



**Alberta Health Services
Performance Report
Q1 2011/12**

September 2011

Prepared by
Data Integration, Measurement and Reporting

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Introduction

This performance report has been constructed to demonstrate the progress of Alberta Health Services (AHS) towards meeting the targets and 5-year priorities as outlined in the [2011-2015 Health Plan](#).

AHS intends to become the best performing publicly-funded health care system in Canada. This means that we have to improve both the well-being of Albertans as well as the quality of health services delivered. The combination of performance tracking in both areas will set us apart from other provinces.

AHS is building measurement of health service quality across six dimensions; accessibility, appropriateness, efficiency, effectiveness, safety, and acceptability. We are also examining the well-being of populations across the life cycle from early childhood to youth, adult and seniors.

This balanced review of where we are ‘the best’ and where we need to improve is contained in our planning documents and strategic analysis. We update these improvement targets every three years within a five-year rolling cycle.

By design, this report is not intended to be a balanced scorecard on service quality and well-being; it is focused very much on the areas where we need to improve. There are other measures of performance where Alberta is the best or among the best performing provinces, which are not included in this report. This is not because they are less important, it is because they require less attention in our goal of becoming the best performing health care system in the country. This report will always be a transparent reflection of areas to improve, and by definition reflects a journey of committed action. In most areas these improvements are not a quick fix but require foundational changes to how and when services are delivered.

The targets – how far and how fast – are set in consultation with clinical leaders, Alberta Health and Wellness (AHW), and a review of national benchmarks. Our [5-year Health Action Plan](#) provides a road map on major strategies and initiatives to deliver on these targets. These strategies and initiatives are organized around four major clinical priority areas: (1) wellness and prevention; (2) strengthening primary care; (3) improving access and reducing wait times; and (4) providing more choice for continuing care. Several efforts are underway in order to deliver on these priority areas; for example:

- Seniors – continued capacity building in home care (providing services to more clients), as well as the addition of new continuing care spaces.
- Access and wait times – AHS and AHW are developing a comprehensive wait times policy and measurement approach combined with innovation in the pathways of care and capacity building.
- New clinical assessment triage investment is underway to ensure that we prioritize the patients’ level of need and readiness for treatment on wait lists. This initiative will ensure that we have consistent measurement of wait times from Ready-to-Treat status to Treatment (RTT). Currently, the wait times for a number of our measures (e.g., coronary artery bypass graft, or CABG) are not taken from this point, but from the date of booking with the specialist. As we consistently move toward this RTT definition, AHS anticipates that improvements in the accuracy of patient wait times will occur in the last quarter of 2011/12.
- Emergency Department wait time improvements continue with focused attention on new capacity and processes in each Zone and a dedicated process improvement collaborative.

Reporting our performance: April 1 – June 30, 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.

There are a number of areas where AHS has met or is on track to meet our performance targets for this year. These include: reducing Emergency Department use for family practice sensitive conditions, Health Link access time, cataract surgery wait time, wait time for radiation therapy (ready-to-treat status until first therapy), patient satisfaction rates (in hospitals, as well as with addictions and mental health services), patients discharged from emergency within 4 hours (all sites), patients admitted from emergency to hospital within 8 hours (all sites), and patients admitted from emergency to hospital within 8 hours (high volume sites). It is worth noting that these targets have been met in spite of significant increases in Emergency Department visits (2%), urgent care visits (13%) and Health Link calls (8%) since the same period last year. In addition:

- AHS has also made significant strides on the average wait time in acute/sub-acute care for placement to continuing care (currently at 42 days, with a 2015 target of 30 days)
- Patient satisfaction measures and incidents of harm are within the target level for the system
- In terms of human resources, AHS continues to improve the ratio of employees in full time positions and the numbers of Registered Nurses hired.

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, and coronary artery bypass graft surgeries.

Highlights of actions underway to improve performance in priority areas:

- Ongoing implementation of 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.
- Implementing new technologies to improve efficiency and reduce wait times; for example:
 - The Real-Time Emergency Department Patient Access & Coordination system (REPAC) uses real-time information on patient volumes and the severity of patient conditions in Calgary and Edmonton hospitals to direct ambulance crews to the most appropriate locations. This helps to manage capacity across each city and allows EMS to get back on the street faster. In addition, public access to estimated ED wait times has recently been provided in Calgary as the first phase of a provincial initiative to help people decide where to access care, with a goal to expand the service to other communities in the province.
 - New 'smart cards' which allow ED physicians to quickly and securely access patient health records, medication prescription information, laboratory results, X-rays, CT scans and MRI images from one of several workstations (previously, physicians would have to log in and out of multiple systems and terminals – each requiring its own username and password – to access this same information). A successful trial at the Rockyview General hospital in Calgary was shown to save doctors up to one hour per shift, which has helped to lower wait times. The technology is rolling out to other Calgary hospitals, as well as to other zones, starting with the Edmonton Zone.
 - New electronic decision support tools are being used by nurses and doctors to facilitate proactive discharge planning for those patients who are ready to leave hospital. This helps to free up hospital beds sooner and 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, in addition to the 1,155 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.
 - *Note: as most of the additional continuing care capacity is planned to open between October, 2011 and March, 2012, performance on the number of people waiting for continuing care is not expected to improve significantly until closer to year-end.*
- Expanding Home Care services in an effort to keep seniors safe, healthy and independent in their homes and reduce the number of avoidable ED visits.
- Increasing funding and implementing care pathways for patients requiring hip or knee replacement. An additional 1,000 hip and knee replacement surgeries have been approved for 2011/12 as a means of reducing wait times for these procedures. Care pathways will also enable a central intake of referrals in 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.

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. As we make improvements, we need an ongoing process to measure effectiveness.

This report is more than just numbers, it 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 overall satisfaction 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.

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

What's being measured?

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. Among others, these measures touch upon various dimensions of quality such as: timeliness, effectiveness, efficiency and satisfaction rates.

Assessment of data quality

AHS has initiated a formal process to assess the quality of the performance measures listed in this report, with priority given to the Tier 1 measures highlighted in the [2011-2015 Health Plan](#). The Data Quality and Operational Readiness (DQOR) review process involves multiple stakeholders in an assessment of the people, processes, and information systems responsible for reporting on a given performance measure which, depending on the measure, can take between three to six months to complete. DQOR assessments have been completed for two measures to date (Hip and Knee Replacement Surgery Wait Times), two measures are nearing completion (ED Length of Stay for both Admitted and Discharged patients within the higher volume EDs), and planning is underway for the remainder of the Tier 1 performance measures.

In the interim, an informal assessment of data quality has been initiated for all performance measures included in this report. Operational areas were asked to complete a questionnaire using a subset of items from the formal DQOR review process. Where complete, the results of this informal assessment have been translated into one of the following statements:

- An internal review of the data quality indicates a very high level of confidence with no known issues.
- An internal review of the data quality indicates a high level of confidence with limited issues.
- An internal review of the data quality indicates a moderate level of confidence with some known minor issues.
- An internal review of the data quality indicates an acceptable level of confidence with known issues.
- An internal review of the data quality indicates a questionable level of confidence with known issues.

How to read this report

This report contains a high level system (provincial) dashboard which offers a summary view of AHS performance against the targets we have established for 2011/12. This provincial dashboard shows the performance at the end of the last fiscal year (March, 2011), the target for the 2011/12 year, as well as the year-to-date prorated target and actual performance. The dashboard also shows trends in performance over the last two quarters, as well as over the past year. If the 'stretch' target has been missed, we would still seek to demonstrate improvement from one period to another enabling us to confidently make the right changes to our health system. Each of these three comparisons uses a common "traffic light" method to illustrate how we are doing, as follows:

1. **Year to Date Actual to Target Comparison:** For measures updated on a quarterly basis, we compare to the year-to-date prorated 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 and, over the course of a year, enables us to determine whether we are achieving the level of performance at the rate we expected.

A green square is used when actual performance is at or is better than the prorated target, a yellow triangle 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 circle shows where performance is beyond an acceptable range. A green square or yellow triangle can also be changed to a red

circle if the trends indicate there is risk of not achieving our performance goals for the end of the year.

Indicators measured annually rather than quarterly are evaluated against the year-end target, where performance within 10 per cent is considered an acceptable range, resulting in a yellow triangle.

2. **Consecutive Period Comparison (quarterly or semi-annual measures only):** Here we compare each measure's value to the previous reporting period, be it on a quarterly or semi-annual basis. A green square indicates we are doing better, a dashed line indicates no significant change (within 5 per cent), and a red circle indicates we are not doing as well.
3. **Prior Year Comparison:** Here we compare each measure's value to the previous year. Quarterly measures are compared to the same quarter a year ago, and annual measures are compared to the previous year. A green square indicates we are doing better, a dashed line indicates no significant change (within 5 per cent), and a red circle indicates we are not doing as well.

In addition to the provincial dashboard, a Zone comparison dashboard has been included to allow for an at-a-glance view of performance against the targets across each Zone ([the five geographies providing integrated health services](#)).

Individual Zone dashboards are included as well (following the same format as the provincial dashboard), which present each Zone's performance against the targets. It should be noted that some performance measures have not been allocated to the Zone level due to the nature of a provincial service delivery model.

Following the dashboard views, you also have access to one-page descriptions of each indicator with additional access to detailed definitions, comments on existing performance, actions being taken by AHS to improve performance, more detailed information by zone or site (as appropriate to the specific indicator), and other useful information.

Data lag

Data availability for quarterly updates varies due to data source differences. All but two of the quarterly performance measures in this report are updated to the first quarter (April-June, 2011). For those indicators reporting 4th quarter data (January-March, 2011), the following table explains the reasons for the one quarter reporting lag:

Quarterly Measures with a One Quarter Reporting Lag	Data Timeline Clarification
<ul style="list-style-type: none"> • Patient Satisfaction – Acute Care 	<p>This measure is generated from survey data, where patients are called up to six weeks after they leave the hospital. Data is then prepared and analyzed for reporting. This results in data being available approximately two months after the end of each quarter.</p>
<ul style="list-style-type: none"> • Central Venous Catheter Bloodstream Infection Rate 	<p>As the first of four Infection Prevention and Control measures to be reported publicly, this measure currently undergoes a more rigorous internal review process at both the Zone and Provincial level prior to results being released.</p>

Data updates

This report contains the most currently available data for all performance measures. In addition to those measures updated quarterly, several other measures are updated on a less frequent basis. These measures are detailed as follows with a timeline for their next anticipated update:














Performance Measure	Reporting Frequency	Next Update
• Life Expectancy	Annual	Q4, 2011/12
• Potential Years of Life Lost	Annual	Q4, 2011/12
• Colorectal Cancer Screening Rate	Annual	Q2, 2011/12
• Breast Cancer Screening Participation Rate	Annual	Q2, 2011/12
• Cervical Cancer Screening Participation Rate	Annual	Q2, 2011/12
• Seniors Influenza Immunization Rate	Annual	Q4, 2011/12
• Children's Influenza Immunization Rate	Annual	Q4, 2011/12
• Childhood Immunization Rate for DTaP *	Annual	Q4, 2011/12
• Childhood Immunization Rate for MMR *	Annual	Q3, 2011/12
• Albertans Enrolled in a Primary Care Network	Semi-annual	Q2, 2011/12
• Rating of Care Nursing Home – Family	Every 3 years	Q2, 2011/12
• Rating of Care Nursing Home – Resident	TBD	TBD
• Staff Overall Engagement	Every 2 years	2012
• Physician Overall Engagement	Every 2 years	2012
• Patient Satisfaction – Addiction and Mental Health	Annual	Q4, 2011/12
• Albertans Reporting Unexpected Harm	Every 2 years	2012
• Patient Satisfaction – Emergency Department	Every 2 years	2012
• Patient Satisfaction – Health Care Personally Received	Every 2 years	2012

* There are systemic data quality and submission issues in reporting these immunization rates across the province (most recent reporting is 2008). Development of one provincial information system is underway with full implementation anticipated by 2014. Interim reporting will commence per the timelines indicated.

Data sources

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

Provincial Dashboard



















Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Staying Healthy / Improving Population Health										
◊ Life Expectancy	81.1 2009	tbd		81.6 2010	na				81.1 2009	
◊ Potential Years Life Lost (per 1,000 population)	47.3 2009	tbd		44.8 2010	na				47.3 2009	
Colorectal Cancer Screening Participation Rate	35.5% 2008	37%+ 2010		na	na				na	na
Breast Cancer Screening Participation Rate	55.1% 2007-2008	57%+ 2009-2010		55.9% 2008-2009	▲ ⁺				55.1% 2007-2008	■
Cervical Cancer Screening Participation Rate	71.4% 2006-2008	72%+ 2008-2010		70.7% 2007-2009	▲ ⁺				71.4% 2006-2008	■
Building a Primary Care Foundation										
◊ Seniors (65+) Influenza Immunization Rate	55.6% 2009-2010	75%		58.9% 2010-2011	●				55.6% 2009-2010	
◊ Children (6 to 23 Months) Influenza Immunization Rate	16% 2009-2010	75%		27% 2010-2011	●				16% 2009-2010	
◊ Childhood Immunization Rates for DTaP	83.8% 2008	97%		na	na				na	na
◊ Childhood Immunization Rates for MMR	89.3% 2008	98%		na	na				na	na
Albertans Enrolled in a Primary Care Network (%)	68% Oct 2010	tbd		72% Apr 2011	na	72% Apr 2011	68% Oct 2010		64% Apr 2010	
◊ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	282 2010/11	297 annual	74 (quarterly)	75 Q1 2011/12	▲	75 Q1 2011/12	74 Q4 2010/11	■	72 Q1 2010/11	■
◊ Family Practice Sensitive Conditions (% of ED visits)	27.5% 2010/11	25.0%	26.9%	26.6% Q1 2011/12		26.6% Q1 2011/12	28.1% Q4 2010/11		27.3% Q1 2010/11	■
Health Link Wait Time (% answered within 2 minutes)	77.7% 2010/11	85%	79.5%	81.6% Q1 2011/12		81.6% Q1 2011/12	71.7% Q4 2010/11		77.0% Q1 2010/11	
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled - All urgency Levels	75% 80% 2010/11	90%	79% 83%	72% 73% Q1 2011/12	● ●	72% 73% Q1 2011/12	na 79% Q4 2010/11	na ●	78% Q1 2010/11	●
Improving Access, Reducing Wait Times										
◊ Urgent CABG Wait Time (90th percentile in weeks)	2.1 2010/11	1.0	1.8	1.9 Q1 2011/12	●	1.9 Q1 2011/12	2.2 Q4 2010/11		1.7 Q1 2010/11	●
◊ Semi-urgent CABG Wait Time (90th percentile in weeks)	6.4 2010/11	2.0	5.3	10.8 Q1 2011/12	●	10.8 Q1 2011/12	9.6 Q4 2010/11	●	6.2 Q1 2010/11	●
◊ Scheduled CABG Wait Time (90th percentile in weeks)	24.0 2010/11	6.0	19.5	25.9 Q1 2011/12	●	25.9 Q1 2011/12	19.9 Q4 2010/11	●	28.0 Q1 2010/11	
Notes ◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. † Interim target pending confirmation. Status based on interim target.										

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Hip Replacement Surgery Wait Time (90 th percentile in weeks)	38.9 2010/11	27.0	35.9	43.3 Q1 2011/12	●	43.3 Q1 2011/12	36.6 Q4 2010/11	●	35.1 Q1 2010/11	●
Knee Replacement Surgery Wait Time (90 th percentile in weeks)	48.9 2010/11	35.0	45.4	48.3 Q1 2011/12	●	48.3 Q1 2011/12	48.0 Q4 2010/11	—	47.7 Q1 2010/11	—
Cataract Surgery Wait Time (90 th percentile in weeks)	46.9 2010/11	30.0	42.7	41.7 Q1 2011/12	■	41.7 Q1 2011/12	46.4 Q4 2010/11	■	45.9 Q1 2010/11	■
Other Scheduled Surgery Wait Time (90 th percentile in weeks)	25.7 2010/11	tbd	na	26.1 Q1 2011/12	na	26.1 Q1 2011/12	26.3 Q4 2010/11	—	24.4 Q1 2010/11	●
Radiation Therapy Access (referral to 1st consult) (90 th percentile in weeks)	6.0 2010/11	4.0	5.5	5.7 Q1 2011/12	●	5.7 Q1 2011/12	5.5 Q4 2010/11	—	5.4 Q1 2010/11	●
Radiation Therapy Access (ready to treat to first therapy) (90 th percentile in weeks) £	3.6 2010/11	4.0	4.0	3.3 Q1 2011/12	■	3.3 Q1 2011/12	3.7 Q4 2010/11	■	3.7 Q1 2010/11	■
Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	64% 2010/11	75%	67%	66% Q1 2011/12	●	66% Q1 2011/12	65% Q4 2010/11	—	62% Q1 2010/11	■
Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	80% 2010/11	84%	81%	81% Q1 2011/12	■	81% Q1 2011/12	80% Q4 2010/11	—	80% Q1 2010/11	—
Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	41% 2010/11	60%	46%	46% Q1 2011/12	■	46% Q1 2011/12	44% Q4 2010/11	—	39% Q1 2010/11	■
Patients Admitted from ED within 8 hours (%) (All Sites) £	53% 2010/11	65%	56%	57% Q1 2011/12	■	57% Q1 2011/12	55% Q4 2010/11	—	52% Q1 2010/11	■
Choice and Quality for Seniors										
People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	471 2010/11	375	447	511 Q1 2011/12	●	511 Q1 2011/12	471 Q4 2010/11	●	777 Q1 2010/11	■
People Waiting in Community for Continuing Care Placement	1,115 2010/11	900	1,061	1,150 Q1 2011/12	●	1,150 Q1 2011/12	1,115 Q4 2010/11	—	1,098 Q1 2010/11	—
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	54 2010/11	tbd	na	42 Q1 2011/12	na	42 Q1 2011/12	47 Q4 2010/11	■	53 Q1 2010/11	■
Number of Home Care Clients	112,173 2010/11	tbd	na	59,051 Q1 2011/12	na	59,051 Q1 2011/12	56,029 Q4 2010/11	■	55,593 Q1 2010/11	■
Rating of Care Nursing Home Family	8.1 2008	na							8.1 2008	
Rating of Care Nursing Home Resident	8.1 2008	na							8.1 2008	
Notes ◇ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. £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%.										

Q1 2011/12 AHS Performance Dashboard

(continued)

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Enabling Our People / Enabling One Health System										
◊ Headcount to FTE Ratio	1.57 2010/11	1.62	1.58	1.58 Q1 2011/12	■	1.58 Q1 2011/12	1.57 Q4 2010/11	■	1.57 Q1 2010/11	■
◊ Registered Nurse Graduates Hired by AHS (%) - All Hires - Non-Casual	87% 41% 2010/11	70%	17%	49% 17% Q1 2011/12	■ ■				49% 7% Q1 2010/11	■ ■
◊ Disabling Injury Rate	3.19 2010	2.20	2.94	3.39 Jan-Jun 2011 (annualized)	●	3.39 Jan-Jun 2011 (annualized)	3.19 2010	●	3.19 2010	●
◊ Staff Overall Engagement (%)	35% 2009/10	54%								
◊ Physician Overall Engagement (%)	26% 2009/10	54%								
Full-time to Part-time Clinical Worker Ratio	0.91 2010/11	na	na	0.91 Q1 2011/12	na	0.91 Q1 2011/12	0.91 Q4 2010/11	■	0.93 Q1 2010/11	■
Employee Absenteeism Rate	12.19 2010/11	na	na	12.12 Q1 2011/12 (annualized)	na				na	na
Overtime Hours to Paid Hours Ratio	1.70% 2010/11	na	na	1.91% Q1 2011/12	na	1.91% Q1 2011/12	2.17% Q4 2010/11	■	1.44% Q1 2010/11	●
Total Labour Cost per Worked Hour	\$52.04 2010/11	tbd	na	\$50.97 Q1 2011/12	na	\$50.97 Q1 2011/12	na Q4 2010/11	na	na Q1 2010/11	na
◊ Number of Netcare Users	11,816 2010/11	12,735	12,046	12,708 Q1 2011/12	■	12,708 Q1 2011/12	11,816 Q4 2010/11	■	10,439 Q1 2010/11	■
On Budget: Year to Date	\$116M Surplus 2010/11	\$36M		\$175M		\$175M Q1 2011/12	\$116M Surplus Q4 2010/11		(\$385M) Deficit Q1 2010/11	
◊ Adherence to 5 Year Budgeted Government Funding	Measurement strategy and targets under development; no reporting strategy or start time available.									
Notes ◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.										

