The First Contact program teams have been established at both the Tom Baker Cancer Centre (four tumour groups) and the Cross Cancer Institute (two tumour groups). This enables new patients to be contacted within 48 hours and given appointment dates. In addition, a Radiation Therapy Wait Time plan has been designed to meet the four-week target by the end of the 2011/12 year, consisting of: (1) improvements in referral management; (2) re-engineering of clinical scheduling processes; and (3) a strategic frontline staff adjustment.

Subsequent actions planned: Subject to approval, implementation of the Radiation Therapy Wait Time plan is scheduled to begin in Summer 2011. As well, implementation will continue on rolling out the First Contact program to all sites and for all tumour groups by the end of 2012/13.

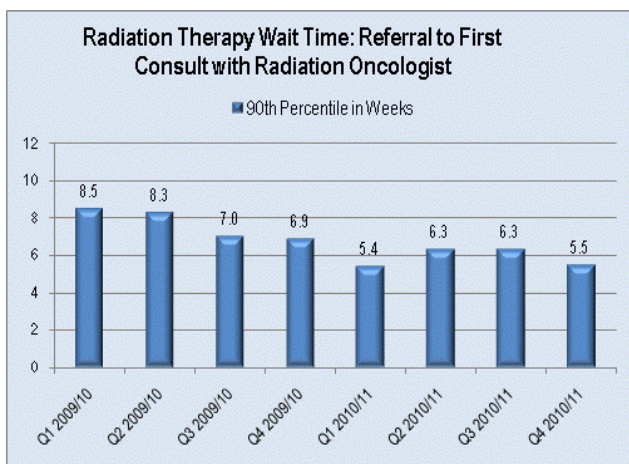
### WHAT ELSE DO WE KNOW?

Sometimes referrals are missing important medical information cancer specialists require before they meet with the patient. This causes delays. We are working with referring physicians to improve this situation.

Information is available by [site](#).

### HOW DO WE COMPARE?

National benchmark comparisons are not currently available but are under development. Ontario targets 14 days from the time between a referral to a specialist to the time of consult with the patient. Current trends indicate that 60 to 75 per cent of patients are seen within this target (Cancer Care Ontario, 2010).



Source: EBI-2009-009 – Timeliness of care – referral to first consult by consult type and facility

Note: Jack Ady Cancer Centre (Lethbridge) data is included as of Q3 2010/11.



## Radiation Therapy Wait Time Ready-to-Treat to First Radiation Therapy

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

Ready-to-treat to first radiation therapy wait time is the time from the date the patient was physically ready to commence treatment to the date that the patient received his/her first radiation therapy.

Currently this data is reported on patients who receive radiation therapy at the Cross Cancer Institute in Edmonton, the Tom Baker Cancer Centre in Calgary, and the Jack Ady Cancer Centre in Lethbridge. The data apply only to patients receiving external beam radiation therapy (i.e. brachytherapy is not included).

The 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their first treatment after being assessed as ready for treatment.


Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

Wait times are an important measure of how quickly people are getting access to cancer care. They reflect the ability of Alberta Health Services (AHS) to meet the needs of cancer patients.

### WHAT IS THE TARGET?

The provincial/territorial benchmark for radiation treatment is that patients will receive the first treatment within four weeks (28 days) of being ready to treat. The Alberta target is four weeks.

 <b>PERFORMANCE STATUS</b> Performance is at or better than target, continue to monitor. Baseline 2009/10: 5.4 weeks	2010/11 TARGET: 4 Q4 TARGET: 4 weeks
	Q4 ACTUAL: 3.7weeks

### HOW ARE WE DOING?

The proportion of patients receiving radiation therapy within the expected time period is better than the target. Significant improvement has occurred since Q4 2009/10. The Q4 2010/11 90<sup>th</sup> percentile time was 3.7 weeks.

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The Jack Ady Cancer Centre in Lethbridge is now fully operational and to March 31, 2011 has delivered almost 250 courses of radiation therapy to patients since opening. All three sites are currently performing better than target.

Subsequent actions planned: Performance at all sites will continue to be monitored and action plans established in the event targets are not being met. Expansion of tumour sites treated at the Jack Ady Cancer Centre will expand in 2011/12 to include radical lung cancer patients. Re-engineering of business processes for radiation therapy consultation will occur in Edmonton and Calgary. In addition, planning remains on track to open the Central Alberta Cancer Centre in Red Deer in 2013.

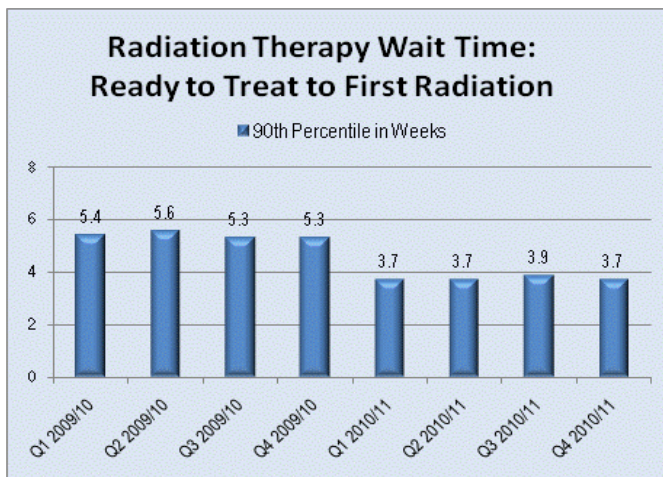
### WHAT ELSE DO WE KNOW?

AHS is reviewing benchmark work done by Provincial/Territory Governments in 2005, and reported in October 2009.

Information is available by [site](#).

### HOW DO WE COMPARE?

Using a similar measure, Alberta ranked sixth among eight provinces for radiation therapy wait times. Alberta = 3.7 weeks, Best Performing Province = 2.9 weeks (Ontario and Saskatchewan) (CIHI, 2010)



Source: EBI -2009-002 Radiation Therapy Time From Ready to Treat to First Radiation Treatment by Institution

Note: Jack Ady Cancer Centre (Lethbridge) data is included as of Q3 2010/11.

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

## Patients Discharged from Emergency Department or Urgent Care Centre within 4 hours (%) (16 Higher Volume EDs)

### WHAT IS BEING MEASURED?

Patients discharged from an Emergency Department (ED) or Urgent Care Centre (UCC) measures the length of time from the first documented time after arrival at the ED/UCC to the time they are discharged (16 higher volume EDs). The percentage of patients discharged whose length of stay in ED/UCC is less than four hours is reported.

Patients who leave without being seen, leave against medical advice, are admitted as an inpatient to the same facility, or die before or during the ED visit, are not included in this measure.

Sites in this grouping are based on criterion of high volume or in a category of teaching, large urban and regional emergency centre. Site-specific data for all 16 facilities are listed [here](#).

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?


The amount of time spent waiting for treatment is a measure of access to the health care system. Patients treated in the ED/UCC should receive care in a timely fashion. Excessive wait times for care can result in treatment delays for individual patients and reduced efficiency in the flow of patients.

### WHAT IS THE TARGET?

Alberta Health Services has established a 2010/11 target of 70 per cent of patients discharged within four hours for the 16 higher volume EDs.

### HOW ARE WE DOING?

In Q4 2010/11, 65 per cent of patients at the 16 higher volume EDs were discharged within four hours. This is below the target.

 <b>PERFORMANCE STATUS</b> Performance is within acceptable range, monitor and take action as appropriate. Baseline 2008/09: 62%	2010/11 TARGET: 70% Q4 TARGET: 70%
	Q4 ACTUAL: 65%

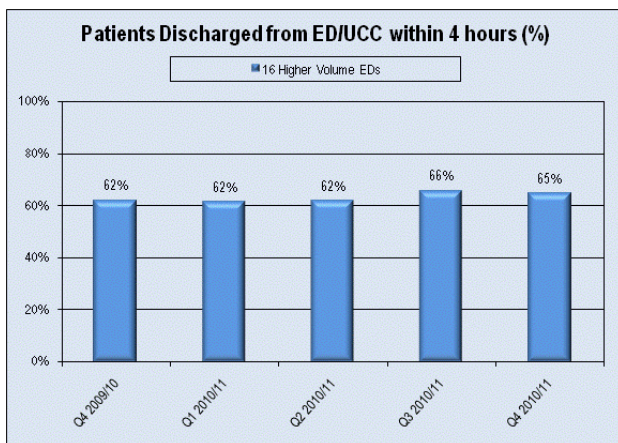
### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Staffing schedules at Health Link Alberta have been optimized to match call presentation patterns, a radio campaign was launched to promote the benefits of Health Link Alberta and urgent care centres, additional efforts have been focused at those sites remaining below target. Calgary Zone (Foothills Medical Centre, Rockyview General Hospital, Peter Lougheed Centre):

- Added an extra physician shift on Mondays due to high activity (Foothills)
- Revised criteria for activating the on-call ED physician to ensure a more proactive response
- Addition of the equivalent of 10 FTE's of physician support in the ED (e.g. the on-call ED physician has been accessed 70-80 per cent of the time)
- Assigned a triage nurse to focus on patient flow within the ED (Foothills)
- Implemented ED physician huddles each morning
- Installed greeters in the waiting rooms to answer questions and to assist patients and families
- Increased use of transporting EMS patients to alternate destinations (i.e. Urgent Care Centers)
- Daily discharge rounds at all sites
- The use of an electronic decision support tool by nurses and doctors, MEDWORXX, to identify those patients who are ready for discharge (Foothills & Rockyview)

In the Edmonton zone (University of Alberta Hospital, Royal Alexandra Hospital, Grey Nuns Community Hospital, Misericordia Community Hospital, Sturgeon Community Hospital):

- Implementation of LEAN improvement projects to improve patient flow and access:
  - Grouping of like patients to designated ED spaces with specific physician/nurse teams and reorganization of common supplies/equipment for each patient type. Preliminary results of 18 per cent more patients discharged within target (Royal Alexandra)
  - Strategies developed to reduce specific process times; e.g. triage to bed location; to physician assessment; to consult times; to admission to ward or discharge from ED (U of A, Misericordia)



Source: Calgary and Edmonton Emergency Department Information System Data (REDIS, EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS)

Performance Measure Update continues on next page ...

