



**Alberta Health Services  
Q3 Performance Report  
2011/12**

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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. With a target date of March 2012, work is underway to implement programs in Emergency Departments to enable Seniors to return home with added home care support rather than remain hospitalized. This initiative will have the added benefit of freeing up beds within Emergency to assist in reducing ED wait times.
- Programs have been put in place to increase the rates of seasonal influenza immunization. This includes mail outs to families to advise them of the importance of Childhood immunizations for children aged 6 to 23 months and new processes which include immunization pilots at day care centers and school sites at end of business day as parents present to pick up children.
- 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.
- Emergency Department wait time improvement efforts continue with focused attention on new capacity and processes in each Zone and a dedicated process improvement collaborative.

## Reporting our performance: October 1 – December 31, 2011

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

AHS has purposefully set aggressive performance targets within the five year health plan. This was done in a fundamental belief that these targets will translate into the type of Health Care System performance demanded by and deserved for Albertans. Several individual targets will be challenging to reach by end of year based on Q3 performance.

When looking at the current period performance and comparing it to the performance one year ago, most measures are demonstrating improvement year over year with some measures demonstrating significant improvement. These include:

- Decreased wait time for Cataract Surgeries (from over 47 weeks to less than 37).
- Reduction in the number of people waiting in Acute and Sub-Acute beds for Continuing Care placement (decrease by 25.5%) with a corresponding reduction in Average Wait time of 21.1%.
- Reduced the Radiation Therapy Access time (ready to treat to time of first therapy) by over 13%.
- Patient Satisfaction with Health Care Services Personally received has improved by over 8%.
- More Graduating Registered Nurses are being hired year to date this year than last year, up by 20%.
- Patient Satisfaction with Emergency Department Services for Children has seen an increase in satisfaction by over 7%.
- The number of Health Care professionals using the Provincial Netcare system has increased by 22% since the prior year.
- The wait times for Urgent Coronary Artery Bypass Grafts has decreased by 7%.
- The time it takes to admit patients from Emergency has improved by over 12% for the 15 higher volume EDs and by 6% for all EDs combined.
- In the past Ontario has claimed to have the lowest emergency department wait times and length of stay in Canada. Using the most recently available comparable data indicates:
  - 90th percentile length of stay for complex patients requiring admission to hospital was 16% lower in Alberta (23.4hrs) than in Ontario (27.8 hours) in December 2011.
  - 90th percentile length of stay for uncomplicated patients was 7% lower in Alberta (3.9hrs) than in Ontario (4.2 hours) in December 2011.
  - In 2011/12, the 90th percentile wait time (time from when a patient is triaged in ED to when they see a physician) was 12% lower in Alberta (2.93 hours) than in Ontario (3.33 hours). Alberta currently has the lowest wait time in this area among the five provinces where comparable data is available.

### ***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. This initiative has been expanded with the recent addition of the Smart Phone “app” which allows users to quickly see the wait times at city EDs, call the appropriate facility and “map” from their current location to the ED of their choice.

- Increase and improve the timeliness of Repatriations of patients from urban and regional facilities back to their home community or referring site within 24 hours of decision that patient can be repatriated. This assists in facilitating needed capacity for those patients who require a higher level of care in an urban or regional hospital
- AHS continues to add continuing care beds. In 2010/11, 1,155 beds were added to the system and a further 1,000 beds will be added this fiscal year. As of Dec. 31, 2011, 868 beds were opened, which reflects 87% of target, bringing the total number of continuing care beds in the province to nearly 21,800. AHS is on track to add more than 5,300 beds between 2010 and 2015.
  - 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.
- 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. AHS added nearly 4,000 home care clients year-to-date, a 5.4 per cent increase. This exceeds our target of 3,000 additional clients by March 2012.
- Increasing funding and implementing care pathways for patients requiring hip or knee replacement. An additional 1,000 hip and knee replacement surgeries were approved for 2011/12 as a means of reducing wait times for these procedures. Year-to-date (April to December, 2011), 873 hip and knee replacement surgeries have been performed out of 1,000 planned volume, which reflects 87% of target. 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 11 of the 12 facilities performing hip and knee replacements.
- For Coronary Artery Bypass Grafts (CABG), we have done 13% more semi-urgent and 3% more scheduled surgeries year to date this year over last year. This amounted to 29 more surgeries being done this year, year to date. In total we have approved 65 additional CABG surgeries.

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](http://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 (April to December, 2011) 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 as of the end of 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 of the target 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 to date Comparison:** Here we compare each measure's year to date value to the previous year's year to date value. 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 Provincial 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 Provincial 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 five of the quarterly performance measures in this report are updated to the third quarter (October-December, 2011). For those indicators reporting 2<sup>nd</sup> quarter data (July-September, 2011), the following table explains the reasons for the one quarter reporting lag:

<b>Quarterly Measures with a One Quarter Reporting Lag</b>	<b>Data Timeline Clarification</b>
<ul style="list-style-type: none"> <li>• Patient Satisfaction – Acute Care</li> </ul>	<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"> <li>• Central Venous Catheter Bloodstream Infection Rate</li> </ul>	<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>
<ul style="list-style-type: none"> <li>• Hospital-acquired Methicillin Resistant <i>Staphylococcus aureus</i> (MRSA) bloodstream infections (BSI)</li> </ul>	<p>As the second of four Infection Prevention and Control measures to be reported publicly, this measure also undergoes a more rigorous internal review process at both the Zone and Provincial level prior to results being released</p>
<ul style="list-style-type: none"> <li>• <i>Clostridium difficile</i> Infection</li> </ul>	<p>As the third of four Infection Prevention and Control measures to be reported publicly, this measure also undergoes a more rigorous internal review process at both the Zone and Provincial level prior to results being released</p>
<ul style="list-style-type: none"> <li>• 30 Day All Cause Unplanned Readmission Rate</li> </ul>	<p>Readmission rates are attributed to the quarter in which a patient is originally discharged from a hospital. This requires that patients be tracked for readmission 30 days after the end of a quarter. Data are lagged by quarter for this reason</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	Q4, 2011/12
• Breast Cancer Screening Participation Rate	Annual	Q3, 2012/13
• Cervical Cancer Screening Participation Rate	Annual	Q3, 2012/13
• 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	Q4, 2011/12
• Albertans Enrolled in a Primary Care Network	Semi-annual	Q1, 2012/13
• Rating of Care Nursing Home – Family	Every 3 years	2014/15
• 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	Annual	2012
• Patient Satisfaction – Emergency Department (All)	Every 2 years	2012
• Patient Satisfaction – Health Care Personally Received	Annual	2012

### Data sources

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

# AHS Performance Dashboard Q3 2011/12

## 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 Year to Date Performance	Comparative Performance
<b>Staying Healthy / Improving Population Health</b>										
◊ <a href="#">Life Expectancy</a>	81.1 2009	improve		<b>81.6</b> 2010	na				81.1 2009	
◊ <a href="#">Potential Years Life Lost</a> (per 1,000 population)	47.3 2009	improve		<b>44.8</b> 2010	na				47.3 2009	
<a href="#">Colorectal Cancer Screening Participation Rate</a>	35.5% 2008	37%+ 2010		na	na				na	na
<a href="#">Breast Cancer Screening Participation Rate</a>	55.9% 2008-2009	57%+ 2009-2010		<b>57.3%</b> 2009-2010					55.9% 2008-2009	
<a href="#">Cervical Cancer Screening Participation Rate</a>	70.7% 2007-2009	72%+ 2008-2010		<b>67.9%</b> 2008-2010					70.7% 2007-2009	
<b>Strengthen Primary Health Care</b>										
◊ <a href="#">Seniors (65+) Influenza Immunization Rate</a>	55.6% 2009-2010	75%		<b>58.9%</b> 2010-2011					56% 2009-2010	
◊ <a href="#">Children (6 to 23 Months) Influenza Immunization Rate</a>	16% 2009-2010	75%		<b>27%</b> 2010-2011					16% 2009-2010	
◊ <a href="#">Childhood Immunization Rates for DTaP</a>	83.8% 2008	97%		na	na				na	na
◊ <a href="#">Childhood Immunization Rates for MMR</a>	89.3% 2008	98%		na	na				na	na
<a href="#">Albertans Enrolled in a Primary Care Network (%)</a>	68% Oct 2010	tbd		<b>74%</b> Oct 2011	na	74% Oct 2011	72% Apr 2011		61% Oct 2009	
◊ <a href="#">Admissions for Ambulatory Care Sensitive Conditions</a> (per 100,000 Population)	282 2010/11	297 annual	223	<b>206</b> YTD (Apr-Dec)		69 Q3 2011/12	66 Q2 2011/12		<b>209</b> Q3 2010/11 YTD	
◊ <a href="#">Family Practice Sensitive Conditions</a> (% of ED visits)	27.5% 2010/11	25.0%	25.6%	<b>26.4%</b> YTD (Apr-Dec)		26.7% Q3 2011/12	26.0% Q2 2011/12		<b>27.3%</b> Q3 2010/11 YTD	
<a href="#">Health Link Wait Time</a> (% answered within 2 minutes)	77.7% 2010/11	85%	83.2%	<b>81.9%</b> YTD (Apr-Dec)		79.4% Q3 2011/12	84.9% Q2 2011/12		<b>80.0%</b> Q3 2010/11 YTD	
◊ <a href="#">Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled</a>	75% 2010/11	90%	86%	<b>73%</b> YTD (Apr-Dec)		83% Q3 2011/12	70% Q2 2011/12		<b>80%</b> Q3 2010/11 YTD	
<b>Improve Access and Reduce Wait Times</b>										
◊ <a href="#">Urgent CABG Wait Time</a> (90th percentile in weeks)	2.1 2010/11	1.0	1.3	<b>1.9</b> YTD (Apr-Dec)		1.8 Q3 2011/12	2.1 Q2 2011/12		<b>2.0</b> Q3 2010/11 YTD	
◊ <a href="#">Semi-urgent CABG Wait Time</a> (90th percentile in weeks)	6.4 2010/11	2.0	3.1	<b>6.4</b> YTD (Apr-Dec)		4.3 Q3 2011/12	3.5 Q2 2011/12		<b>5.8</b> Q3 2010/11 YTD	
◊ <a href="#">Scheduled CABG Wait Time</a> (90th percentile in weeks)	24.0 2010/11	6.0	10.5	<b>27.8</b> YTD (Apr-Dec)		30.9 Q3 2011/12	24.7 Q2 2011/12		<b>25.2</b> Q3 2010/11 YTD	
<b>Notes</b>										
◊ 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 Year to Date Performance	Comparative Performance
<a href="#">Hip Replacement Surgery Wait Time</a> (90th percentile in weeks)	38.9 2010/11	27.0	30.0	<b>39.9</b> YTD (Apr-Dec)	●	35.7 Q3 2011/12	39.7 Q2 2011/12	■	<b>39.9</b> Q3 YTD 2010/11	■
<a href="#">Knee Replacement Surgery Wait Time</a> (90th percentile in weeks)	48.9 2010/11	35.0	38.5	<b>49.1</b> YTD (Apr-Dec)	●	49.1 Q3 2011/12	49.9 Q2 2011/12	■	<b>49.1</b> Q3 YTD 2010/11	■
<a href="#">Cataract Surgery Wait Time</a> (90th percentile in weeks)	46.9 2010/11	30.0	34.2	<b>36.6</b> YTD (Apr-Dec)	▲	30.7 Q3 2011/12	36.3 Q2 2011/12	■	<b>47.4</b> Q3 YTD 2010/11	■
<a href="#">Other Scheduled Surgery Wait Time</a> (90th percentile in weeks)	25.7 2010/11	na	6.4	<b>26.0</b> YTD (Apr-Dec)	na	26.9 Q3 2011/12	25.0 Q2 2011/12	●	<b>25.7</b> Q3 YTD 2010/11	■
<a href="#">Radiation Therapy Access (referral to 1st consult)</a> (90th percentile in weeks)	6.0 2010/11	4.0	4.5	<b>5.7</b> YTD (Apr-Dec)	●	4.9 Q3 2011/12	6.6 Q2 2011/12	■	<b>6.0</b> Q3 YTD 2010/11	■
<a href="#">Radiation Therapy Access (ready to treat to first therapy)</a> (90th percentile in weeks) £	3.6 2010/11	4.0	4.0	<b>3.1</b> YTD (Apr-Dec)	■	3.0 Q3 2011/12	3.1 Q2 2011/12	■	<b>3.6</b> Q3 YTD 2010/11	■
<a href="#">Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume)</a> £	64% 2010/11	75%	72%	<b>66%</b> YTD (Apr-Dec)	●	66% Q3 2011/12	65% Q2 2011/12	■	<b>63%</b> Q3 YTD 2010/11	■
<a href="#">Patients Discharged from ED or UCC within 4 hours (%) (All Sites)</a> £	80% 2010/11	84%	83%	<b>81%</b> YTD (Apr-Dec)	▲	81% Q3 2011/12	81% Q2 2011/12	■	<b>80%</b> Q3 YTD 2010/11	■
<a href="#">Patients Admitted from ED within 8 hours (%) (15 Higher Volume)</a> £	41% 2010/11	60%	55%	<b>45%</b> YTD (Apr-Dec)	●	44% Q3 2011/12	46% Q2 2011/12	■	<b>40%</b> Q3 YTD 2010/11	■
<a href="#">Patients Admitted from ED within 8 hours (%) (All Sites)</a> £	53% 2010/11	65%	62%	<b>56%</b> YTD (Apr-Dec)	●	54% Q3 2011/12	55% Q2 2011/12	■	<b>53%</b> Q3 YTD 2010/11	■
<b>Provide More Choice for Continuing Care</b>										
<a href="#">People Waiting in Acute/Sub-acute Beds for Continuing Care Placement</a>	471 2010/11	375	399	<b>489</b> Dec 2011	●	489 Dec 2011	675 Sep 2011	■	<b>656</b> Dec 2010	■
<a href="#">People Waiting in Community for Continuing Care Placement</a>	1,115 2010/11	900	954	<b>1,038</b> Dec 2011	●	1,038 Dec 2011	1,140 Sep 2011	■	<b>1,077</b> Dec 2010	■
<a href="#">Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)</a>	54 2010/11	tbd	na	<b>45</b> YTD (Apr-Dec)	na	49 Q3 2011/12	42 Q2 2011/12	●	<b>57</b> Q3 YTD 2010/11	■
<a href="#">Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed</a>	55%* 2010/11	tbd	na	<b>62%</b> YTD (Apr-Dec)	na	60% Q3 2011/12	60% Q2 2011/12	■	na* Q3 YTD 2010/11	na
<a href="#">Number of Home Care Clients</a>	112,173 2010/11	tbd	na	na YTD (Apr-Dec)	na	58,754 Q3 2011/12	58,253 Q2 2011/12	■	na Q3 YTD 2010/11	na
<a href="#">Rating of Care Nursing Home - Family</a>	71.00% 2007/08	tbd	na	<b>73.40%</b> 2010/11	na				<b>71.00%</b> 2007/08	■
<b>Notes</b> ◇ 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%. * Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed – data for this measure are reportable as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).										