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Quality and Patient Safety										
◊ Patient Satisfaction - Acute Care	na 2010/11	80% 2010/11	80% 2010/11	81.4% Q4 2010/11		81.4% Q4 2010/11	82.2% Q3 2010/11		na Q4 2009/10	na
◊ Patient Satisfaction - Addictions and Mental Health (AHS)	na 2009/10	85%		93% 2010/11					na 2009/10	na
Percentage of Patient Feedback as Commendations	na 2010/11	tbd		8.53% Q1 2011/12	na	8.53% Q1 2011/12	9.12% Q4 2010/11		na Q1 2010/11	na
Percentage of Patient Concerns Escalated to Patient Concerns Officer	na 2010/11	tbd		0.63% Q1 2011/12	na	0.63% Q1 2011/12	0.29% Q4 2010/11		na Q1 2010/11	na
◊ Albertans Reporting Unexpected Harm	10% 2008	9%		9% 2010					10% 2008	
◊ Patient Satisfaction Emergency Department	58% 2008	70%		59% 2010					58% 2008	
◊ Patient Satisfaction Health Care Services Personally Received	60% 2008	tbd		62% 2010	na				60% 2008	
Central Venous Catheter Bloodstream Infection Rate	na 2010/11	tbd	na	1.26 Q4 2010/11	na	1.26 Q4 2010/11	1.02 Q3 2010/11		0.65 Q4 2009/10	
◊ 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 2011/12									
Time to Resolve Patient Concerns	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/12									
Notes										
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.										
Status						Period Comparative Performance				
 Performance is at or better than target, continue to monitor						 Current period performance is better than comparative period				
 Performance is within acceptable range of target, monitor and take action as appropriate						 Current period performance is within 5% of comparative period				
 Performance is outside acceptable range of target, take action and monitor progress						 Current period performance is worse than comparative period				























Zone Comparison Dashboard Q1 2011/12

Performance Measure	Zone 1 - South	Zone 2 - Calgary	Zone 3 - Central	Zone 4 - Edmonton	Zone 5 - North	AHS	AHS Annual Target 2011/12
Staying Healthy / Improving Population Health							
Life Expectancy	80.3 2010	82.9 2010	80.7 2010	81.8 2010	79.8 2010	81.6 2010	na
Potential Years of Life Lost (per 1,000 Population)	49.6 2010	37.0 2010	51.4 2010	45.7 2010	56.8 2010	44.8 2010	na
Colorectal Cancer Screening Participation Rate	Measure not reported at Zone level.					35.5% 2008	37%+ 2010
Breast Cancer Screening Participation Rate	57.2% 2008-2009	51.9% 2008-2009	54.1% 2008-2009	54.7% 2008-2009	57.8% 2008-2009	55.9% 2008-2009	57%+ 2009-2010
Cervical Cancer Screening Participation Rate	65.1 Jan 2007 - Dec 2009	74.8 Jan 2007 - Dec 2009	64.8 Jan 2007 - Dec 2009	70.1 Jan 2007 - Dec 2009	62.1 Jan 2007 - Dec 2009	70.7 Jan 2007 - Dec 2009	72%+ 2008-10
Building a Primary Care Foundation							
Seniors (65+) Influenza Immunization Rate	59.1% 2010-2011	62.2% 2010-2011	53.9% 2010-2011	60.4% 2010-2011	48.8% 2010-2011	58.9% 2010-2011	75%
Children (6 to 23 Months) Influenza Immunization Rate	21% 2010-2011	39% 2010-2011	22% 2010-2011	20% 2010-2011	18% 2010-2011	27% 2010-2011	75%
Childhood Immunization Rates for DTaP	83.6% 2008	86.2% 2008	75.1% 2008	87.0% 2008	78.2% 2008	83.8% 2008	97%
Childhood Immunization Rates for MMR	88.30% 2008	87.77% 2008	86.82% 2008	92.45% 2008	89.24% 2008	89.27% 2008	98%
Albertans Enrolled in a Primary Care Network (%)	74% Apr 2011	77% Apr 2011	66% Apr 2011	70% Apr 2011	63% Apr 2011	72% Apr 2011	tbd
Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	100 Q1 2011/12	56 Q1 2011/12	92 Q1 2011/12	64 Q1 2011/12	136 Q1 2011/12	75 Q1 2011/12	297 (annual)
Family Practice Sensitive Conditions (% of ED visits)	29.1% Q1 2011/12	20.6% Q1 2011/12	31.9% Q1 2011/12	14.8% Q1 2011/12	38.6% Q1 2011/12	26.6% Q1 2011/12	25%
Health Link Wait Time (% answered within 2 minutes)	Measure not reported at Zone level.					81.6% Q1 2011/12	85%
Children Receiving Community Mental Health Treatment within 30 Days (%)	93% Q1 2011/12	74% Q1 2011/12	95% Q1 2011/12	34% Q1 2011/12	68% Q1 2011/12	72% Q1 2011/12	90%
	93% Q1 2011/12	76% Q1 2011/12	95% Q1 2011/12	36% Q1 2011/12	74% Q1 2011/12	73% Q1 2011/12	
Improving Access, Reducing Wait Times							
Urgent CABG Wait Time (90th percentile in weeks)	np	1.7 Q1 2011/12	np	1.9 Q1 2011/12	np	1.9 Q1 2011/12	1
Semi-urgent CABG Wait Time (90th percentile in weeks)	np	8.6 Q1 2011/12	np	13.0 Q1 2011/12	np	10.8 Q1 2011/12	2
Scheduled CABG Wait Time (90th percentile in weeks)	np	30.8 Q1 2011/12	np	20.6 Q1 2011/12	np	25.9 Q1 2011/12	6
Hip Replacement Surgery Wait Time (90th percentile in weeks)	35.4 Q1 2011/12	30.6 Q1 2011/12	32.7 Q1 2011/12	54.0 Q1 2011/12	49.6 Q1 2011/12	43.3 Q1 2011/12	27
Knee Replacement Surgery Wait Time (90th percentile in weeks)	50.7 Q1 2011/12	34.9 Q1 2011/12	32.7 Q1 2011/12	57.9 Q1 2011/12	50.9 Q1 2011/12	48.3 Q1 2011/12	35
Cataract Surgery Wait Time (90th percentile in weeks)	45.6 Q1 2011/12	47.0 Q1 2011/12	28.4 Q1 2011/12	37.3 Q1 2011/12	53.8 Q1 2011/12	41.7 Q1 2011/12	30
Other Scheduled Surgery Wait Time (90th percentile in weeks)	25.0 Q1 2011/12	27.6 Q1 2011/12	24.6 Q1 2011/12	26.0 Q1 2011/12	23.7 Q1 2011/12	26.1 Q1 2011/12	tbd
np - service not provided. CABG procedures not currently provided in South, Central and North Zones; Radiation Therapy not currently provided in Central and North Zones.							

Performance Measure	Zone 1 - South	Zone 2 - Calgary	Zone 3 - Central	Zone 4 - Edmonton	Zone 5 - North	AHS	AHS Annual Target 2011/12
Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	3.0 Q1 2011/12	6.3 Q1 2011/12	np	4.9 Q1 2011/12	np	5.7 Q1 2011/12	4
Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks)	2.0 Q1 2011/12	3.4 Q1 2011/12	np	3.3 Q1 2011/12	np	3.3 Q1 2011/12	4
Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume EDs) £	83% Q1 2011/12	63% Q1 2011/12	72% Q1 2011/12	60% Q1 2011/12	78% Q1 2011/12	66% Q1 2011/12	75%
Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	91% Q1 2011/12	75% Q1 2011/12	90% Q1 2011/12	66% Q1 2011/12	90% Q1 2011/12	81% Q1 2011/12	84%
Patients Admitted from ED within 8 hours (%) (15 Higher Volume EDs) £	91% Q1 2011/12	45% Q1 2011/12	51% Q1 2011/12	31% Q1 2011/12	67% Q1 2011/12	46% Q1 2011/12	60%
Patients Admitted from ED within 8 hours (%) (All Sites) £	91% Q1 2011/12	47% Q1 2011/12	75% Q1 2011/12	32% Q1 2011/12	85% Q1 2011/12	57% Q1 2011/12	65%
Choice and Quality for Seniors							
People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	15 Q1 2011/12 (Target = 10)	199 Q1 2011/12 (Target = 138)	57 Q1 2011/12 (Target = 52)	165 Q1 2011/12 (Target = 127)	75 Q1 2011/12 (Target = 52)	511 Q1 2011/12	375
People Waiting in Community for Continuing Care Placement	73 Q1 2011/12 (Target = 52)	517 Q1 2011/12 (Target = 404)	169 Q1 2011/12 (Target = 118)	284 Q1 2011/12 (Target = 235)	107 Q1 2011/12 (Target = 92)	1,150 Q1 2011/12	900
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	13 Q1 2011/12	50 Q1 2011/12	35 Q1 2011/12	33 Q1 2011/12	118 Q1 2011/12	42 Q1 2011/12	tbd
Number of Home Care Clients	5,700 Q1 2011/12	16,303 Q1 2011/12	9,243 Q1 2011/12	20,945 Q1 2011/12	6,860 Q1 2011/12	59,051 Q1 2011/12	tbd
Rating of Care Nursing Home Family	Measure not reported at Zone level.					8.1 2008	
Rating of Care Nursing Home Resident	Measure not reported at Zone level.					8.1 2008	
Enabling Our People / Enabling One Health System							
Headcount to FTE Ratio	Measure not reported at Zone level.					1.58 Q1 2011/12	1.62
Registered Nurse Graduates Hired by AHS (%)	- All Hires - Non-Casual Measure not reported at Zone level.					49%	70%
						17% Q1 2011/12	
Disabling Injury Rate	Measure not reported at Zone level.					3.99 Apr-Jun 2011 (annualized)	2.2
Staff Overall Engagement (%)	35% 2009/10	33% 2009/10	35% 2009/10	37% 2009/10	41% 2009/10	35% 2009/10	54%
Physician Overall Engagement (%)	20% 2009/10	27% 2009/10	27% 2009/10	25% 2009/10	27% 2009/10	26% 2009/10	54%
Full-time to Part-time Clinical Worker Ratio	Measure not reported at Zone level.					0.91 Q1 2011/12	tbd
Employee Absenteeism Rate	Measure not reported at Zone level.					12.12 Q1 2011/12 (annualized)	tbd
Overtime Hours to Paid Hours Ratio	Measure not reported at Zone level.					1.91% Q1 2011/12	tbd
Total Labour Cost per Worked Hour	Measure not reported at Zone level.					\$50.97 Q1 2011/12	tbd

np - service not provided. CABG procedures not currently provided in South, Central and North Zones; Radiation Therapy not currently provided in Central and North Zones.

£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%.

Performance Measure	Zone 1 - South	Zone 2 - Calgary	Zone 3 - Central	Zone 4 - Edmonton	Zone 5 - North	AHS	AHS Annual Target 2011/12
Number of Netcare Users	Measure not reported at Zone level.					12,708 Q1 2011/12	13,311
On Budget: Year to Date	Measure not reported at Zone level.					Q1 2011/12	\$0
Adherence to 5 Year Budgeted Government Funding	Measurement strategy and targets under development.						
Quality and Patient Safety							
Patient Satisfaction - Acute Care	77.7% Q4 2010/11 	83.1% Q4 2010/11 	81.7% Q4 2010/11 	80.3% Q4 2010/11 	82.4% Q4 2010/11 	81.4% Q4 2010/11 	80% 2010/11
Patient Satisfaction – Addictions and Mental Health	na	na	na	na	na	93% 2010/11 	85%
Percentage of Patient Feedback as Commendations	Measure not reported at Zone level.					8.53% Q1 2011/12	tbd
Percentage of Patient Concerns Escalated to Patient Concerns Officer	Measure not reported at Zone level.					0.63% Q1 2011/12	tbd
Albertans Reporting Unexpected Harm	8% 2010 	10% 2010 	8% 2010 	9% 2010 	8% 2010 	9% 2010 	9%
Patient Satisfaction Emergency Department	59% 2010 	61% 2010 	63% 2010 	55% 2010 	58% 2010 	59% 2010 	70%
Patient Satisfaction Health Care Services Personally Received	66% 2010	60% 2010	66% 2010	65% 2010	53% 2010	62% 2010	tbd
Central Venous Catheter Bloodstream Infection Rate	Measure not reported at Zone level.					1.26 Q4 2010/11	tbd
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	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Staying Healthy / Improving Population Health										
◊ Life Expectancy	80.1 2009	tbd		80.3 2010	na				80.1 2009	■
◊ Potential Years Life Lost (per 1,000 population)		tbd		49.6 2010	na				54.8 2009	■
Breast Cancer Screening Participation Rate	na	na		na	na	na	57.2% 2008-2009	na	na	na
Cervical Cancer Screening Participation Rate	na	na		na	na	na	65.1% 2007-2009	na	na	na
Building a Primary Care Foundation										
◊ Seniors (65+) Influenza Immunization Rate	57.7% 2009-2010	75%		59.1% 2010-2011	●				55.7% 2009-2010	
◊ Children (6 to 23 Months) Influenza Immunization Rate	22% 2009-2010	75%		21.0% 2010-2011	●				22% 2009-2010	
◊ Childhood Immunization Rates for DTaP	83.6% 2008	97%		na	na				na	na
◊ Childhood Immunization Rates for MMR	88.30% 2008	98%		na	na				na	na
Albertans Enrolled in a Primary Care Network (%)	74% Oct 2010	tbd		74% Apr 2011	na	74% Apr 2011	74% Oct 2010	■	74% Apr 2010	■
◊ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	390 2010/11	297 Annual	74 (quarterly)	100 Q1 2011/2012	●	100 Q1 2011/12	102 Q4 2010/11	■	106 Q1 2010/11	■
◊ Family Practice Sensitive Conditions (% of ED visits)	29.2% 2010/11	25.0%	26.9%	29.1% Q1 2011/2012	●	29.1% Q1 2011/2012	30.2% Q4 2010/11	■	29.4% Q1 2010/11	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled - All urgency Levels	95.0% 94.0% 2010/11	90%	79% 83%	93% 93% Q1 2011/12	■ ■	93% 93% Q1 2011/12	na 91% Q4 2010/11	na ■	na 97% Q1 2010/11	na ■
Improving Access, Reducing Wait Times										
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	43.4 2010/11	27.0	35.9	35.4 Q1 2011/12	■	35.4 Q1 2011/12	42.3 Q4 2010/11	■	45.6 Q1 2010/11	■
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	57.5 2010/11	35.0	45.4	50.7 Q1 2011/12	●	50.7 Q1 2011/12	63.8 Q4 2010/11	■	54.9 Q1 2010/11	■
◊ Cataract Surgery Wait Time (90th percentile in weeks)	44.3 2010/11	30.0	42.7	45.6 Q1 2011/12	●	45.6 Q1 2011/12	42.1 Q4 2010/11	●	46.6 Q1 2010/11	■
Other Scheduled Surgery Wait Time (90th percentile in weeks)	26.1 2010/11	tbd	na	25.0 Q1 2011/12	na	25.0 Q1 2011/12	23.3 Q4 2010/11	●	26.4 Q1 2010/11	■
Notes ◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. † Interim target pending confirmation. Status based on interim target.										

Q1 2011/12 AHS Performance Dashboard

South Zone (continued)

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
◇ Radiation Therapy Access (referral to 1 st consult) (90 th percentile in weeks)	4.5 2010/11	4.0	5.5	3.0 Q1 2011/12	■	3.0 Q1 2011/12	4.9 Q4 2010/11	■	na Q1 2010/11	
◇ Radiation Therapy Access (ready to treat to first therapy) (90 th percentile in weeks) £	2.1 2010/11	4.0	4.0	2.0 Q1 2011/12	■	2.0 Q1 2011/12	1.6 Q4 2010/11	●	na Q1 2010/11	
◇ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	83.0% 2010/11	75%	67%	83% Q1 2011/12	■	83% Q1 2011/12	82% Q4 2010/11	■	85% Q1 2010/11	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	90.0% 2010/11	84%	81%	91% Q1 2011/12	■	91% Q1 2011/12	89% Q1 2011/12	■	91% Q1 2010/11	■
◇ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	89.0% 2010/11	60%	46%	91% Q1 2011/12	■	91% Q1 2011/12	88% Q4 2010/11	■	90% Q1 2010/11	■
◇ Patients Admitted from ED within 8 hours (%) (All Sites) £	90.0% 2010/11	65%	56%	91% Q1 2011/12	■	91% Q1 2011/12	88% Q1 2010/11	■	91% Q1 2010/11	■
Choice and Quality for Seniors										
◇ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	22 2010/11	10	19	15 Q1 2011/12	●	15 Q1 2011/12	22 Q4 2010/11	■	31 Q1 2010/11	■
◇ People Waiting in Community for Continuing Care Placement	67 2010/11	52	63	73 Q1 2011/12	●	73 Q1 2011/12	67 Q4 2010/11	●	68 Q1 2010/11	●
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	21 2010/11	tbd	na	13 Q1 2011/12	na	13 Q1 2011/12	16 Q4 2010/11	■	24 Q1 2010/11	■
◇ Number of Home Care Clients	5,587 Q4 2010/11	tbd	na	5,700 Q1 2011/12	na	5,700 Q1 2011/12	5,587 Q1 2011/12	■	5,995 Q1 2010/11	■
Enabling Our People / Enabling One Health System										
◇ Staff Overall Engagement (%)	35% 2009/10	54%								
◇ Physician Overall Engagement (%)	20% 2009/10	54%								
Quality and Patient Safety										
◇ Patient Satisfaction – Acute Care	na 2010/11	80% 2010/11	80%	77.7% Q4 2010/11	▲	77.7% Q4 2010/11	na	na	na	na
◇ Albertans Reporting Unexpected Harm	10% 2008	9%		8% 2010	■	8% 2010	10% 2008	■	na	na
◇ Patient Satisfaction Emergency Department	62% 2008	70%		59% 2010	●	59% 2010	62% 2008	■	na	na
◇ Patient Satisfaction Health Care Services Personally Received	65% 2008	tbd	na	66% 2010	na	66% 2010	65% 2008	■		
Notes ◇ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. £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%.										

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

Comparative Performance

- Current period performance is better than comparative period
- Current period performance is within 5% of comparative period
- Current period performance is worse than comparative period

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Staying Healthy / Improving Population Health										
◊ Life Expectancy	82.4 2009	tbd		82.9 2010	na				82.4 2009	■
◊ Potential Years Life Lost (per 1,000 population)	38.5 2009	tbd		37.0 2010	na				38.5 2009	■
Breast Cancer Screening Participation Rate	51.7% 2007-2008	57%+ 2009-2010		51.9% 2008-2009	na				51.7% 2007-2008	■
Cervical Cancer Screening Participation Rate	75.5% Jan 2006 - Dec 2008	72%+ 2008-2010		74.8% Jan 2007 - Dec 2009	na				75.5% Jan 2006 - Dec 2008	■
Building a Primary Care Foundation										
◊ Seniors (65+) Influenza Immunization Rate	56.5% 2009-2010	75%		62.2% 2010-2011	●				56.5% 2009-2010	■
◊ Children (6 to 23 Months) Influenza Immunization Rate	19.0% 2009-2010	75%		39.0% 2010-2011	●				19.0% 2009-2010	■
◊ Childhood Immunization Rates for DTaP	86.2% 2008	97%		na	na				86.9% 2005	
◊ Childhood Immunization Rates for MMR	87.8% 2008	98%		na	na				94.8% 2005	
Albertans Enrolled in a Primary Care Network (%)	74% Oct 2010	tbd		77% Apr 2011	na	77% Apr 2011	74% Oct 2010	■	68% Apr 2009	■
◊ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	221 2010/11	297 annual	74 (quarterly)	56 Q1 2011/12	■	56 Q1 2011/12	56 Q4 2010/11	■	56 Q1 2010/11	■
◊ Family Practice Sensitive Conditions (% of ED visits)	21.3% 2010/11	25%	26.9%	20.6% Q1 2011/12	■	20.6% Q1 2011/12	22.2% Q4 2010/11	■	21.3% Q1 2010/11	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) – Scheduled – All urgency Levels	73.0% 76.0% 2010/11	90% 90%	79% 83%	74% 76% Q1 2011/12	● ●	74% 76% Q1 2011/12	na 80% Q4 2010/11	na ●	na 72% Q1 2010/11	na ■
Notes ◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. + Interim target pending confirmation. Status based on interim target. * Trend for these measures cannot be determined until subsequent data is available										

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Improving Access, Reducing Wait Times										
◇ Urgent CABG Wait Time (90th percentile in weeks)	1.6 2010/11	1.0	1.8	1.7 Q1 2011/12	■	1.7 Q1 2011/12	1.8 Q4 2010/11	■	1.6 Q1 2010/11	●
◇ Semi-urgent CABG Wait Time (90th percentile in weeks)	3.2 2010/11	2.0	5.3	8.6 Q1 2011/12	●	8.6 Q1 2011/12	6.1 Q4 2010/11	●	2.4 Q1 2010/11	●
◇ Scheduled CABG Wait Time (90th percentile in weeks)	28.0 2010/11	6.0	19.5	30.8 Q1 2011/12	●	30.8 Q1 2011/12	24.7 Q4 2010/11	●	38.1 Q1 2010/11	■
◇ Hip Replacement Surgery Wait Time (90th percentile in weeks)	30.4 2010/11	27.0	35.9	30.6 Q1 2011/12	■	30.6 Q1 2011/12	29.8 Q4 2010/11	■	27.6 Q1 2010/11	●
◇ Knee Replacement Surgery Wait Time (90th percentile in weeks)	34.3 2010/11	35.0	45.4	34.9 Q1 2011/12	■	34.9 Q1 2011/12	33.3 Q4 2010/11	●	33.0 Q1 2010/11	●
◇ Cataract Surgery Wait Time (90th percentile in weeks)	61.9 2010/11	30.0	42.7	47.0 Q1 2011/12	●	47.0 Q1 2011/12	56.9 Q4 2010/11	■	63.5 Q1 2010/11	■
Other Scheduled Surgery Wait Time (90th percentile in weeks)	26.7 2010/11	tbd	na	27.6 Q1 2011/12	na	27.6 Q1 2011/12	27.7 Q4 2010/11	■	26.3 Q1 2010/11	■
◇ Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	6.0 2010/11	4.0	5.5	6.3 Q1 2011/12	●	6.3 Q1 2011/12	6.0 Q4 2010/11	■	4.9 Q1 2010/11	●
◇ Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks) £	3.7 2010/11	4.0	4.0	3.4 Q1 2011/12	■	3.4 Q1 2011/12	3.7 Q4 2010/11	■	3.9 Q1 2010/11	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	57.0% 2010/11	75%	67%	63% Q1 2011/12	●	63% Q1 2011/12	61% Q4 2010/11	■	52% Q1 2010/11	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	72.0% 2010/11	84%	81%	75% Q1 2011/12	●	75% Q1 2011/12	73% Q4 2010/11	■	70% Q1 2010/11	■
◇ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	35.0% 2010/11	60%	46%	45% Q1 2011/12	▲	45% Q1 2011/12	42% Q4 2010/11	■	31% Q1 2010/11	■
◇ Patients Admitted from ED within 8 hours (%) (All Sites) £	37.0% 2010/11	65%	56%	47% Q1 2011/12	●	47% Q1 2011/12	44% Q4 2010/11	■	33% Q1 2010/11	■
Choice and Quality for Seniors										
◇ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	146 2010/11	138	144	199 Q1 2011/12	●	199 Q1 2011/12	146 Q4 2010/11	●	258 Q1 2010/11	■
◇ People Waiting in Community for Continuing Care Placement	504 2010/11	404	479	517 Q1 2011/12	●	517 Q1 2011/12	504 Q4 2010/11	■	432 Q1 2010/11	●
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	55 2010/11	tbd	na	50 Q1 2011/12	na	50 Q1 2011/12	47 Q4 2010/11	●	57 Q1 2010/11	■
◇ Number of Home Care Clients	na 2010/11	tbd	na	16,303 Q1 2011/12	na	16,303 Q1 2011/12	14,252 Q4 2010/11	●	15,796 Q1 2010/11	■
Notes ◇ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. £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%.										

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Enabling Our People / Enabling One Health System										
◇ Staff Overall Engagement (%)	33% 2009/10	54%								
◇ Physician Overall Engagement (%)	27% 2009/10	54%								
Quality and Patient Safety										
◇ Patient Satisfaction – Acute Care	na 2010/11	80% 2010/11	80%	83.1% Q4 2010/11	■	83.1% Q4 2010/11	na Q3 2010/11	na	na Q4 2009/10	na
◇ Albertans Reporting Unexpected Harm	10% 2008	9%		10% 2010	▲	10% 2010	10% 2008	■	14% 2003	■
◇ Patient Satisfaction Emergency Department	58% 2008	70%		61% 2010	●	61% 2010	58% 2008	■	46% 2003	■
◇ Patient Satisfaction Health Care Services Personally Received	57% 2008	tbd	na	60% 2010	na	60% 2010	57% 2008	■	0%	na
Notes										
◇ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.										