- Improved turn-around times for lab testing (Grey Nuns, Misericordia)
- The Sturgeon facility moved into its new physical ED space; education on redesigned ED processes delivered to physicians and nurses
- Addition of Care Manager to facilitate elderly population accessing community resources (Misericordia)
- Enhanced multidisciplinary support in ED (Physiotherapy and Social Work) to identify patients that can go home with added resources (Grey Nuns)
- Increased staffing in Rapid Assessment Zone and Fast Track to improve turn-around time and thus free up treatment spaces (Grey Nuns)

**Subsequent actions planned:** In the Calgary zone (Foothills, Rockyview, Peter Lougheed):

- Process improvement review to reduce the time from triage to patient registration (Rockyview)
- Review feasibility of adding an extra surge shift for ED physicians on Monday/Tuesday (busiest days) (Rockyview)
- Potential relocation of Transition Services support within the ED to better manage complex discharge processes (Foothills)

In the Edmonton zone (U of A, Royal Alexandra, Grey Nuns, Misericordia, Sturgeon):

- Implementation of software using real-time information from the ED to display patient volumes, incoming EMS volumes and the severity of patient conditions across Edmonton sites (the system has been used in Calgary since 2007 and has helped to provide a window into ED workload, assist with managing existing capacity and allow EMS to return to service faster)
- Implementation of LEAN improvement project to identify and decrease obstacles to timely patient discharge from the ED (Royal Alexandra)
- Investigate with Diagnostic Imaging ability for enhanced after hours services (Sturgeon)
- Add Care Manager to facilitate elderly population accessing community resources (Grey Nuns)
- Benchmark and model efficiencies gained from the Royal Alexandra LEAN improvement project (U of A)
- Addition of 12 new treatment spaces to the Stollery Children's Hospital ED is on track for March 2012
- Complete process mapping to identify opportunities to improve patient flow from triage to admission/discharge (Stollery)

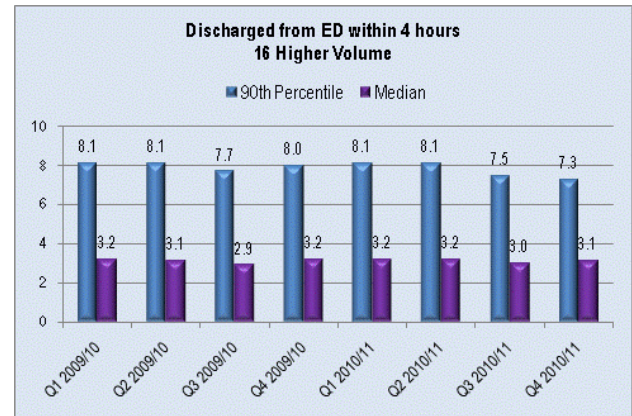
ED physicians will enhance coverage by modifying shift rotations to ensure maximum coverage during peak times (U of A, Stollery)

## WHAT ELSE DO WE KNOW?

Reasons for variation of length of stay across sites include complexity of patients, capacity limitations, operational efficiency and access to other primary care options (family physicians, walk-in clinics).

Information is available by [site](#).

[Weekly ED Length of Stay \(LOS\)](#) is available for a subset of sites where more timely data is readily available.



Median and 90<sup>th</sup> Percentile data are available by [site](#).

## HOW DO WE COMPARE?

Relevant national comparisons will be included as available.



## Patients Discharged from Emergency Department or Urgent Care Centre within 4 hours (%) (All Sites)

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

Patients discharged from an Emergency Department (ED) or Urgent Care Centre (UCC) measures the length of time from the first documented time after arrival at the ED/UCC to the time they are discharged (all sites). The percentage of patients discharged whose length of stay in ED/UCC is less than four hours is reported.

Patients who leave without being seen, leave against medical advice, are admitted as an inpatient to the same facility, or die before or during the ED visit, are not included in this measure.

This ED/UCC measure is presented for all sites.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

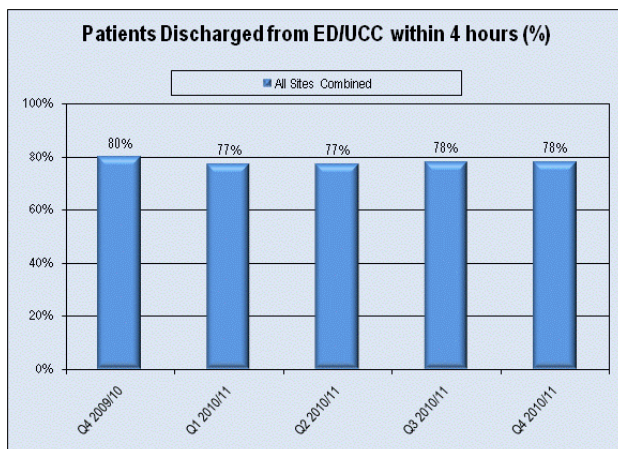
The amount of time spent waiting for treatment is a measure of access to the health care system. Patients treated in the ED/UCC should receive care in a timely fashion. Excessive wait times for care can result in treatment delays for individual patients and reduced efficiency in the flow of patients.

### WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target for 2010/11 of 82 per cent of patients discharged within four hours for all sites.

### HOW ARE WE DOING?

In Q4 2010/11, 78 per cent of patients presenting and subsequently discharged at ED/UCC sites within four hours.



Source: Calgary and Edmonton Emergency Department Information System Data (REDIS, EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS)



### PERFORMANCE STATUS

Performance is within acceptable range monitor and take action as appropriate.  
Baseline 2008/09: 80%

2010/11 TARGET: 82%  
Q4 TARGET: 82%

Q4 ACTUAL: 78%

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Staffing schedules at Health Link Alberta have also been optimized to match call presentation patterns, and a radio campaign was launched to promote the benefits of Health Link Alberta and urgent care centres. Additional efforts have been focused at those sites which remain below target.

Calgary zone (Foothills Medical Centre, Rockyview General Hospital, Peter Lougheed Centre):

- Added an extra physician shift on Mondays due to high activity (Foothills)
- Revised criteria for activating the on-call ED physician to ensure a more proactive response
- Addition of the equivalent of 10 FTE's of physician support in the ED (e.g. the on-call ED physician has been accessed 70-80 per cent of the time)
- Assigned a triage nurse to focus on patient flow within the ED (Foothills)
- Implemented ED physician huddles each morning
- Installed greeters in the waiting rooms to answer questions and to assist patients and families
- Increased use of transporting EMS patients to alternate destinations (i.e. Urgent Care Centers)
- Daily discharge rounds at all sites
- The use of an electronic decision support tool by nurses and doctors, MEDWORXX, to identify those patients who are ready for discharge (Foothills & Rockyview)

Edmonton zone (University of Alberta Hospital, Royal Alexandra Hospital, Grey Nuns Community Hospital, Misericordia Community Hospital, Sturgeon Community Hospital):

- Implementation of LEAN improvement projects to improve patient flow and access:
  - Grouping of like patients to designated ED spaces with specific physician/nurse teams and reorganization of common supplies/equipment for each patient type. Preliminary results of 18 per cent more patients discharged within target (Royal Alexandra)
  - Strategies developed to reduce specific process times; e.g. triage to bed location; to physician assessment; to consult times; to admission to ward or discharge from ED (U of A, Misericordia)



- Improved turn-around times for lab testing (Grey Nuns, Misericordia)
- The Sturgeon facility moved into its new physical ED space; education on redesigned ED processes delivered to physicians and nurses
- Addition of Care Manager to facilitate elderly population accessing community resources (Misericordia)
- Enhanced multidisciplinary support in ED (Physiotherapy and Social Work) to identify patients that can go home with added resources (Grey Nuns)
- Increased staffing in Rapid Assessment Zone and Fast Track to improve turn-around time and thus free up treatment spaces (Grey Nuns)

**Subsequent actions planned:** Calgary zone (Foothills, Rockyview, Peter Lougheed):

- Process improvement review to reduce the time from triage to patient registration (Rockyview)
- Review feasibility of adding an extra surge shift for ED physicians on Monday/Tuesday (busiest days) (Rockyview)
- Potential relocation of Transition Services support within the ED to better manage complex discharge processes (Foothills)

**Edmonton Zone (U of A, Royal Alexandra, Grey Nuns, Misericordia, Sturgeon):**

- Implementation of software using real-time information from the ED to display patient volumes, incoming EMS volumes and the severity of patient conditions across Edmonton sites (the system has been used in Calgary since 2007 and has helped to provide a window into ED workload, assist with managing existing capacity and allow EMS to return to work faster)
- Implementation of LEAN improvement project to identify and decrease obstacles to timely patient discharge from the ED (Royal Alexandra)
- Investigate with Diagnostic Imaging ability for enhanced after hours services (Sturgeon)
- Add Care Manager to facilitate elderly population accessing community resources (Grey Nuns)
- Benchmark and model efficiencies gained from the Royal Alexandra LEAN improvement project (U of A)
- Addition of 12 new treatment spaces to the Stollery Children's Hospital ED is on track for March 2012

- Complete process mapping to identify opportunities to improve patient flow from triage to admission/discharge (Stollery)
- ED physicians will enhance coverage by modifying shift rotations to ensure maximum coverage during peak times (U of A, Stollery)

**WHAT ELSE DO WE KNOW?**

There are many reasons why ED/UCC length of stay may vary across sites, including complexity of patients, limitations (treatment spaces, staffing), operational efficiency and access to other primary care options (family physicians, walk-in clinics).