# Q3 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 Year to Date Performance	Comparative Performance
<b>Build One Health System</b>										
◊ <a href="#">Head Count to FTE Ratio</a>	1.57 2010/11	1.62	1.62	<b>1.54</b> Dec 2011	■	1.54 Dec 2011	1.58 Sep 2011	■	<b>1.57</b> Dec 2010	■
◊ <a href="#">Registered Nurse Graduates Hired by AHS (%)</a> - Total - Non-Casual	88% 41% 2010/11	70%	57% 57%	<b>88%</b> <b>48%</b> Dec 2011	■ ●				<b>76%</b> <b>31%</b> Dec 2010	■ ■
◊ <a href="#">Disabling Injury Rate</a>	3.19 2010	2.20	2.45	<b>3.32</b> 2011	●				<b>3.19</b> 2010	●
◊ <a href="#">Staff Overall Engagement (%)</a>	35% 2009/10	43%		35% 2009/10	●					
◊ <a href="#">Physician Overall Engagement (%)</a>	26% 2009/10	43%		26% 2009/10	●					
<a href="#">Direct Nursing Average Full Time Equivalency</a>	0.59 2010/11	0.62	0.61	<b>0.60</b> Dec 2011	▲	0.60 Dec 2011	0.59 Sep 2011	■	<b>0.59</b> Dec 2010	■
<a href="#">Absenteeism</a>	12.19 2010/11	11.95	12.01	<b>11.74</b> YTD (Apr-Dec) (annualized)	■				<b>11.94</b> Q3 2010/11 YTD (annualized)	■
<a href="#">Overtime Hours to Paid Hours Ratio</a>	1.70% 2010/11	1.67%	1.68%	<b>1.92%</b> YTD (Apr-Dec)	●	1.98% Q3 2011/12	1.87% Q2 2011/12	■	<b>1.55%</b> Q3 2010/11 YTD	●
<a href="#">Total Labour Cost per Worked Hour</a>	\$49.54 2010/11	\$48.55	\$48.80	<b>\$50.76</b> YTD (Apr-Dec)	▲	\$50.76 Q3 2011/12	\$51.07 Q2 2011/12	■	\$48.43 Q3 2010/11 YTD	■
◊ <a href="#">Number of Netcare Users</a>	11,816 2010/11	12,998	12,703	<b>14,066</b> YTD (Apr-Dec)	■	14,066 Q3 2011/12	12,994 Q2 2011/12	■	<b>11,571</b> Q3 2010/11 YTD	■
<a href="#">On Budget: Year to Date</a>	\$116M Surplus 2010/11	\$36M	na	\$252M Dec 2011	na	\$252M Dec 2011	\$268M Sep 2011	■	\$383M Dec 2010	na
◊ Adherence to 5 Year Budgeted Government Funding	Measurement strategy and targets under development; no reporting strategy or start time available.									
<b>Notes</b>										
◊ 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 Year to Date Performance	Comparative Performance
<b>Quality and Patient Safety</b>										
◊ <a href="#">Patient Satisfaction – Adult Acute Care</a>	81.8% <sup>^</sup> 2010/11	tbd	na	<b>84.2%</b> YTD (Apr-Sep)	na	83.7% Q2 2011/12	84.5% Q1 2011/12	■	na Q2 2010/11 YTD	na
◊ <a href="#">Patient Satisfaction - Addictions and Mental Health (AHS)</a>	na 2009/10	tbd		<b>93%</b> 2010/11	na				na	na
<a href="#">Percentage of Patient Feedback as Commendations</a>	na 2010/11	tbd		<b>10.44%</b> YTD (Apr - Dec)	na	12.28% Q3 2011/12	10.67% Q2 2011/12	■	na Q3 2010/11 YTD	na
<a href="#">Percentage of Patient Concerns Escalated to Patient Concerns Officer</a>	na 2010/11	tbd		<b>0.57%</b> YTD (Apr - Dec)	na	0.45% Q3 2011/12	0.61% Q2 2011/12	■	na Q3 2010/11 YTD	na
◊ <a href="#">Albertans Reporting Unexpected Harm</a>	9% 2010	9%		<b>12%</b> 2011	●				9% 2010	●
<a href="#">Patient Satisfaction Emergency Department (15 Higher Volume)</a>	na	tbd	na	69%	na	69%	70%	■	68%	■
	na 2010/11	tbd	na	78% YTD (Apr - Sep)	na	81% Q2 2011/12	78% Q1 2011/12	■	78% Q2 2010/11 YTD	■
◊ <a href="#">Patient Satisfaction Emergency Department</a>	58% 2008	70%		<b>59%</b> 2010	●				58% 2008	■
◊ <a href="#">Patient Satisfaction Health Care Services Personally Received</a>	62% 2010	tbd		<b>67%</b> 2011	na				62% 2010	■
<a href="#">Central Venous Catheter Bloodstream Infection Rate</a>	na 2010/11	tbd	na	<b>1.05</b> YTD (Apr-Sep)	na	0.67 Q2 2011/12	1.43 Q1 2011/12	■	na Q2 2010/11 YTD	na
◊ <a href="#">Methicillin-Resistant Staphylococcus aureus – Bloodstream Infection</a>	na 2010/11	tbd	na	<b>0.20</b> YTD (Apr-Sep)	na	0.22 Q2 2011/12	0.17 Q1 2011/12	●	na Q2 2010/11 YTD	na
<a href="#">C-Difficile Infection Rate</a>	na 2010/11	tbd	na	<b>3.9</b> YTD (Apr-Sep)	na	3.9 Q2 2011/12	3.9 Q1 2011/12	■	na Q2 2010/11 YTD	na
<a href="#">30 Day Unplanned Readmission Rate</a>	7.8% 2010/11	tbd	na	<b>8.1%</b> YTD (Apr-Sep)	na	8.1% Q2 2011/12	7.9% Q1 2011/12	■	7.6% Q2 2010/11 YTD	■
◊ Surgical Site Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13									
Time to Resolve Patient Concerns	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2011/12									
<b>Notes</b>										
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.										
^ Patient Satisfaction – Adult Acute Care – sampling strategy changed as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).										

**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

# Zone Comparison Dashboard 2011/12














## Year to Date (Apr-Dec)

Performance Measure	Zone 1 - South	Zone 2 - Calgary	Zone 3 - Central	Zone 4 - Edmonton	Zone 5 - North	AHS	YTD Pro-rated Target (Apr-Dec 2011/12)	AHS Annual Target 2011/12
<b>Staying Healthy / Improving Population Health</b>								
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	59.2% 2009-2010	58.5% 2009-2010	53.4% 2009-2010	56.6% 2009-2010	54.7% 2009-2010	57.3% 2009-2010		57%+ 2009-2010
Cervical Cancer Screening Participation Rate	64.2% Jan 2008 - Dec 2010	72.7% Jan 2008 - Dec 2010	62.3% Jan 2008 - Dec 2010	67.9% Jan 2008 - Dec 2010	59.5% Jan 2008 - Dec 2010	67.9% Jan 2008 - Dec 2010		72%+ 2008-10
<b>Strengthen Primary Health Care</b>								
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 (%)	82.0% Oct 2011	80.0% Oct 2011	69.0% Oct 2011	72.0% Oct 2011	66.0% Oct 2011	74.0% Oct 2011		tbd
Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	262 YTD (Apr-Dec)	159 YTD (Apr-Dec)	251 YTD (Apr-Dec)	181 YTD (Apr-Dec)	346 YTD (Apr-Dec)	206 YTD (Apr-Dec)	223	297 (annual)
Family Practice Sensitive Conditions (% of ED visits)	28.2% YTD (Apr-Dec)	20.2% YTD (Apr-Dec)	31.9% YTD (Apr-Dec)	14.6% YTD (Apr-Dec)	38.5% YTD (Apr-Dec)	26.4% YTD (Apr-Dec)	25.6%	25%
Health Link Wait Time (% answered within 2 minutes)	Measure not reported at Zone level.					81.9% YTD (Apr-Dec)	83.2%	85%
Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	93% YTD (Apr-Dec)	72% YTD (Apr-Dec)	95% YTD (Apr-Dec)	48% YTD (Apr-Dec)	68% YTD (Apr-Dec)	73% YTD (Apr-Dec)	86%	90%
<b>Improve Access and Reduce Wait Times</b>								
Urgent CABG Wait Time (90th percentile in weeks)	np	2.1 YTD (Apr-Dec)	np	1.8 YTD (Apr-Dec)	np	1.9 YTD (Apr-Dec)	1.3	1.0
Semi-urgent CABG Wait Time (90th percentile in weeks)	np	3.2 YTD (Apr-Dec)	np	8.7 YTD (Apr-Dec)	np	6.4 YTD (Apr-Dec)	3.1	2.0
Scheduled CABG Wait Time (90th percentile in weeks)	np	32.9 YTD (Apr-Dec)	np	19.5 YTD (Apr-Dec)	np	27.8 YTD (Apr-Dec)	10.5	6.0
Hip Replacement Surgery Wait Time (90th percentile in weeks)	38.6 YTD (Apr-Dec)	29.4 YTD (Apr-Dec)	29.8 YTD (Apr-Dec)	51.0 YTD (Apr-Dec)	52.6 YTD (Apr-Dec)	39.9 YTD (Apr-Dec)	30.0	27.0
Knee Replacement Surgery Wait Time (90th percentile in weeks)	53.1 YTD (Apr-Dec)	34.9 YTD (Apr-Dec)	33.1 YTD (Apr-Dec)	57.0 YTD (Apr-Dec)	51.1 YTD (Apr-Dec)	49.1 YTD (Apr-Dec)	38.5	35.0
Cataract Surgery Wait Time (90th percentile in weeks)	42.4 YTD (Apr-Dec)	40.9 YTD (Apr-Dec)	25.9 YTD (Apr-Dec)	34.3 YTD (Apr-Dec)	53.8 YTD (Apr-Dec)	36.6 YTD (Apr-Dec)	34.2	30.0
† Interim target pending confirmation. Status based on interim target. 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	YTD Pro-rated Target (Apr-Dec 2011/12)	AHS Annual Target 2011/12
Other Scheduled Surgery Wait Time (90th percentile in weeks)	23.9 YTD (Apr-Dec)	27.1 YTD (Apr-Dec)	25.1 YTD (Apr-Dec)	25.9 YTD (Apr-Dec)	25.6 YTD (Apr-Dec)	26.0 YTD (Apr-Dec)	na	tbd
Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	3.8  YTD (Apr-Dec)	6.6  YTD (Apr-Dec)	np	4.9  YTD (Apr-Dec)	np	5.7  YTD (Apr-Dec)	4.5	4
Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks)	1.7  YTD (Apr-Dec)	3.3  YTD (Apr-Dec)	np	3.0  YTD (Apr-Dec)	np	3.1  YTD (Apr-Dec)	4.0	4
Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume EDs) £	83%  YTD (Apr-Dec)	62%  YTD (Apr-Dec)	69%  YTD (Apr-Dec)	59%  YTD (Apr-Dec)	80%  YTD (Apr-Dec)	66%  YTD (Apr-Dec)	72%	75%
Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	90%  YTD (Apr-Dec)	75%  YTD (Apr-Dec)	90%  YTD (Apr-Dec)	66%  YTD (Apr-Dec)	90%  YTD (Apr-Dec)	81%  YTD (Apr-Dec)	83%	84%
Patients Admitted from ED within 8 hours (%) (15 Higher Volume EDs) £	90%  YTD (Apr-Dec)	45%  YTD (Apr-Dec)	45%  YTD (Apr-Dec)	31%  YTD (Apr-Dec)	67%  YTD (Apr-Dec)	45%  YTD (Apr-Dec)	55%	60%
Patients Admitted from ED within 8 hours (%) (All Sites) £	90%  YTD (Apr-Dec)	47%  YTD (Apr-Dec)	72%  YTD (Apr-Dec)	32%  YTD (Apr-Dec)	85%  YTD (Apr-Dec)	56%  YTD (Apr-Dec)	62%	65%
<b>Provide More Choice for Continuing Care</b>								
People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	9  Dec 2011 (Target = 16)	162  Dec 2011 (Target = 142)	71  Dec 2011 (Target = 59)	163  Dec 2011 (Target = 139)	84  Dec 2011 (Target = 70)	489  Dec 2011	na	375
People Waiting in Community for Continuing Care Placement	46  Dec 2011 (Target = 60)	545  Dec 2011 (Target = 454)	103  Dec 2011 (Target = 123)	252  Dec 2011 (Target = 273)	92  Dec 2011 (Target = 99)	1038  Dec 2011	na	900
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	14 YTD (Apr-Dec)	58 YTD (Apr-Dec)	37 YTD (Apr-Dec)	35 YTD (Apr-Dec)	92 YTD (Apr-Dec)	45 YTD (Apr-Dec)	na	tbd
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	76% YTD (Apr-Dec)	56% YTD (Apr-Dec)	64% YTD (Apr-Dec)	62% YTD (Apr-Dec)	47% YTD (Apr-Dec)	62% YTD (Apr-Dec)	na	tbd
Number of Home Care Clients	na YTD (Apr-Dec)	na YTD (Apr-Dec)	na YTD (Apr-Dec)	na YTD (Apr-Dec)	na YTD (Apr-Dec)	na YTD (Apr-Dec)	na	tbd
Rating of Care Nursing Home Family	Measure not reported at Zone level.					73.40% 2010/11	na	tbd
<b>Build One Health System</b>								
Head Count to FTE Ratio	Measure not reported at Zone level.					1.57 Dec 2011	1.62	1.62
Registered Nurse Graduates Hired by AHS (%) - All Hires - Non-Casual	Measure not reported at Zone level.					88%  48%  Dec 2011	53%	70%
Disabling Injury Rate	Measure not reported at Zone level.					3.32  2011 (Jan-Dec)	2.25	2.20
Staff Overall Engagement (%)	35% 2009/10	33% 2009/10	35% 2009/10	37% 2009/10	41% 2009/10	35% 2009/10		43%
Physician Overall Engagement (%)	20% 2009/10	27% 2009/10	27% 2009/10	25% 2009/10	27% 2009/10	26% 2009/10		43%
Direct Nursing Average Full Time Equivalency	Measure not reported at Zone level.					0.60  Dec 2011	0.62	0.62
Absenteeism	Measure not reported at Zone level.					11.74  Apr-Dec 2011 (annualized)	12.01	11.95
Overtime Hours to Paid Hours Ratio	Measure not reported at Zone level.					1.92%  YTD (Apr-Dec)	1.68%	1.67%
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. Data are accurate to ±2%.								




