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

Period Comparative Performance







- Current period performance is better than comparative period
- Current period performance is within 5% of comparative period
- Current period performance is worse than comparative period

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Staying Healthy / Improving Population Health										
◊ Life Expectancy	80.1 2009	tbd		80.7 2010	na				80.1 2009	■
◊ Potential Years Life Lost (per 1,000 population)	56.1 2009	tbd		51.4 2010	na				56.1 2009	
Breast Cancer Screening Participation Rate	53.5% 2007-2008	57%+ 2009-2010		54.1% 2008-2009	na				53.5% 2007-2008	
Cervical Cancer Screening Participation Rate	65.5 Jan 2006 - Dec 2008	72%+ 2008-2010		64.8 Jan 2007 - Dec 2009	na				65.5 Jan 2006 - Dec 2008	
Building a Primary Care Foundation										
◊ Seniors (65+) Influenza Immunization Rate	43.8% 2009-2010	75.0%		53.9% 2010-2011	●				43.8% 2009-2010	■
◊ Children (6 to 23 Months) Influenza Immunization Rate	9% 2009-2010	75.0%		22% 2010-2011	●				9% 2009-2010	■
◊ Childhood Immunization Rates for DTaP	75.1% 2008	97%		na	na				na	na
◊ Childhood Immunization Rates for MMR	86.8% 2008	98%		na	na				na	na
Albertans Enrolled in a Primary Care Network (%)	61% Oct 2010	tbd		66% Apr 2011	na	66% Apr 2011	61% Oct 2010	■	53% Apr 2010	■
◊ Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)	352 2010/11	297 annual	74 (quarterly)	92 Q1 2011/12	●	92 Q1 2011/12	96 Q4 2010/12	■	89 Q1 2010/12	■
◊ Family Practice Sensitive Conditions (% of ED visits)	32.6% 2010/11	25.0%	26.9%	31.9% Q1 2011/12	●	31.9% Q1 2011/12	33.9% Q4 2010/12	■	32.1% Q1 2010/12	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	89.0%	90%	79%	95% Q1 2011/12	■	95%	na	na	na	na
- All urgency Levels	90.0% 2010/11	90%	83%	95%	■	95%	96% Q4 2010/11	■	85% Q1 2010/11	■
Notes ◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. † Interim target pending confirmation. Status based on interim target. * Trend for these measures cannot be determined until subsequent data is available										




Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Improving Access, Reducing Wait Times										
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	26.4 2010/11	27.0	35.9	32.7 Q1 2011/12	■	32.7 Q1 2011/12	27.0 Q4 2010/11	●	19.4 Q1 2010/11	●
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	30.2 2010/11	35.0	45.4	32.7 Q1 2011/12	■	32.7 Q1 2011/12	27.5 Q4 2010/11	●	40.4 Q1 2010/11	■
◊ Cataract Surgery Wait Time (90th percentile in weeks)	28.6 2010/11	30.0	42.7	28.4 Q1 2011/12	■	28.4 Q1 2011/12	26.7 Q4 2010/11	●	35.1 Q1 2010/11	■
Other Scheduled Surgery Wait Time (90th percentile in weeks)	25.1 2010/11	tbd	na	24.6 Q1 2011/12	na	24.6 Q1 2011/12	25.1 Q4 2010/11	■	23.1 Q1 2010/11	●
◊ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	74.0% 2010/11	75%	67%	72% Q1 2011/12	■	72% Q1 2011/12	74% Q4 2010/11	■	74% Q1 2010/11	■
◊ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	91.0% 2010/11	84%	81%	90% Q1 2011/12	■	90% Q1 2011/12	91% Q4 2010/11	■	91% Q1 2010/11	■
◊ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	47.0% 2010/11	60%	46%	51% Q1 2011/12	■	51% Q1 2011/12	54% Q4 2010/11	●	42% Q1 2010/11	■
◊ Patients Admitted from ED within 8 hours (%) (All Sites) £	74.0% 2010/11	65%	56%	75% Q1 2011/12	■	75% Q1 2011/12	76% Q4 2010/11	■	73% Q1 2010/11	■
Choice and Quality for Seniors										
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	65 2010/11	52	62	57 Q1 2011/12	▲	57 Q1 2011/12	65 Q4 2010/11	■	109 Q1 2010/11	■
◊ People Waiting in Community for Continuing Care Placement	128 2010/11	118	126	169 Q1 2011/12	●	169 Q1 2011/12	128 Q4 2010/11	●	152 Q1 2010/11	●
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	57 2010/11	tbd	na	35 Q1 2011/12	na	35 Q1 2011/12	37 Q4 2010/11	■	61 Q1 2010/11	■
◊ Number of Home Care Clients	9,071 Q4 2010/11	tbd	na	9,243 Q1 2011/12	na	9,243 Q1 2011/12	9,071 Q4 2010/11	■	6,574 Q1 2010/11	●
Enabling Our People / Enabling One Health System										
◊ Staff Overall Engagement (%)	35% 2009/10	54.0%								
◊ Physician Overall Engagement (%)	27% 2009/10	54.0%								
Notes ◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. £ 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%.										

Q1 2011/12 AHS Performance Dashboard




Central Zone (continued)

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Quality and Patient Safety										
◇ Patient Satisfaction – Acute Care	na 2010/11	80% 2010/11	80%	81.7% Q4 2010/11		81.7% Q4 2010/11	na Q3 2010/11	na	na Q4 2009/10	na
◇ Albertans Reporting Unexpected Harm	10% 2008	9%		8% 2010		8% 2010	10% 2008		na	
◇ Patient Satisfaction Emergency Department	64% 2008	70%		63% 2010		63% 2010	58% 2008		na	
◇ Patient Satisfaction Health Care Services Personally Received	57% 2008	tbd	na	66% 2010	na	60% 2010	57% 2008		na	
Notes ◇ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.										

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

Comparative Performance

-  Current period performance is better than comparative period
-  Current period performance is within 5% of comparative period
-  Current period performance is worse than comparative period

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Staying Healthy / Improving Population Health										
◊ Life Expectancy	81.0 2009	tbd		81.8 2010	na				81.0 2009	■
◊ Potential Years Life Lost (per 1,000 population)	48.4 2009	tbd		45.7 2010	na				48.4 2009	■
Breast Cancer Screening Participation Rate	na	na		54.7% 2008-2009	na				na	na
Cervical Cancer Screening Participation Rate	na	na		70.1% Jan 2007 - Dec 2009	na				na	na
Building a Primary Care Foundation										
◊ Seniors (65+) Influenza Immunization Rate	61.0% 2009/10	75.0%		60.4% 2010/11	●				61.0% 2009/10	■
◊ Children (6 to 23 Months) Influenza Immunization Rate	14.0% 2009-2010	75.0%		20.0% 2010-2011	●				14.0% 2009-2010	■
◊ Childhood Immunization Rates for DTaP	87.0% 2008	97.0%		na	na				na	na
◊ Childhood Immunization Rates for MMR	92.5% 2008	98.0%		na	na				na	na
Albertans Enrolled in a Primary Care Network (%)	66% Oct 2010	tbd		70% Apr 2011	na	70% Apr 2011	66% Oct 2010	■	64% Apr 2010	■
◊ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	231 2010/11	297 annual	74 (quarterly)	64 Q1 2011/12	■	64 Q1 2011/12	60 Q4 2010/11	●	58 Q1 2010/11	●
◊ Family Practice Sensitive Conditions (% of ED visits)	16.5% 2010/11	25.0%	26.9%	14.8% Q1 2011/12	■	14.8% Q1 2011/12	16.9% Q4 2010/11	■	16.2% Q1 2010/11	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	42.0%	90%	79%	34%	●	34%	na	na	na	na
- All urgency Levels	57.0% 2010/11	90%	83%	36% Q1 2011/12	●	36% Q1 2011/12	45% Q4 2010/11	●	65% Q1 2010/11	●
Notes ◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. † Interim target pending confirmation. Status based on interim target. * Trend for these measures cannot be determined until subsequent data is available										

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Improving Access, Reducing Wait Times										
◇ Urgent CABG Wait Time (90th percentile in weeks)	2.1 2010/11	1.0	1.8	1.9 Q1 2011/12	●	1.9 Q1 2011/12	2.5 Q4 2010/11	■	1.9 Q1 2010/11	■
◇ Semi-urgent CABG Wait Time (90th percentile in weeks)	11.9 2010/11	2.0	5.3	13.0 Q1 2011/12	●	13.0 Q1 2011/12	15.5 Q4 2010/11	■	9.5 Q1 2010/11	●
◇ Scheduled CABG Wait Time (90th percentile in weeks)	18.0 2010/11	6.0	19.5	20.6 Q1 2011/12	▲	20.6 Q1 2011/12	17.4 Q4 2010/11	●	16.2 Q1 2010/11	●
◇ Hip Replacement Surgery Wait Time (90th percentile in weeks)	48.6 2010/11	27.0	35.9	54.0 Q1 2011/12	●	54.0 Q1 2011/12	49.8 Q4 2010/11	●	48.9 Q1 2010/11	■
◇ Knee Replacement Surgery Wait Time (90th percentile in weeks)	60.7 2010/11	35.0	45.4	57.9 Q1 2011/12	●	57.9 Q1 2011/12	58.6 Q4 2010/11	■	61.8 Q1 2010/11	■
◇ Cataract Surgery Wait Time (90th percentile in weeks)	40.1 2010/11	30.0	42.7	37.3 Q1 2011/12	■	37.3 Q1 2011/12	38.0 Q4 2010/11	■	42.9 Q1 2010/11	■
◇ Other Scheduled Surgery Wait Time (90th percentile in weeks)	24.6 2010/11	tbd	na	26.0 Q1 2011/12	na	26.0 Q1 2011/12	26.1 Q4 2010/11	■	21.9 Q1 2010/11	●
◇ Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	6.0 2010/11	4.0	5.5	4.9 Q1 2011/12	■	4.9 Q1 2011/12	5.3 Q4 2010/11	■	6.0 Q1 2010/11	■
◇ Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks) £	3.4 2010/11	4.0	4.0	3.3 Q1 2011/12	■	3.3 Q1 2011/12	3.9 Q4 2010/11	■	3.6 Q1 2010/11	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	56.0% 2010/11	75%	67%	60% Q1 2011/12	●	60% Q1 2011/12	57% Q4 2010/11	■	54% Q1 2010/11	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	64.0% 2010/11	84%	81%	66% Q1 2011/12	●	66% Q1 2011/12	64% Q4 2010/11	■	63% Q1 2010/11	■
◇ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	29.0% 2010/11	60%	46%	31% Q1 2011/12	●	31% Q1 2011/12	30% Q4 2010/11	■	28% Q1 2010/11	■
◇ Patients Admitted from ED within 8 hours (%) (All Sites) £	30.0% 2010/11	65%	56%	32% Q1 2011/12	●	32% Q1 2011/12	31% Q4 2010/11	■	29% Q1 2010/11	■
Notes ◇ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. £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%.										

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Choice and Quality for Seniors										
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	151 2010/11	127	145	165 Q1 2011/12	●	165 Q1 2011/12	151 Q4 2010/11	●	284 Q1 2010/11	■
◊ People Waiting in Community for Continuing Care Placement	310 2010/11	235	291	284 Q1 2011/12	●	284 Q1 2011/12	310 Q4 2010/11	■	334 Q1 2010/11	■
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	51 2010/11	tbd	na	33 Q1 2011/12	na	33 Q1 2011/12	45 Q4 2010/11	■	48 Q1 2010/11	■
◊ Number of Home Care Clients	na 2010/11	tbd	na	20,945 Q1 2011/12	na	20,945 Q1 2011/12	20,205 Q4 2010/11	—	19,873 Q1 2010/11	●
Enabling Our People / Enabling One Health System										
◊ Staff Overall Engagement (%)	37% 2009/10	54%								
◊ Physician Overall Engagement (%)	25% 2009/10	54%								
Quality and Patient Safety										
◊ Patient Satisfaction – Acute Care	na 2010/11	80% 2010/11	80%	80.3% Q4 2010/11	■	Q4 2010/11	na Q3 2010/11	na	na Q4 2009/10	na
◊ Albertans Reporting Unexpected Harm	11% 2008	9%		9% 2010	■				11% 2008	■
◊ Patient Satisfaction Emergency Department	53% 2008	70%		55% 2010	●				53% 2008	—
◊ Patient Satisfaction Health Care Services Personally Received	62% 2008	tbd	na	65% 2010	na				62% 2008	—
Notes										
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.										































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




Period Comparative Performance

- Current period performance is better than comparative period
- Current period performance is within 5% of comparative period
- Current period performance is worse than comparative period




Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
Staying Healthy / Improving Population Health										
◊ Life Expectancy	79.3 2009	tbd		79.8 2010	na				79.3 2009	■
◊ Potential Years Life Lost (per 1,000 population)	57.6 2009	tbd		56.8 2010	na				57.6 2009	■
Breast Cancer Screening Participation Rate	n/a	57% ⁺ 2009-2010		57.8% 2008-2009	na				na	na
Cervical Cancer Screening Participation Rate	n/a	72% ⁺ 2008-2010		62.1% Jan 2007 - Dec 2009	na				na	na
Building a Primary Care Foundation										
◊ Seniors (65+) Influenza Immunization Rate	51.5% 2009-2010	75.0%		48.8% 2010-2011	●				51.5% 2009-2010	●
◊ Children (6 to 23 Months) Influenza Immunization Rate	na* 2009-2010	75.0%		18.0% 2010-2011	●				na* 2009-2010	na
◊ Childhood Immunization Rates for DTaP	78.2% 2008	97.0%		na	na				na	na
◊ Childhood Immunization Rates for MMR	89.2% 2008	98.0%		na	na				na	na
Albertans Enrolled in a Primary Care Network (%)	49% Apr 2010	tbd		63% Apr 2011	na	63% Apr 2011	62% Oct 2010	■	49% Apr 2010	■
◊ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	473 2010/11	297 annual	74 (quarterly)	136 Q1 2011/12	●	136 Q1 2011/12	125 Q4 2010/11	●	122 Q1 2010/11	●
◊ Family Practice Sensitive Conditions (% of ED visits)	39.0% 2010/11	25.0%	26.9%	38.6% Q1 2011/12	●	38.6% Q1 2011/12	38.8% Q4 2010/11	■	38.8% Q1 2010/11	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	74.0% 2010/11	90%	79%	68% Q1 2011/12	●	68% Q1 2011/12	na	na	na	na
- All urgency Levels	78.0% 2010/11	90%	83%	74% Q1 2011/12	●	74% Q1 2011/12	79% Q4 2010/11	●	79% Q1 2010/11	●
Improving Access, Reducing Wait Times										
◊ Hip Replacement Surgery Wait Time (90 th percentile in weeks)	36.6 2010/11	27.0	35.9	49.6 Q1 2011/12	●	49.6 Q1 2011/12	39.4 Q4 2010/11	●	30.3 Q1 2010/11	●
◊ Knee Replacement Surgery Wait Time (90 th percentile in weeks)	40.6 2010/11	35.0	45.4	50.9 Q1 2011/12	●	50.9 Q1 2011/12	43.1 Q4 2010/11	●	39.7 Q1 2010/11	●
◊ Cataract Surgery Wait Time (90 th percentile in weeks)	39.1 2010/11	30.0	42.7	53.8 Q1 2011/12	●	53.8 Q1 2011/12	47.1 Q4 2010/11	●	34.9 Q1 2010/11	●
Other Scheduled Surgery Wait Time (90 th percentile in weeks)	26.3 2010/11	tbd	na	23.7 Q1 2011/12	na	23.7 Q1 2011/12	26.5 Q4 2010/11	■	26.3 Q1 2010/11	■
Notes										
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.										
± Interim target pending confirmation. Status based on interim target.										
* Children (6 to 23 Months) Influenza Immunization Rate – Data not available for North Zone.										

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Performance	Comparative Performance
◊ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	82.0% 2010/11	75%	67%	78% Q1 2011/12		78% Q1 2011/12	81% Q4 2010/11		82% Q1 2010/11	
◊ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	91.0% 2010/11	84%	81%	90% Q1 2011/12		90% Q1 2011/12	91% Q4 2010/11		90% Q1 2010/11	
◊ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	70.0% 2010/11	60%	46%	67% Q1 2011/12		67% Q1 2011/12	70% Q4 2010/11		73% Q1 2010/11	
◊ Patients Admitted from ED within 8 hours (%) (All Sites) £	87.0% 2010/11	65%	56%	85% Q1 2011/12		85% Q1 2011/12	87% Q4 2010/11		88% Q1 2010/11	
Choice and Quality for Seniors										
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	87 2010/11	52	78	75 Q1 2011/12		75 Q1 2011/12	87 Q4 2010/11		95 Q1 2010/11	
◊ People Waiting in Community for Continuing Care Placement	106 2010/11	92	103	107 Q1 2011/12		107 Q1 2011/12	106 Q4 2010/11		Q1 2010/11	
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	110 2010/11	tbd	na	118 Q1 2011/12	na	118 Q1 2011/12	119 Q4 2010/11		108 Q1 2010/11	
◊ Number of Home Care Clients	na 2010/11	tbd	na	6,860 Q1 2011/12	na	6,860 Q1 2011/12	6,914 Q4 2010/11		7,355 Q1 2010/11	
Enabling Our People / Enabling One Health System										
◊ Staff Overall Engagement (%)	41% 2009/10	54%								
◊ Physician Overall Engagement (%)	27% 2009/10	54%								
Quality and Patient Safety										
◊ Patient Satisfaction - Acute Care	na 2010/11	80% 2010/11	80%	82.4% Q4 2010/11		82.4% Q4 2010/11	na Q3 2010/11	na	na Q4 2009/10	na
◊ Albertans Reporting Unexpected Harm	9% 2008	9%		8% 2010		8% 2010	9% 2008		16% 2003	
◊ Patient Satisfaction Emergency Department	58% 2008	70%		58% 2010		58% 2010	58% 2008		47% 2003	
◊ Patient Satisfaction Health Care Services Personally Received	57% 2008	tbd	na	53% 2010	na	53% 2010	57% 2008		na	na
Notes ◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. £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%.										

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

Period Comparative Performance

-  Current period performance is better than comparative period
-  Current period performance is within 5% of comparative period
-  Current period performance is worse than comparative period

Treatment Level Activity Report

Activity Measure	2009/10 Fiscal Year	2010/11 Q1	2010/11 Q2	2010/11 Q3	2010/11 Q4	2010/11 Fiscal Year	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4	2011/12 Fiscal Year
Number of Hospital Discharges ¹ (by Site)	362,314	92,634	89,129	89,957	92,301	364,021	95,593				
Average Hospital Length of Stay (Days) ^{1,2} (by Site)	6.9	6.8	6.9	7.2	7.1	7.0	6.8				
Per Cent of Alternate Level of Care (ALC) ^{1,3} Days	9.4%	8.2%	9.9%	10.0%	8.0%	9.0%	7.0%				
Number of Hospital Births ¹	50,738	12,882	12,985	11,952	11,937	49,756	12,894				
Number of Emergency Department Visits ⁴ (by Site)	1,952,803	491,908	491,130	472,003	486,761	1,941,802	502,973				
Number of Urgent Care Centre (UCC) Visits ⁵	125,916	44,198	44,215	42,366	46,383	177,172	49,747				
Number of Health Link Calls	1,030,192	175,319	167,602	203,281	212,769	758,971	189,135				
Number of Total Primary Hip Replacements ⁶	3,131	833	667	795	861	3,156	883				
Number of Total Primary Knee Replacements ⁶	4,128	1,225	897	1,132	1,141	4,395	1,297				
Number of Cataract Surgeries	28,601	7,610	7,230	8,024	10,915	33,779	8,607				
Number of MRI Exams ⁷	165,948	45,008	43,369	40,389	48,656	177,422	40,604				
Number of CT Exams ⁸	350,781	88,727	87,485	77,670	79,281	333,163	85,168				
Number of Lab Tests ⁹	67,831,892	17,255,062	16,771,693	16,975,779	17,122,616	68,125,150	17,698,155				

Notes: * 2011/12 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 Centre (UCC) 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 and 2010/11 figures include out sourced 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 have been updated and include zone, genetic, provincial and tests referred elsewhere (AHS, CLS, DLDx, Covenant, MHDL and tests referred elsewhere).

10. Cataract figures include those performed with a vitrectomy.

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

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.

An internal review of the data quality indicates a high level of confidence with limited issues.

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 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.

2009 Actual: 81.1 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, Alberta Health Services 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.

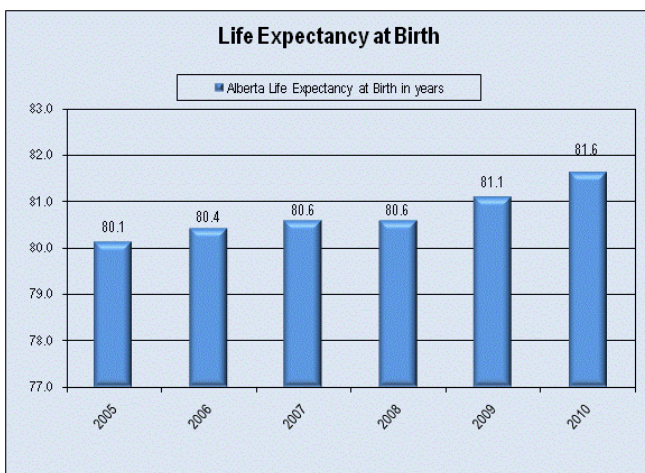
WHAT ELSE DO WE KNOW?

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.

An internal review of the data quality indicates a high level of confidence with limited issues

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.

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.

PERFORMANCE STATUS

Performance improvement observed since last reported period.

2009 Actual: 47.3 years

TARGET:
Not Specific

2010 ACTUAL:
44.8 years

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, Alberta Health Services 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.

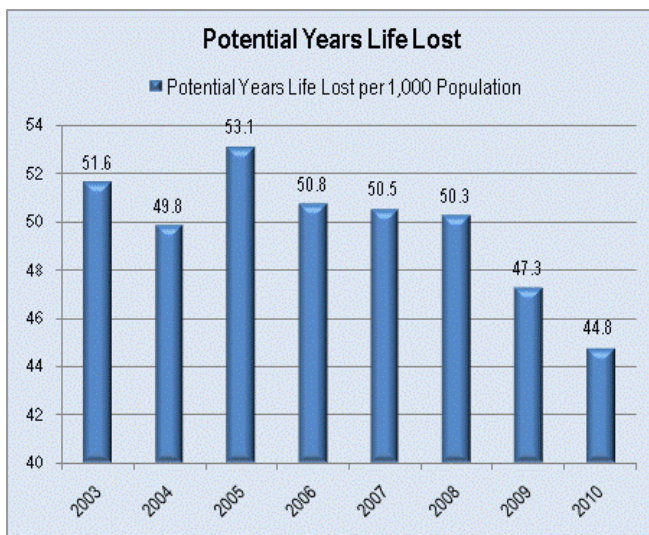
WHAT ELSE DO WE KNOW?

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 sixth among the 10 provinces for PYLL. Alberta = 48.7, Best Performing Province = 41.6 (Ontario), Canada = 45.5 (Statistics Canada, 2005/2007).



Source: Alberta Health & Wellness

Data updated annually.
Most current data is 2008.
Next data update expected for Q2 2011/12.

Performance Measure Update

Colorectal Cancer Screening Participation Rate

WHAT IS BEING MEASURED?

The colorectal cancer (CRC) screening participation rate measures the percentage of Albertans between the ages of 50 and 74 years who have had at least one of the following tests for screening: a fecal occult blood Test (FOBT) within the last two years, a flexible sigmoidoscopy within the last five years, or a colonoscopy within the last ten years.

Screening refers to the use of a test for a person without symptoms or signs of colorectal cancer.

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a high level of confidence with limited issues

WHY IS THIS IMPORTANT?

Death from colorectal cancer is 90 per cent preventable if the disease is caught at early stages. There is substantial evidence that organized colorectal cancer screening can reduce the mortality and incidence of colorectal cancer, and will significantly reduce the suffering and substantial costs of end stage colorectal cancer treatment.

WHAT IS THE TARGET?

The Alberta 2015 target is for 55 per cent of targeted individuals to have had a fecal occult blood test within the last two years, a flexible sigmoidoscopy within the last five years, or a colonoscopy within the last ten years. The 2010 target is 37 per cent (to be confirmed). A target of 67 per cent has been set for 2020.