Information is available by [zone](#) and [site](#).

[Weekly ED Length of Stay \(LOS\)](#) is available for a subset of sites where more timely data is readily available.

**HOW DO WE COMPARE?**

Relevant national comparisons will be included as available.

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

# Performance Measure Update

## Patients Admitted from Emergency Department within 8 hours (%) (15 Higher Volume EDs)

### WHAT IS BEING MEASURED?

The total time patients spend in an Emergency Department (ED) is calculated from the first documented time after arrival at emergency until the time they enter the hospital as an inpatient (15 higher volume EDs). The percentage of admitted patients whose length of stay in ED is less than eight hours is reported.

This measure does not apply to Urgent Care Centre (UCC) facilities as these facilities do not have inpatient spaces to receive admitted patients.

Sites in this grouping are based on criterion of high volume or in a category of teaching, large urban and regional emergency centre. Site-specific data for all 15 facilities are listed [here](#).

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?


ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent can be a measure of access to the health care system and a reflection of efficient use of resources.

### WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target of 45 per cent of patients admitted leaving the ED within eight hours for the 15 higher volume EDs for 2010/11.

### HOW ARE WE DOING?

In Q4 2010/11, 44 per cent of admitted patients at the 15 higher volume EDs left the ED within eight hours.

 <b>PERFORMANCE STATUS</b> Performance is within acceptable range of target, monitor and take action as appropriate. Baseline 2008/09: 36%	2010/11 TARGET: 45% Q4 TARGET: 45%
	Q4 ACTUAL: 44%

### WHAT ACTIONS ARE WE TAKING?

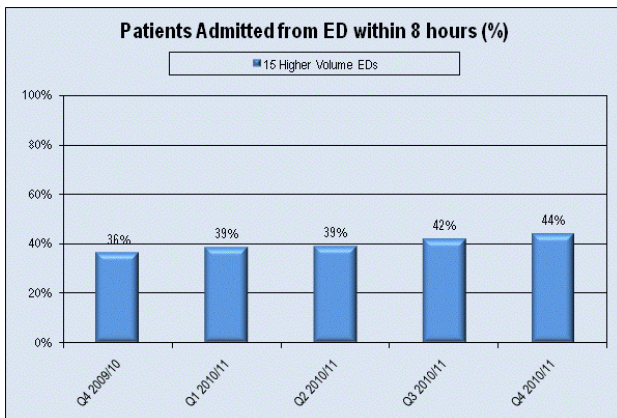
**Actions completed to date:** A total of 323 new hospital beds have been opened in Calgary and Edmonton as of March 31, 2011 to improve patient flow. Staffing schedules at Health Link Alberta have also been optimized to match call presentation patterns, and a radio campaign was launched to promote the benefits of Health Link Alberta and urgent care centres. Additional efforts have been focused at those sites which remain below target.

Calgary Zone (Foothills Medical Centre, Rockyview General Hospital, Peter Lougheed Centre):

- Addition of the equivalent of 10 FTE's of physician support in the ED (e.g. the on-call ED physician has been accessed 70-80 per cent of the time)
- Bed huddles implemented three times a day
- Software implemented to initiate earlier discharge planning on inpatient units
- Optimization of Medical Assessment Unit (Rockyview)
- Ongoing implementation of over-capacity protocols
- Monitoring of Length of Stay data for those services that are above the national average and developing strategies and processes to reduce LOS

Edmonton Zone (University of Alberta Hospital, Royal Alexandra Hospital, Grey Nuns Community Hospital, Misericordia Community Hospital, Sturgeon Community Hospital):

- Medicine Unit Manager coverage expanded to the weekend and initiation of weekend bed huddle meetings to enhance patient movement out of ED seven days per week (Royal Alexandra)
- Expanded bed huddles with support services to develop daily plans to expedite transfer of patients to inpatient bed spaces
- Addition of a Triage Liaison Physician to facilitate timely consults, review admission issues, need for telemetry and suggest orders to ensure patients requiring admission are moved in a timely manner
- The Sturgeon facility moved into its new physical ED space; education on redesigned ED processes delivered to physicians and nurses



Source: Calgary and Edmonton Emergency Department Information System Data (REDIS, EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS)

Performance Measure Update continues on next page ...

- Length of stay (LOS) task force established and LEAN training delivered to managers, directors, educators and unit supervisors to identify further opportunities for reducing LOS

**Subsequent actions planned:** The five-year expansion plan for additional continuing care spaces is expected to reduce ED length of stay for patients requiring admission from ED.

Calgary Zone (Foothills, Rockyview, Peter Lougheed):

- Process improvement efforts to reduce: (1) time between triage and admission process; and (2) turn-around time for inpatient bed availability
- Additional community capacity planned for Alternate Level of Care, Mental Health and Home Care
- Ongoing work with Mental Health on transition units to support transfer of mental health patients where appropriate
- Work is ongoing with Community partners to identify opportunities for decreasing the number of patients on delay for supported living

Edmonton Zone (U of A, Royal Alexandra, Grey Nuns, Misericordia, Sturgeon):

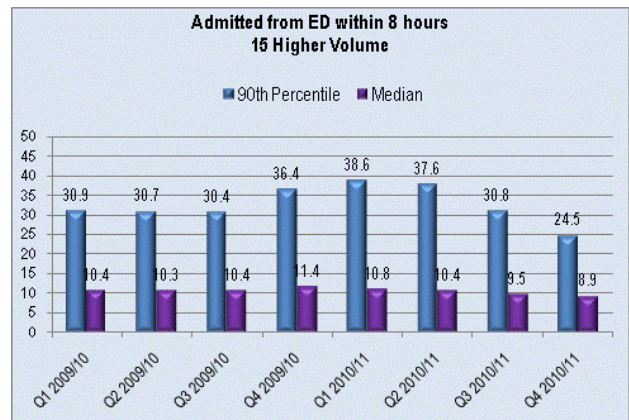
- Implementation of software using real-time information from the ED to display patient volumes, incoming EMS volumes and the severity of patient conditions across Edmonton sites (the system has been used in Calgary since 2007 and has helped to provide a window into ED workload, assist with managing existing capacity and allow EMS to return to work faster)
- Increases to the number of daily bed huddles
- Sharing of the most effective/efficient triage models across inpatient services to improve flow
- I-Care Unit to open at U of A to accommodate general internal medicine patients that require closer observation and telemetry for a further 24-48 hours (patients previously boarded in ED)
- Ongoing review of ED patients exceeding the eight hour target: examination of barriers, issues and opportunities for improvement
- Addition of 12 new treatment spaces to the Stollery Children’s Hospital ED is on track for March 2012

**WHAT ELSE DO WE KNOW?**

Reasons for length of stay variation across sites include the complexity of patient conditions presenting to ED, capacity limitations, as well as operational efficiency. The demand for ED services can vary also significantly between sites and/or communities as a result of access to other primary care options (e.g. family physicians, walk-in clinics).

Information is available by [site](#).

[Weekly ED Length of Stay \(LOS\)](#) is available for a subset of sites where more timely data is readily available.



Median and 90<sup>th</sup> Percentile data are available by [site](#).

**HOW DO WE COMPARE?**

Relevant national comparisons will be included as available.



Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

## Patients Admitted from Emergency Department within 8 hours (%) (All Sites)

### WHAT IS BEING MEASURED?

The total time patients spend in an Emergency Department (ED) is calculated from the first documented time after arrival at emergency until the time they enter the hospital as an inpatient (all sites). The percentage of admitted patients whose length of stay in ED is less than eight hours is reported.

The performance for the 15 highest volume teaching, large urban and regional ED sites as well as the average performance across all AHS sites combined is measured.

Detailed [definition](#) is available.

### WHY IS THIS IMPORTANT?


ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent by a patient in an ED can be a measure of access to the health care system and a reflection of efficient use of resources.

### WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target for all ED sites combined of 55 per cent of patients admitted leaving the ED within eight hours.

### HOW ARE WE DOING?

In Q4 2010/11, 55 per cent of admitted patients left the ED within eight hours.

 <b>PERFORMANCE STATUS</b> Performance is at or better than quarterly target, continue to monitor. Baseline 2008/09: 48%	2010/11 TARGET: 55% Q4 TARGET: 55%
	<b>Q4 ACTUAL: 55%</b>

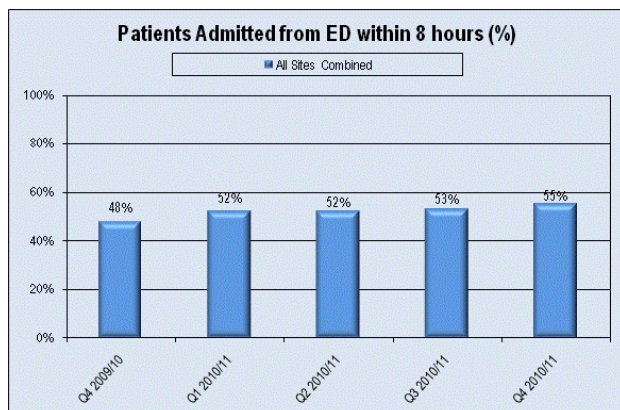
### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** A total of 323 new hospital beds have been opened in Calgary and Edmonton as of March 31, 2011 to improve patient flow. Staffing schedules at Health Link Alberta have also been optimized to match call presentation patterns, and a radio campaign was launched to promote the benefits of Health Link Alberta and urgent care centres. Additional efforts have been focused at those sites which remain below target. Calgary zone (Foothills Medical Centre, Rockyview General Hospital, Peter Lougheed Centre):

- Addition of the equivalent of 10 FTE's of physician support in the ED (e.g. the on-call ED physician has been accessed 70-80 per cent of the time)
- Bed huddles implemented three times a day
- Software implemented to initiate earlier discharge planning on inpatient units
- Optimization of Medical Assessment Unit (Rockyview)
- Ongoing implementation of over-capacity protocols
- Monitoring of Length of Stay data for those services that are above the national average and developing strategies and processes to reduce LOS

Edmonton Zone (University of Alberta Hospital, Royal Alexandra Hospital, Grey Nuns Community Hospital, Misericordia, Sturgeon Community Hospital):

- Medicine Unit Manager coverage expanded to the weekend and initiation of weekend bed huddle meetings to enhance patient movement out of ED seven days per week (Royal Alexandra)
- Expanded bed huddles with support services to develop daily plans to expedite transfer of patients to inpatient bed spaces
- Addition of a Triage Liaison Physician to facilitate timely consults, review admission issues, need for telemetry and suggest orders to ensure patients requiring admission are moved in a timely manner
- The Sturgeon facility moved into its new physical ED space; education on redesigned ED processes delivered to physicians and nurses



Source: Calgary and Edmonton Emergency Department Information System Data (REDIS, EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS)

Performance Measure Update continues on next page ...