(continued)

Performance Measure	Zone 1 - South	Zone 2 - Calgary	Zone 3 - Central	Zone 4 - Edmonton	Zone 5 - North	AHS	YTD Pro-rated Target (Apr-Dec 2011/12)	AHS Annual Target 2011/12
Total Labour Cost per Worked Hour	Measure not reported at Zone level.					\$50.76 YTD (Apr-Dec) 	\$48.80	\$48.55
Number of Netcare Users	Measure not reported at Zone level.					14,066 YTD (Apr-Dec) 	12,703	12,998
On Budget: Year to Date	Measure not reported at Zone level.						na	\$36M
Adherence to 5 Year Budgeted Government Funding	Measurement strategy and targets under development.							
<b>Quality and Patient Safety</b>								
Patient Satisfaction – Adult Acute Care	86.0% YTD (Apr-Sep)	83.2% YTD (Apr-Sep)	86.7% YTD (Apr-Sep)	84.5% YTD (Apr-Sep)	80.9% YTD (Apr-Sep)	84.2% YTD (Apr-Sep)	na	tbd
Patient Satisfaction – Addictions and Mental Health	na	na	na	na	na	93% 2010/11 	na	85%
Percentage of Patient Feedback as Commendations	na	na	na	na	na	10.44% YTD (Apr-Dec)	na	tbd
Percentage of Patient Concerns Escalated to Patient Concerns Officer	1.24% YTD (Apr-Dec)	0.80% YTD (Apr-Dec)	0.51% YTD (Apr-Dec)	0.40% YTD (Apr-Dec)	0.00% YTD (Apr-Dec)	0.57% YTD (Apr-Dec)	na	tbd
Albertans Reporting Unexpected Harm	na 2011	na 2011	na 2011	na 2011	na 2011	12% 2011 		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.					1.05 YTD (Apr-Sep)	na	tbd
Methicillin-Resistant Staphylococcus aureus – Bloodstream Infection	Measure not reported at Zone level.					0.20 YTD (Apr-Sep)	na	tbd
C-Difficile Infection Rate	Measure not reported at Zone level.					3.9 YTD (Apr-Sep)	na	tbd
30 Day Unplanned Readmission Rate	8.3% YTD (Apr-Sep)	7.0% YTD (Apr-Sep)	9.7% YTD (Apr-Sep)	8.0% YTD (Apr-Sep)	9.7% YTD (Apr-Sep)	8.1% YTD (Apr-Sep)	na	tbd
<b>Status</b>								
 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*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
<b>Staying Healthy / Improving Population Health</b>										
◊ Life Expectancy	80.1 2009	tbd		<b>80.3</b> 2010	na				80.1 2009	■
◊ Potential Years Life Lost (per 1,000 population)		tbd		<b>49.6</b> 2010	na				54.8 2009	■
Breast Cancer Screening Participation Rate	57.8% 2008-2009	na		59.2% 2009-2010	■				57.8% 2008-2009	■
Cervical Cancer Screening Participation Rate	65.1% 2007-2009	na		64.2% Jan 2008 – Dec 2010	●				65.1% 2007-2009	■
<b>Strengthen Primary Health Care</b>										
◊ Seniors (65+) Influenza Immunization Rate	57.7% 2009-2010	75%		<b>59.1%</b> 2010-2011	●				55.7% 2009-2010	
◊ Children (6 to 23 Months) Influenza Immunization Rate	22% 2009-2010	75%		<b>21.0%</b> 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		<b>82%</b> Oct 2011	na	82% Oct 2011	74% Apr 2011	■	74% Oct 2010	■
◊ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	390 2010/11	297 Annual	223	<b>262</b> YTD (Apr-Dec)	●	93 Q2011/12	74 Q2 2011/12	●	<b>288</b> Q3 2010/11 YTD	■
◊ Family Practice Sensitive Conditions (% of ED visits)	29.2% 2010/11	25.0%	25.6%	<b>28.2%</b> YTD (Apr-Dec)	▲	27.8% Q3 2011/12	27.8% Q2 2011/12	■	<b>28.9%</b> Q3 2010/11 YTD	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	95.0%	90%	86%	<b>93%</b> YTD (Apr-Dec)	■	96% Q3 2011/12	96% Q2 2011/12	■	na Q3 2010/11 YTD	na
<b>Improve Access and Reduce Wait Times</b>										
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	43.4 2010/11	27.0	30.0	<b>38.6</b> YTD (Apr-Dec)	●	34.1 Q3 2011/12	39.5 Q2 2011/12	■	<b>44.5</b> Q3 2010/11 YTD	■
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	57.5 2010/11	35.0	38.5	<b>53.1</b> YTD (Apr-Dec)	●	57.4 Q3 2011/12	45.7 Q2 2011/12	●	<b>56.4</b> Q3 2010/11 YTD	■
◊ Cataract Surgery Wait Time (90th percentile in weeks)	44.3 2010/11	30.0	34.2	<b>42.4</b> YTD (Apr-Dec)	●	33.3 Q3 2011/12	46.1 Q2 2011/12	■	<b>45.1</b> Q3 2010/11 YTD	■
Other Scheduled Surgery Wait Time (90th percentile in weeks)	26.1 2010/11	tbd	na	<b>23.9</b> YTD (Apr-Dec)	na	24.1 Q3 2011/12	23.1 Q2 2011/12	■	<b>26.1</b> Q3 2010/11 YTD	■
<b>Notes</b> ◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. † Interim target pending confirmation. Status based on interim target.										

# Q3 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*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
◇ Radiation Therapy Access (referral to 1 <sup>st</sup> consult) (90 <sup>th</sup> percentile in weeks)	4.5 2010/11	4.0	4.5	<b>3.8</b> YTD (Apr-Dec)		2.6 Q3 2011/12	5.0 Q2 2011/12		4.3 Q3 2010/11 YTD	
◇ Radiation Therapy Access (ready to treat to first therapy) (90 <sup>th</sup> percentile in weeks) £	2.1 2010/11	4.0	4.0	<b>1.7</b> YTD (Apr-Dec)		1.0 Q3 2011/12	1.6 Q2 2011/12		4.0 Q3 2010/11 YTD	
◇ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	83.0% 2010/11	75%	72%	<b>83%</b> YTD (Apr-Dec)		82% Q3 2011/12	82% Q2 2011/12		<b>84%</b> Q3 2010/11 YTD	
◇ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	90.0% 2010/11	84%	83%	<b>90%</b> YTD (Apr-Dec)		90% Q3 2011/12	90% Q2 2011/12		<b>91%</b> Q3 2010/11 YTD	
◇ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	89.0% 2010/11	60%	55%	<b>90%</b> YTD (Apr-Dec)		89% Q3 2011/12	90% Q2 2011/12		<b>90%</b> Q3 2010/11 YTD	
◇ Patients Admitted from ED within 8 hours (%) (All Sites) £	90.0% 2010/11	65%	62%	<b>90%</b> YTD (Apr-Dec)		89% Q3 2011/12	90% Q2 2011/12		<b>90%</b> Q3 2010/11 YTD	
<b>Provide More Choice for Continuing Care</b>										
◇ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	22 2010/11	10	13	<b>9</b> Dec 2011		9 Dec 2011	22 Sep 2011		<b>18</b> Dec 2010	
◇ People Waiting in Community for Continuing Care Placement	67 2010/11	52	56	<b>46</b> Dec 2011		46 Dec 2011	61 Sep 2011		<b>62</b> Dec 2010	
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	21 2010/11	tbd	na	<b>14</b> YTD (Apr-Dec)	na	14 Q3 2011/12	16 Q2 2011/12		<b>23</b> Q3 2010/11 YTD	
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	68%* 2010/11	tbd	na	<b>76%</b> YTD (Apr-Dec)	na	83% Q3 2011/12	62% Q2 2011/12	na	na Q3 YTD 2010/11	na
◇ Number of Home Care Clients	9,606 2010/11	tbd	na	na YTD (Apr-Dec)	na	5,784 Q3 2011/12	5,868 Q2 2011/12		na Q3 2010/11 YTD	na
<b>Build One Health System</b>										
◇ Staff Overall Engagement (%)	35% 2009/10	43%								
◇ Physician Overall Engagement (%)	20% 2009/10	43%								
<b>Notes</b> ◇ 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%. * Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed – data for this measure are reportable as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).										