HOW ARE WE DOING?

The 2008 Canadian Community Health Survey (CCHS) showed 35.5 per cent of Albertans between the ages of 50 and 74 years reported having a fecal test within the past two years, or flexible sigmoidoscopy within the past five years or colonoscopy within the last ten years.

Table: Percentage of population aged 50-74 who are up to date for colorectal cancer screening (2008)

Province	Screening Rate (%)
Alberta 2008	35.5%

Source: Canadian Community Health Survey (CCHS) 2008

PERFORMANCE STATUS

Status to be determined.

Target to be confirmed

2010 TARGET:
37%

2008 ACTUAL:
35.5%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Resources and education to healthcare providers to promote cancer screening is ongoing, as are outreach screening services to rural and hard-to-reach populations in order to reduce disparities in cancer screening participation. A new Colonoscopy reporting system has been implemented in all planned sites, and an evaluation is currently underway. In addition, a business case for a province-wide colorectal cancer screening program has been developed, approved and funded to establish consistent practices and reduce wait times for colorectal cancer screening.

Subsequent actions planned: AHS will continue to refine the operations of the Fecal Immunochemical Test (FIT) project in two Primary Care Networks and initiate an evaluation in late 2011. Online cancer screening content will be updated and educational resources will continue to be distributed. A community action strategy for cancer screening will begin within the Central and South Zones as well.

WHAT ELSE DO WE KNOW?

The changes to colorectal cancer screening participation are gradual and may be affected by many factors, including an individuals' knowledge and attitude toward colorectal cancer screening, access to services, as well as seasonal variation and service interruptions, therefore annual reporting will be provided.

HOW DO WE COMPARE?

Alberta ranked fourth among the 10 provinces for self-reported colorectal cancer screening. Alberta = 35.5 per cent, Best Performing Province = 54.6 per cent, Manitoba, Canada = 39.7 per cent (Statistics Canada, 2008).

Data updated annually.
Most current data is 2008-2009.
Next data update expected for Q2 2011/12.

WHAT IS BEING MEASURED?

The breast cancer screening participation rate measures the percentage of women in Alberta between the ages of 50 and 69 years who have had a breast screening mammogram in the last two years (biennially).

Women who are not eligible for screening mammograms are included in the data. That is, women who have had breast cancer, breast symptoms, breast implants, or prophylactic bilateral mastectomies are not removed. This leads to a slight underestimate in the screening mammogram participation rate.

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

Adequate participation in breast cancer screening is essential for reductions in mortality for women between the ages of 50 and 69 years. Regular screening following clinical practice [guidelines](#) can identify unsuspected breast cancer at a stage when early intervention can positively affect the outcome. The goal is to reduce breast cancer mortality through early detection when treatment is more likely to be effective.

WHAT IS THE TARGET?

The Alberta target is for 70 per cent of eligible women, 50 to 69 years of age, to have a screening mammogram at least biennially by 2020. The 2009-2010 target is 57 per cent (to be confirmed).


Table: Percentage of women 50-69 who have a screening mammogram at least biennially

Time Period	Target Population (Alberta)	Number of Women Screened	Screening Rate (%)
2007 - 2008	354,216	195,005	55.1%
2008 - 2009	371,359	207,617	55.9%

Source: Alberta Breast Cancer Screening Program (ABCSP) and Alberta Health and Wellness (AHW).

Performance Measure Update

Breast Cancer Screening Participation Rate

 PERFORMANCE STATUS Status to be determined. Target to be confirmed.	2009 - 2010 TARGET: 57%
	2008-2009 ACTUAL: 55.9%

HOW ARE WE DOING?

During the two-year period between January 2008 and December 2009, 55.9 per cent of women aged 50 to 69 years received a screening mammogram. The rate for 2009-2010 is not yet available.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Screening mammography services were provided to nearly 2,000 clients in 35 rural communities between April and June, 2011. Development of a social marketing strategy for breast and cervical cancer screening is ongoing. Implementation of a community action strategy for cancer screening has also been initiated in the North Zone.

Subsequent actions planned: Mobile screening mammography services to clients in rural and remote communities will continue. Phase One of the social marketing campaign will launch in Fall, 2011. Online cancer screening content will be updated and educational resources will continue to be distributed. The community action strategy for cancer screening will begin expansion into the Central and South Zones.

WHAT ELSE DO WE KNOW?

In order to more accurately reflect the way in which the population receives screening mammography, the Alberta Breast Cancer Screening Program is working with the Public Health Agency of Canada to evaluate a biennial mammography utilization indicator that might include bilateral diagnostic mammograms in addition to screening mammograms.

Information is available by [zone](#).

HOW DO WE COMPARE?

Using a similar definition, Alberta tied with New Brunswick for first among the 10 provinces for self-reported mammography. Alberta = 74.0 per cent, Best performing province = 74.0 per cent (Alberta and New Brunswick), Canada = 72.5 per cent (Statistics Canada, 2008)

Data updated annually.
Most current data is 2007-2009.
Next data update expected for Q2 2011/12.

Performance Measure Update

Cervical Cancer Screening Participation Rate

WHAT IS BEING MEASURED?

The cervical cancer screening participation rate measures the percentage of women between the ages of 21 and 69 years who have had a Pap test in the last three years.

Women who are not eligible for Pap tests due to hysterectomy are included in the data. This leads to a slight underestimate in the Pap test screening participation rate.

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

Research indicates that over 90 per cent of cervical cancers can be cured when detected early and treated. Widespread Pap testing in Alberta over the past 40 years has resulted in a significant reduction in cervical cancer mortality. Nevertheless, failure to be screened, and under screening, remain the most important risk factors for cervical cancer in Alberta women. There is also strong evidence of disparities in coverage across Alberta by geography, socioeconomic status and ethnicity. Cervical cancer is almost entirely preventable through the effective application of cervical screening and human papillomavirus (HPV) immunization.

WHAT IS THE TARGET?

The target for 2008-2010 is 72 per cent (to be confirmed).

HOW ARE WE DOING?

During the three-year period between January 2007 and December 2009, 70.7 per cent of eligible women aged 21 to 69 years received a screening Pap test.

Table: Percentage of women aged 21-69 who have had a Pap test at least every three years

Time Period	Target Population (Alberta)	Number of Women Screened	Screening Rate (%)
2005-2007	1,061,565	755,682	71.2%
2006-2008	1,095,468	782,421	71.4%
2007-2009	1,133,789	802,137	70.7%

Source: Extracted from AHW FFS data



PERFORMANCE STATUS

Status to be determined.

Target to be confirmed.

2008 - 2010
TARGET: 72%

2007-2009 ACTUAL:
70.7%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Collaborations continue with Primary Care Networks to improve cervical screening participation. Data analysis and the final report for the Enhanced Participation in Cancer Screening (EPICS) project is near completion. Development of a social marketing strategy for breast and cervical cancer screening is ongoing. Implementation of a community action strategy for cancer screening including cervical has also been initiated in the North Zone.

Subsequent actions planned: Roll out of the cervical cancer screening program correspondence will continue in the Central, Edmonton and North Zones. An electronic colposcopy reporting system will be implemented to enable the provincial cervical cancer program to better track screening and diagnostic follow up. As well, online cancer screening content will be updated and educational resources will continue to be distributed.

WHAT ELSE DO WE KNOW?

Pap test coverage tends to be unevenly distributed within Alberta, with coverage rates of less than 40 per cent in some communities.

Information is available by [zone](#).

HOW DO WE COMPARE?

Using a similar definition, Alberta ranked fourth among the 10 provinces for self-reported cervical cancer screening. Alberta = 76.6 per cent, Best Performing Province = 81.0 per cent (Nova Scotia), Canada = 72.8 per cent (Statistics Canada, 2005).

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 Alberta Health Services 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. The Lloydminster population has been removed from the denominator.

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a very high level of confidence with no known issues.

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. A high rate of coverage will reduce the impact of disease on the healthcare system.

WHAT IS THE TARGET?

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

<p>PERFORMANCE STATUS</p> <p>Performance is outside acceptable range, take action and monitor progress.</p> <p>Actual 2009/10: 56%</p>	<p>2010/11 TARGET: 75%</p> <p>2011/12 TARGET: 75%</p>
	<p>2010/11 ACTUAL: 59%</p>

HOW ARE WE DOING?

The seasonal influenza immunization rate for seniors aged 65 and older for 2010/11 is 59 per cent. While slightly better than the 2009/10 rate of 56 per cent, it is below the target of 75 per cent.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Many 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, and the administration of vaccine for home-bound seniors. In addition, a series of planning meetings for the 2011/12 season have been held between 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.

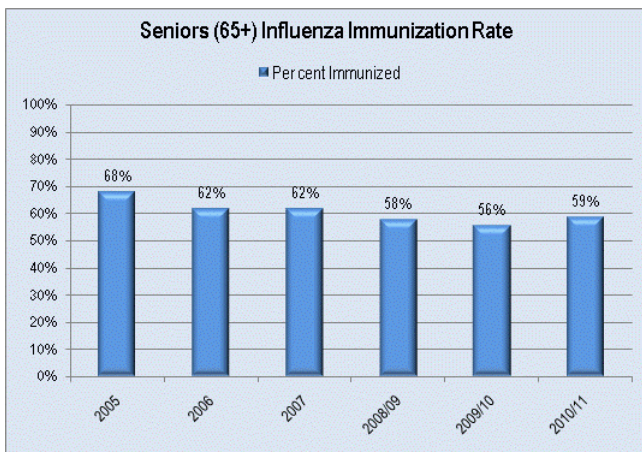
WHAT ELSE DO WE KNOW?

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; 2009/10 figures are preliminary calculations from AHS.

Children (6 to 23 Months) Influenza Immunization Rate

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

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.

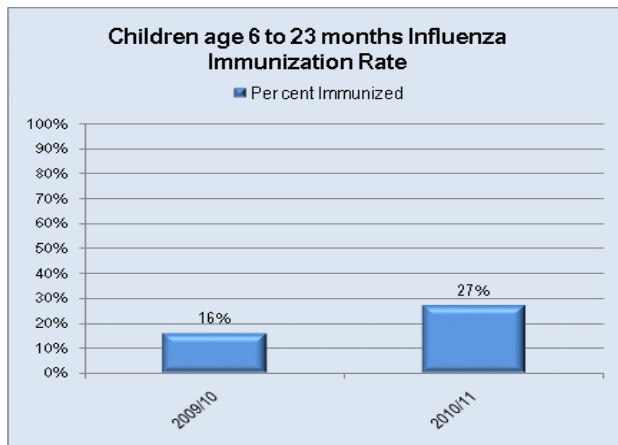
An internal review of the data quality indicates a very high level of confidence with no known issues.

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. 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.



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.

PERFORMANCE STATUS

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

2010/11 TARGET: 75%
2011/12 TARGET:
75%

2010/11 ACTUAL:
27%

HOW ARE WE DOING?

The influenza immunization rate for children between the ages of 6-23 months was 27 per cent for 2010/11, which remains below target of 75%.

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, a series of planning meetings for the 2011/12 season have been held between AHS and AHW, along with physicians, pharmacists and other health care providers to discuss strategies to optimize immunization coverage in the next influenza 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.

Childhood Immunization Rate Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza type B

Data updated annually.
Most current data is 2008.
Next data update expected for Q4 2011/12.

WHAT IS BEING MEASURED?

Childhood immunization rates for Diphtheria, Tetanus and Pertussis (DTaP) measures the percentage of children who have received the required number of doses of DTaP vaccine by two years of age.

Data on children receiving combined components of the DTaP-IPV-Hib vaccine is currently not available from all AHS Zones. As coverage rates for DTaP-IPV and Hib are reported separately in some Zones, DTaP is used as the proxy measure. Data on immunizations comes from AHS Zones and the First Nations and Inuit Health (FNIH), Health Canada, Alberta Region.

Detailed indicator [definition](#) is available.

A data quality assessment is not available for this data at this time.

WHY IS THIS IMPORTANT?

A high rate of immunization for a population reduces the incidence of vaccine preventable childhood diseases, and controls outbreaks. Immunizations protect children and adults from a number of preventable diseases, some of which can be fatal or produce permanent disabilities.

WHAT IS THE TARGET?

The Alberta Health and Wellness (AHW) target is for 97 per cent of children to have received the required number of doses of DTaP-IPV-Hib vaccine by two years of age.

PERFORMANCE STATUS

Status to be determined.

2011/12 TARGET:
97%

2008 ACTUAL:
83.8%

HOW ARE WE DOING?

The DTaP immunization rate for children up to two years of age for 2008 was 83.8 per cent (below target). The rate for 2009 is not yet available.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: An Immunization Steering Committee has been created to investigate strategies to improve immunization coverage, with two initiatives already underway: (1) an exhaustive literature review of evidence-based strategies to improve immunization rates; and (2) an environmental scan of currently implemented strategies within each Zone. In addition, plans have been completed to enable more timely reporting of immunization coverage.

Subsequent actions planned: New processes to improve on the timeliness and frequency of immunization reporting are slated to come into effect later in 2011.

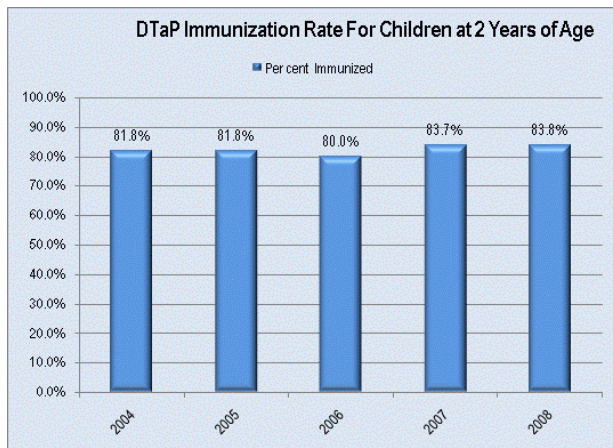
WHAT ELSE DO WE KNOW?

There are pockets of low immunization across the province. Specific strategies need to be developed to increase the immunization rate closer to the target by identifying why some children are not immunized, to increase access and modify existing immunization delivery programs to best suit the local population.

Information is available by [zone](#).

HOW DO WE COMPARE?

Limited comparable data is available. In 2007, Manitoba reported 73.3 per cent of children were complete for DTaP, 88.0 per cent for Polio and 79.3 per cent for Hib by the age of two years. British Columbia reported that 73.3 per cent of children born in 2008 were up-to-date by two years of age for DTaP/IPV/HIB (BC Centre for Disease Control 2010).



Source: Alberta Health & Wellness and Alberta Health Services

Childhood Immunization Rate for Measles, Mumps, Rubella

Data updated annually.
Most current data is 2008.
Next data update expected for Q3 2011/12.

WHAT IS BEING MEASURED?

The childhood immunization rate for Measles, Mumps and Rubella (MMR) measures the percentage of children who have received the required number of doses of MMR vaccine by two years of age.

Data on immunizations comes from Alberta Health Services (AHS) Zones and the First Nations and Inuit Health (FNIH), Health Canada, Alberta Region.

Detailed indicator [definition](#) is available.

A data quality assessment is not available for this data at this time.

WHY IS THIS IMPORTANT?

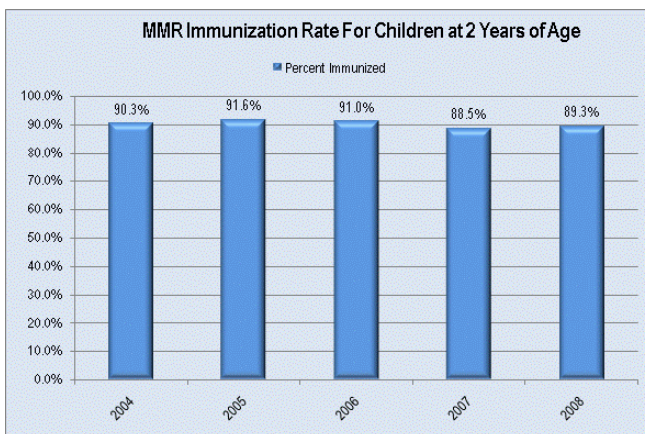
A high rate of immunization for a population can help ensure that the incidence of childhood diseases remains low and outbreaks are controlled. Immunizations protect children and adults from a number of diseases, some of which can be fatal or produce permanent disabilities.

WHAT IS THE TARGET?

The Alberta Health and Wellness (AHW) Business Plan target is for 98 per cent of children to have received the required number of doses of MMR vaccine by two years of age.

HOW ARE WE DOING?

The 2008 MMR immunization rate for children at two years of age is 89.3 per cent (below target). The rate for 2009 is not yet available.



Source: Alberta Health & Wellness and Alberta Health Services

PERFORMANCE STATUS

Status to be determined.

2011/12 TARGET:
98%

2008 ACTUAL:
89.3%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: An Immunization Steering Committee has been created to investigate strategies to improve immunization coverage, with two initiatives already underway: (1) an exhaustive literature review of evidence-based strategies to improve immunization rates; and (2) an environmental scan of currently implemented strategies within each Zone. In addition, plans have been completed to enable more timely reporting of immunization coverage. This will involve obtaining coverage rates from each zone-based system.

Subsequent actions planned: New processes to improve the timeliness and frequency of immunization reporting are slated to come into effect later in 2011.

WHAT ELSE DO WE KNOW?

There are pockets of low immunization across the province. Specific strategies need to be developed to increase immunization rates closer to the target by identifying why some children are not immunized, to increase access and modify existing immunization delivery programs to best suit the local population.

Information is available by [zone](#).

HOW DO WE COMPARE?

Limited comparable data is available. In 2007, Manitoba reported 86.5 per cent of children were complete for Measles, 86.4 per cent for Mumps and 86.4 per cent for Rubella by two years. British Columbia reported that 73.7 per cent of children born in 2008 were up-to-date by two years of age for MMR (BC Centre for Disease Control 2010).

Data updated twice yearly.
Most current data is April 2011.
Next data update expected for Q2 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.

A data quality assessment is not available for this data at this time.

WHY IS THIS IMPORTANT?

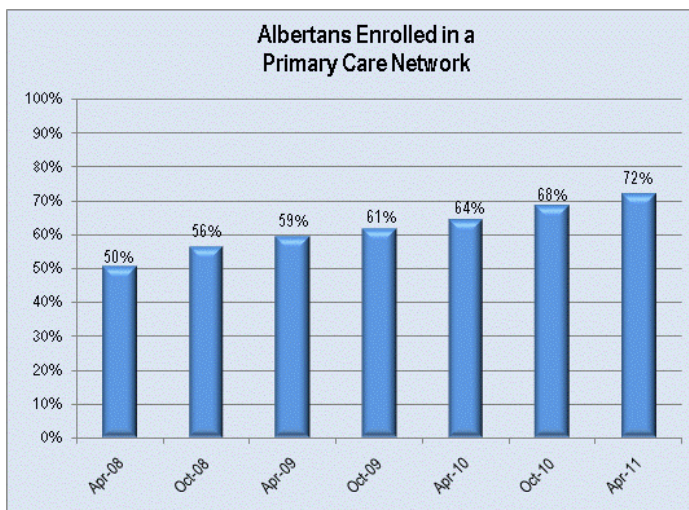
A PCN is an arrangement between a group of family physicians and Alberta Health Services to provide and coordinate a comprehensive set of primary health care services to patients. Primary Care is the care individuals receive at the first point of contact with the healthcare system. Patients receive care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

WHAT IS THE TARGET?

Targets are currently being developed for this indicator.

HOW ARE WE DOING?

The percentage of Albertans enrolled in a PCN is 72 per cent as of April 2011.



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

PERFORMANCE STATUS

Status to be determined

Apr 2010 Actual: 64%

2011/12 TARGET:
tbd

ACTUAL: 72%
April 2011

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Zones are actively recruiting new physicians to form PCNs or to join existing PCNs. 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. In addition, 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 Q1 2011/12.
Next data update expected for Q2 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.

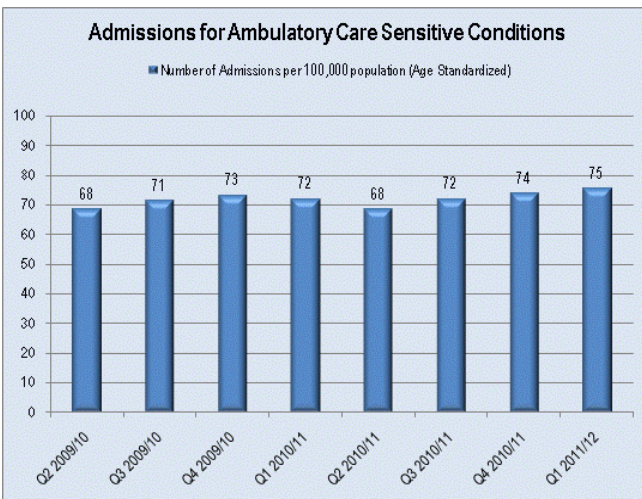
An internal review of the data quality indicates a high level of confidence with limited issues.

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 297 (74 per quarter) ACSC admissions per 100,000 population under age 75 years, has been established for 2011/12. As large variations exist in the rate of hospitalization for these conditions across Canada, the “most appropriate” target is not yet known ([CIHI Health Indicators 2009](#)).



Source: AHS Discharge Abstract Database



PERFORMANCE STATUS

Performance is within acceptable range, monitor and take action as appropriate.

2010/11 Annual: 282 annually

2011/12 TARGET: 297
admissions per 100,000
Q1 TARGET: 74

Q1 ACTUAL: 75
admissions per 100,000

HOW ARE WE DOING?

There has been a slight increase in overall ACSC admissions in the most recent quarter resulting in the performance being slightly below target.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Deep-dive process improvement projects are being implemented across Zones to reduce ACSC admissions. Provincial standards for the Stanford Chronic Disease Management Self-Management Program have been developed. Other initiatives include pilot projects to divert patients to appropriate day programs or clinics to prevent unnecessary hospital admissions.

Subsequent actions planned: AHS and Primary 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. Additional access opportunities through Health Link Alberta and PCN after-hours clinics will be developed. Implementation of a provincial obesity plan will begin in early 2012. As well, a primary care integration strategy will be drafted.

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)

Family Practice Sensitive Conditions

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 2011/12.

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.

An internal review of the data quality indicates a high level of confidence with limited issues.

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 25 per cent of ED or urgent care visits.

HOW ARE WE DOING?

The percentage of family practice sensitive conditions remains slightly above the year end target but is better than the pro-rated quarterly target.

 PERFORMANCE STATUS Performance is at or better than quarterly target, continue to monitor. 2010/11 Actual: 27.5%	2010/11 TARGET: 25% of ED/UCC visits Q1 TARGET: 26.9%
	Q1 2011/12 ACTUAL: 26.6% of ED/UCC visits

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. Community-based chronic disease management (CDM) programs, especially those which target vulnerable populations, are also expected to reduce the number of ED visits. After-hours clinics operated by select Primary Care Networks (PCNs) are in place to see patients who are triaged through Health Link Alberta. In addition, pilot projects are underway to divert patients to appropriate day programs or clinics to prevent unnecessary ED visits.