- Length of stay (LOS) task force established and LEAN training delivered to managers, directors, educators and unit supervisors to identify further opportunities for reducing LOS
- Outpatient services were redesigned to be able to accommodate earlier discharged/more complex inpatients (Glenrose Rehabilitation Hospital)

**Subsequent actions planned:** The five-year expansion plan for additional continuing care spaces is expected to reduce ED length of stay for patients requiring admission from ED.

Calgary Zone (Foothills, Rockyview, Peter Lougheed):

- Process improvement efforts to reduce: (1) time between triage and admission process; and (2) turn-around time for inpatient bed availability
- Additional community capacity planned for Alternate Level of Care, Mental Health and Home Care
- Ongoing work with Mental Health on transition units to support transfer of mental health patients where appropriate
- Work is ongoing with Community partners to identify opportunities for decreasing the number of patients on delay for supported living

Edmonton Zone (U of A, Royal Alexandra, Grey Nuns, Misericordia, Sturgeon):

- Implementation of software using real-time information from the ED to display patient volumes, incoming EMS volumes and the severity of patient conditions across Edmonton sites (the system has been used in Calgary since 2007 and has helped to provide a window into ED workload, assist with managing existing capacity and allow EMS to return to work faster)
- Increases to the number of daily bed huddles
- Sharing of the most effective/efficient triage models across inpatient services to improve flow
- I-Care Unit to open at U of A to accommodate general internal medicine patients that require closer observation and telemetry for a further 24-48 hours (patients previously boarded in ED)
- Ongoing review of ED patients exceeding the eight hour target: examination of barriers, issues and opportunities for improvement
- Addition of 12 new treatment spaces to the Stollery Children's Hospital ED is on track for March 2012

### WHAT ELSE DO WE KNOW?

There are many reasons why length of stay may vary across sites. Examples include the complexity of patient conditions presenting to ED, capacity limitations (e.g. treatment spaces, staffing levels) as well as operational efficiency. In addition, the demand for ED services can vary significantly between sites and/or communities as a result of access to other primary care options (e.g. family physicians, walk-in clinics).

Information is available by [site](#) and [zone](#).

[Weekly ED Length of Stay \(LOS\)](#) is available for a subset of sites where more timely data is readily available.

### HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

## WHAT IS BEING MEASURED?

People waiting in acute/sub-acute (hospital) beds for continuing care placement is a count of the number of persons who have been assessed and approved for placement in continuing care, who are waiting in a hospital acute care or sub-acute bed. This includes acute care palliative and acute mental health. The numbers presented represent a snapshot of the last day of the reporting period.

Detailed indicator [definition](#) is available.

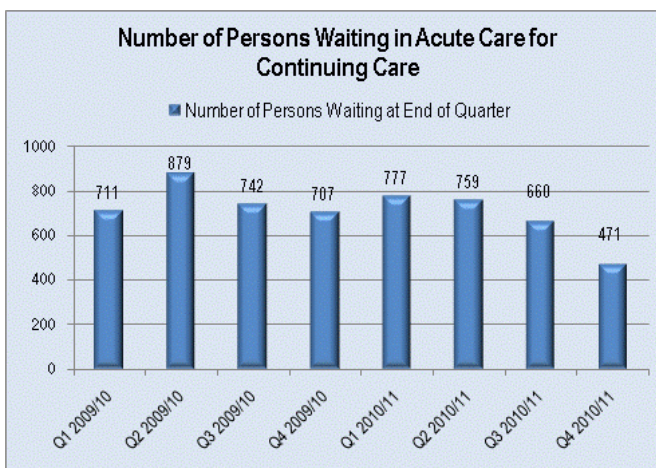
## WHY IS THIS IMPORTANT?

Access to continuing care services is a significant issue in Alberta. As such, a focused, multiple-strategy approach is needed to provide both seniors and persons with disabilities more options for quality accommodations specific to their service needs and lifestyles.

By reducing the number of people waiting in a hospital environment for continuing care, we will be able to improve patient flow throughout the system, provide more appropriate care to meet patient needs, decrease wait times and deliver care in a more cost effective manner.


## WHAT IS THE TARGET?

The target for 2010/11 is for 400 or fewer people to be waiting in acute/sub-acute (hospital) beds for continuing care placement. This is a decrease from the baseline of 700 in 2008/09.



Source: AHS "Snapshots" of the Wait List at the end of the month

## People Waiting in Acute/Sub-Acute Beds for Continuing Care Placement

 <b>PERFORMANCE STATUS</b> Performance is within acceptable range of target, monitor and take action as appropriate. Baseline March 31, 2010: 777	2010/11 TARGET: 400 Q4 TARGET: 400
	Q4 ACTUAL: 471

## HOW ARE WE DOING?

At the end of Q4 2010/11, 471 people were waiting in acute/sub-acute (hospital) beds for continuing care placement, which is above the target of 400.

## WHAT ACTIONS ARE WE TAKING?

Actions completed to date: 1,166 continuing care spaces were opened across the province as of March 31, 2011. This represents the number of incremental continuing care spaces established. In addition, Home Care services continue to be expanded across the province. As well, implementation has begun on an "ED2Home" program to expedite discharge of seniors and disabled adults from the Emergency Department to their homes with appropriate connections to community supports, thus reducing avoidable stays in a hospital bed.

Subsequent actions planned: An additional 1,000 continuing care spaces are planned to open during the 2011/12 year. This number builds off the 1,166 spaces opened in 2010/11, and serves as the next phase towards the long-term target of opening 5,300 new continuing care spaces by 2015. Roll-out of new programs such as ED2Home will be expanded. Planning is also underway to identify additional strategies to reduce the number of persons waiting in acute/sub-acute beds for continuing care (including expansion in the number of clients receiving Home Care services).

## WHAT ELSE DO WE KNOW?

The decisions made by the working group reviewing areas of ambiguity in the guidelines will be posted on the internal staff AHS website for reference by case managers.

Information is available by [zone](#).

## HOW DO WE COMPARE?

Relevant national comparisons will be included as available.



Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

## People Waiting in Community for Continuing Care Placement

### WHAT IS BEING MEASURED?

People waiting in community for continuing care placement is a count of the number of persons who have been assessed and approved for placement in continuing care, and are waiting in the community (at home). The numbers presented are a snapshot of the last day of the reporting period.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

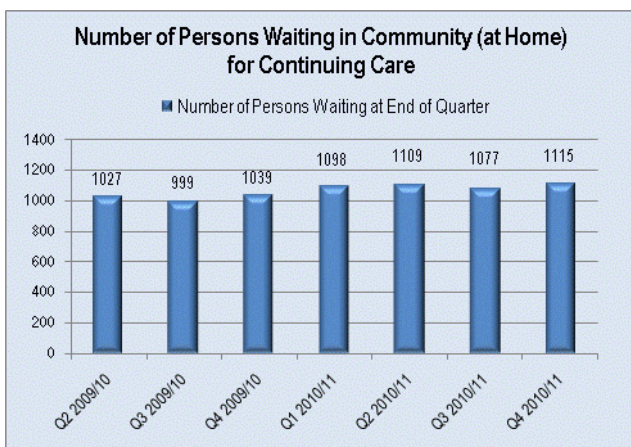
Access to continuing care services is a significant issue in Alberta. As such, a focused, multiple-strategy approach is needed to provide both seniors and persons with disabilities more options for quality accommodations specific to their service needs and lifestyles.

### WHAT IS THE TARGET?


The target for 2010/11 is for 975 or fewer people to be waiting in the community (at home) for continuing care placement. This is a decrease from the baseline of 1,065 in 2008/09.

### HOW ARE WE DOING?

At the end of Q4 2010/11, 1,115 people were waiting in the community (at home) for continuing care placement, which is above the target of 975.



Source: AHS "Snapshots" of the Wait List at the end of the quarter



**PERFORMANCE STATUS**

2010/11 TARGET: 975  
Q4 TARGET: 975

Performance is outside acceptable range, take action and monitor progress.  
Baseline March 31, 2010: 1,233

**Q4 ACTUAL: 1,115**

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: 1,166 continuing care spaces were opened across the province as of March 31, 2011. This represents the number of incremental continuing care spaces established. In addition, plans have been approved to expand Home Care hours to allow at least 3,000 more people to receive Home Care services in the year (e.g. through increased funding for Home Care service providers, enhancing existing services, as well as expanding eligibility for Home Care support).

Subsequent actions planned: An additional 1,000 continuing care spaces are planned to open during the 2011/12 year. This number builds off the 1,166 spaces opened in 2010/11, and serves as the next phase towards the long-term target of opening 5,300 new continuing care spaces by 2015. Planning is also underway to identify additional strategies to reduce the number of persons waiting in the community for continuing care (including expansion in the number of clients receiving Home Care services).