# Q3 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*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
<b>Quality and Patient Safety</b>										
◇ Patient Satisfaction – Adult Acute Care	80.2% <sup>^</sup> 2010/11	tbd	na	<b>86.0%</b> YTD (Apr-Sep)	na	85.7% Q2 2011/12	86.3% Q1 2011/12	■	na Q2 2010/11 YTD	na
◇ Patient Satisfaction - Addictions and Mental Health (AHS)	na 2010/11	85% 2010/11		na	na	na	na	na	na	na
Percentage of Patient Feedback as Commendations	na 2010/11	tbd	na	na YTD (Apr-Dec)	na	7.58% Q3 2011/12	13.21% Q2 2011/12	●	na Q3 2010/11 YTD	na
Percentage of Patient Concerns Escalated to Patient Concerns Officer	na 2010/11	tbd	na	<b>1.24%</b> YTD (Apr-Dec)	na	0.00% Q3 2011/12	2.25% Q2 2011/12	■	na Q3 2010/11 YTD	na
◇ Albertans Reporting Unexpected Harm	8% 2010	9%		na 2011	na				<b>8%</b> 2010	na
◇ Patient Satisfaction Emergency Department	62% 2008	70%		<b>59%</b> 2010	●				<b>62%</b> 2008	■
◇ Patient Satisfaction Health Care Services Personally Received	66% 2010	tbd		na 2011	na				<b>66%</b> 2010	na
30 Day Unplanned Readmission Rate	8.21% 2010/11	tbd	na	<b>8.32%</b> YTD (Apr-Sep)	na	8.44% Q2 2011/12	8.16% Q1 2011/12	■	<b>8.10%</b> Q2 2010/11 YTD	■

**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%.  
 ^ Patient Satisfaction – Adult Acute Care – sampling strategy changed as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).

Status	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

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
<b>Staying Healthy / Improving Population Health</b>										
◊ 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	57.2% 2008-2009	57%± 2009-2010		58.5% 2009-2010	■				57.2% 2008-2009	■
Cervical Cancer Screening Participation Rate	74.8% Jan 2007 - Dec 2009	72%± 2008-2010		72.7% Jan 2008 - Dec 2010	■				74.8% Jan 2007 - Dec 2009	■
<b>Strengthen Primary Health Care</b>										
◊ 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	na
◊ Childhood Immunization Rates for MMR	87.8% 2008	98%		na	na				94.8% 2005	na
Albertans Enrolled in a Primary Care Network (%)	74% Oct 2010	tbd		80% Oct 2011	na	80% Oct 2011	77% Apr 2011	■	74% Oct 2010	■
◊ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	221 2010/11	297 annual	223	159 YTD (Apr-Dec)	■	54 Q3 2011/12	54 Q2 2011/12	■	288 Q3 2010/11 YTD	■
◊ Family Practice Sensitive Conditions (% of ED visits)	21.3% 2010/11	25%	25.6%	20.2% YTD (Apr-Dec)	■	20.4% Q3 2011/12	19.6% Q2 2011/12	■	20.8% Q3 2010/11 YTD	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	73.0% 2010/11	90%	86%	72% YTD (Apr-Dec)	●	77% Q3 2011/12	71% Q2 2011/12	■	na Q3 2010/11 YTD	na
<b>Notes</b> ◊ 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*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
<b>Improve Access and Reduce Wait Times</b>										
◇ Urgent CABG Wait Time (90th percentile in weeks)	1.6 2010/11	1.0	1.3	<b>2.1</b> YTD (Apr-Dec)	●	2.0 Q3 2011/12	2.1 Q2 2011/12	—	<b>1.5</b> Q3 2010/11 YTD	●
◇ Semi-urgent CABG Wait Time (90th percentile in weeks)	3.2 2010/11	2.0	3.1	<b>3.2</b> YTD (Apr-Dec)	▲	3.2 Q3 2011/12	2.9 Q2 2011/12	●	<b>2.4</b> Q3 2010/11 YTD	●
◇ Scheduled CABG Wait Time (90th percentile in weeks)	28.0 2010/11	6.0	10.5	<b>32.9</b> YTD (Apr-Dec)	●	34.1 Q3 2011/12	31.4 Q2 2011/12	●	<b>24.4</b> Q3 2010/11 YTD	●
◇ Hip Replacement Surgery Wait Time (90th percentile in weeks)	30.4 2010/11	27.0	30.0	<b>29.4</b> YTD (Apr-Dec)	■	28.3 Q3 2011/12	27.4 Q2 2011/12	—	<b>34.1</b> Q3 2010/11 YTD	—
◇ Knee Replacement Surgery Wait Time (90th percentile in weeks)	34.3 2010/11	35.0	38.5	<b>34.9</b> YTD (Apr-Dec)	■	39.1 Q3 2011/12	32.8 Q2 2011/12	●	<b>37.6</b> Q3 2010/11 YTD	—
◇ Cataract Surgery Wait Time (90th percentile in weeks)	61.9 2010/11	30.0	34.2	<b>40.9</b> YTD (Apr-Dec)	●	30.9 Q3 2011/12	40.6 Q2 2011/12	■	<b>60.7</b> Q3 2010/11 YTD	■
Other Scheduled Surgery Wait Time (90th percentile in weeks)	26.7 2010/11	tbd	na	<b>27.1</b> YTD (Apr-Dec)	na	28.1 Q3 2011/12	25.4 Q2 2011/12	●	<b>28.1</b> Q3 2010/11 YTD	—
◇ Radiation Therapy Access (referral to 1 <sup>st</sup> consult) (90th percentile in weeks)	6.0 2010/11	4.0	4.5	<b>6.6</b> YTD (Apr-Dec)	●	5.4 Q3 2011/12	7.6 Q2 2011/12	■	<b>5.9</b> Q3 2010/11 YTD	●
◇ Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks) £	3.7 2010/11	4.0	4.0	<b>3.3</b> YTD (Apr-Dec)	■	3.1 Q3 2011/12	3.7 Q2 2011/12	■	<b>3.9</b> Q3 2010/11 YTD	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	57.0% 2010/11	75%	72%	<b>62%</b> YTD (Apr-Dec)	●	63% Q3 2011/12	60% Q2 2011/12	■	<b>60%</b> Q3 2010/11 YTD	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	72.0% 2010/11	84%	83%	<b>75%</b> YTD (Apr-Dec)	▲	75% Q3 2011/12	74% Q2 2011/12	—	<b>73%</b> Q3 2010/11 YTD	—
◇ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	35.0% 2010/11	60%	55%	<b>45%</b> YTD (Apr-Dec)	●	44% Q3 2011/12	46% Q2 2011/12	—	<b>37%</b> Q3 2010/11 YTD	■
◇ Patients Admitted from ED within 8 hours (%) (All Sites) £	37.0% 2010/11	65%	62%	<b>47%</b> YTD (Apr-Dec)	●	46% Q3 2011/12	46% Q2 2011/12	—	<b>39%</b> Q3 2010/11 YTD	■
<b>Notes</b> ◇ 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*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
<b>Provide More Choice for Continuing Care</b>										
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	146 2010/11	138	140	<b>162</b> Dec 2011	●	162 Dec 2011	317 Sep 2011	■	<b>237</b> Dec 2010	■
◊ People Waiting in Community for Continuing Care Placement	504 2010/11	404	429	<b>545</b> Dec 2011	●	545 Dec 2011	608 Sep 2011	■	<b>483</b> Dec 2010	●
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	55 2010/11	tbd	na	<b>58</b> YTD (Apr-Dec)	na	69 Q3 2011/12	50 Q1 2011/12	●	<b>52</b> Q3 2010/11 YTD	▲
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	59%* 2010/11	tbd	na	56% YTD (Apr-Dec)	na	48% Q3 2011/12	60% Q2 2011/12	●	na <sup>†</sup> Q3 YTD 2010/11	na
◊ Number of Home Care Clients	32,874 2010/11	tbd	na	na YTD (Apr-Dec)	na	15,121 Q3 2011/12	14,887 Q2 2011/12	■	na Q3 2010/11 YTD	na
<b>Build One Health System</b>										
◊ Staff Overall Engagement (%)	33% 2009/10	43%								
◊ Physician Overall Engagement (%)	27% 2009/10	43%								
<b>Quality and Patient Safety</b>										
◊ Patient Satisfaction – Adult Acute Care	80.6%* 2010/11	tbd	na	<b>83.2%</b> YTD (Apr-Sep)	na	82.9% Q2 2011/12	83.4% Q1 2011/12	■	na Q2 2010/11 YTD	na
◊ Patient Satisfaction - Addictions and Mental Health (AHS)	na 2010/11	85% 2010/11		na	na				na	na
Percentage of Patient Feedback as Commendations	na 2010/11	tbd	na	na YTD (Apr-Dec)	na	13.71% Q3 2011/12	13.92% Q2 2011/12	■	na Q3 2010/11 YTD	na
Percentage of Patient Concerns Escalated to Patient Concerns Officer	na 2010/11	tbd	na	<b>0.80%</b> YTD (Apr-Dec)	na	0.50% Q3 2011/12	0.75% Q2 2011/12	■	na Q3 2010/11 YTD	na
◊ Albertans Reporting Unexpected Harm	10% 2010	9%		na 2011	na				<b>10%</b> 2010	na
◊ Patient Satisfaction Emergency Department	58% 2008	70%		<b>61%</b> 2010	●				<b>58%</b> 2008	■
◊ Patient Satisfaction Health Care Services Personally Received	60% 2010	tbd		na 2011	na				<b>60%</b> 2010	na
30 Day Unplanned Readmission Rate	6.7% 2010/11	tbd	na	<b>7.0%</b> YTD (Apr-Sep)	na	7.0% Q2 2011/12	6.9% Q1 2011/12	■	<b>6.6%</b> Q2 2010/11 YTD	●
<b>Notes</b> ◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. * Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed – data for this measure are reportable as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011). † Patient Satisfaction – Adult Acute Care – sampling strategy changed as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).										

**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*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
<b>Staying Healthy / Improving Population Health</b>										
◊ 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	51.9% 2008-2009	57% <sup>+</sup> 2009-2010		53.4% 2009-2010	▲				51.9% 2008-2009	■
Cervical Cancer Screening Participation Rate	64.8 Jan 2007 - Dec 2009	72% <sup>+</sup> 2008-2010		62.3 Jan 2008 - Dec 2010	●				64.8 Jan 2007 - Dec 2009	■
<b>Strengthen Primary Health Care</b>										
◊ 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		69% Oct 2011	na	69% Oct 2011	66% Apr 2011	■	61% Oct 2010	■
◊ Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)	352 2010/11	297 annual	223	251 YTD (Apr-Dec)	●	81 Q3 2011/12	82 Q2 2011/12	■	288 Q3 2010/11 YTD	■
◊ Family Practice Sensitive Conditions (% of ED visits)	32.6% 2010/11	25.0%	25.6%	31.9% YTD (Apr-Dec)	●	32.4% Q3 2011/12	31.1% Q2 2011/12	■	32.2% Q3 2010/11 YTD	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	89.0% 2010/11	90%	86%	95% YTD (Apr-Dec)	■	96% Q3 2011/12	92% Q2 2011/12	■	80.0% Q3 2010/11 YTD	na
<b>Notes</b> ◊ 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*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
<b>Improve Access and Reduce Wait Times</b>										
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	26.4 2010/11	27.0	30.0	<b>29.8</b> YTD(Apr-Dec)	■	27.0 Q3 2011/12	28.4 Q2 2011/12	■	<b>24.2</b> Q3 2010/11 YTD	●
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	30.2 2010/11	35.0	38.5	<b>33.1</b> YTD (Apr-Dec)	■	33.1 Q1 2011/12	33.7 Q2 2011/12	■	<b>31.9</b> Q3 2010/11 YTD	■
◊ Cataract Surgery Wait Time (90th percentile in weeks)	28.6 2010/11	30.0	34.2	<b>25.9</b> YTD (Apr-Dec)	■	23.1 Q1 2011/12	24.6 Q2 2011/12	■	<b>29.5</b> Q3 2010/11 YTD	■
Other Scheduled Surgery Wait Time (90th percentile in weeks)	25.1 2010/11	tbd	na	<b>25.1</b> YTD (Apr-Dec)	na	25.3 Q3 2011/12	25.4 Q3 2011/12	■	<b>25.1</b> Q3 2010/11 YTD	■
◊ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	74.0% 2010/11	75%	72%	<b>69%</b> YTD (Apr-Dec)	▲	67% Q3 2011/12	69% Q2 2011/12	■	<b>74%</b> Q3 2010/11 YTD	●
◊ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	91.0% 2010/11	84%	83%	<b>90%</b> YTD (Apr-Dec)	■	90% Q3 2011/12	90% Q2 2011/12	■	<b>91%</b> Q3 2010/11 YTD	■
◊ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	47.0% 2010/11	60%	55%	<b>45%</b> YTD (Apr-Dec)	●	40% Q3 2011/12	44% Q2 2011/12	●	<b>44%</b> Q3 2010/11 YTD	■
◊ Patients Admitted from ED within 8 hours (%) (All Sites) £	74.0% 2010/11	65%	62%	<b>72%</b> YTD (Apr-Dec)	■	71% Q3 2011/12	72% Q2 2011/12	■	<b>74%</b> Q3 2010/11 YTD	■
<b>Provide More Choice for Continuing Care</b>										
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	65 2010/11	52	55	<b>71</b> YTD (Apr-Dec)	●	71 Q3 2011/12	60 Q2 2011/12	●	<b>91</b> Q3 2010/11 YTD	■
◊ People Waiting in Community for Continuing Care Placement	128 2010/11	118	121	<b>103</b> YTD (Apr-Dec)	■	103 Q3 2011/12	103 Q2 2011/12	■	<b>141</b> Q3 2010/11 YTD	■
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	57 2010/11	tbd	na	<b>37</b> YTD (Apr-Dec)	na	40 Q3 2011/12	36 Q2 2011/12	■	<b>67</b> Q3 2010/11 YTD	■
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	57%* 2010/11	tbd	na	<b>64%</b> YTD (Apr-Dec)	na	63% Q3 2011/12	61% Q2 2011/12	■	na* Q3 YTD 2010/11	na
◊ Number of Home Care Clients	19,224 2010/11	tbd	na	na YTD (Apr-Dec)	na	9,544 Q3 2011/12	9,382 Q2 2011/12	■	na Q3 2010/11 YTD	na
<b>Build One Health System</b>										
◊ Staff Overall Engagement (%)	35% 2009/10	43.0%								
◊ Physician Overall Engagement (%)	27% 2009/10	43.0%								
<b>Notes</b> ◊ 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%. * Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed – data for this measure are reportable as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).										