Subsequent actions planned: AHS and PCNs will continue to collaborate on strategies to reduce inappropriate ED visits (e.g., improving access to PCNs, increasing after-hours usage of PCN clinics, developing care pathways and toolkits). A community-based CDM program that incorporates the needs for self-management as well as the needs of diverse populations will be developed over the long-term in order to improve access to CDM services. Collaborations with Home Care are also planned to facilitate after-hours and weekend access to services which are more appropriately delivered in the community as opposed to an ED setting.

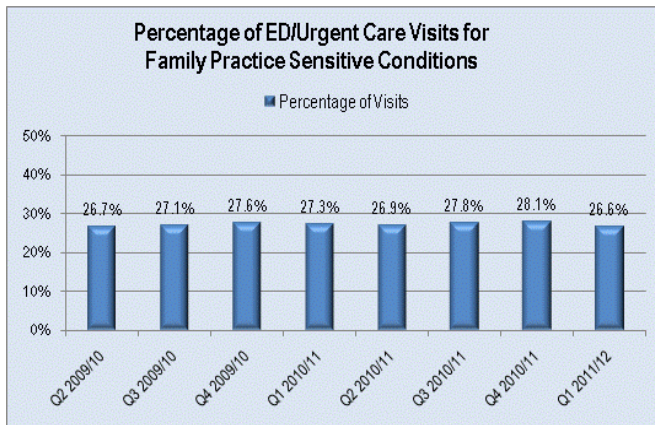
WHAT ELSE DO WE KNOW?

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

Data updated quarterly.
 Most current data is Q1 2011/12.
 Next data update expected for Q2 2011/12

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

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 could discourage some callers.

Detailed indicator [definition](#) is available.


An internal review of the data quality indicates a very high level of confidence with no known issues.

WHAT IS THE TARGET?

Alberta Health Services has established a 2011/12 annual target of 85 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 81.6 per cent for Q1 2011/12. This is better than the Q1 2011/12 target.

 PERFORMANCE STATUS Performance is at or better than quarterly target, continue to monitor.	2011/12 TARGET: 85% Q1 TARGET: 79.5%
	Q1 2011/12 ACTUAL: 81.6%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The Calgary Nurse rotation plan was completed and hours were also expanded for Information and Referral Agents. Advanced training on queue management was delivered to all managers. In addition, e-mail distributions to new parents continue to be provided to an ever-expanding subscriber base.

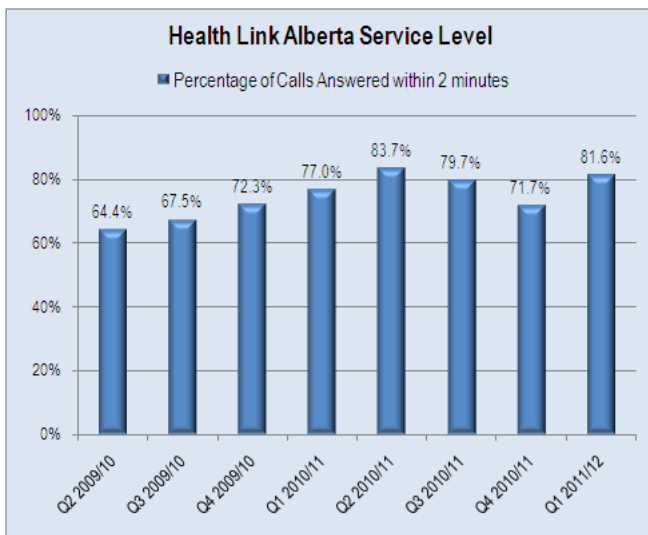
Subsequent actions planned: Changes to the call centre will be implemented based on what has been learned to date. Rotation rebuilds for staff will be implemented in Edmonton. Community and rural planning framework engagement sessions will be held and will include presentations on Health Link Alberta and the services provided to community members. As well, a comprehensive 5-year plan for Health Link Alberta will be finalized in the coming months.

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.



Source: Health Link Alberta, Nortel Contact Centre Management 6.0

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 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.

Detailed indicator [definition](#) is available.


An internal review of the data quality indicates a high level of confidence with limited issues.

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 2011/12 target for children receiving community mental health treatment within 30 days is 90 per cent. Provincial wait-time standards reflect the maximum time children should wait to receive mental health services in Alberta.

 PERFORMANCE STATUS Performance is outside acceptable range, take action and monitor progress. 2010/11 Actual: 75% (scheduled) 80% (all urgency levels)	2011/12 TARGET: 90% Q1 TARGET: 79% (scheduled) 83% (all urgency levels)
	Q1 2011/12 ACTUAL: 72% (scheduled) 73% (all urgency levels)

HOW ARE WE DOING?

Currently, AHS is not meeting the 90 per cent target of referred children receiving a face-to-face assessment within 30 days.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Over 30 mental health capacity building projects have been implemented under the Children's Mental Health Plan to enhance access to mental health services in schools and communities across the province. Recruitment of additional staff has been initiated in order to reduce wait times. Partnerships have also been established between AHS and stakeholder organizations that provide services to at-risk youth. Additional Zone-specific actions completed are available [here](#).

Subsequent actions planned: Recruitment will continue until all vacant positions are filled. Pilot programs and additional process improvement initiatives to enhance access will be implemented according to local priorities. Additional Zone-specific actions planned are available [here](#).

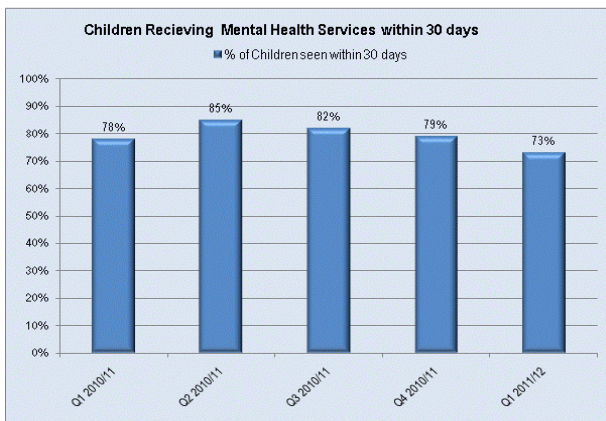
WHAT ELSE DO WE KNOW?

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

1. These results are limited to children enrolled in programs at community mental health clinics across Alberta.
2. Results reflect all levels of urgency: "scheduled", "emergent", and "urgent".
3. Commencing fiscal year 2011-2012, results for children enrolled in Edmonton Northgate clinic are included. Results from Edmonton Northgate clinic are an under-representation as some data quality issues exist. Improvements in data collection processes are being explored.
4. Commencing fiscal year 2010-2011, results for children enrolled in clinics in the Lethbridge area of the South Zone are included.
5. This indicator includes all children under 18 years of age.
6. These results exclude some enrolments that have not been completed within the selected time period.
7. Waiting times from other areas of the service continuum are not included (such as cases from select outpatient areas, inpatient facilities, general practitioners, private psychiatrists/ psychologists, and contracted service agencies.) These results are the most readily available information, and when results from other areas of the mental health continuum become consistently available, they will be included.
8. Results reported in this analysis may differ slightly from previous documents due to updates in datasets.
9. To meet timelines for AHS Tier-1 dashboard reporting, June data were received on July 15 instead of August 2. As a result, this earlier data extraction does not include all data for June.

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 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.

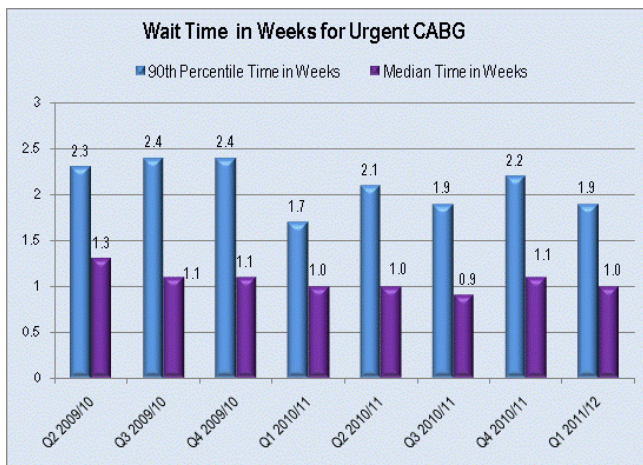
An internal review of the data quality indicates a very high level of confidence with no known issues.

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 90th percentile target for 2011/12 is one week for Urgent CABG surgeries.



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

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

PERFORMANCE STATUS Performance is outside acceptable range, take action and monitor progress. 2010/11 Actual: 2.1 weeks	2011/12 TARGET: 1 Q1 TARGET: 1.8 weeks
	Q1 ACTUAL: 1.9 weeks

HOW ARE WE DOING?

The wait time for urgent CABG surgery remains longer than target.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A process improvement initiative to streamline and remove inefficiencies across the cardiac surgery patient journey has been initiated. Processes continue to be enhanced to ensure appropriate triage of surgical patients ensuring that patients are categorized and attended to appropriately based upon the severity of their condition. Working groups have been established to identify and explore potential strategies for improving wait times.

Subsequent actions planned: Process mapping will be initiated to identify the top 3-5 areas to improve the cardiac surgery patient journey. A trial program in Edmonton to open one additional bed within the cardiovascular ICU will be expanded so the bed is available seven days per week (additional ward beds are being considered). As well, a peer review process will be enhanced to ensure appropriate triage of surgical patients across the three urgency categories.

WHAT ELSE DO WE KNOW?

All patient conditions are carefully reviewed to ensure patients are assigned a wait time that matches the severity 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.

Data updated quarterly.
 Most current data is Q1 2011/12.
 Next data update expected for Q2 2011/12.

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

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.

An internal review of the data quality indicates a very high level of confidence with no known issues.

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 AHS 90th percentile target for 2011/12 is two weeks for semi-urgent CABG surgeries.

PERFORMANCE STATUS Performance is outside acceptable range, take action and monitor progress. 2010/11 Actual: 6.4 weeks	2011/12 TARGET: 2 Q1 TARGET: 5.3 weeks
	Q1 ACTUAL: 10.8 weeks

HOW ARE WE DOING?

While the median wait time for semi-urgent CABG surgery has remained consistent, Q4 and Q1 saw a large increase in 90th 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 process improvement initiative to streamline and remove inefficiencies across the cardiac surgery patient journey has been initiated. Processes continue to be enhanced to ensure appropriate triage of surgical patients ensuring that patients are categorized and attended to appropriately based upon the severity of their condition. Working groups have been established to identify and explore potential strategies for improving wait times.

Subsequent actions planned: Process mapping will be initiated to identify the top 3-5 areas to improve the cardiac surgery patient journey. A trial program in Edmonton to open one additional bed within the cardiovascular ICU will be expanded so the bed is available seven days per week (additional ward beds are being considered). As well, a peer review process will be enhanced to ensure appropriate triage of surgical patients across the three urgency categories.

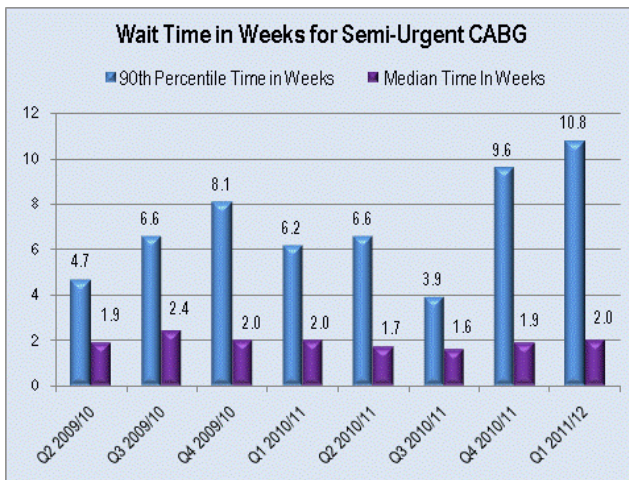
WHAT ELSE DO WE KNOW?

All patient conditions are carefully reviewed to ensure that patients are assigned a wait time that matches the severity 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.



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

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 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 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.

An internal review of the data quality indicates a very high level of confidence with no known issues.

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 2011/12 AHS 90th percentile target is 6 weeks.

<p>PERFORMANCE STATUS</p> <p>Performance is outside acceptable range, take action and monitor progress. 2010/11 Actual: 24.0 weeks</p>	<p>20011/12 TARGET: 6 Q1 TARGET: 19.5 weeks</p>
	<p>Q1 ACTUAL: 25.9 weeks</p>

HOW ARE WE DOING?

Wait time for scheduled CABG surgery remains significantly longer than target.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A process improvement initiative to streamline and remove inefficiencies across the cardiac surgery patient journey has been initiated. Processes continue to be enhanced to ensure appropriate triage of surgical patients ensuring that patients are categorized and attended to appropriately based upon the severity of their condition. Working groups have been established to identify and explore potential strategies for improving wait times.

Subsequent actions planned: Process mapping will be initiated to identify the top 3-5 areas to improve the cardiac surgery patient journey. A trial program in Edmonton to open one additional bed within the cardiovascular ICU will be expanded so the bed is available seven days per week (additional ward beds are being considered). As well, a peer review process will be enhanced to ensure appropriate triage of surgical patients across the three urgency categories.

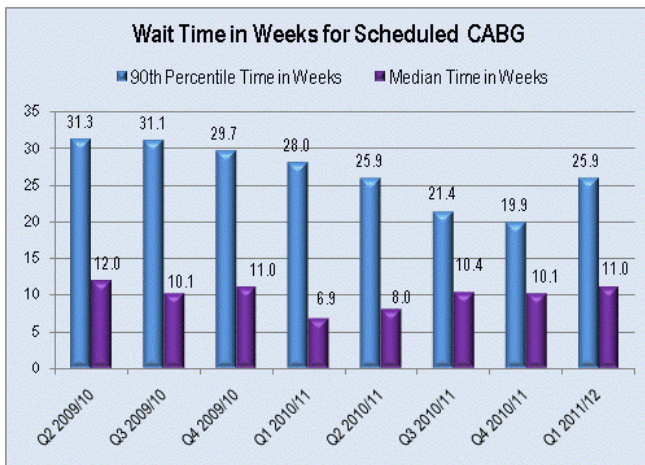
WHAT ELSE DO WE KNOW?

All patient conditions are carefully reviewed to ensure that patients are assigned a wait time that matches the severity 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.



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

Hip Replacement Wait Time

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 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 90th 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.

An in-depth data quality review on the hip surgery wait times revealed that the data are accurate within 1.0% or ±0.5 weeks in the current quarter.

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 27 weeks.

HOW ARE WE DOING?

The wait time for hip replacement surgery in Q1 2011/12 was 43.3 weeks, which is significantly longer than the target.



PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.
2010/11 Actual: 38.9 weeks

2011/12 TARGET: 27
Q1 TARGET: 35.9
weeks

Q1 ACTUAL:
43.3 weeks

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: An additional 1,000 hip and knee replacement surgeries have been approved for 2011/12 as a means of reducing wait times for these procedures. All sites have established plans and operating room (OR) schedules to accommodate the increased volumes, including changes to existing OR processes where required. In addition, certain Zones have identified opportunities to transfer minor orthopaedic procedures to rural sites as a means of increasing the number of surgical suites available for hip and knee replacement surgeries.

Subsequent actions planned: All sites will continue with plans to complete their share of the additional 1,000 hip and knee replacement surgeries for 2011/12, with most of the increased activity to occur beginning in September 2011. Process improvement initiatives are ongoing to eliminate inefficient processes and use of inpatient and sub-acute bed days. 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) is to be developed by early 2012.

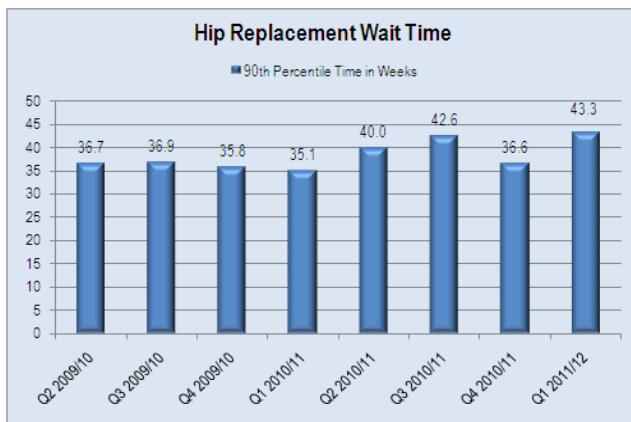
WHAT ELSE DO WE KNOW?

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)



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

Data updated quarterly.
Most current data is Q1 2011/12.
Data update expected for Q2 2011/12.

Knee Replacement Wait Time

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 90th 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.

An in-depth data quality review on the knee surgery wait times revealed that the data are accurate within 2.7% or ±1.3 weeks in the current quarter.

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 2011/12 is 35 weeks.

HOW ARE WE DOING?

The wait time for knee replacement surgery in Q1 2011/12 was 48.3 weeks, which is longer than the target.

 PERFORMANCE STATUS Performance is outside acceptable range, take action and monitor progress. 2010/11 Actual: 48.9weeks	2011/12 TARGET: 35 Q1 TARGET: 45.4 weeks
	Q1 ACTUAL: 48.3 weeks

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: An additional 1,000 hip and knee replacement surgeries have been approved for 2011/12 as a means of reducing wait times for these procedures. All sites have established plans and operating room (OR) schedules to accommodate the increased volumes, including changes to existing OR processes where required. In addition, certain Zones have identified opportunities to transfer minor orthopaedic procedures to rural sites as a means of increasing the number of surgical suites available for hip and knee replacement surgeries.

Subsequent actions planned: All sites will continue with plans to complete their share of the additional 1,000 hip and knee replacement surgeries for 2011/12, with most of the increased activity to occur beginning in September 2011. Process improvement initiatives are ongoing to eliminate inefficient processes and use of inpatient and sub-acute bed days. 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) is to be developed by early 2012.

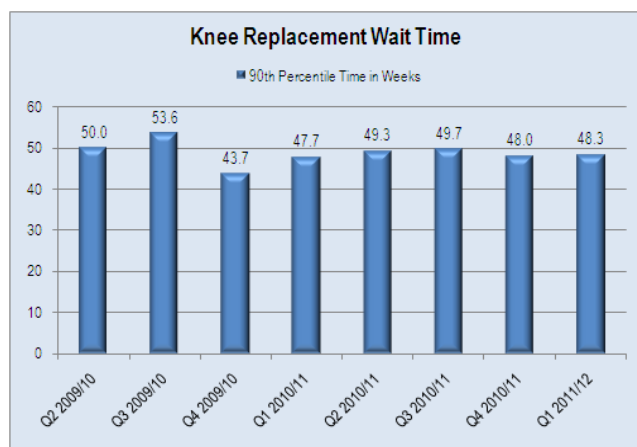
WHAT ELSE DO WE KNOW?

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 Q1 2011/12.
Next data update expected for Q2 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 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery.

Detailed indicator [definition](#) is available.


A data quality assessment is not available for this data at this time.

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 target for 2011/12 is 30 weeks.

 PERFORMANCE STATUS Performance is at or better than quarterly target, continue to monitor. 2010/11 Actual: 46.9 weeks	2011/12 TARGET: 30 Q1 2011/12 TARGET: 42.7 weeks
	Q1 ACTUAL: 41.7 weeks

HOW ARE WE DOING?

The 90th percentile wait time for Cataract Surgery for Q1 2011/12 was 41.7 weeks which exceeds the 2011/12 target time of 30 weeks, although performance is trending positively since Q2 2010/11.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Increases to the number of cataract surgeries since 2009/10 has worked to bring wait times down. Additional surgeries for 2011/12 have also been approved to further reduce these wait times. Further Zone-specific actions completed are available [here](#).

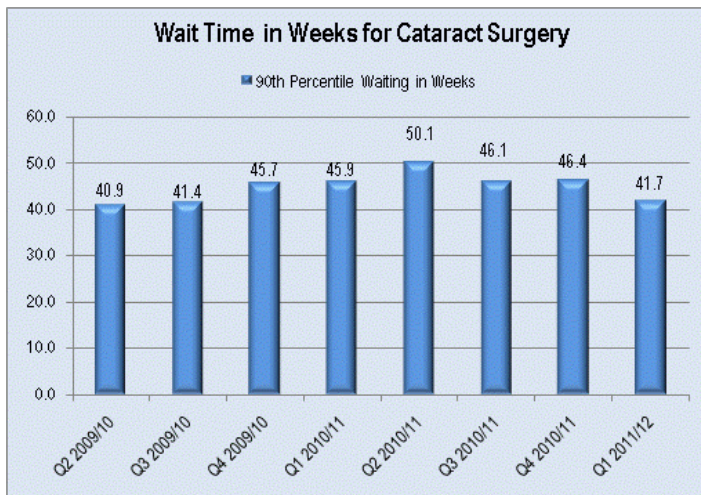
Subsequent actions planned: Completion of allocated cataract surgeries will continue across the province throughout 2011/12. Additional Zone-specific actions planned are available [here](#).

WHAT ELSE DO WE KNOW?

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 Q1 2011/12.
Next data update expected for Q2 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 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery.

Detailed indicator [definition](#) is available.

A data quality assessment is not available for this data at this time.

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. Targets will be set in fall/winter 2011/12.

PERFORMANCE STATUS

Performance target for 2011/12 is not yet established.

2010/11 Actual: 25.7 weeks

2011/12 TARGET:
(to be developed)

Q1 ACTUAL:
26.1 weeks

HOW ARE WE DOING?

Using latest developed measurement methodology (under review) 90th percentile wait times for other surgeries was 26.1 weeks for Q1 2011/12.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Wait time targets for cancer surgery have been developed, and initial implementation has begun on a provincial plan to improve access to lung cancer treatment. The Surgical Services Health Plan Working Group (SSHPWG) was also established to develop a coordinated and comprehensive set of projects that will deliver a sustainable surgical service delivery model for Albertans. Process improvement efforts to deliver better efficiencies are underway in select facilities (e.g. reducing the time for operating room change-overs).

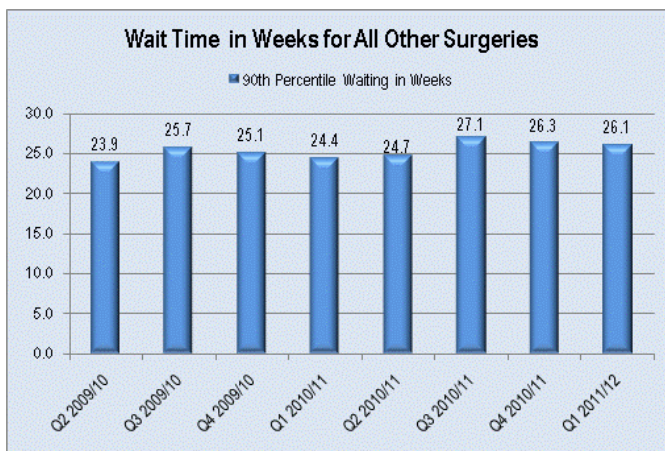
Subsequent actions planned: New surgical volume investments will be made for cancer surgery, bariatric surgery, spinal implants and other general surgeries. The SSHPWG will complete a comprehensive plan by Fall 2011 to: (1) measure and manage wait times from referral to discharge; (2) maintain and improve 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.).

WHAT ELSE DO WE KNOW?

Information is available by [zone](#).

HOW DO WE COMPARE?

National benchmark comparisons are not available.



Source: Alberta Health & Wellness

Data updated quarterly.
 Most current data is Q1 2011/12.
 Next data update expected for Q2 2011/12.