### WHAT ELSE DO WE KNOW?

The decisions made by the working group reviewing areas of ambiguity in the guidelines will be posted on the internal staff AHS website for reference use by case managers.

Information is available by [zone](#).

### HOW DO WE COMPARE?

No national benchmark comparisons were found.



Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

## Performance Measure Update

### Average Wait Time in Acute/Sub-Acute Care for Continuing Care

#### WHAT IS BEING MEASURED?

Average Wait Time in Acute/Sub-Acute Care for Continuing Care measures the average number of days between an individual being assessed and approved for continuing care placement and their admission date to a Long Term Care Facility or Supportive Living space. Currently, summary data is provided by nine former health regions and collated.

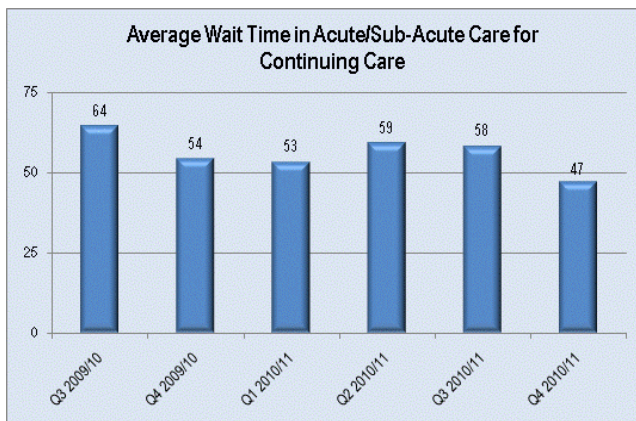
The average wait time may be overstated by days spent waiting in the Community prior to admission (i.e. only a portion of the wait was spent in Acute/Sub-acute Care), as well as "delay" days in Acute/Sub-acute Care (i.e. days where hospitalization is required due to an individual becoming medically unstable – continuing care placement is delayed until their medical condition stabilizes).

Detailed indicator definition is currently in development.

#### WHY IS THIS IMPORTANT?

Access to continuing care services is a significant issue in Alberta. As such, a focused, multiple-strategy approach is needed to provide both seniors and persons with disabilities more options for quality accommodations specific to their service needs and lifestyles.

By reducing the wait time and the number of people waiting in a hospital environment for continuing care, we will be able to improve patient flow throughout the system, provide more appropriate care to meet patient needs, and deliver care in a more cost effective manner.



Source: Continuing Care Wait Time Data  
Note: Figures will be revised as available.

#### PERFORMANCE STATUS

Performance Target for 2010/11 has not been established for comparison.

2010/11 TARGET:  
TBD

Q4 ACTUAL: 47

#### WHAT IS THE TARGET?

Targets are currently being developed for this indicator.

#### HOW ARE WE DOING?

The average wait time in acute/sub-acute care for continuing care was 47 days in Q4 of 2010/11.

#### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: 1,166 continuing care spaces were opened across the province as of March 31, 2011. This represents the number of incremental continuing care spaces established. In addition, Home Care services continue to be expanded across the province. As well, implementation has begun on an "ED2Home" program to expedite discharge of seniors and disabled adults from the Emergency Department to their homes with appropriate connections to community supports, thus reducing avoidable stays in a hospital bed.

Subsequent actions planned: An additional 1,000 continuing care spaces are planned to open during the 2011/12 year. This number builds off the 1,166 spaces opened in 2010/11, and serves as the next phase towards the long-term target of opening 5,300 new continuing care spaces by 2015. Roll-out of new programs such as ED2Home will be expanded. Planning is also underway to identify additional strategies to reduce waiting time for continuing care (e.g. expanding the number of clients receiving Home Care services, expanding the role of transition coordinators, facilitating advanced discharge planning with patients and their families).

#### WHAT ELSE DO WE KNOW?

Information is available by [zone](#).

#### HOW DO WE COMPARE?

National benchmark comparisons are not available.

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

Number of Home Care Clients measures the number of unique / individual clients served during the reporting period. This includes all clients in all age groups within former categories of short term, long term, and palliative, as well as day programs, Supportive Living Level 1, and Supportive Living Level 2.

Detailed indicator definition is currently in development.

### WHY IS THIS IMPORTANT?

As the population ages, providing seniors with access to services and supports to remain healthy and independent as long as possible has never been more important. Enhancing support services and offering more choice and care options to Albertans in their homes is a key strategy to enable individuals to “age in the right place”.

### WHAT IS THE TARGET?

Targets are currently being developed for this indicator.

### HOW ARE WE DOING?

The number of unique / individual Home Living Clients was 56,041\* in Q4 of 2010/11.

Table: Number of Home Living Clients

Time Period	Home Care Clients
Q1 2010/11	55,593
Q2 2010/11	55,617
Q3 2010/11	55,543
Q4 2010/11	56,041*

Source: AHS

\* Q4 2010/11 includes estimated data for Central Zone.

### PERFORMANCE STATUS

Performance Target for 2010/11 has not been established for comparison.

2010/11 TARGET:  
TBD

Q4 ACTUAL: 56,041

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Plans have been approved to expand Home Care hours to allow at least 3,000 more people to receive Home Care services in the year (e.g. through increased funding for Home Care service providers, enhancing existing services, as well as expanding eligibility for Home Care support). Home Care coordinators in the Emergency Department (ED) have also been established to assess and coordinate the needs of patients and their families and to facilitate safe discharge from ED and expedited access to home care services.

Subsequent actions planned: Implementation will continue to meet the goal of expanding Home Care to at least 3,000 more people per year by March, 2012. Planning is also underway to enhance the level and amount of Home Care support to existing and future clients (e.g. increasing the dollars available for short-term Home Care services to support patients' transition from hospital/ED to their home living environment, providing 24/7 telephone access to a Home Care case coordinator, increasing available Home Care services on weekends and holidays).

### WHAT ELSE DO WE KNOW?

Information is available by [zone](#).

### HOW DO WE COMPARE?

National benchmark comparisons are not available.

Data updated quarterly.  
 Most current data is Q4 2010/11.  
 Next data update expected for Q1 2011/12.

# Performance Measure Update

## Head Count to FTE Ratio

### WHAT IS BEING MEASURED?

The Head Count to FTE (Full-Time Equivalent) Ratio is the number of people employed by Alberta Health Services for every 1 FTE. A full-time equivalent is the number of hours that represent what a full time employee would work over a given time period, for example a year or a pay period.

The measure is calculated as the number of unique/discrete individuals employed by Alberta Health Services (AHS) divided by the reported assigned FTE level for all employees. A lower ratio (lower number of head count to FTE) reflects optimization of workforce.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

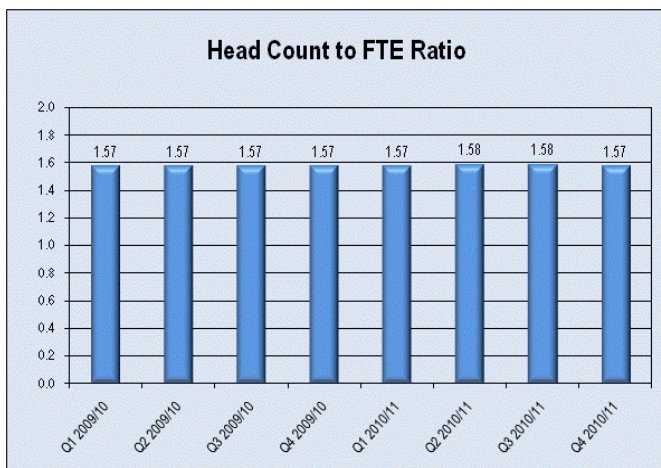
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

### WHAT IS THE TARGET?

AHS has established a 2010/11 target head count to FTE ratio of 1.63. AHS will decrease the head count to FTE ratio.

### HOW ARE WE DOING?

In 2009/10 the head count to FTE ratio was 1.57. In Q1 2010/11 the ratio was 1.57. In Q2 and Q3 2010/11 the ratio was 1.58 and back to 1.57 in Q4. No change from 2009/10.



Source: Alberta Health Services Human Resources

<b>PERFORMANCE STATUS</b> Performance is at or better than target, continue to monitor.	<b>2010/11 TARGET:</b> 1.63
	<b>Q4 2010/11 ACTUAL:</b> 1.57

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The health workforce summit held in November 2010 brought 100 front line clinicians, managers, union leaders, regulators and educators together to continue a dialogue about workforce issues. The summit built on consultations held across the province during the first two quarters of the year about what AHS' workforce planning priorities and actions should be going forward. A number of themes emerged from those consultations and were further explored during the summit. A high degree of consensus was reached and AHS clearly achieved an agenda to move forward on issues such as retention and recruitment, the efficient utilization of the clinical workforce and shaping future workforce requirements.

This Clinical Workforce Strategic Plan is imperative in identifying the most effective Head Count to FTE mix.

Subsequent actions planned: A Clinical Workforce Strategic Plan will be developed by March, 2011. This plan is imperative in identifying the most effective head count to FTE mix.

### WHAT ELSE DO WE KNOW?

The head count includes full-time, part-time and casual employees. The FTE includes full-time, and part-time employees as casual employees have no assigned FTE.

This measure could be skewed due to a reduction in the casual workforce rather than the creation of fuller employer opportunities.

This measure does not include Capital Care Group, Calgary Laboratory Services or Carewest even though these are wholly owned entities of AHS. Some employees currently not on AHS pay systems may not be included (e.g., Emergency Medical Services).

### HOW DO WE COMPARE?

This measure is not benchmarked externally.



Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

## Registered Nurse Graduates Hired by AHS (%)

### WHAT IS BEING MEASURED?

The percentage of Registered Nurse (RN) graduates hired by Alberta Health Services (AHS) measures the estimated number of RN graduates for the given year and the number of hires likely to be new university/college registered nursing graduates.