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
<b>Quality and Patient Safety</b>										
◇ Patient Satisfaction – Adult Acute Care	82.7% <sup>^</sup> 2010/11	tbd	na	<b>86.7%</b> YTD (Apr-Sep)	na	85.8% Q2 2011/12	87.7% Q1 2011/12	■	na Q2 2010/11 YTD	na
◇ Patient Satisfaction - Addictions and Mental Health (AHS)	na 2010/11	85% 2010/11		na	na				na	na
Percentage of Patient Feedback as Commendations	na	na	na	na YTD (Apr-Dec)	na	6.62% Q3 2011/12	5.08% Q2 2011/12	■	na Q3 2010/11 YTD	na
Percentage of Patient Concerns Escalated to Patient Concerns Officer	na	na	na	<b>0.51%</b> YTD (Apr-Dec)	na	0.82% Q3 2011/12	0.64% Q2 2011/12	●	na Q3 2010/11 YTD	na
◇ Albertans Reporting Unexpected Harm	8% 2010	9%		na 2011	na				<b>18%</b> 2010	na
◇ Patient Satisfaction Emergency Department	64% 2008	70%		<b>63%</b> 2010	▲				<b>58%</b> 2008	■
◇ Patient Satisfaction Health Care Services Personally Received	60% 2010	tbd		na 2011	na				<b>60%</b> 2010	na
30 Day Unplanned Readmission Rate	9.2% 2010/11	tbd	tbd	<b>9.7%</b> YTD (Apr-Sep)	na	10.0% Q2 2011/12	9.2% Q12011/12	●	<b>9.0%</b> Q2 2010/11 YTD	●
<b>Notes</b> ◇ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. ^ Patient Satisfaction – Adult Acute Care – sampling strategy changed as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).										

**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

# AHS Performance Dashboard Q3 2011/12

## Edmonton Zone

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
<b>Staying Healthy / Improving Population Health</b>										
◊ 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	54.1% 2008-2009	57%+ 2009-2010		56.6% 2009-2010	▲				54.1% 2008-2009	■
Cervical Cancer Screening Participation Rate	70.1% Jan 2007-Dec 2009	72%+ 2008-2010		67.9% Jan 2008 - Dec 2010	▲				70.1% Jan 2007 - Dec 2009	■
<b>Strengthen Primary Health Care</b>										
◊ 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		72% Oct 2011	na	72% Oct 2011	70% Apr 2011	■	66% Oct 2010	■
◊ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	231 2010/11	297 annual	223	181 YTD (Apr-Dec)	■	64 Q3 2011/12	57 Q2 2011/12	●	171 Q3 2010/11 YTD	●
◊ Family Practice Sensitive Conditions (% of ED visits)	16.5% 2010/11	25.0%	25.6%	14.6% YTD (Apr-Dec)	■	14.8 Q3 2011/12	14.1% Q2 2011/12	■	16.3% Q3 2010/11 YTD	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	42.0% 2010/11	90%	86%	48% YTD (Apr-Dec)	●	71% Q3 2011/12	33% Q2 2011/12	■	na Q3 2010/11 YTD	na
<b>Notes</b> ◊ 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*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
<b>Improve Access and Reduce Wait Times</b>										
◇ Urgent CABG Wait Time (90 <sup>th</sup> percentile in weeks)	2.1 2010/11	1.0	1.3	<b>1.8</b> YTD (Apr-Dec)	●	1.5 Q3 2011/12	1.8 Q2 2011/12	■	2.1 Q3 2010/11 YTD	■
◇ Semi-urgent CABG Wait Time (90 <sup>th</sup> percentile in weeks)	11.9 2010/11	2.0	3.1	<b>8.7</b> YTD (Apr-Dec)	●	5.3 Q3 2011/12	4.1 Q2 2011/12	●	10.1 Q3 2010/11 YTD	●
◇ Scheduled CABG Wait Time (90 <sup>th</sup> percentile in weeks)	18.0 2010/11	6.0	10.5	<b>19.5</b> YTD (Apr-Dec)	●	17.1 Q3 2011/12	20.7 Q2 2011/12	■	18.5 Q3 2010/11 YTD	●
◇ Hip Replacement Surgery Wait Time (90 <sup>th</sup> percentile in weeks)	48.6 2010/11	27.0	30.0	<b>51.0</b> YTD (Apr-Dec)	●	45.1 Q3 2011/12	45.0 Q2 2011/12	■	47.8 Q3 2010/11 YTD	●
◇ Knee Replacement Surgery Wait Time (90 <sup>th</sup> percentile in weeks)	60.7 2010/11	35.0	38.5	<b>57.0</b> YTD (Apr-Dec)	●	54.7 Q3 2011/12	58.5 Q2 2011/12	■	61.0 Q3 2010/11 YTD	■
◇ Cataract Surgery Wait Time (90 <sup>th</sup> percentile in weeks)	40.1 2010/11	30.0	34.2	<b>34.3</b> YTD (Apr-Dec)	▲	29.6 Q3 2011/12	34.7 Q2 2011/12	■	42.1 Q3 2010/11 YTD	■
Other Scheduled Surgery Wait Time (90 <sup>th</sup> percentile in weeks)	24.6 2010/11	tbd	na	<b>25.9</b> YTD (Apr-Dec)	na	26.3 Q3 2011/12	24.7 Q2 2011/12	●	24.5 Q3 2010/11 YTD	●
◇ Radiation Therapy Access (referral to 1 <sup>st</sup> consult) (90 <sup>th</sup> percentile in weeks)	6.0 2010/11	4.0	4.5	<b>4.9</b> YTD (Apr-Dec)	▲	4.7 Q3 2011/12	5.1 Q2 2011/12	■	6.3 Q3 2010/11 YTD	■
◇ Radiation Therapy Access (ready to treat to first therapy) (90 <sup>th</sup> percentile in weeks) £	3.4 2010/11	4.0	4.0	<b>3.0</b> YTD (Apr-Dec)	■	2.9 Q3 2011/12	3.0 Q2 2011/12	■	3.3 Q3 2010/11 YTD	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	56.0% 2010/11	75%	72%	<b>59%</b> YTD (Apr-Dec)	●	59% Q3 2011/12	59% Q2 2011/12	■	55% Q3 2010/11 YTD	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	64.0% 2010/11	84%	83%	<b>66%</b> YTD (Apr-Dec)	●	65% Q3 2011/12	65% Q2 2011/12	■	64% Q3 2010/11 YTD	■
◇ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	29.0% 2010/11	60%	55%	<b>31%</b> YTD (Apr-Dec)	●	29% Q3 2011/12	33% Q2 2011/12	●	29% Q3 2010/11 YTD	■
◇ Patients Admitted from ED within 8 hours (%) (All Sites) £	30.0% 2010/11	65%	62%	<b>32%</b> YTD (Apr-Dec)	●	31% Q3 2011/12	33% Q2 2011/12	●	30% Q3 2010/11 YTD	■
<b>Notes</b> ◇ 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*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
<b>Provide More Choice for Continuing Care</b>										
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	151 2010/11	127	133	<b>163</b> Dec 2011	●	163 Dec 2011	202 Sep 2011	■	<b>223</b> Dec 2010	■
◊ People Waiting in Community for Continuing Care Placement	310 2010/11	235	254	<b>252</b> Dec 2011	■	252 Dec 2011	262 Sep 2011	■	<b>281</b> Dec 2010	■
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	51 2010/11	tbd	na	<b>35</b> YTD (Apr-Dec)	na	35 Q3 2011/12	38 Q2 2011/12	■	<b>53</b> Q3 2010/11 YTD	■
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	49% <sup>*</sup> 2010/11	tbd	na	<b>62%</b> YTD (Apr-Dec)	na	64% Q3 2011/12	61% Q2 2011/12	■	na <sup>*</sup> Q3 YTD 2010/11	na
◊ Number of Home Care Clients	38,488 2010/11	tbd	na	na YTD (Apr-Dec)	na	21,227 Q3 2011/12	21,169 Q2 2011/12	■	na Q3 2010/11 YTD	na
<b>Build One Health System</b>										
◊ Staff Overall Engagement (%)	37% 2009/10	43%								
◊ Physician Overall Engagement (%)	25% 2009/10	43%								
<b>Quality and Patient Safety</b>										
◊ Patient Satisfaction – Adult Acute Care	83.1% <sup>^</sup> 2010/11	tbd	na	<b>84.5%</b> YTD (Apr-Sep)	na	85.2% Q2 2011/12	83.8% Q1 2011/12	■	na Q2 2010/11 YTD	na
◊ Patient Satisfaction - Addictions and Mental Health (AHS)	na 2010/11	85% 2010/11		na	na	na	na	na	na	na
Percentage of Patient Feedback as Commendations	na 2010/11	tbd	na	na	na	12.53% Q3 2011/12	9.10% Q2 2011/12	■	na Q3 2010/11 YTD	na
Percentage of Patient Concerns Escalated to Patient Concerns Officer	na 2010/11	tbd	na	<b>0.40%</b> YTD (Apr-Dec)	na	0.47% Q3 2011/12	0.43% Q2 2011/12	●	na Q3 2010/11 YTD	na
◊ Albertans Reporting Unexpected Harm	9% 2010	9%		na 2011	na				<b>9%</b> 2010	na
◊ Patient Satisfaction Emergency Department	53% 2008	70%		<b>55%</b> 2010	●				<b>53%</b> 2008	■
◊ Patient Satisfaction Health Care Services Personally Received	65% 2010	tbd		na 2011	na				<b>65%</b> 2010	na
30 Day Unplanned Readmission Rate	7.8% 2010/11	tbd	na	<b>8.0%</b> YTD (Apr-Sep)	na	8.1% Q2 2011/12	7.8% Q1 2011/12	■	<b>7.5%</b> Q2 2010/11 YTD	●
<b>Notes</b> ◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. * Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed – data for this measure are reportable as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011). ^ Patient Satisfaction – Adult Acute Care – sampling strategy changed as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).										