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 collected on patients referred to Jack Ady Cancer Centre in Lethbridge. There is a project underway to collect this data at three additional cancer centres that provide consultations to patients in Medicine Hat, Red Deer, and Grande Prairie.

The 90th 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.


An internal review of the data quality indicates a high level of confidence with limited issues.

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 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.



PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.
 2010/11 Actual: 6.0 weeks

2011/12 TARGET: 4
 Q1 TARGET: 5.5
 weeks

Q1 2011/12 Actual:
 5.7 weeks

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.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: AHS has started the Radiation Therapy Wait Time Reduction Initiative to meet the 4-week target by the end of the 2011/12 year. This initiative focuses on three main strategies: (1) improvements in referral management; (2) re-engineering of clinical scheduling processes; and (3) a strategic frontline staff adjustment. Strategies 1 and 2 are being worked on concurrently through LEAN management at the present time.

Subsequent actions planned: In order to meet the 4-week target by March 31, 2012, the LEAN improvement process will be rolled out as follows:

- Phase One: Build awareness and train staff; form steering committee and core group; develop communication plan (2-3 months)
- Phase Two: Select 3-5 smaller initiatives that will lead to achievement of overall target (1-2 months)
- Phase Three: Implement all initiatives identified in phase two (3-6 months)

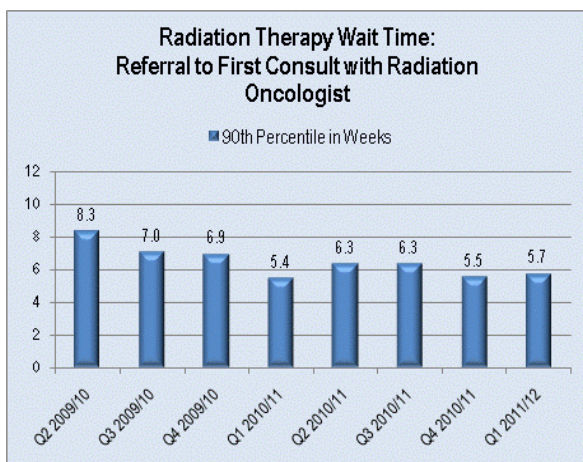
WHAT ELSE DO WE KNOW?

Sometimes referrals are missing important medical information cancer specialists require before they meet with the patient. 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.

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 2011/12.

Performance Measure Update

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

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.

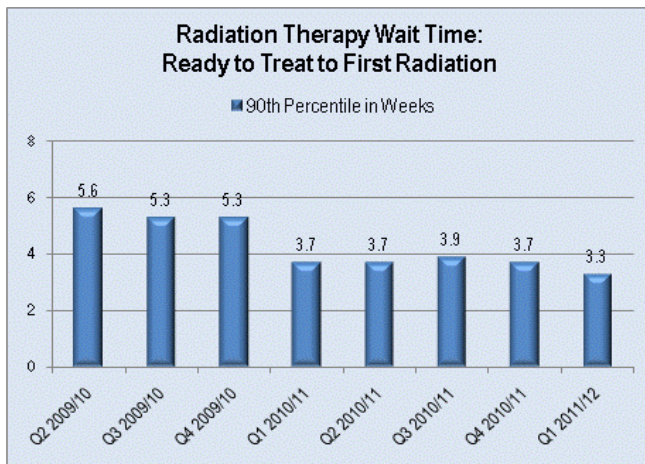
An internal review of the data quality indicates a very high level of confidence with no known issues.

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 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.



Source: EBI -2009-010 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

 PERFORMANCE STATUS Performance is at or better than target, continue to monitor. 2010/11 Actual: 3.6 weeks	2011/12 TARGET: 4 Q1 TARGET: 4 weeks
	Q1 ACTUAL: 3.3 weeks

HOW ARE WE DOING?

The proportion of patients receiving radiation therapy within the expected time period is better than the target. The Q1 2011/12 90th percentile time was 3.3 weeks.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The Jack Ady Cancer Centre in Lethbridge has been operational for the past year, bringing the total number of centres providing radiation therapy in Alberta to three. All 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?

Alberta Health Services 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)

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 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.

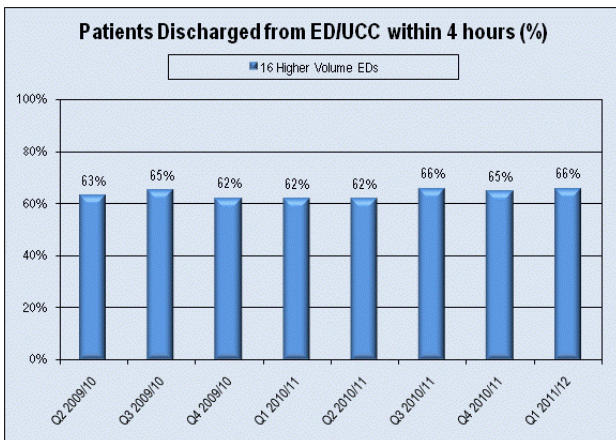
An internal review of the data quality indicates an acceptable level of confidence with known issues. A more formal internal Data Quality and Operational Readiness review is being conducted.

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 2011/12 target of 75 per cent of patients discharged within four hours for the 16 higher volume EDs.



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

PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.
2010/11 Actual: 64%

2011/12 TARGET: 75%
Q1 TARGET: 67%

Q1 ACTUAL: 66%

HOW ARE WE DOING?

In Q1 2011/12, 66 per cent of patients at the 16 higher volume EDs were discharged within four hours. This is below the target.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Overcapacity protocols and other process improvement initiatives continue to be implemented across the province. Additional Zone-specific actions completed are available [here](#).

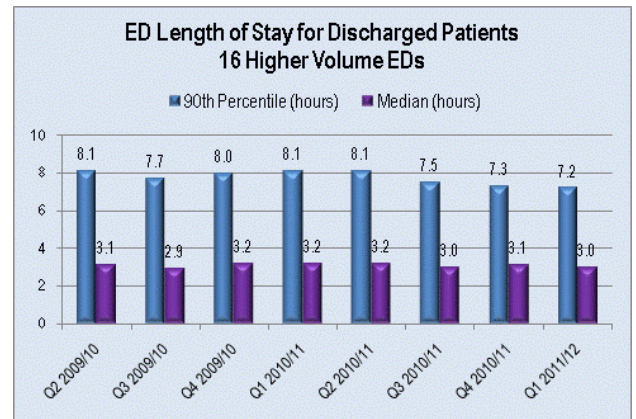
Subsequent actions planned: System process improvement efforts will continue across all Zones to determine root causes of delays and develop solutions. Additional Zone-specific actions planned are available [here](#).

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 available.



Median and 90th 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 Q1 2011/12.
Next data update expected for Q2 2011/12.

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

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.


An internal review of the data quality indicates an acceptable level of confidence with known issues.

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 2011/14 of 84 per cent of patients discharged within four hours for all sites.

 PERFORMANCE STATUS Performance is at or better than quarterly target, continue to monitor 2010/11 Actual: 80%	2011/12 TARGET: 84% Q1 TARGET: 81%
	Q1 ACTUAL: 81%

HOW ARE WE DOING?

In Q1 2011/12, 81 per cent of patients presenting and subsequently discharged at ED/UCC sites within four hours.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Overcapacity protocols and other process improvement initiatives continue to be implemented across the province. Additional Zone-specific actions completed are available [here](#).

Subsequent actions planned: Process improvement efforts will continue across all Zones to determine root causes of delays and develop solutions. Additional Zone-specific actions planned are available [here](#).

WHAT ELSE DO WE KNOW?

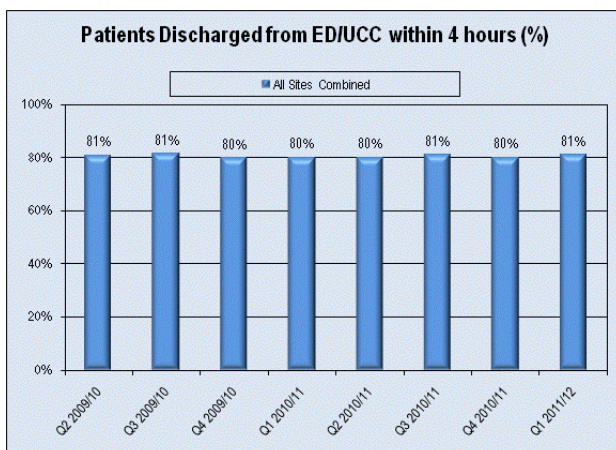
There are many reasons why ED/UCC length of stay may vary across sites, including complexity of patients, limitations (treatment spaces, staffing), operational efficiency and access to other primary care options (family physicians, walk-in clinics).

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 available.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.



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

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 2011/12.

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.

An internal review of the data quality indicates an acceptable level of confidence with known issues. An internal Data Quality and Operational Readiness review is being conducted.

WHY IS THIS IMPORTANT?

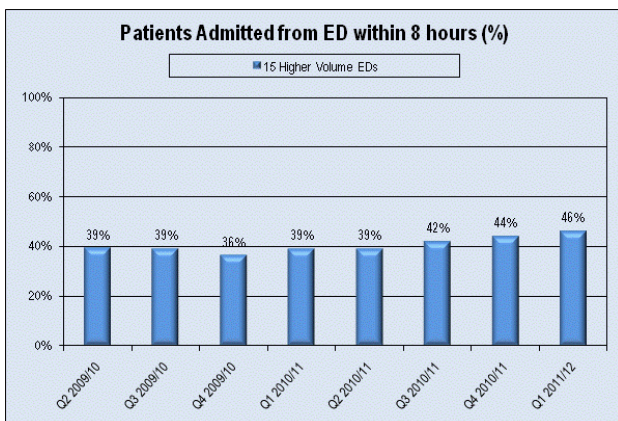
ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent can be a measure of access to the health care system and a reflection of efficient use of resources.

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 Q1 2011/12, 46 per cent of admitted patients at the 15 higher volume EDs left the ED within eight hours.



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

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

PERFORMANCE STATUS

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

2010/11 Actual: 41%

2011/12 TARGET: 60%
Q1 TARGET: 46%

Q1 ACTUAL: 46%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Overcapacity protocols and other process improvement initiatives continue to be implemented across the province. Additional Zone-specific actions completed to date are available [here](#).

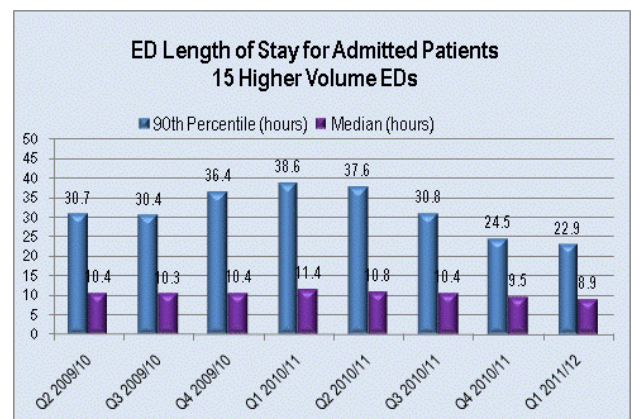
Subsequent actions planned: System process improvement efforts will continue across all Zones to determine root causes of delays and develop solutions. Additional Zone-specific actions planned are available [here](#).

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 90th 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 Q1 2011/12.
Next data update expected for Q2 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.

An internal review of the data quality indicates an acceptable level of confidence with known issues.

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 65 per cent of patients admitted leaving the ED within eight hours.

HOW ARE WE DOING?

In Q1 2011/12, 57 per cent of admitted patients left the ED within eight hours.

 PERFORMANCE STATUS Performance is at or better than quarterly target, continue to monitor. 2010/11 Annual: 53%	2011/12 TARGET: 65% Q1 TARGET: 56%
	Q1 ACTUAL: 57%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Overcapacity protocols and other process improvement initiatives continue to be implemented across the province. Additional Zone-specific actions completed to date are available [here](#).

Subsequent actions planned: Process improvement efforts will continue across all Zones to determine root causes of delays and develop solutions. Additional Zone-specific actions planned are available [here](#).

WHAT ELSE DO WE KNOW?

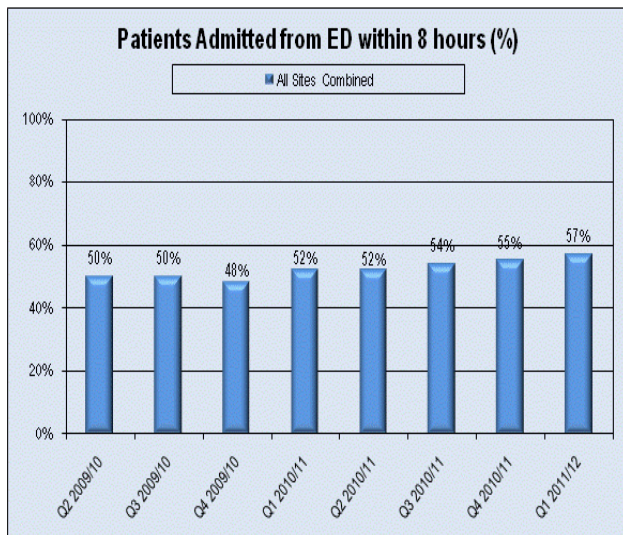
There are many reasons why length of stay may vary across sites. Examples include the complexity of patient conditions presenting to ED, capacity limitations (e.g. treatment spaces, staffing levels) as well as operational efficiency. In addition, the demand for ED services can vary significantly between 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



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

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 2011/12.

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

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.

An internal review of the data quality indicates a high level of confidence with limited issues.

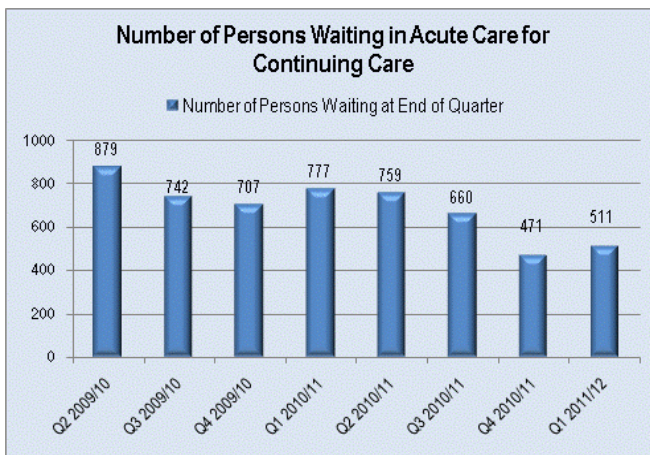
WHY IS THIS IMPORTANT?

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 2011/12 is for 375 or fewer people to be waiting in acute/sub-acute (hospital) beds for continuing care placement.



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

PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress.
2010/11 Actual: 471

2011/12 TARGET: 375
Q1 TARGET: 447

Q1 ACTUAL: 511

HOW ARE WE DOING?

At the end of Q1 2011/12, 511 people were waiting in acute/sub-acute (hospital) beds for continuing care placement. While above target, an improving trend has been seen over the past two years.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A total of 150 new continuing care spaces were opened across the province between April 1 and June 30, 2011. In addition, Home Care services continue to be expanded across the province. As well, implementation continues 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. Additional Zone-specific actions completed to date are available [here](#).

Subsequent actions planned: A total of 1,000 new continuing care spaces are planned for this year, with the remaining 850 beds to open by March 31, 2012. This number builds off the 1,155 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 the ED2Home program will be expanded to other cities/communities. Further expansion of Home Care services will also occur. Other Zone-specific actions planned are available [here](#).

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 Alberta Health Services 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 Q1 2011/12.
Next data update expected for Q2 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.

An internal review of the data quality indicates a high level of confidence with limited issues.

WHY IS THIS IMPORTANT?

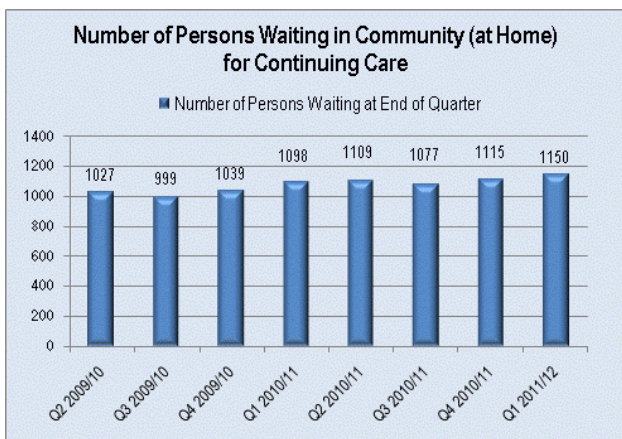
Access to continuing care services is a significant issue in Alberta. As such, a focused, multiple-strategy approach is needed to provide both seniors and persons with disabilities more options for quality accommodations specific to their service needs and lifestyles.

WHAT IS THE TARGET?


The target for 2011/12 is for 900 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 Q1 2011/12, 1,150 people were waiting in the community (at home) for continuing care placement, which is above the target of 900.



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

 **PERFORMANCE STATUS**

Performance is outside acceptable range, take action and monitor progress
2010/11 Actual: 1,115

2011/12 TARGET: 900
Q1 Target: 1,061

Q1 2011/12 ACTUAL: 1,150

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A total of 150 new continuing care spaces were opened across the province between April 1 and June 30, 2011. In addition, Home Care services continue to be expanded across the province. Additional Zone-specific actions completed to date are available [here](#).

Subsequent actions planned: A total of 1,000 new continuing care spaces are planned for this year, with the remaining 850 beds to open by March 31, 2012. This number builds off the 1,155 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. Further expansion of Home Care services will also occur. Other Zone-specific actions planned are available [here](#).

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 Q1 2011/12.
Next data update expected for Q2 2011/12.

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.

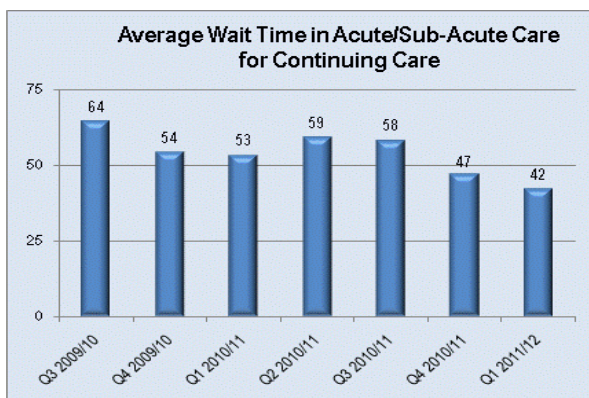
An internal review of the data quality indicates an acceptable level of confidence with known issues.

WHY IS THIS IMPORTANT?

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.

WHAT IS THE TARGET?

Targets are currently being developed for this indicator.



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 Actual: 54

2011/12 TARGET:
TBD

Q1 2011/12 ACTUAL
42

HOW ARE WE DOING?

The average wait time in acute/sub-acute care for continuing care was 42 days in Q1 of 2011/12.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A total of 150 new continuing care spaces were opened across the province between April 1 and June 30, 2011. In addition, Home Care services continue to be expanded across the province. As well, implementation continues 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. Additional Zone-specific actions completed to date are available [here](#).

Subsequent actions planned: A total of 1,000 new continuing care spaces are planned for this year, with the remaining 850 beds to open by March 31, 2012. This number builds off the 1,155 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 the ED2Home program will be expanded to other cities/communities. Further expansion of Home Care services will also occur. Other Zone-specific actions planned are available [here](#).

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 Q1 2011/12.
Next data update expected for Q2 2011/12.

Number of Home Care Clients

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.

An internal review of the data quality indicates an acceptable level of confidence with known issues.

WHY IS THIS IMPORTANT?

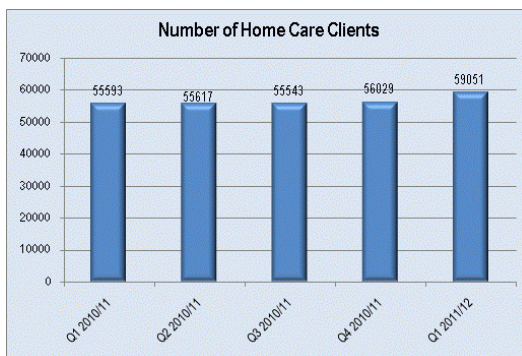
Providing seniors with access to services and supports to remain healthy and independent as long as possible is very important. Enhancing support services and offering more choice and care options to Albertans in their homes is a key strategy to enable individuals to “age in the right place”.

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 59,051 in Q1 of 2011/12.



PERFORMANCE STATUS Performance Target for 2011/12 has not been established for comparison. 2010/11 Actual: 112,173	2011/12 TARGET: TBD
	Q1 2011/12 ACTUAL: 59,051

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Home Care services continue to be expanded across the province to equip individuals with the necessary supports to remain at home. Home Care coordinators in the Emergency Department (ED) have been established through the “ED2Home” program to assess and coordinate the needs of patients and their families, facilitate safe discharge from ED, and provide access to home care services. Telephone access to on-call Home Care consultation services are also available 24/7 in many communities.

Subsequent actions planned: Roll-out of the ED2Home program will be expanded to other cities/communities. Further expansion of both the level and amount of Home Care services will also occur through the hiring of additional Home Care Coordinators, Case Managers, and/or Home Care Aides, dependent on the requirements within each Zone.

WHAT ELSE DO WE KNOW?

Information is available by [zone](#).

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Most current data is 2008.
The next survey is scheduled for 2011.

Performance Measure Update

Rating of Care Nursing Home – Family

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asked family members of Alberta nursing home residents about their rating of the care in the [Alberta Long Term Care Family Experience Survey](#). The first report was released in 2008 and is based on a survey from October 2007.

Rating of Care Nursing Home – Family measures the overall family rating of care at Alberta nursing homes, on a scale from 0 to 10. The average score is reported.

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

This global rating of care is an overall judgment by family members about the quality of care provided to their loved one. We know this rating is significantly influenced by the specific issues captured in the complete survey, and we also see there is considerable performance variation in this rating between facilities in the province. It is most relevant and important for facility level results.

WHAT IS THE TARGET?

Alberta Health Services has not yet established a 2011/12 target for the average overall family rating of care at Alberta nursing homes.

HOW ARE WE DOING?

In 2008 the average overall family rating of care at Alberta nursing homes was 8.1, on a scale from 0 to 10.

Table: Global Rating of Care at the Nursing Home
(2008)

Province	Average Score
Alberta	8.1

Source: Health Quality Council of Alberta (HQCA) Alberta Long Term Care Family Experience Survey

PERFORMANCE STATUS	2011/12 TARGET: TBD
Performance Target for 2011/12 has not been established for comparison.	2008 ACTUAL: 8.1

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The 2010 Long Term Care Family Experience Survey was issued by HQCA in late 2010 to all families identified by the province's long term care facilities. Surveys have since been returned by mail, and all data entry and validation has been completed. HQCA is currently in the process of analyzing the data and developing the final report.

Subsequent actions planned: HQCA will complete the survey analysis including comparison with the 2007 survey. Public release of the report is slated for fall 2011. AHS will then review the results, identify opportunities for improvement, and develop and implement action plans as appropriate. Future surveys are anticipated to occur on a rotating 3-year basis, dependent on budget approval.

WHAT ELSE DO WE KNOW?