As the actual number of graduates for a given year is not known until November, the number of graduates from the previous year is used.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

The performance of our health care system is directly related to the ability of AHS to sustain the delivery of nursing care services, by utilizing a locally educated nursing workforce.

A commitment has been made in the 2010-13 United Nurses of Alberta (UNA) collective agreement stating AHS will hire a minimum of 70 per cent of Alberta nursing graduates positions annually. If 70 per cent of Alberta nursing student graduates are not hired into regular or temporary positions of greater than six month, the UNA Joint Committee will examine the reasons.

### WHAT IS THE TARGET?

Consistent with the UNA Collective Agreement, AHS has established a target of 70 per cent of Alberta graduates hired in 2010/11. The percent of graduates hired into non-casual positions will also be reported.

### HOW ARE WE DOING?

As the numbers of RN graduates for the previous year are not available until November, the number of graduates from 2008/09 is used. Alberta Advanced Education reported there were 1,582 Alberta RN graduates in 2008/09.

By the end of fiscal year 2010/11 AHS hired 1,383 (87 per cent) RN graduates. Of these, 653 (41 per cent) were hired into non-casual positions.

### PERFORMANCE STATUS

Continue to monitor performance.

2010/11 TARGET:  
70%

2010/11 ACTUAL:  
■ Total: 87%  
● Non-Casual: 41%

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Progress on various initiatives include: initiation of a “Transitional Grad Nurse Program”, commencement of a targeted recruitment initiative to retain the current new graduates and attract future classes, early development of a Northern Recruitment Strategy to encourage new graduates to apply for job opportunities outside of the major urban centres, as well as early development of professional practice and specialty-specific orientations to support new hires. In addition, grant funding has been received for a multi-stakeholder provincial steering committee – “*The Successful Transition of the Newly Graduated Nurse*” – to develop a resource tool kit to support the successful transition of new graduates to the workplace.

Subsequent actions planned include: implementing the Transitional Grad Nurse Program, continuing with the targeted recruitment plan for new graduates, enhancing the recruitment strategy and actively marketing job opportunities with AHS for new graduates, implementing the professional practice orientation, and implementing the Northern Recruitment Strategy with a view to building upon it to attract new graduates in rural areas.

### WHAT ELSE DO WE KNOW?

Recruitment challenges may exist in certain “difficult to recruit to” areas. For example, vacancies in rural/remote locations due to many new graduates seeking employment in the metro areas; as well, new graduates are not necessarily competent to work in specialized areas without additional support. In addition, collective agreement requirements to hire internal candidates wherever possible can put new graduates at a disadvantage.

The collection of relevant data is difficult due to system issues. AHS does not currently track the source of new hires. This measure refers to those nurses compensated at a Step One level, and may include new grads from outside Alberta as well as RNs whose previous experience has not yet been verified for step increments. Once experience is verified, adjustments will be made.

### HOW DO WE COMPARE?

This measure is not benchmarked externally.

## Disabling Injury Rate

Data updated quarterly.  
Most current data is Calendar Year 2011 Q1.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

The number of disabling injury claims per 100 AHS workers is calculated as: the number of disabling injury claims accepted from Alberta Health Services by the Workers' Compensation Board (WCB) in Alberta multiplied by 100 and divided by Alberta Health Services person-years.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

The performance of our health care system is directly related to the health and wellness of the people who provide care and services. Alberta Health Services (AHS) is committed to enabling staff to deliver high quality and safe care by providing the appropriate supports, such as education, a safe and supportive work environment and the required tools.

### WHAT IS THE TARGET?

AHS has established a 2010 target of 2.41 disabling injury claims per 100 workers. This represents a 15 per cent reduction in the disabling injury rate for the calendar year.

### HOW ARE WE DOING?

In 2009, the disabling injury rate was 2.83. In 2010 the disabling injury rate was 3.19. This represents a 13 per cent increase in the disabling injury rate. For the 2011 Q1 (Jan-Mar) the actual disabling injury rate was 0.70. If this rate continues the annual projected disabling rate for 2011 would be 3.14

Table: Disabling Injury Claims per 100 Workers

Time Period	Disabling Injury Rate
2009	2.83
2010	3.19

Source: Alberta Health Services and Alberta Workers' Compensation Board (WCB)

### PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.  
Baseline 2009: 2.83

2011 CY TARGET:  
2.20

2011 CY Q1 (Jan-Mar)  
ACTUAL: 0.70  
2011 CY ANNUALIZED:  
3.14

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Over 1,750 staff have been trained and 151 ceiling lifts have been installed in acute care environments in three Zones (South, North and Edmonton) as part of the Safe Client Handling Program. As well, Workplace Health and Safety Improvement Plans for 2011-12 are currently being developed with improved processes and metrics based on learnings from the 2010-11 year.

Subsequent actions planned: Implementation of the Safe Client Handling Program will continue. As well, AHS will partner with WCB to develop an improvement plan for 2011-12. One initiative in particular is to aggressively target and reduce lost time claims of under eight days duration.

### WHAT ELSE DO WE KNOW?

The data for this measure is provided by WCB Alberta and is a measure of the calendar year rather than the fiscal year.

The calendar year rate (AHS Q3) may be adjusted by WCB in the first quarter of 2011 once WCB conducts the yearly reconciliation. WCB will adjust for the additional 2010 transactions to year end and will calculate person years based on actual rather than estimated payroll.

Previous years are not available by quarter or other time sub-sets. From 2010 forward, WCB Alberta will provide quarterly data. Caution must be used when comparing this measure over time as it is reported cumulatively throughout the calendar year (Q1 = 3 months of data, Q2 = 6 months, etc). Starting in 2011, quarterly intervals will be comparable.

### HOW DO WE COMPARE?

In 2009, the disabling injury rate for AHS was slightly better than the industry average. However, as an industry, healthcare's disabling injury rate is about average when compared with all [Alberta industries](#).



Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

The Full-time to Part-time Clinical Worker Ratio is the number of full-time clinical people employed by Alberta Health Services for every one part-time employee.

A full-time employee is one who is hired to work the full specified annual hours of work. A part-time employee is one who is hired to work for scheduled shifts, and whose hours of work are less than the specified annual hours of work.

A clinical worker is one coded to 712, 713, 714 or 715 of the MIS Primary Chart of Accounts:

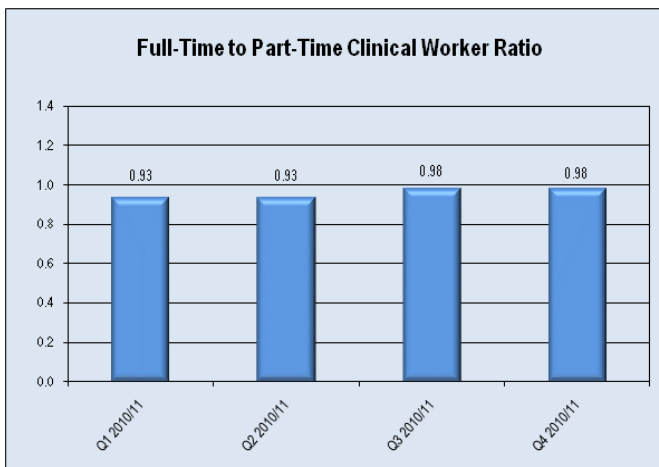
- 712XXXXXX–NURSING INPATIENT/RESIDENT SERVICES
- 713XXXXXX–AMBULATORY CARE SERVICES
- 714XXXXXX–DIAGNOSTIC & THERAPEUTIC SERVICES
- 715XXXXXX–COMMUNITY & SOCIAL SERVICES

The measure is calculated as the number of unique/discrete clinical individuals employed by AHS in full-time positions divided by the number of unique/discrete clinical individuals employed by AHS in part-time positions. A higher ratio (higher number of full-time to part-time clinical workers) reflects optimization of workforce.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure supports the clinical workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.



Source: Alberta Health Services Human Resources

## Performance Measure Update

### Full-time to Part-time Clinical Worker Ratio

PERFORMANCE STATUS Performance Target for 2010/11 has not been established for comparison.	2010/11 TARGET: TBD
	Q4 ACTUAL: 0.98

### WHAT IS THE TARGET?

AHS did not yet establish a 2010/11 target full-time to part-time clinical worker ratio. The target will be reviewed through the Strategic Clinical Workforce Plan by March, 2011 and will be set for 2011/12.

### HOW ARE WE DOING?

In 2009/10 the full-time to part-time clinical worker ratio was 0.92. In Q1 and Q2 of 2010/11 the ratio was 0.93. In Q3 and Q4 of 2010/11 the ratio was 0.98 which is a positive trend. The ratio was 0.91 for the 2010/11 fiscal year.

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A Clinical Workforce Strategic Plan (CWSP) has been developed and submitted to the Board for review/approval. Immediate actions arising from the CWSP have commenced, including preliminary workforce data projections for the next eight quarters by Zone and occupation. In addition, the Chief Executive Officer (CEO) has announced a target to increase the proportion of full-time positions by 6 per cent by 2012.

Subsequent actions planned: An implementation plan for the CWSP will be developed with short, medium and longer term actions. As well, an overarching Program Charter for workforce initiatives will be developed by Spring 2011. Zone Workforce Planning infrastructure in alignment with Zone Integrated Plans will also be developed.

### WHAT ELSE DO WE KNOW?

Note that this measure does not include the Capital Care Group, Calgary Laboratory Services or Carewest entities even though these are wholly owned entities of AHS. Some employees currently not on AHS pay systems may not be included (e.g., Emergency Medical Services).

Information will be available by zone.

### HOW DO WE COMPARE?

This measure is not benchmarked externally.

## Employee Absenteeism Rate

*New measure Q4 2010/11.*  
Data updated quarterly.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

Absenteeism rate is the total sick leave hours (paid and unpaid plus Leave of Absence (LOA) Special & Family) of full-time and part-time employees converted to days by dividing by daily hours of work (7.75) per Full Time Equivalent (FTE).