**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



# AHS Performance Dashboard Q3 2011/12

## North Zone

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
<b>Staying Healthy / Improving Population Health</b>										
◊ 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	54.7% 2008-2009	57% <sup>‡</sup> 2009-2010		54.7% 2009-2010	▲				54.7% 2008-2009	●
Cervical Cancer Screening Participation Rate	62.1% Jan 2007 - Dec 2009	72% <sup>‡</sup> 2008-2010		59.5% Jan 2008 - Dec 2010	●				62.1% Jan 2007 - Dec 2009	■
<b>Strengthen Primary Health Care</b>										
◊ 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		66% Oct 2011	na	66% Oct 2011	63% Apr 2011	■	34% Oct 2010	■
◊ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	473 2010/11	297 annual	223	346 YTD (Apr-Dec)	●	105 Q3 2011/12	111 Q2 2011/12	■	288 Q3 2010/11 YTD	●
◊ Family Practice Sensitive Conditions (% of ED visits)	39.0% 2010/11	25.0%	25.6%	38.5% YTD (Apr-Dec)	●	38.7% Q3 2011/12	38.5% Q2 2011/12	■	39.1% Q3 2010/11 YTD	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	74.0% 2010/11	90%	86%	68% YTD (Apr-Dec)	●	77% Q3 2011/12	65% Q2 2011/12	■	na	na
<b>Improve Access and Reduce Wait Times</b>										
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	36.6 2010/11	27.0	30.0	52.6 YTD (Apr-Dec)	●	51.8 Q3 2011/12	57.1 Q2 2011/12	■	34.6 Q3 2010/11 YTD	●
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	40.6 2010/11	35.0	38.5	51.1 YTD (Apr-Dec)	●	50.2 Q3 2011/12	52.1 Q2 2011/12	■	39.3 Q3 2010/11 YTD	●
◊ Cataract Surgery Wait Time (90th percentile in weeks)	39.1 2010/11	30.0	38.5	53.8 YTD (Apr-Dec)	●	52.7 Q3 2011/12	53.5 Q2 2011/12	■	38.9 Q3 2010/11 YTD	●
Other Scheduled Surgery Wait Time (90th percentile in weeks)	26.3 2010/11	tbd	na	23.6 YTD (Apr-Dec)	na	27.9 Q3 2011/12	23.7 Q2 2011/12	●	26.1 Q3 2010/11 YTD	■
<b>Notes</b> ◊ 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*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
◇ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	82.0% 2010/11	75%	72%	<b>80%</b> YTD (Apr-Dec)	■	79% Q3 2011/12	82% Q2 2011/12	■	<b>82%</b> Q3 2010/11 YTD	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	91.0% 2010/11	84%	83%	<b>90%</b> YTD (Apr-Dec)	■	90% Q3 2011/12	91% Q2 2011/12	■	<b>90%</b> Q3 2010/11 YTD	■
◇ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	70.0% 2010/11	60%	55%	<b>67%</b> YTD (Apr-Dec)	■	66% Q3 2011/12	69% Q2 2011/12	■	<b>70%</b> Q3 2010/11 YTD	■
◇ Patients Admitted from ED within 8 hours (%) (All Sites) £	87.0% 2010/11	65%	62%	<b>85%</b> YTD (Apr-Dec)	■	84% Q3 2011/12	85% Q2 2011/12	■	<b>87%</b> Q3 2010/11 YTD	■
<b>Provide More Choice for Continuing Care</b>										
◇ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	87 2010/11	52	61	<b>84</b> Dec 2011	●	84 Dec 2011	74 Sep 2011	●	<b>91</b> Dec 2010	■
◇ People Waiting in Community for Continuing Care Placement	106 2010/11	92	96	<b>92</b> Dec 2011	■	92 Dec 2011	106 Sep 2011	■	<b>110</b> Dec 2010	■
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	110 2010/11	tbd	na	<b>92</b> YTD (Apr-Dec)	na	69 Q3 2011/12	118 Q2 2011/12	■	<b>107</b> Q3 2010/11 YTD	■
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	41%* 2010/11	tbd	na	<b>47%</b> YTD (Apr-Dec)	na	51% Q3 2011/12	50% Q2 2011/12	na	na* Q3 YTD 2010/11	na
◇ Number of Home Care Clients	11,981 2010/11	tbd	na	na YTD (Apr-Dec)	na	7,078 Q3 2011/12	6,947 Q2 2011/12	■	na Q3 2010/11 YTD	na
<b>Build One Health System</b>										
◇ Staff Overall Engagement (%)	41% 2009/10	43%								
◇ Physician Overall Engagement (%)	27% 2009/10	43%								
<b>Notes</b> ◇ 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%. * Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed – data for this measure are reportable as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).										

## Q3 2011/12 AHS Performance Dashboard North Zone (continued)

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2011/12 Annual Target*	Provincial Year To Date Prorated Target	Year to Date Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
<b>Quality and Patient Safety</b>										
◇ Patient Satisfaction – Adult Acute Care	81.4% <sup>^</sup> 2010/11		na	<b>80.9%</b> YTD (Apr-Sep)	na	78.2% Q2 2011/12	83.4% Q1 2011/12	●	na Q2 2010/11 YTD	na
◇ Patient Satisfaction - Addictions and Mental Health (AHS)	na 2010/11	85% 2010/11		na	na				na	na
Percentage of Patient Feedback as Commendations	na 2010/11	tbd	na	na	na	9.24% Q3 2011/12	4.67% Q2 2011/12	■	na Q3 2010/11 YTD	na
Percentage of Patient Concerns Escalated to Patient Concerns Officer	na 2010/11	tbd	na	<b>0.00%</b> YTD (Apr-Dec)	na	0.00% Q3 2011/12	0.00% Q2 2011/12	■	na Q3 2010/11 YTD	na
◇ Albertans Reporting Unexpected Harm	8% 2010	9%		na 2011	na				<b>8%</b> 2010	na
◇ Patient Satisfaction Emergency Department	58% 2008	70%		<b>58%</b> 2010	●				<b>58%</b> 2008	■
◇ Patient Satisfaction Health Care Services Personally Received	53% 2010	tbd		na 2011	na				<b>53%</b> 2010	●
30 Day Unplanned Readmission Rate	7.8% 2010/11	tbd	na	<b>9.7%</b> YTD (Apr-Sep)	na	9.7% Q2 2011/12	9.6% Q1 2011/12	■	<b>9.8%</b> Q2 2010/11 YTD	■
<b>Notes</b> ◇ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. ^ Patient Satisfaction – Adult Acute Care – sampling strategy changed as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).										
<b>Status</b> ■ 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					<b>Period Comparative Performance</b> ■ 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 <sup>1</sup> ( <a href="#">by Site</a> )	362,314	92,641	89,135	89,960	92,305	<b>364,041</b>	95,597	92,576	92,685		
Average Hospital Length of Stay (Days) <sup>1,2</sup> ( <a href="#">by Site</a> )	6.9	6.8	6.9	7.1	7.1	<b>7.0</b>	6.8	6.7	7.1		
Per Cent of Alternate Level of Care (ALC) <sup>1,3</sup> Days	9.4%	8.2%	9.9%	10.0%	8.0%	<b>9.0%</b>	6.9%	7.3%	8.3%		
Number of Hospital Births <sup>1</sup>	50,738	12,882	12,985	11,952	11,937	<b>49,756</b>	12,894	13,103	12,006		
Number of Emergency Department Visits <sup>4</sup> ( <a href="#">by Site</a> )	1,952,803	491,934	491,155	472,121	486,793	<b>1,942,003</b>	502,973	508,794	502,931		
Number of Urgent Care Service (UCS) Visits <sup>5</sup>	125,916	44,189	44,238	42,428	46,442	<b>177,297</b>	49,909	49,110	47,892		
Number of Health Link Calls	1,030,192	175,319	167,602	203,281	212,769	<b>758,971</b>	189,135	174,190	203,008		
Number of Total Hip Replacements <sup>6</sup>	3,131	832	666	794	861	<b>3,153</b>	882	747	960		
Number of Total Knee Replacements <sup>6</sup>	4,128	1,225	898	1,132	1,142	<b>4,397</b>	1,294	1,087	1,314		
Number of Cataract Surgeries <sup>9</sup>	28,601	7,610	7,230	8,026	10,915	<b>33,781</b>	8,592	8,168	10,300		
Number of MRI Exams <sup>7</sup>	165,948	45,008	43,369	40,389	48,656	<b>177,422</b>	40,907	40,505	40,795		
Number of CT Exams <sup>8</sup>	350,781	88,727	87,485	77,670	79,281	<b>333,163</b>	83,366	85,196	83,177		
Number of Lab Tests	67,831,892	16,722,715	16,200,487	16,565,953	16,936,697	<b>66,425,852</b>	17,806,352	17,021,500	17,370,577		

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 Service (UCS) Visits: Figures are based on the certification effective dates below.

Airdrie Regional Health Centre 18-Dec-2009

Cochrane Community Health Centre 15-Feb-2011

Health First Strathcona 01-May-2008

Okotoks Health and Wellness Centre 17-Mar-2010

Sheldon M Chumir Centre 01-Apr-2008

South Calgary Health Centre 01-May-2008

6. Number of Total Hip Replacements and Number of Total Knee Replacements data source is inpatient data abstracts reported as of discharge date. Figures exclude revisions and partial joint replacement procedures.

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. Cataract figures include those performed with a vitrectomy.

Data updated annually.  
Most current data is 2010.  
Next data update expected for Q4 Report.

### 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.

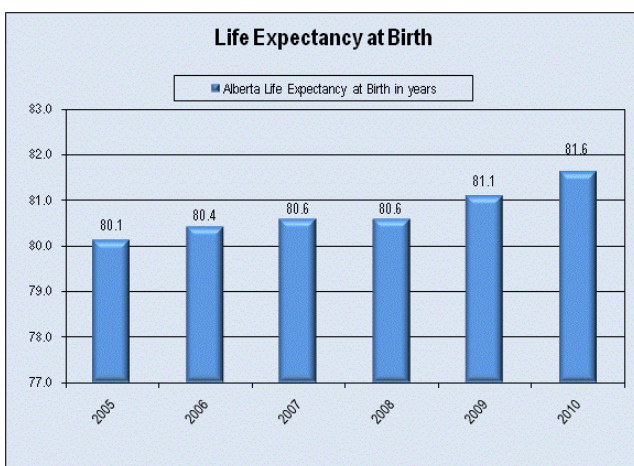
### WHY IS THIS IMPORTANT?

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

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



Source: Alberta Health & Wellness

### PERFORMANCE STATUS

Performance improvement observed since last reported period.

**TARGET:**  
Improve

**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. 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 = 80.6, Best Performing Province = 81.4 (British Columbia), Canada = 80.9 (Statistics Canada 2006/2008).



Data updated annually.  
Most current data is 2010.  
Next data update expected for Q4 Report.

## Potential Years of Life Lost

### 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.

**TARGET:**  
Improve

**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.

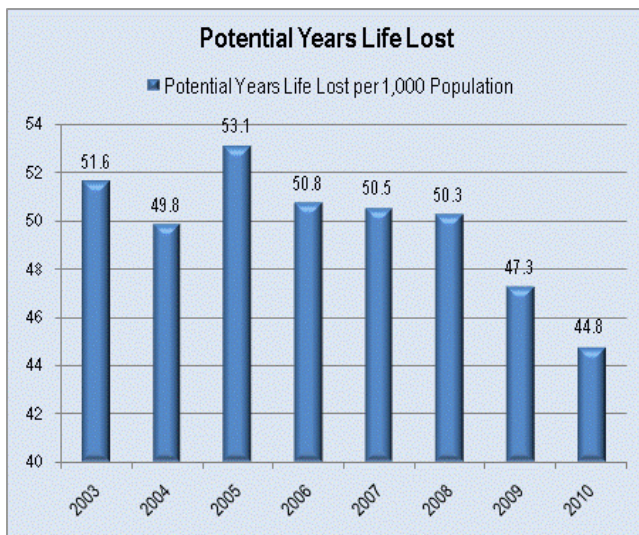
### WHAT ELSE DO WE KNOW?

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

## Colorectal Cancer Screening Participation Rate

Data updated annually.  
Most current data is 2008.  
Next data update expected for Q4 report.

### 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 FOBT 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 FOBT 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.	<b>2010 TARGET:</b> 37%
Target to be confirmed	<b>2008 ACTUAL:</b> 35.5%

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Implement transition screening-related colonoscopy capacity expansion. Received Zone Charters related to the expansion from all 5 zones. Target volume increase for 2011/12=8810 (Calgary 5560, Edmonton 2500, South 720, North 30, Central 0). Develop a strategy for quality monitoring and improvement for screening-related colonoscopy services. Preliminary indicators for monitoring and improvement selected, Quality Medical Lead hired. Additional Zone-specific actions completed are available [here](#).

**Subsequent actions planned:** Initiate staff recruitment/training and equipment procurement underway. Continue to support implementation of transition screening colonoscopy expansions. Establish Monitoring and Quality Improvement Working Group to finalize indicators and develop/implement strategy. Additional Zone-specific actions planned are available [here](#).

### 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).

## Breast Cancer Screening Participation Rate

Data updated annually.  
Most current data is 2009-2010.  
Next data update expected for Q1 2012/13 report.

### 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.

 <b>PERFORMANCE STATUS</b> Performance is at or better than quarterly target, continue to monitor.	<b>2009 - 2010 TARGET: 57%</b>
	<b>2009-2010 ACTUAL: 57.3%</b>

### HOW ARE WE DOING?

During the two-year period between January 2009 and December 2010, 57.3 per cent of women aged 50 to 69 years received a screening mammogram. The rate for 2010-2011 is not yet available.

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Complete and submit updated Privacy Impact Assessment (PIA) to the Office of the Information and Privacy Commissioner (OIPC).