High level surveys and aggregate results do not capture the unique nature of individual family experiences and the sometimes significant challenges and issues they face.

We know that smaller facilities and facilities in small communities are pre-disposed to better performance in terms of family and resident experience ratings. Despite this, there is still considerable variation in performance between facilities which are comparable in size and location.

HOW DO WE COMPARE?

National benchmark comparisons are not currently available. The survey instrument is available in the public domain and has been adopted in part by the Ontario Government and Ontario Quality Council, future benchmarks and comparisons are likely possible

Most current data is 2008.
The next survey is not yet scheduled.

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asked residents of Alberta nursing homes about their rating of the care in the [Alberta Long Term Care Resident Experience Survey](#). The first report was released in 2008 and is based on a survey conducted between June and August of 2007. The next Alberta Long Term Care Resident Experience Survey has not yet been scheduled.

Rating of Care Nursing Home – Resident measures the overall resident rating of care at Alberta nursing homes, on a scale from 0 to 10, the average score is reported.

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

This global rating of care is an overall judgment by residents about the quality of care provided. We know this rating is significantly influenced by the specific issues captured in the complete survey, and we also see there is considerable performance variation in this rating between facilities in the province. It is most relevant and important for facility level results.

WHAT IS THE TARGET?

Alberta Health Services has not yet established a 2011/12 target for the average overall resident rating of care at Alberta nursing homes.

HOW ARE WE DOING?

In 2008 the average overall resident rating of care at Alberta nursing homes was 8.1, on a scale from 0 to 10.

Table: Overall Care Rating (2008)

Province	Average Score
Alberta 2008	8.1

Source: Health Quality Council of Alberta (HQCA) Alberta Long Term Care Resident Experience Survey

PERFORMANCE STATUS

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

2011/12 TARGET:
TBD

2008 ACTUAL: 8.1

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: 200 beds were opened at Michener Hill in Red Deer. Provincial education for behavioral and symptom management was undertaken with three rural communities receiving training on best practices in nursing care to older adults. A review of access to specialized geriatric consultative services was also completed.

Subsequent actions planned: A report on the financial barriers to obtaining timely Living Option access will be completed in early 2011. As well, the current training program will be reviewed to develop a distributive model of education that will spread best practices in a more efficient way.

WHAT ELSE DO WE KNOW?

Due to issues of cognitive function, only about 35 per cent of Long Term Care residents are capable of completing an interview. The result is very small sample sizes at the facility level. It is likely that no measurement process in this population could avoid this problem.

High level surveys and aggregate results do not capture the unique nature of individual resident experiences and the sometimes significant challenges and issues they face.

We know that smaller facilities and facilities in small communities are pre-disposed to better performance in terms of family and resident experience ratings. Despite this, there is still considerable variation in performance between facilities which are comparable in size and location.

HOW DO WE COMPARE?

National benchmark comparisons are not currently available. The survey instrument is available in the public domain and has been adopted in part by the Ontario Government and Ontario Quality Council, future benchmarks and comparisons are likely possible.

Head Count to FTE Ratio

Data updated quarterly.
 Most current data is Q1 2011/12.
 Next data update expected for Q2 2011/12.

WHAT IS BEING MEASURED?

The Head Count to FTE (Full-Time Equivalent) Ratio is the number of people employed by Alberta Health Services (AHS) 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 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.

An internal review of the data quality indicates a questionable level of confidence with known issues.

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?

Alberta Health Services has established a 2011/12 target head count to FTE ratio of 1.62. This is a reduction from the 2010/11 target of 1.63.

HOW ARE WE DOING?

In 2009/10 and 2010/11 the head count to FTE ratio was 1.57. In Q1 2011/12 the ratio was 1.58.

 PERFORMANCE STATUS Performance is at or better than target, continue to monitor. 2010/11 Actual: 1.57	2011/12 TARGET: 1.62 Q1 TARGET: 1.58
	Q1 2011/12 ACTUAL 1.58

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Head Count to FTE Ratio is one of the supporting metrics being evaluated to determine if it can provide AHS and operational Managers information needed to maximize staff utilization. Communication to AHS management to increase the proportion of full-time staff has been issued, which is expected to improve the Head Count to FTE Ratio.

Subsequent actions planned: A Managers' Workforce Indicator Report and interpretation guides will be piloted.

WHAT ELSE DO WE KNOW?

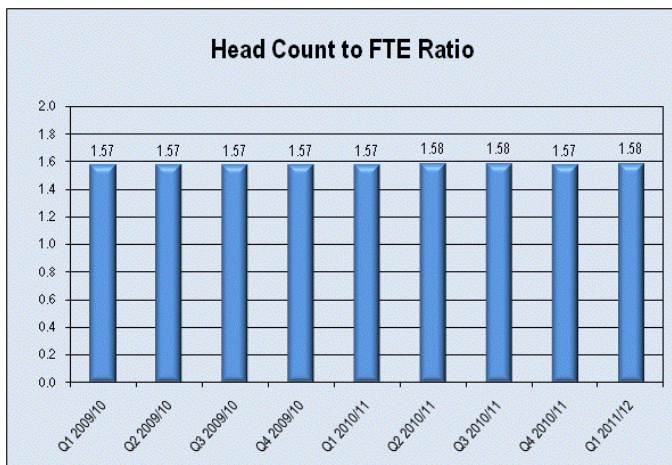
The head count includes full-time, part-time and casual employees. The FTE includes full-time, and part-time employees as casual employees have no assigned FTE.

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 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).

HOW DO WE COMPARE?

This measure is not benchmarked externally.



Source: Alberta Health Services Human Resources

Registered Nurse Graduates Hired by AHS (%)

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 2011/12.

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.

An internal review of the data quality indicates a questionable level of confidence with known issues.

WHY IS THIS IMPORTANT?

The performance of our health care system is directly related to the ability of Alberta Health Services 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 Alberta Health Services will hire a minimum of 70 per cent of Alberta nursing graduates positions annually. If 70% 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.

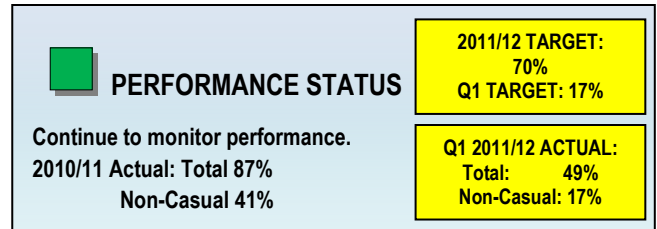
WHAT IS THE TARGET?

Consistent with the UNA Collective Agreement, Alberta Health Services has established a target of 70 per cent of Alberta graduates hired in 2011/12.

HOW ARE WE DOING?

By the end of fiscal year 2010/11 Alberta Health Services hired 1,383 (87%) of nursing graduates. Of these, 653 (41%) were hired into non-casual positions.

In the first quarter of 2011/12, Alberta Health Services hired 756 (49%) of nursing graduates. Of these, 268 (17%) were hired into non-casual positions. This is the same percentage of total hires (49%) as Q1 2010/11 but it is two and a half times the number hired into non-casual positions (7%) last year at this time.



WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A program has been put in place to promote AHS as an employer of choice to new graduates at a number of academic institutions in Alberta. In June 2011, an AHS advertising campaign was launched in Edmonton and Calgary to attract new graduates.

Subsequent actions planned: AHS is actively planning for some transitional graduate nurse positions in specific areas of the province. As well, AHS is considering initiatives to cover expected growth, expected replacement, and time to bring in external candidates.

WHAT ELSE DO WE KNOW?

It may be difficult to recruit new graduates into some of the “difficult to recruit to” areas – in part because of the rural/remote geographical areas when many new grads are seeking employment in the metro areas, and in part because new grads are not necessarily competent to work in specialized areas without additional support. As such, new vacancies may not match new graduate expectations for places of work.

HOW DO WE COMPARE?

This measure is not benchmarked externally.

Disabling Injury Rate

Data updated quarterly.
Most current data is Calendar Year (CY) 2011 Q2.
Next data update expected for Q2 2011/12.

WHAT IS BEING MEASURED?

The number of disabling injury claims per 100 Alberta Health Services (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.

An internal review of the data quality indicates a very high level of confidence with no known issues.

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 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?

Alberta Health Services has established a 2011 target of 2.20 disabling injury claims per 100 workers. This is an 8.7% reduction in the disabling injury target (2.41) set for 2010 and represents a 31% reduction in the disabling injury claim rate actually achieved in 2010.


HOW ARE WE DOING?

In 2009, the disabling injury rate (DIR) was 2.83. In 2010 the disabling injury rate was 3.19. This represents a 13% increase in the disabling injury rate. For 2011 Q2, the actual disabling injury rate was 1.69 (cumulative Jan - Jun). If this rate continues, the annual projected disabling rate for 2011 would be 3.39.



Source: Alberta Health Services and Alberta Workers' Compensation Board

Notes: * 2011 figure is annualized Calendar year to date.

 PERFORMANCE STATUS Performance is outside acceptable range, take action and monitor progress. 2010/11 Actual: 3.19	2011 CY TARGET: 2.20
	2011 CY Q2 (Jan-Jun) ACTUAL: 1.69 2011 CY ANNUALIZED: 3.39

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: In recognition of a negative trend in the Disabling Injury Rate for AHS for 2010, an aggressive, enterprise-wide initiative (Short Term Action Plan) was proposed to improve performance in various areas, which included the following items: a commitment to ongoing implementation of the "It's Your Move" Safe Client Handling Program; initiation and beta-testing of an AHS Safe Manual Material Handling Program; initiation of an AHS Falls Prevention Program in three program areas; timely injury reporting to WCB; implementation of a mandatory Modified Work Program; as well as meaningful quarterly reporting as an interim step to the implementation of a provincial Workplace Health and Safety (WHS) Application in 2012/13.

Subsequent actions planned: Approval and execution of the Short Term Action Plan deliverables.

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.

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 Alberta Health Services 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](#). In 2010, the disabling injury rate for Alberta Health services was slightly worse when compared with all Alberta industries (2.70).

Most current data is 2009/10.
The next survey is planned for 2012

Staff Overall Engagement (%)

WHAT IS BEING MEASURED?

Staff overall engagement measures the per cent of Alberta Health Services employees (excluding physicians and volunteers) who report they are favorably engaged at work. To determine the level of staff engagement, AHS undertook a workforce engagement survey in January/February 2010.

Results were calculated as the number of positive category responses (strongly agree or agree), divided by the total number of responses across all categories (strongly agree, agree, neutral, disagree, strongly disagree, not applicable) to the survey's seven engagement questions:

1. I am proud to tell others I am associated with Alberta Health Services.
2. I am optimistic about the future of Alberta Health Services.
3. Alberta Health Services inspires me to do my best work.
4. I would recommend Alberta Health Services to a friend as a great place to work.
5. My work provides me with sense of accomplishment.
6. I can see a clear link between my work and Alberta Health Services long-term objectives.
7. Overall, I am satisfied with Alberta Health Services.

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a high level of confidence with limited issues.

WHY IS THIS IMPORTANT?

The engagement of AHS' workforce is critical to the delivery of safe and quality health services to Albertans, and to the success of the organization. Studies have shown an engaged workforce results in improved performance, retention, productivity and patient satisfaction.

WHAT IS THE TARGET?

Alberta Health Services has established a target of 43 per cent of employees reporting they are favorably engaged at work for 2010/11 and 2011/12.

HOW ARE WE DOING?

Of the employees responding to the 2009/10 engagement survey, 35 per cent reported that they were favorably engaged.

The results of this first workforce engagement survey will serve as a baseline on which to assess future performance. Subsequent surveys are planned to occur every two years.

PERFORMANCE STATUS

Performance is outside acceptable range of 2010/11 target (>10%), take action and monitor progress.

TARGET
43%

ACTUAL
35%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Early implementation of a Leadership Program, establishment of a Provincial Working Group for the Just and Trusting Culture initiative, establishment of a Learning and Professional Development Fund, development of a process for informal employee appreciation, establishment of various programs for management and out-of-scope staff (compensation, flex benefits and career framework). In addition, many recruitment strategy components are underway with engagement from an employee working group.

Subsequent actions planned include presentations for Long Service Awards, roll-out of a performance management process for unionized staff, development of a rewards and recognition program for staff (as part of a broader Workforce Engagement framework), roll-out of leadership competencies to managers across the organization, as well as preliminary planning for the next Workforce Engagement Survey in early 2012 (will be repeated every two years).

WHAT ELSE DO WE KNOW?

Timing of the survey may have had an impact on both the results, as well as the low response rate for employees (21 per cent). Uncertainties related to Alberta Health Services' budget, the implementation of a vacancy management process, the potential for staff layoffs, and other factors occurring at the time of the survey could have influenced the survey results.

Information is available by [zone](#).

HOW DO WE COMPARE?

The survey was administered by an external third party provider (TalentMap). Based on engagement data drawn from 28 Canadian healthcare organizations (40 per cent from Western Canada), TalentMap's Healthcare Benchmark for overall engagement is 76 per cent. This is significantly higher than the Alberta Health Services employee engagement survey result.

Most current data is 2009/10.
The next survey is planned for 2012

Physician Overall Engagement (%)

WHAT IS BEING MEASURED?

Physician overall engagement measures the per cent of physicians associated with AHS who report they are favorably engaged in this association. To determine the level of physician engagement, Alberta Health Services undertook a Workforce Engagement Survey in January/February of 2010.

Results were calculated as the number of positive category responses (strongly agree or agree), divided by the total number of responses across all categories (strongly agree, agree, neutral, disagree, strongly disagree, not applicable) to the survey's seven engagement questions:

1. I am proud to tell others I am associated with Alberta Health Services.
2. I am optimistic about the future of Alberta Health Services.
3. Alberta Health Services inspires me to do my best work.
4. I would recommend Alberta Health Services to a friend as a great place to work.
5. My work provides me with sense of accomplishment.
6. I can see a clear link between my work and Alberta Health Services long-term objectives.
7. Overall, I am satisfied with Alberta Health Services.

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a high level of confidence with limited issues.

WHY IS THIS IMPORTANT?

The engagement of the Alberta Health Services physician community is critical to the delivery of safe and quality health services to Albertans and to the success of the organization. Studies have shown an engaged workforce results in improved performance, retention, productivity and patient satisfaction.

WHAT IS THE TARGET?

Alberta Health Services has established a target of 43 per cent of the physician community reporting they are favorably engaged at work for 2010/11 and 2011/12.

HOW ARE WE DOING?

Of the physicians responding to the 2009/10 engagement survey, 26 per cent reported they were favorably engaged.

The results of this first workforce engagement survey will serve as a baseline on which to assess future performance. Subsequent surveys are planned to occur every two years.



PERFORMANCE STATUS

Performance outside acceptable range of 2010/11 target (>10%), take action and monitor progress.

TARGET
43%

ACTUAL
26%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: In addition to the strategies identified under AHS' Workforce Engagement Plan (which includes physicians), a Physician Engagement Plan has been developed and each Zone Medical Affairs group has articulated a local plan for enhancing physician participation and engagement. A medical staff website was implemented on the external AHS website as part of the AHS Physician communication strategy. Accreditation activities were also used as an opportunity to facilitate physician participation in AHS processes.

Subsequent actions planned: A rewards and recognition program for physicians will be implemented later in 2011. As well, negotiations continue between AHS, AHW and the AMA on the next Trilateral Master Agreement.

WHAT ELSE DO WE KNOW?

The timing of the survey may have had an impact on both the poor results, as well as the low response rate for physicians (12 per cent). Uncertainties related to Alberta Health Services budget, the implementation of a vacancy management process, the potential for staff layoffs, and other factors occurring at the time of the survey, could have influenced the survey results.

Information is available by [zone](#).

HOW DO WE COMPARE?

The survey was administered by an external third party provider (TalentMap). Based on engagement data drawn from 28 Canadian healthcare organizations (40 per cent from Western Canada), TalentMap's Healthcare Benchmark for overall engagement is 76 per cent. This is significantly higher than the Alberta Health Services physician engagement survey result

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 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

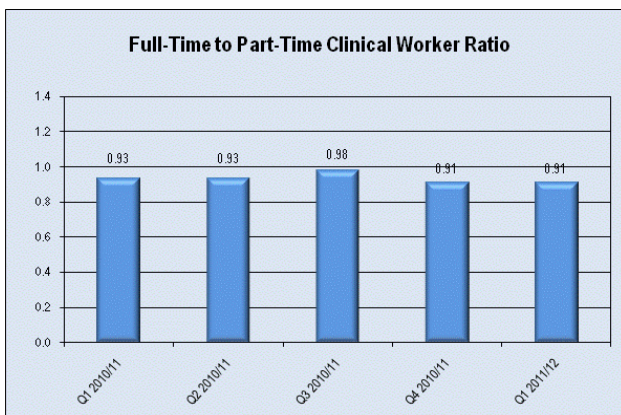
The measure is calculated as the number of unique/discrete clinical individuals employed by Alberta Health Services in full-time positions divided the number of unique/discrete clinical individuals employed by Alberta Health Services (AHS) in part-time positions. A higher ratio (higher number of full-time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

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates an acceptable level of confidence with known issues.

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

Full-time to Part-time Clinical Worker Ratio

PERFORMANCE STATUS Performance Target for 2011/12 has not been established for comparison. 2010/11 Actual: 0.91	2011/12 TARGET: TBD
	Q1 2011/12 ACTUAL: 0.91:1.00

WHAT IS THE TARGET?

AHS has not yet established a 2011/12 target full-time to part-time clinical worker ratio.

HOW ARE WE DOING?

The full-time to part-time clinical worker for Q1 2011/12 is 0.91, which matches the figure at the end of the 2010/11 year.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Initiatives are underway to address productivity and effective utilization of the clinical workforce. An example is the Joint Workforce Regularization Project (JWRP), in which AHS and the United Nurses Association (UNA) are working jointly to identify areas where there may be opportunity to create more regular positions, and increased full-time positions. In addition, communication has been issued to AHS management to increase the proportion of full-time staff.

Subsequent actions planned: Additional communication to Managers in the form of a Workforce Indicator Report along with an interpretation guide will be piloted. There is also an initiative to hire 300-plus “anticipatory” positions which is currently pending approval.

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 Alberta Health Services. Some employees currently not on Alberta Health Services 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

Data updated quarterly.
Most current data is Q1 2011/12
Next data update expected for Q2 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.

An internal review of the data quality indicates a questionable level of confidence with known issues.

WHY IS THIS IMPORTANT?

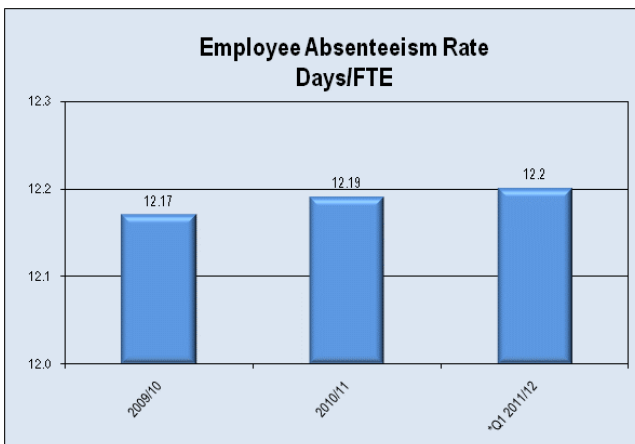
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

WHAT IS THE TARGET?

No targets have been defined. A target will be set in 2011/12

HOW ARE WE DOING?

Sick leave days taken per FTE have remained fairly constant throughout 2009/10 and 2010/11 fiscal years. In Q1 2011/12, The AHS employee absenteeism rate increased to 12.20 annualized days per FTE.



Source: Alberta Health Services, Labour Cost System
Notes: * Q1 2011/12 figure is annualized fiscal year to date.

PERFORMANCE STATUS

Performance Target for 2011/12 has not been established for comparison.
2010/11 Actual: 12.19

2011/12 TARGET:
TBD

Q1 2011/12:
12.20 days/FTE

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Collection and analysis of attendance awareness programs from former health entities has been completed to identify effective practices. In addition, a review of data on absenteeism that is available from various legacy payroll systems has been done. These actions have resulted in a first draft of an attendance awareness program which is now under development.

Subsequent actions planned: Conduct a legal review of the draft program developed and then follow up with the engagement and consultation with front line managers to obtain feedback on the new program and develop appropriate supporting tools. Engage with the unions to consult to build awareness and understanding.

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 7 western provinces' health regions participating in a survey.

This measure can be benchmarked externally:

	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

Overtime Hours to Paid Hours

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 2011/12.

WHAT IS BEING MEASURED?

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

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a questionable level of confidence with known issues.

WHY IS THIS IMPORTANT?

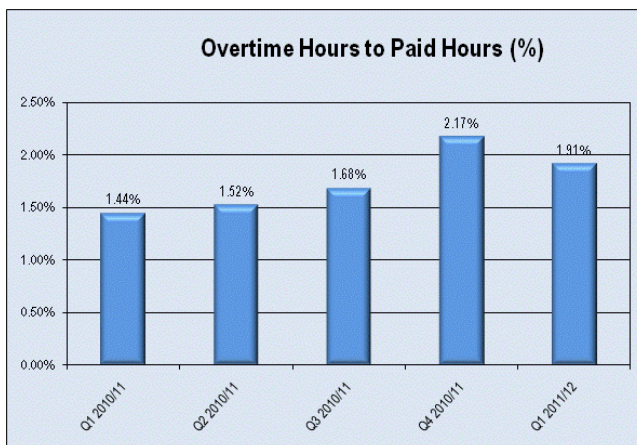
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

WHAT IS THE TARGET?

No targets have been defined. A target will be set in 2011/12.

HOW ARE WE DOING?

Overtime hours accounted for only 1.62% of total paid hours in 2009/10. This increased slightly in 2010/11 to 1.70%. Overtime hours accounted for 1.91% of total paid hours in Q1 2011/12.



Source: Labour Cost Forecasting System (LCFS)

PERFORMANCE STATUS

Performance Target for 2011/12 has not been established for comparison.
2010/11 Actual: 1.70%

2011/12 TARGET:
TBD

Q1 2011/12 ACTUAL:
1.91%

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. Through performance agreements, managers, in all areas, are responsible for adherence to budgets for their sections.

Subsequent actions planned: A new Managers' workforce indicator report and interpretation guide will be piloted.

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.

New Measure, data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 2011/12.

WHAT IS BEING MEASURED?

The total labour cost (salaries and benefits) divided by the number of worked hours. Includes terminated employees.

Salaries and benefits are comprised of base salary (pensionable base pay as well as statutory and vacation accruals) including honoraria, bonuses, overtime, vacation payouts and lump sum payments. Employer paid benefits and contributions or payments made on behalf of employees including pension, health care, dental coverage, vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, long and short term disability plans and include current and prior service cost of supplemental pension plans and severances.

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a high level of confidence with limited issues.

WHY IS THIS IMPORTANT?

This measure supports workforce efficiencies and addressing productivity challenges. Improving scheduling effectiveness, reducing overtime and using appropriate staffing mix can result in decreased costs.

WHAT IS THE TARGET?

AHS has not yet established a 2011/12 target for this measure.

HOW ARE WE DOING?

For the first quarter of 2011/12, the Labour Cost per worked hour has decreased from the 2010/11 average.