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

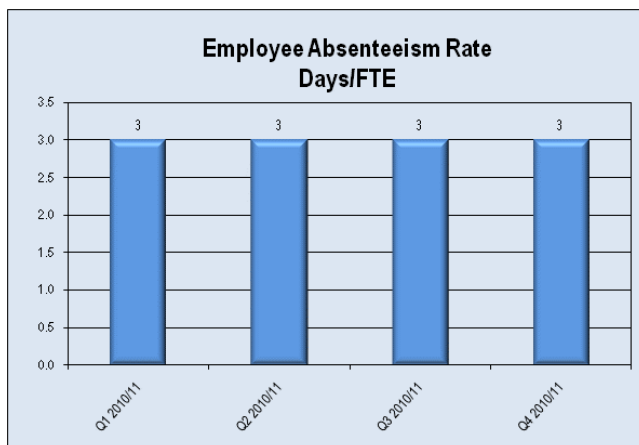
### WHAT IS THE TARGET?

No targets have been defined. Baseline for Alberta Health Services (AHS) will be established and confirmed in 2010/11. A target will be set in early 2011/12.

### HOW ARE WE DOING?

Sick leave days taken per FTE have remained fairly constant throughout the 2010/11 fiscal year at one per month or three per quarter. There was a slight drop in the summer months (Q2).

In 2010/11, AHS employees used 12.19 days per FTE.



Source: Alberta Health Services, Labour Cost System

### PERFORMANCE STATUS

Performance Target for 2010/11 has not been established for comparison.

2010/11 TARGET:  
TBD

Q4 2010/11 (annualized):  
12 days/FTE

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Developing and implementing an Attendance Management program; redistributing Workplace Health and Safety (WHS) workload to allow advisors to bring attention to this measure with managers.

Subsequent actions planned: The WHS Indicator Development group is reviewing indicators available and meaningful to workplace health and safety. The group will be looking at meaningful analysis methods and reporting levels.

### WHAT ELSE DO WE KNOW?

The number of sick leave days per FTE can be generated monthly, quarterly and annually. Monthly and quarterly data has been annualized for this measure.

### HOW DO WE COMPARE?

In 2009/10, AHS had one of the lowest absenteeism rates of the seven western provinces' health regions participating in a survey.

	Overall (n=103)	Public sector (n=41)	Private sector (n=62)
Absenteeism rate* (days per FTE)	6.6	8.1	5.6

Source: the Conference Board of Canada. *Valuing Your Talent* – June 2010

*New measure Q4 2010/11.*  
 Data updated quarterly.  
 Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

The total overtime hours worked by employees divided by total paid hours is measured.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

### WHAT IS THE TARGET?

No targets have been defined. Baseline will be established and confirmed in 2010/11.

### HOW ARE WE DOING?

Overtime hours accounts for 1.70 per cent of total paid hours in 2010/11. This rate has been fairly constant throughout the 2010/11 fiscal year.

<b>PERFORMANCE STATUS</b>	<b>2010/11 TARGET:</b> TBD
Performance Target for 2010/11 has not been established for comparison.	<b>Q4 ACTUAL:</b> 2.17%

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: In the direct nursing functional bargaining unit a joint working group has been established to review the possibility of converting overtime hours (and others) into regular positions. As well, managers in all areas are responsible for adherence to budgets for their sections as part of the Alberta Health Services' (AHS) performance management process.

Subsequent actions planned: In the direct nursing functional bargaining unit, analysis will be undertaken on casual, overtime, additional part time and agency nursing hours to support the joint workforce regularization processes commencing in the Zones.

### WHAT ELSE DO WE KNOW?

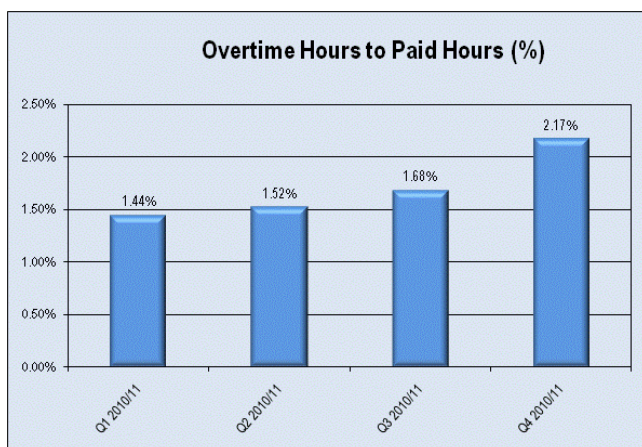
Measuring Overtime as a percentage of time worked helps AHS understand the impact that efficient organization of work has on the organization. Trends over time will allow us to monitor how well AHS is doing at creating an effective work mix.

### HOW DO WE COMPARE?

In 2009/10, AHS had one of the lowest overtime to paid hours ratios of seven western provinces' health regions participating in a survey.

In a Conference Board survey, overtime expenses average approximately 5.7 per cent of gross annual payroll among the surveyed organizations. Since 1997, the ratio of overtime hours worked to workers' standard or usual hours of work has remained relatively constant, at about five per cent of all regular hours worked.

Source: The Conference Board of Canada. *Working 9 to 9. Overtime Practices in Canadian Organizations* – August 2009.



Source: Alberta Health Services, Labour Cost System.

Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update expected for Q1 2011/12.

## Number of Netcare Users

### WHAT IS BEING MEASURED?

The number of Netcare Users measures the number of physicians and nurses who access the Alberta Netcare Electronic Health Record (EHR) system across the continuum of care.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?


The Alberta Netcare EHR Portal improves patient care by providing up-to-date information immediately at the point of care. Making basic patient information available to health service providers supports better care decisions and improves patient safety.

### WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target of a 15 per cent increase in Netcare users from 2009/10 to 2010/11.

### HOW ARE WE DOING?

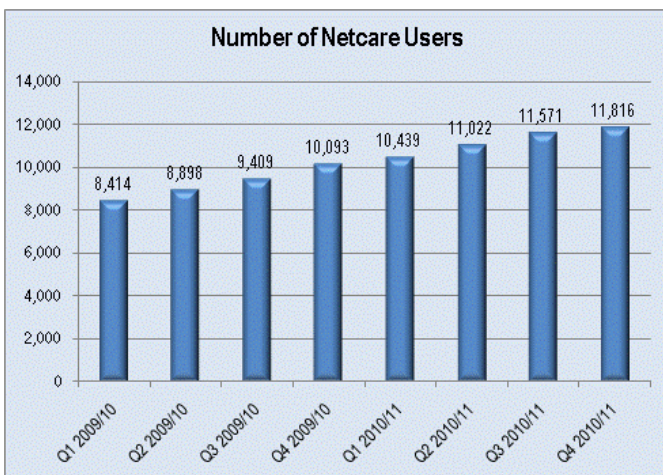
The peak quarterly number of nurses and physicians accessing Netcare was 11,816 in Q4 of 2010/11. This represents a 2 per cent increase over the previous quarter.

 <b>PERFORMANCE STATUS</b> Performance is at or better than target, continue to monitor. Baseline 2009/10: 10,067	<b>2010/11 TARGET:</b> 11,575
	<b>Q4 ACTUAL:</b> 11,816

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Recent activity has focused on enhancing both the number of Netcare users as well as expanding the scope of Netcare functionality for users in the Calgary Zone. As a result, Netcare usage within the Calgary Zone has expanded by 25% over the past 12 months.

Subsequent actions planned: Expansion of Netcare to additional users will continue in the months and years ahead. In the more immediate term, however, electronic viewing of Diagnostic Imaging tests will be made available to Netcare users by Summer 2011, which will have a province-wide positive impact on this measure for the new fiscal year. As well, the upcoming Netcare integration with other patient care information systems should increase significantly the rate of adoption for Calgary-based physicians and nurses in the coming months. In addition, Patient Events in selected sites are planned to be made available as part of the June 2011 (Edmonton, Cross Cancer Centre) and November 2011 (Calgary and Rural Zones) quarterly Netcare releases.



Source: Alberta Netcare Portal

### WHAT ELSE DO WE KNOW?

Alberta Netcare EHR Portal is a highly secure system that protects patient privacy and complies with the *Health Information Act* (HIA).

Information is available by [zone](#).

### HOW DO WE COMPARE?

National benchmark comparisons are not available.



Data updated quarterly.  
Most current data is Q4 2010/11.  
Next data update Q1 2011/12.

### WHAT IS BEING MEASURED?

On Budget Year to Date is an outcome measure that compares the AHS budgeted accumulated surplus (deficit) against the actual accumulated surplus values for the current reporting period.

An accumulated surplus arises when, for all fiscal periods from inception to date, the total operating surpluses exceed the total operating deficits. Operating surpluses (deficits) are the excess (deficiency) of revenue over expenses.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

AHS measures the accumulated surplus in order to identify any areas where the actual performance is changing relative to budget. This enables AHS to identify required changes in its operating plans to expand on positive outcomes or correct potential issues.

The Provincial Government has provided AHS with a five year Health Action Plan funding commitment from which AHS will provide future health care services to Albertans. Over this time period AHS must monitor its operating surpluses closely in order to ensure that the five year funding commitments are not exceeded and to ensure budget sustainability into the future. The annual funding limits from the Government are fixed per the plan and as such AHS must ensure that its planned expenses do not exceed these funding commitments. Knowing the AHS funding targets for the next five years allows AHS to make long term plans while maintaining budget control.

### WHAT IS THE TARGET?

As at March 31, 2011, AHS had established \$0 as the accumulated surplus budget. AHS is committed to having an accumulated surplus greater than \$0 at the end of the five years.