**Subsequent actions planned:** Updated PIA almost complete and due for submission by January 31, 2012.

### WHAT ELSE DO WE KNOW?

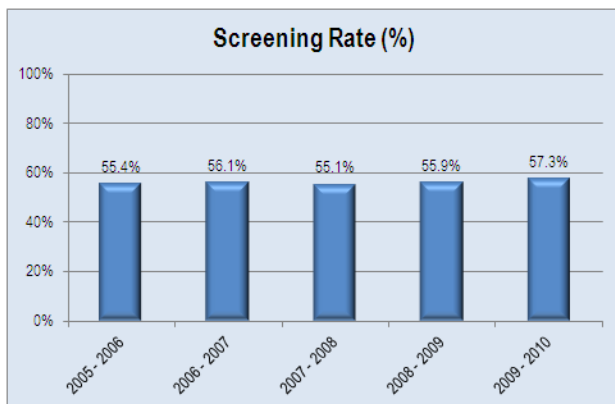
In order to more accurately reflect the way in which the population receives screening mammography, the Alberta Breast Cancer Screening Program is working with the Public Health Agency of Canada to evaluate a biennial mammography utilization indicator that might include bilateral diagnostic mammograms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

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



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



## Cervical Cancer Screening Participation Rate

Data updated annually.  
Most current data is 2008-2010.  
Next data update expected for Q1 2012/13 report.

### 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.

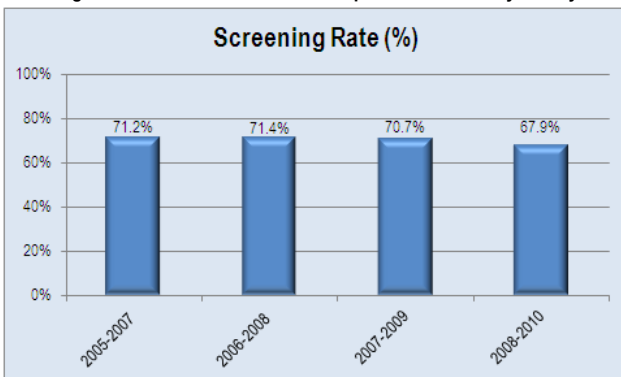
### WHY IS THIS IMPORTANT?

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).

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



Source: Extracted from AHW FFS data.

(3) The trend in cervical cancer screening participation reflects implementation of the 2009 Guideline for Screening for Cervical Cancer in Alberta. Previous guidelines recommended annual screening for all women 21-69 years. The three revisions in the 2009 guidelines that affect screening participation are as follows:

- Screening is no longer recommended for women who have never been sexually active;
- Women should not be screened until approximately three years after becoming sexually active;
- Many women can extend their screening interval to three years



### PERFORMANCE STATUS

Performance is within acceptable range, monitor and take action as appropriate. Target to be confirmed.

2008 - 2010  
TARGET: 72%

2008-2010 ACTUAL:  
67.9%

### HOW ARE WE DOING?

During the three-year period between January 2008 and December 2010, 67.9 per cent of eligible women aged 21 to 69 years received a screening Pap test. While this is a bit below target, the screening percentage has been affected by new Screening guidelines introduced in 2009 (see note below graph).

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Expand routine Alberta Cervical Cancer Screening Program (ACCSP) - returned introductory letters processed, increased call volumes handled and have returned to normal levels. Prepare for and incorporate Human Papillomavirus (HPV) reflex testing in the ACCSP application and correspondence processes - information packages provided to health care practitioners, including information for patients.

Refer to [map](#) showing letter distribution across Alberta.

**Subsequent actions planned:** Work with colposcopists regarding direct ordering process for high risk HPV testing.

### 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 report.

## Performance Measure Update

### 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 (AHS) Zones and the First Nations and Inuit Health (FNIH), Health Canada, Alberta Region. Seniors in Lloydminster primarily receive immunizations from Saskatchewan Health and are missing from the numerator count. The Lloydminster population has been removed from the denominator.

Detailed indicator [definition](#) is available.

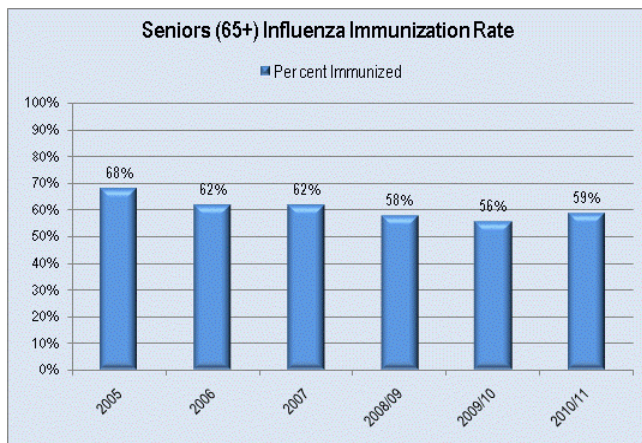
An internal review of the data quality indicates a very high level of confidence with no known issues.

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



Source: Alberta Health & Wellness; 2009/10 figures are preliminary calculations from AHS.

#### PERFORMANCE STATUS

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

2011/12 TARGET:  
75%

2010/11 ACTUAL:  
59%

#### 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:** Implemented Increase outreach clinics for seniors, e.g. recreation centres, lodges, seniors' residences, seniors' community centres, assisted living sites and snowbird clinics in all zones in October 2011.

**Subsequent actions planned:** Outreach evaluation results will be included in the comprehensive 2011-2012 influenza immunization program evaluation.

#### 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](#).

As detailed in the indicator definition, this indicator is based upon the influenza season and therefore considers doses delivered from October through to May 15<sup>th</sup>. The annual Alberta Health and Wellness (AHW) report includes only doses delivered up to March 31<sup>st</sup>.

#### HOW DO WE COMPARE?

Using a similar definition, Alberta ranked eighth among the 10 provinces for self-reported influenza immunization. Alberta = 59.7 per cent, Best Performing Province = 73.5 per cent (Nova Scotia), Canada = 59.4 per cent (Statistics Canada, 2010)

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

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

### 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?

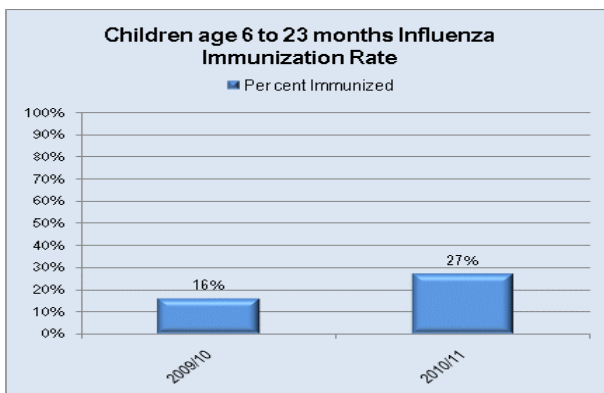
A high rate of seasonal influenza immunization among children reduces the incidence of complications and death associated with influenza disease and reduces the spread of disease to older age groups during the influenza season. A high rate of coverage will reduce the impact of disease on the healthcare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

### HOW ARE WE DOING?

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



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%

**2010/11 ACTUAL:**  
27%

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** New processes include immunization pilots at day care centres and school sites at end of business day as parents present to pick-up children. Centralized data entry of all influenza immunization administered by Public Health began in November 2011 and will be ongoing to the end of the annual influenza immunization program. South Zone pilot implemented at beginning of 2011-2012 influenza immunization program and Calgary zone real-time data entry pilot implemented in November 2011. Evaluation of data entry pilots in progress.

**Subsequent actions planned:** Pilot and Data-entry evaluation results will be included in the comprehensive 2011-2012 influenza immunization program evaluation.

### 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](#).

As detailed in the indicator definition, this indicator is based upon the influenza season and therefore considers doses delivered from October through to May 15<sup>th</sup>. The annual Alberta Health and Wellness (AHW) report includes only doses delivered up to March 31<sup>st</sup>.

### HOW DO WE COMPARE?

Limited comparable data is available

Data updated annually.  
Most current data is 2008.  
Next data update expected for Q4 report.

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

### 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 Alberta Health Services (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.

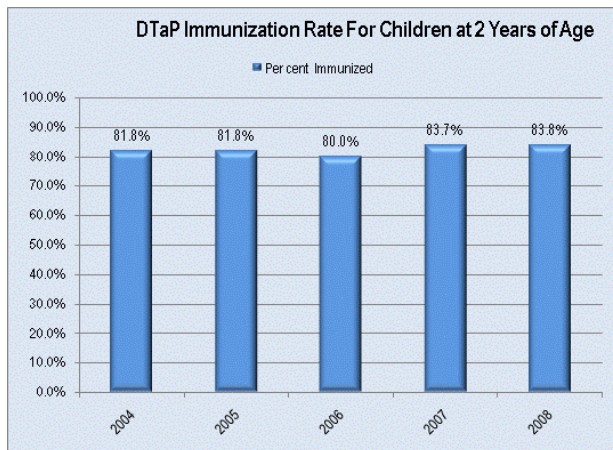
A data quality assessment is not available for this data at this time.

### 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.



Source: Alberta Health & Wellness and Alberta Health Services

<b>PERFORMANCE STATUS</b> Status to be determined.	<b>2011/12 TARGET:</b> 97%
	<b>2008 ACTUAL:</b> 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:** Continue to work with zones to look at barriers to immunization including access. Have begun to collect common barriers – will work toward looking at common barriers that can be addressed province-wide.

**Subsequent actions planned:** Identify common barriers and individual zone barriers. Identify what can be implemented across the province and what can be implemented in each zone.

### 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).



Data updated annually.  
Most current data is 2008.  
Next data update expected for Q4 report.

## Performance Measure Update

### Childhood Immunization Rate for Measles, Mumps, Rubella

#### 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.

#### PERFORMANCE STATUS

Status to be determined

2011/12 TARGET:  
98%

2008 ACTUAL:  
89.3%

#### 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.

#### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Continue to work with zones to look at barriers to immunization including access. Have begun to collect common barriers – will work toward looking at common barriers that can be addressed province-wide.

**Subsequent actions planned:** Identify common barriers and individual zone barriers. Identify what can be implemented across the province and what can be implemented in each zone.

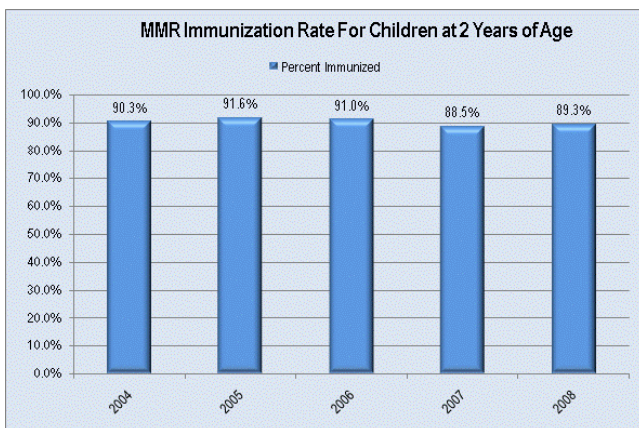
#### WHAT ELSE DO WE KNOW?

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).



Source: Alberta Health & Wellness and Alberta Health Services

Data updated twice yearly  
Most current data is October 2011  
Next data update expected in April 2012

## 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.

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

### WHY IS THIS IMPORTANT?

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

### WHAT IS THE TARGET?

Targets are currently being developed for this indicator.

### HOW ARE WE DOING?

The percentage of Albertans enrolled in a PCN is 74 per cent as of October 2011.

### PERFORMANCE STATUS

Status to be determined.

2011/12 TARGET:  
tbd

ACTUAL: 74%  
October 2011

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Status as of December 1, 2011;

- 40 PCNs operating in Alberta with 2,505 physicians.
- 4 PCNs in various stages of development involving another 50 family physicians.
- 2,806,926 Albertans enrolled in PCNs.

**Subsequent actions planned:** Continue supporting zones to expand and develop PCNs. Ongoing review of PCN business plan renewals.

### WHAT ELSE DO WE KNOW?

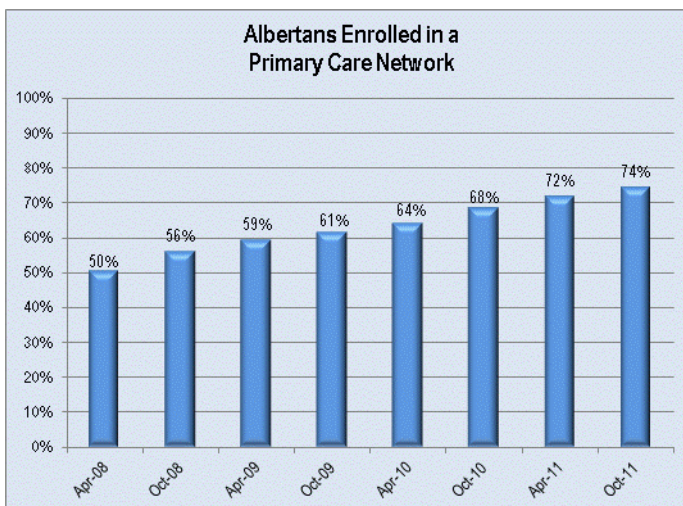
AHS is working to apply and advance a patient-focused model of primary health care that offers care in the community, and provides a team-based health care provider approach.