Time Period	Labour Cost (Billions)	Worked Hours	Labour Cost Per Worked Hour
2008/09	\$5.02	N/A	N/A
2009/10	\$5.48	110,519,520	\$49.61
2010/11	\$5.67	111,517,162	\$52.04
2011/12 Q1	\$1.48	28,970,210	\$50.97

PERFORMANCE STATUS

Performance target has not been established for comparison.
2010/11 Actual: \$52.04

2011/12 TARGET: TBD

2011/12 Q1:
\$50.97

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: AHS works to ensure quality, accessible health care is provided in a cost effective manner. Establishment of the United Nurses Association 2% productivity increase will include initiatives on management rights.

Subsequent actions planned: Milestones will be developed for the next reporting period.

WHAT ELSE DO WE KNOW?

Productivity metrics similar to this are being refined to support the implementation of the Clinical Workforce Strategy.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Number of Netcare Users

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update expected for Q2 2011/12.

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.

A data quality assessment is not available for this data at this time.

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 has established a target of a 10 per cent increase in Netcare users from 2010/11 to 2011/12.

HOW ARE WE DOING?

The peak quarterly number of nurses and physicians accessing Netcare was 12,708 in Q1 of 2011/12. This represents an 8 per cent increase over the previous quarter.

 PERFORMANCE STATUS Performance is at or better than target, continue to monitor. 2010/11 Actual: 11,816	2011/12 TARGET: 12,998 Q1 2011/12 Target: 12,046
	Q1 2011/12 ACTUAL: 12,708

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Enhancements to Netcare within the acute care setting in the Calgary Zone has been completed, with additional data added and all users now able to access Netcare through their Enterprise Medical Record software, thereby allowing seamless access to patient information. Training has also been completed for Emergency Departments. In addition, early use within Home Care settings has been initiated, whereby all Edmonton Zone users can now access Netcare through their Homecare Medical Record software. Home Care providers are also beginning to use Drug Summaries for Medication Reconciliation, thereby improving Patient Safety.

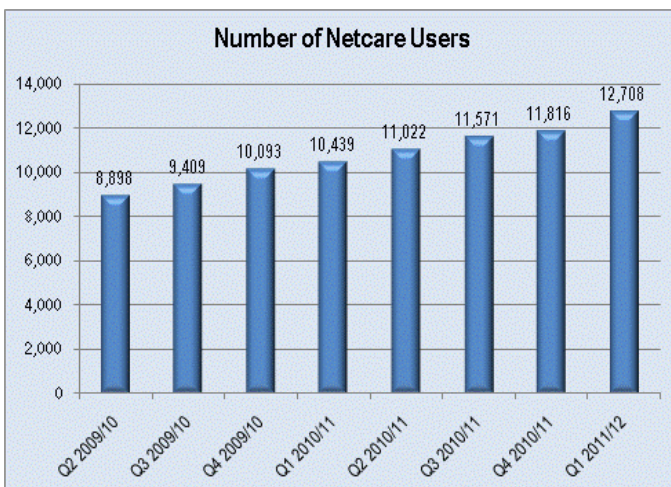
Subsequent actions planned: Expansion of Netcare to additional users will continue in the months and years ahead. Information about Netcare data content and new Netcare initiatives will also be provided to Zone leaders in order to increase awareness of the benefits of Netcare.

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).

HOW DO WE COMPARE?

National benchmark comparisons are not available.



Source: Alberta Netcare Portal

Data updated quarterly.
Most current data is Q1 2011/12.
Next data update Q2 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/deficit is the surplus or deficit that has accrued since AHS was formed.

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?

AHS had established a budgeted accumulated surplus as at March 31, 2011, of \$0M. AHS is committed to have an accumulated surplus greater than \$0M at the end of the five years. For the year ended March 31, 2012, the targeted accumulated surplus is \$36M.

Table: Accumulated surplus in \$Millions as at:

	Actual (\$Millions)
September 30, 2010	\$268
December 31, 2010	383
March 31, 2011	116
June 30, 2011	175

Source: Unaudited Quarterly Financial Statements for the period ended June 30, 2011.



PERFORMANCE STATUS

Performance is better than annual target, continue to monitor.

2011/12 TARGET
ACCUMULATED
SURPLUS: \$36M

Q1 ACTUAL
ACCUMULATED
SURPLUS: \$175M

HOW ARE WE DOING?

At June 30, 2011, the first quarter accumulated surplus was \$139M higher than budget.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: 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 Hyperion module is also in progress.

WHAT ELSE DO WE KNOW?

The first quarter accumulated surplus has increased from March 31, 2011 by \$59M primarily due to an operating surplus of \$65M. The operating surplus is primarily due to delayed implementation of new initiatives, difficulties in recruitment for staff vacancies and planned spending increases occurring in the latter half of the fiscal year.

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 website.

HOW DO WE COMPARE?

National benchmark comparisons are not applicable.

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q2 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.

An internal review of the data quality indicates a very high level of confidence with no known issues.

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 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.

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. Based on the evolving strategic and quality needs of AHS, a decision was made in late 2010 to assess patient satisfaction at all hospitals annually (using 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.



PERFORMANCE STATUS

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

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

Q4 2010/11 ACTUAL:
81.4%

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.

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 percent (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).

Year 2010/11	Q1	Q2	Q3	Q4
Number of Respondents	1581	1515	2244	2243
Valid Answers	1573	1509	2234	2227
Number of Sites	29	29	93	93
Rated experience as 8-10	84.5%	84.6%	82.2%	81.4%

New measure Q1 2011/12.
Data updated annually.
Most current data is 2010/11.

Patient Satisfaction Addiction and Mental Health

WHAT IS BEING MEASURED?

Patient Satisfaction Addiction and Mental Health measures an annual patient/client rating of the overall satisfaction with addiction and mental health services. This measure includes results for patients indicating that they were overall 'Mostly Satisfied' or 'Delighted/Very Satisfied' with the service they received. Individuals receiving general community services were surveyed (this includes ambulatory services such as outpatient clinics, community-based clinics, and day treatment programs). It excludes inpatient and residential services as well as services that narrowly focus on a certain diagnosis or specific demographic group(s).

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a moderate level of confidence with some known minor issues.

WHY IS THIS IMPORTANT?

Patient satisfaction with addiction and mental health services is an important dimension of a patient's experience with health care. Insight into patient's experience with the care they receive is critical to improving the quality of services available. It is also important to carrying out Alberta Health Service's (AHS) mission of providing patient-centered care.

WHAT IS THE TARGET?

Alberta Health Services has established a target of 85 per cent of patients indicating that overall they are satisfied with addiction and mental health services they received.

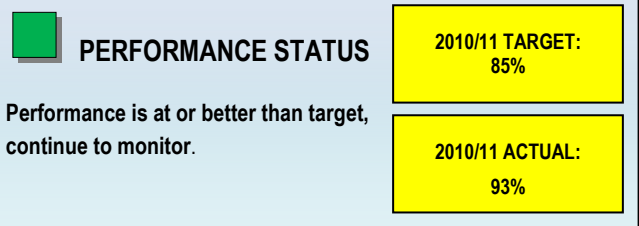
HOW ARE WE DOING?

The 2010/11 results within Addiction and Mental Health have surpassed the AHS target of 85 per cent of patients satisfied with the service they received.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Significant progress has been made in developing a coordinated, provincial approach to collecting patient satisfaction data. Taking advantage of this opportunity, measures of patient engagement have been included in the satisfaction surveys in some zones.

Subsequent actions planned: Engagement measures will be implemented across the province as another dimension of a patient's experience in care. Satisfaction and engagement measures will be



used to assess the quality of care that patients receive, to evaluate programs, and to inform service planning and strategic initiatives.

As improvements in patient satisfaction are often best achieved through local action, the results will be reported at both the zone and service/site levels. The surveys cover satisfaction with different dimensions of care (e.g. access, patient-clinician interaction) and include a narrative component. As such, the results highlight dimensions of care where the service has excelled as well as where they could improve. Patient comments can provide useful, site specific suggestions to staff and managers on possible improvements. There is also the opportunity for comparison with provincial and zone results.

WHAT ELSE DO WE KNOW?

These results are based on standardized satisfaction surveys (e.g., the Client Satisfaction Questionnaire and the Service Satisfaction Survey).

In total, 1,469 patients reported their overall satisfaction. The distribution of patients surveyed in each zone was not proportional to the number of patients served in the zone. The results were, therefore, weighted by the number of patients receiving general community services by zone. This had a negligible impact on the overall provincial results and, consequently, was not reported.

Information is available by [zone](#).

HOW DO WE COMPARE?

Addiction and mental health services are moving towards a consistent, regular reporting of patient satisfaction. The recently released *System Level Performance for Mental Health and Addiction in Alberta, 2008/09* report collated satisfaction results from a variety of surveys to give an overview of how satisfied patients were in Alberta Health Services. The results ranged from 55% to 97%. This is similar to what is found in the literature on patient satisfaction with addiction and mental health services. The results for this performance measure are close to the upper limit of this range.

Data updated quarterly.
Current data Q1 2011/12
Next data update expected for Q2 2011/12.

Percentage of Patient Feedback as Commendations

WHAT IS BEING MEASURED?

This measure calculates the number of commendations received as a per cent of all feedback received by the 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.

An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

It is important for AHS to hear what is working well for patients and families, as well as areas for improvement. Tracking the per cent 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.

PERFORMANCE STATUS Performance Target for 2011/12 has not been established for comparison.	2011/12 TARGET: TBD
	Q1 2011/12 ACTUAL: 8.53 %

HOW ARE WE DOING?

Of the 2,729 pieces of feedback provided to the Patient Relations Department between April-June 2011, (including Covenant Health), 8.53 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.

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
Q1 2011/12	233	8.53 %
Q4 2010/11	252	9.12%

Data updated quarterly.
Most recent data Q1 2011/12
Next data update expected for Q2 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.

An internal review of the data quality indicates a very high level of confidence with no known issues.

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 quarter represents the second 3 month time period 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.

PERFORMANCE STATUS	2011/12 TARGET: TBD
	Q1 ACTUAL: 0.63 %

HOW ARE WE DOING?

During the period of April-June 2011, 14 Patient Concerns Officer reviews were initiated on files that had been reviewed by the Patient Relations Department, which amounted to 0.63 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	
	#	%
Q1 2011/12	14	0.63%
Q4 2010/11	6	0.29%

Data updated every two years.
Most current data is 2010
The next survey is anticipated for 2012.

Performance Measure Update

Albertans Reporting Unexpected Harm

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asks Albertans about unexpected harm in the [Health Services Satisfaction Survey](#), which is conducted every two years. The most recent report was released in 2010 and is based on data collected between February and May 2010.

Unexpected harm measures the per cent of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year.

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

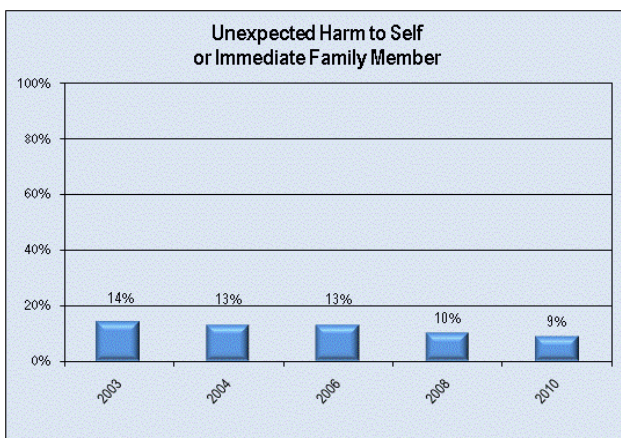
Patient experience with adverse events is a high level indicator of system safety. Unlike complications, which may occur as an expected risk of some treatments, unexpected harm can affect a patient's health and/or quality of life and can result in additional or prolonged treatment, pain or suffering, disability or death.

WHAT IS THE TARGET?

Based on previous survey data, AHS has established a 2011/12 target of 9 per cent for the per cent of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year.

HOW ARE WE DOING?

The per cent of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year is at the target of 9 per cent.



Source: Health Quality Council of Alberta (HQCA) Health Services Satisfaction Survey

Note: This measure applies only to adults aged 18 years and over who used health care services in Alberta in the past year.



PERFORMANCE STATUS

Performance is at or better than target, continue to monitor.
2008 Actual: 10%

2011/12 TARGET:
9%

2010 ACTUAL:
9.0%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Safety alert and safer practices notices are disseminated to frontline care teams as required. As well, a province-wide reporting and learning system has been implemented and will be used to analyze patient safety related adverse events, close calls and hazards and also recommend solutions to decrease adverse events or unexpected harm. In addition, a draft patient safety plan has been developed which contains a number of initiatives to improve patient safety.

Subsequent actions planned: Risk reduction strategies will be established to prioritize actions on reported adverse events, close calls and hazards. As well, options will be investigated to allow for potential self-reporting of unexpected harm from patients and families. Policies/procedures for disclosing harm to patients, and also for the management of serious adverse events will be implemented. Measurement and action plans for controlling specific hospital-acquired infections (e.g. MRSA, C-difficile, central venous catheter bloodstream infections) will also be implemented in 2011 and 2012.

WHAT ELSE DO WE KNOW?

The origins of unexpected harm are complex and the contributing factors are not always clear. Further analysis is necessary in order to guide future decisions and to gain an understanding of what has occurred. Though it may be impossible to eliminate unexpected harm entirely, it is feasible to continually learn and improve systems and processes in order to minimize harm.

Information is available by [zone](#).

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Data updated every two years.
Most current data is 2010.
Next survey is anticipated for 2012

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asks Albertans about their satisfaction with Emergency Departments in the [Health Services Satisfaction Survey](#), which is conducted every two years. The most recent report was released in 2010 and is based on data collected between Feb to May 2010.

Patient Satisfaction Emergency Department (ED) measures the per cent of Albertans who were satisfied (4 or 5 out of 5) with their or a close family member's services at an emergency department in the past year.

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

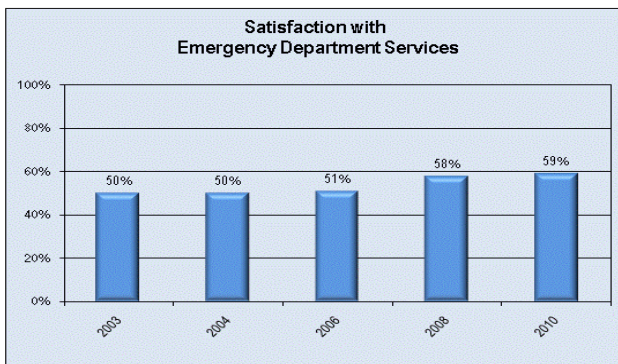
Patient satisfaction with the emergency department is a crucial and critical dimension of quality; it is a high level indicator of the structure, process and outcome of care in emergency departments. The information provides insights into the consequences of policy and strategic changes from the perspective of a key health care partner - Albertans.

WHAT IS THE TARGET?

The Alberta Health Services target established for 2011/12 for patient satisfaction with the emergency department is 70 per cent.

HOW ARE WE DOING?

In 2010 59 per cent of Albertans were satisfied with their or a close family member's services at an emergency department in the past year.



Source: Health Quality Council of Alberta (HQCA) Health Services Satisfaction Survey

Note: This measure applies only to adults aged 18 years and over who had gone to an emergency department in the past year for an illness or injury for themselves or a close family member.



PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress
2008 Actual: 58%

2011/12 TARGET:
70%

2010 ACTUAL: 59%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A total of 360 new hospital beds have been opened as of June 30, 2011 and additional staff (physicians/unit managers/Home Care coordinators) have been hired. In addition, "over capacity" protocols and escalation plans continue to be used to manage periods of peak pressures in ED.

Subsequent actions planned: EDs are working collaboratively with other sectors to help patients avoid unnecessary (avoidable) ED visits and return home with appropriate services so as to minimize return visits. New software will also be implemented to make hospital discharges more efficient and timely.

WHAT ELSE DO WE KNOW?

Research conducted with Calgary emergency department users identified public expectations of emergency department care. These included: staff communication with patients; appropriate waiting times; the triage process; information management; quality of care; and improvement to existing services. These expectations were held similarly by those who had recently used the emergency department and those who had not. The authors also concluded that "emergency department care providers understand some, but not all, of the public's expectations. (Watt, Wertzler and Brannan. 2005. *Patient expectations of emergency care: phase I – a focus group study*. Canadian Journal of Emergency Medicine).

Information is available by [zone](#).

HOW DO WE COMPARE?

Alberta ranked ninth among the 10 provinces for satisfaction with hospital emergency rooms. Alberta = 55 per cent, Best Performing Province = 67 per cent (British Columbia), Canada = 56 per cent (Angus Reid, 2009-2010).

Data updated every two years.
Most current data is 2010.
Next survey is anticipated for 2012

Performance Measure Update

Patient Satisfaction Health Care Services Personally Received

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asks Albertans about satisfaction with health care services in the [Health Services Satisfaction Survey](#), which is conducted every two years. The most recent report was released in 2010 and is based on data collected between February and May 2010.

Patient Satisfaction Health Care Services Personally Received measures the per cent of Albertans who were satisfied (4 or 5 out of 5) with the health care services they personally received in Alberta within the past year.

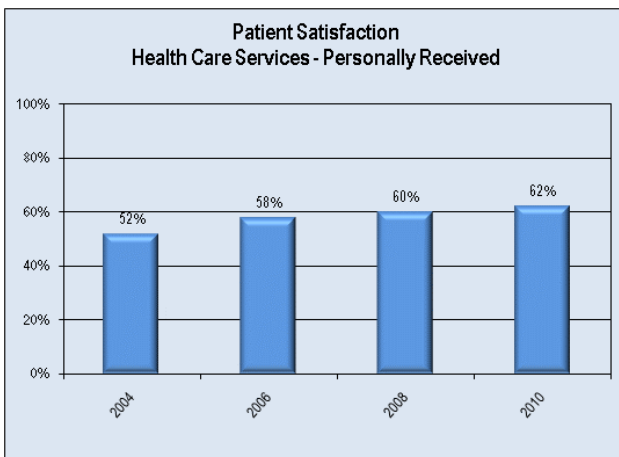
Health care services include personal family doctor, other health care professionals at family doctor's office, community walk-in clinics, specialists, MRI, other diagnostic imaging, pharmacists, emergency departments, inpatient hospital services, outpatient hospital services and mental health services.

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

Patient satisfaction with health care services received is a crucial and critical dimension of quality; it is an indicator of the structure, process and outcome of care in Alberta's health care system. The information provides high level insights into the consequences of policy and strategic changes from the perspective of a key health care partner - Albertans.



Source: Health Quality Council of Alberta (HQCA) Health Services Satisfaction Survey

Note: This measure applies only to adults aged 18 years and over who used health care services in Alberta in the past year.

PERFORMANCE STATUS

Performance Target for 2011/12 has not been established for comparison.

2008 Actual: 60%

2011/12 TARGET:
TBD

2010 ACTUAL: 62%

WHAT IS THE TARGET?

Alberta Health Services has established a 2010/11 target of 65 per cent of Albertans who were satisfied with the health care services they personally received in Alberta within the past year. The target for 2011/12 has not yet been set.

HOW ARE WE DOING?

The per cent of Albertans who were satisfied with the health care services they personally received in Alberta within the past year was 62% (below target).

WHAT ACTIONS ARE WE TAKING?

Alberta Health Services is undertaking focused improvement activities in access areas including Emergency Department and Primary Care Physician as well as specialty services such as Cancer Treatment and Surgery.

WHAT ELSE DO WE KNOW?

From the public's perspective, access – the ease of obtaining health care services – continues to be the most important factor associated with their overall satisfaction with health care services received.

Information is available by [zone](#).

HOW DO WE COMPARE?

Alberta ranked 10th among the 10 provinces for satisfaction with health care services received. Alberta = 81.0 per cent, Best Performing Province = 90.5 per cent (New Brunswick), Canada = 85.7 per cent (Statistics Canada, 2007)

Data updated quarterly.
Most current data is Q4 2010/11.
Next data update expected for Q2 2011/12.

Central Venous Catheter Bloodstream Infection Rate

WHAT IS BEING MEASURED?

Healthcare associated and nosocomial bloodstream infections (BSI) are an important cause of morbidity and mortality in severely ill patients, and a significant proportion of these infections are associated with central venous catheters (CVC) used in the intensive care units (ICUs) of adult acute care sites. As several potentially modifiable factors influence the risk of developing a catheter-associated BSI, appropriate infection prevention and control activities have an important impact on infection rates.⁽¹⁻⁴⁾

Detailed indicator [definition](#) is currently in development.

An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

Monitoring for bloodstream infections related to central venous catheters, and intervention when needed, are important for quality improvement and patient safety.

WHAT IS THE TARGET?

Targets will be set jointly by Alberta Health and Wellness and AHS following the collection of baseline data and information on infection prevention and control program activity by AHS.

PERFORMANCE STATUS

Performance target for 2011/12 is not yet established for comparison

2011/12 TARGET:
TBD

Q4 2010/11 ACTUAL:
1.26

HOW ARE WE DOING?

The central venous catheter bloodstream infection rate for adult sites was 1.26 per 1,000 line-days in Q4 2010/11.

WHAT ACTIONS ARE WE TAKING?

AHS has implemented the Canadian Patient Safety Institute's *Safer Healthcare Now* [bundle of recommendations](#), which is designed to reduce the number of bloodstream infections. These activities (which include optimizing hand hygiene practices) ensure that best practice is employed for central line insertion and maintenance in order to prevent infection. Infection rates are also provided to physicians and staff who insert and care for central lines so they can monitor their practice.

WHAT ELSE DO WE KNOW?

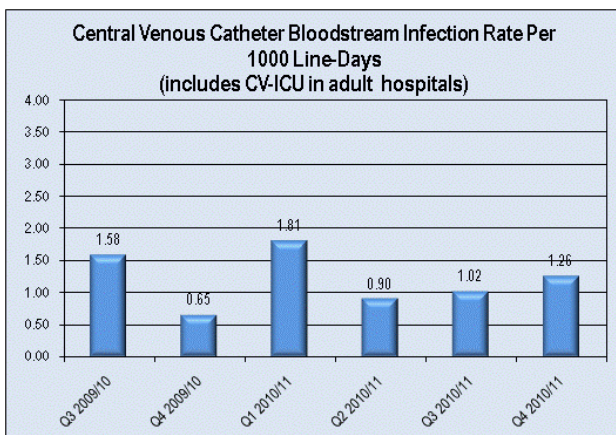
The skin is the main source of organisms causing CVC-BSI. Infection may occur because of migration of organisms from the insertion site along the percutaneous tract. Other risk factors include catheter insertion and care practices, products administered through the line, frequency of manipulation, age group, underlying disease and severity of illness of the patient. Infection risk also increases with understaffing in the ICU.

Infection risk can be lowered by maintaining appropriate aseptic technique during catheter insertion, care of the entry site and catheter manipulation.

Information is available by adult acute care [sites](#) presented as a one year rolling rate.

HOW DO WE COMPARE?

The CVC-BSI incidence rate was 1.3 per 1000 CVC days for adult intensive care units in Canadian hospitals participating in the Canadian Nosocomial Infection Surveillance Program (CNISP) in 2009. (CNISP 2011-2012 CVC-BSI Surveillance Protocol)



Source: ADULT General Systems ICUs only except Tertiary which also includes Cardiac Surgery ICUs.

References:

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