Table: Accumulated Surplus (Deficit) as at:

	Actual (\$ Millions)
March 31, 2010 - actual	(527)
June 30, 2010 - actual	(385)
September 30, 2010 - actual	268
December 30, 2010 - actual	383
March 31, 2011 – actual	116

Source: Audited Annual Financial Statements for the year ended March 31, 2011.



### PERFORMANCE STATUS

Performance is better than annual target, continue to monitor.

2010/11 TARGET  
SURPLUS: \$0

2010/11 ACTUAL  
ACCUMULATED  
SURPLUS: \$116 M

### HOW ARE WE DOING?

At March 31, 2011, the year end accumulated surplus was \$116 million better than budget.

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: From its inception, AHS has worked to establish consistent and comprehensive financial reporting across the organization. In view of staying on budget each year, AHS has developed Budget Monitoring Reports for the Executive Committee. AHS has also worked to improve our culture of accountability by creating a Program Governance Office to track progress of our major initiatives and identify investment opportunities.

Subsequent actions planned: We are currently implementing a process that will continuously monitor budgeted long term costs and revenues to ensure AHS meets the no accumulated deficit target at the end of the five year funding agreement. Implementation of an AHS integrated full service budget and planning module is also in progress.

### WHAT ELSE DO WE KNOW?

The 2011 \$116 million accumulated surplus is due to the one-time \$527 million funding provided by the provincial government to cover the prior years' accumulated deficit. In addition, AHS generated \$329 million of operating surplus, above the \$527 million one-time funding, which was utilized for \$67 million of internal restrictions for the South Health Campus and parking infrastructure reserve, \$138 million for net internally funded capital purchases and \$8 million for repayment of long term debt related to capital assets.

The approved AHS Operating Budget and Business Plan as well as the AHS Quarterly and Annual Audited Financial Statements can be obtained from the [www.albertahealthservices.ca](http://www.albertahealthservices.ca) website.

### HOW DO WE COMPARE?

National benchmark comparisons are not applicable.

Data updated quarterly.  
Most current data is Q3 2010/11.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

Patient satisfaction adult acute care measures the percentage of adults aged 18 years and older discharged from acute care facilities (hospitals) who rate their overall stay as eight, nine or ten on a zero to ten scale, where zero is the worst hospital possible and ten is the best.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

Gathering perceptions and feedback from individuals who use hospital acute care services is a critical aspect of measuring progress and improving the health system. This measure reflects overall patient perceptions associated with the hospital where they received care and is derived from a well-established Hospital Consumer Assessment of Healthcare Providers Survey (HCAHPS).

### WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target of 80 per cent of patients rating their overall hospital stay as eight, nine or ten.

### HOW ARE WE DOING?

The percentage of adults rating their overall hospital stay as eight, nine or ten is above the target of 80 per cent.

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: HCAHPS continues to be rolled out province-wide, which will allow AHS to report by province, zone and site. As a result of the evolving strategic and quality needs of AHS, a decision was made in late 2010 to assess patient satisfaction at all sites on a yearly basis (based on proportional random sampling for each hospital). Over time data will be collected in a variety of ways to reflect patient experience and prompt actions for improvement.

Table: HCACHPS Satisfaction Survey Results

Year 2010/11	Q1	Q2	Q3
Number of Respondents	1581	1515	2244
Valid Answers	1573	1509	2234
Number of Sites	29	29	93
Rated experience as 8 to 10	84.5%	84.6%	82.2%

Source: Alberta Health Services



### PERFORMANCE STATUS

Performance is at or better than target, continue to monitor.

2010/11 TARGET:  
80%

Q3 2010/11 ACTUAL:  
82.2%

Subsequent actions planned: While the H-CAHPS survey tool currently provides valuable data regarding patient satisfaction in acute care, strategies will be developed to establish a comprehensive approach for measuring patient experience. This approach may include the review of data from multiple sources such as satisfaction surveys, the patient concerns process, and commendations. The early 2011 launch of a Feedback and Concerns Tracking (FACT) system will allow this data to be captured and analyzed with a view to establishing provincial best practices. In addition, local improvement initiatives shown to have a strong influence on patient satisfaction will be shared across the system.

### WHAT ELSE DO WE KNOW?

The HCAHPS survey has not been validated for patients with psychiatric diagnoses. An indicator specific to Patient Satisfaction within Addictions and Mental Health is under development.

### HOW DO WE COMPARE?

Comparable HCAHPS data from other provinces are not available. Using a similar measure Alberta ranked ninth among the 10 provinces for satisfaction with hospital services received in 2007. Alberta = 78.5 per cent, Best Performing Province = 87.8 per cent (New Brunswick), Canada = 81.5 per cent (Statistics Canada, 2007). Using a similar measure Alberta ranked 10th among the 10 provinces for satisfaction with their last hospital stay for one or more nights. Alberta = 75 per cent, Best Performing Province = 90 per cent (Prince Edward Island), Canada = 79 per cent (Angus Reid 2009-2010).

## Percentage of Patient Feedback as Commendations

New measure Q4 2010/11.  
Data updated quarterly.  
Next data update expected for Q1 2011/12.

### WHAT IS BEING MEASURED?

This measure calculates the number of commendations received as a percentage of all feedback received by the Alberta Health Services (AHS) Patient Relations Department.

All patient feedback received by the Patient Relations Department is classed as Commendations, Concerns or Questions. The Patient Relations Department also tracks Consultations and Advisements regarding patient concerns received from internal staff. This allows for provincial reporting broken down by locations, programs, and categories/subject of feedback.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

It is important for AHS to learn what is working well for patients and families, as well as areas for improvement. Tracking the percentage of commendations received of all patient feedback assists AHS in assessing the quality of our services and determining if quality improvements are having an impact on patients and families. In addition, the results allow our staff to see where their dedicated efforts are making a difference in people's lives.

### WHAT IS THE TARGET?

A consistent provincial method for tracking patient feedback received by the Patient Relations Department has only been possible since November of 2010 when a new provincial database was implemented. Time is still required to establish benchmarks and identify targets for growth.

<b>PERFORMANCE STATUS</b>  Performance Target for 2010 / 2011 has not been established for comparison.	<b>2010/11 TARGET:</b> TBD
	<b>Q4 ACTUAL:</b> 9.12 %

### HOW ARE WE DOING?

Of the 2,764 pieces of feedback provided to the Patient Relations Department between January-March, 2011 (including Covenant Health), 9.12 per cent were commendations.

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** A provincial Database has been implemented with consistent processes for documenting and reporting on patient feedback. The patient feedback process has also been reviewed to ensure accessibility for patients/families who wish to provide direct feedback to AHS.

**Subsequent actions planned:** Ongoing tracking and reporting of patient feedback will continue and over the course of the next year benchmarks will be established and targets developed. New reporting tools will also be developed to enable more robust reporting that will separate data from Covenant Health. Processes will also be reviewed to simplify the process for patients and families to provide AHS with direct feedback.

### WHAT ELSE DO WE KNOW?

Public messaging and staff education is also being developed on how to provide patient feedback directly to AHS.

Information is available by [zone](#).

### HOW DO WE COMPARE?

This measure is not benchmarked externally.

Table: Patient Commendations

	Total	
	# Commendations	Per cent
Q4 2010/11	252	9.12%

*New measure Q4 2010/11.*  
 Data updated quarterly.  
 Next data update expected for Q1 2011/12.

## Percentage of Patient Concerns Escalated to Patient Concerns Officer

### WHAT IS BEING MEASURED?

This measure calculates the per cent of concerns referred to a Patient Concerns Officer at the conclusion of a review with Patient Relations for the same complaint.

Individuals are encouraged to work with their care team to address any service delivery issues or they may work with the Patient Relations Department. However, some patients/families prefer not to work with either the healthcare team or the Patient Relations Department or may remain dissatisfied with the outcome of the concerns resolution process. These patients/families are referred to the AHS Patient Concerns Officer to conduct an independent investigation as required by provincial regulation.

Detailed indicator [definition](#) is available.

### WHY IS THIS IMPORTANT?

AHS addresses concerns with patients/families as part of our commitment to the provision of quality care and engagement with patients/families. Patient feedback is important to inform quality improvements and it is essential that patients/families feel there is an avenue to express their concerns.

If patients do not feel they can discuss their concerns at the service delivery level, or if they feel concerns are not adequately addressed when referred to the Patient Relations Department, then it is an indication that there is need for AHS to better engage with patients/families and that trust needs to be built with the public.

### WHAT IS THE TARGET?

Provincial tracking of concerns in a consistent manner has only been possible since November of 2010 when a new provincial database was implemented. This is the first quarter for which it has been possible to provide accurate data on concerns that have been consistently tracked, so time is still required to establish benchmarks and identify targets for growth.

<b>PERFORMANCE STATUS</b>  Performance Target for 2010 / 2011 has not been established for comparison	<b>2010/11 TARGET:</b> TBD
	<b>Q4 ACTUAL:</b> 0.29 %

### HOW ARE WE DOING?

During the period of January-March, 2011 six Patient Concerns Officer reviews were initiated on files that had been reviewed by the Patient Relations Department, which amounted to 0.29 per cent.

### WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A provincial database has been implemented with consistent processes for documenting and reporting on patient feedback. The Patient Concerns Resolution Process has also been reviewed to ensure accessibility to the Patient Concerns Officer for patients/families who prefer to address their concerns through this avenue.

Subsequent actions planned: Ongoing tracking and reporting of concerns will continue and over the course of the next year benchmarks will be established and targets developed. Processes will also be reviewed to simplify access to the concerns resolution process to better enable AHS to engage with patients and families.

### WHAT ELSE DO WE KNOW?

Public messaging and staff education is also being developed on how to access the patient concerns resolution process.

Information is available by [zone](#).

### HOW DO WE COMPARE?

This measure is not benchmarked externally.

Table: Patient Concerns Officer Reviews Initiated

	Total	
	#	%
Q4 2010/11	6	0.29%

Source: Alberta Health Services