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 = 78.8 per cent, Best Performing Province = 93.6 per cent (Nova Scotia), Canada = 84.8 per cent (Statistics Canada, 2010). Alberta ranked fourth among the 10 provinces in terms of number of family physicians per 100,000 population. Alberta = 113, Best Performing Province = 119 (British Columbia), Canada = 103 (Canadian Institute for Health Information, 2009)



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

Data updated quarterly.  
Most current data is Q3 2011/12  
Next data update expected for Q4 Report

# Performance Measure Update

## 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.

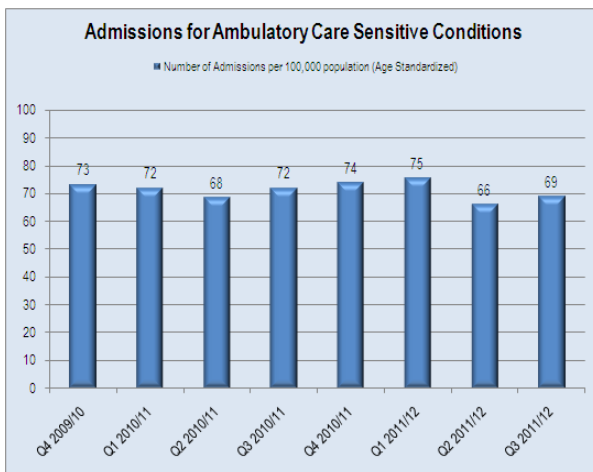
An internal review of the data quality indicates a high level of confidence with limited issues.

### 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

 <b>PERFORMANCE STATUS</b> Performance is at or better than target, continue to monitor.	<b>2011/12 TARGET:</b> 297 admissions per 100,000
	<b>YTD TARGET: 223</b> <b>ACTUAL: 206</b> admissions per 100,000 (Apr-Dec)

### HOW ARE WE DOING?

While there has been a slight increase in overall ACSC admissions in the most recent quarter, year to date performance remains better than target.

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Development is underway for a provincial pathway for improving diabetes care in Alberta in alignment with the Chronic Disease Management Strategy. Work is underway to finalize standards of care and a clinical group has been established to oversee this work along with the development a pathway for severe recurrent hypoglycaemia.

**Subsequent actions planned:** Draft standards and pathway will be circulated to clinicians for input. The paediatric care pathway will be expanded to include components that support decision making and patient flow. A provincial pathway for improving care for Albertans who are overweight or obese is being developed. As well, detailed clinical pathways for adult specialty care are under development by the provincial Bariatric Resource Team.

### 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 fourth among the 10 provinces for lowest admissions for ambulatory care sensitive conditions. Alberta = 311, Best Performing Province = 251 (British Columbia), Canada = 302 (CIHI 2009/10)

Data updated quarterly  
Most current data is Q3 2011/12  
Next data update expected for Q4 report

### 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 (AHS) 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 meeting the pro-rated year to date (YTD) target.

 **PERFORMANCE STATUS**

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

**2011/12 TARGET: 25%**  
of ED/UCC visits

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**YTD TARGET: 25.6%**  
**ACTUAL: 26.4%**  
of ED/UCC visits  
(Apr-Dec)

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Develop Chronic Disease Management (CDM) supports for diverse and vulnerable populations. Chronic disease screening project underway: deliverables include literature review and environmental scan of screening practices in Alberta, gap analysis and recommendations. A self-management workbook to assist with complex care planning was developed and a distribution plan was implemented

**Subsequent actions planned:** Adapt/modify obesity/CDM patient education and provider education tools. Complete an evaluation framework based on the Social Determinants of Health. In collaboration with Zones, identify communities in North, Central and South Zones for expanded services. Develop proposal for self-management support model and alternates. Present to working group for recommendations on how to test proof of concept.

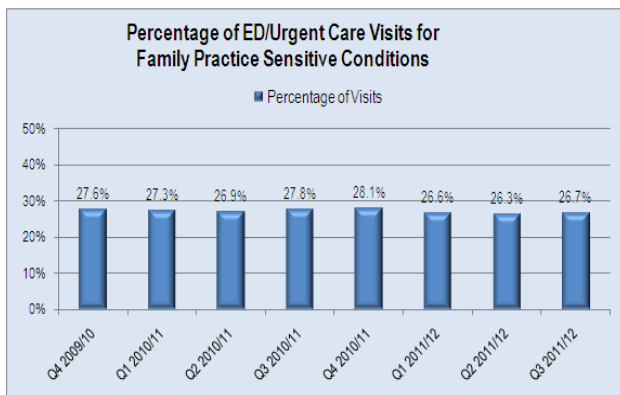
### WHAT ELSE DO WE KNOW?

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

Information is available by [zone](#).

### HOW DO WE COMPARE?

National benchmark comparisons are not available



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



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

Data updated quarterly  
Most current data is Q3 2011/12  
Next data update expected for Q4 report

### 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.

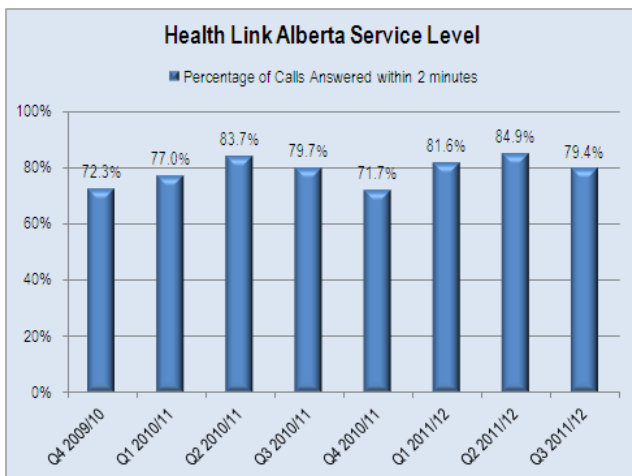
An internal review of the data quality indicates a very high level of confidence with no known issues.

### 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 79.4 per cent for Q3 2011/12, and the Year to Date (YTD) performance was 81.9 per cent.



Source: Health Link Alberta, Nortel Contact Centre Management 6.0



### PERFORMANCE STATUS

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

2011/12 TARGET:  
85%

YTD TARGET: 83.2 %  
ACTUAL: 81.9%  
(Apr-Dec)

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Health Link Alberta is developing a five year Strategic Plan. Stakeholder consultations are complete. Visioning Day held Nov 21 with 27 participants. Draft strategy is now in the review process. Improvements towards the Health Link Alberta target continue: Target 80% of calls answered in 2 minutes - Overall service level target met – October – December 2011. 81.9 % of calls were answered in 2 minutes. HealthLink has responded to more than 20,000 calls year-to-date (April to December, 2011), over the same period last year. This is an increase of 4% in call volume.

**Subsequent actions planned:** Strategic Planning Steering Committee approval of proposed strategy. Executive Committee approval of proposed strategy. Development of Business Case and Charters. Continue to monitor progress.

### WHAT ELSE DO WE KNOW?

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

### HOW DO WE COMPARE?

National benchmark comparisons are not available.

Data updated quarterly.  
Most current data is Q3 2011/12  
Next data update expected for Q4 report

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

### 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 a face-to-face scheduled 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.

Table:


Access to Children's Mental Health Services: Per cent of children aged 0 to 17 years receiving mental health treatment within 30 days

Time Period	% of Children Seen Within 30 Days	Number of New Enrollments (to Community MH Clinics Only)
Q1 2011/12	72%	1,575
Q2 2011/12	70%	1,354
Q3 2011/12	83%	1,859

Source: AHS Mental Health Services

Notes:

1. These results are limited to children enrolled in programs at community mental health clinics across Alberta.
2. Results from Edmonton Northgate clinic are an under-representation as some data quality issues exist. Improvements in data collection processes are being explored.
3. This indicator includes all children under 18 years of age.
4. These results exclude some enrolments that have not been completed within the selected time period.
5. 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.
6. Results reported in this analysis may differ slightly from previous documents due to updates in datasets.
7. Age is calculated at time of service (enrolment date).
8. Commencing fiscal year 2011-2012, results include information from Regional Access and Intake System for children enrolled in clinics in the Calgary Zone. The number of new enrolment for scheduled cases in the Calgary Zone is slightly under-represented as some data quality issues exist. Improvements in data collection processes are being explored.

 <b>PERFORMANCE STATUS</b> Performance is outside acceptable range, take action and monitor progress.	<b>2011/12 TARGET:</b> 90%
	<b>YTD TARGET: 86%</b> <b>ACTUAL: 73%</b> (Apr-Dec)

### 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:** The Children's Mental Health Plan for Alberta: Three Year Action Plan supports a coordinated and collaborative approach to optimizing the mental health and well-being of infants, children and youth up to 24 years of age, and their families. Over 65 mental health staff have been hired to provide direct service delivery from psychiatric inpatient, mental health clinics and schools as well as contracted services and in support of pilot programs. Additional Zone-specific actions completed are available [here](#).

**Subsequent actions planned:** Child and Adolescent Addiction and Mental Health Provincial Working Group will gather information about any implementation challenges; will review and make recommendations for addressing same. 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. There is no comparable information from other provinces regarding the wait times for children to receive community mental health treatment.

Data updated quarterly  
Most current data is Q3 2011/12  
Next data update expected for Q4 report

## WHAT IS BEING MEASURED?

Coronary artery bypass graft (CABG) wait time definitions have been refined and standardized between Calgary and Edmonton to ensure accurate and consistent reporting of data.

Only scheduled CABG surgeries on adults 18 years of age and older are included in this measure; emergency procedures are not included. Patients whose urgency level changed are excluded.

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

Detailed indicator [definition](#) is available.

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

## WHY IS THIS IMPORTANT?

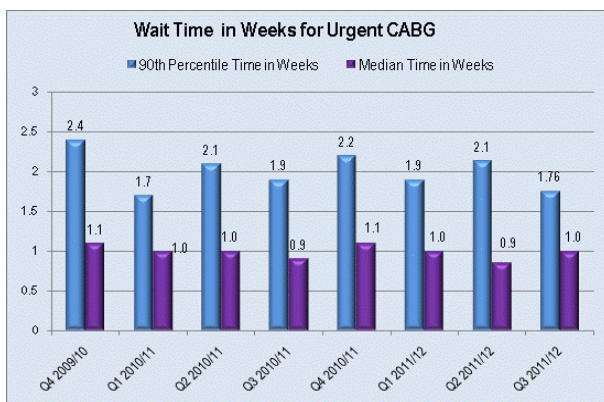
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources. Access in combination with a high quality of service delivery will help ensure optimal patient outcomes.

## WHAT IS THE TARGET?

The provincial/territorial benchmark for Urgency I CABG surgeries is within two weeks. The AHS 90<sup>th</sup> percentile target for 2011/12 is one week for Urgent CABG surgeries.


## HOW ARE WE DOING?

The wait time for urgent CABG surgery has decreased between Q2 and Q3 although the year to date wait time remains longer than the pro-rated target.



Source: AHS Open Heart Waitlist Database (Edmonton), VELOS and APPROACH (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.

**2011/12 TARGET:**  
1 week

**YTD TARGET:** 1.3 weeks  
**ACTUAL:** 1.9 weeks  
(Apr-Dec)

## WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Work is being done in relation to definitions for the Adult Access Targets for Surgery (aCATs) Scoring system. Cardiac surgery will follow the pilot surgical specialties in implementing aCats. Meeting with surgeons to identify and explore potential strategies for improving wait times for CABG patients while not impacting the wait for other Open Heart procedure patients. Strategies are being developed to redistribute elective CABG waitlisted patients among surgeons.

**Subsequent actions planned:** Calgary Zone to complete approximately 20 additional CABG cases in 2011/12 and Edmonton Zone to complete approximately 45 additional CABG cases in 2011/12. This will assist all 3 categories of CABG wait lists. Additional OR capacity to become available in January 2012. Continue to monitor surgical wait time database, identifying strategies for continuous improvement. Implement Process Improvement initiative to improve patient access and flow and reduce/eliminate system inefficiencies by March 31 2012

## WHAT ELSE DO WE KNOW?

All patient conditions are carefully reviewed to ensure patients are assigned an appropriate urgency level. Patients are reassessed and re-prioritized should their condition change while awaiting their surgical procedure.

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 Q3 2011/12  
Next data update expected for Q4 report

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

### WHAT IS BEING MEASURED?

Coronary artery bypass graft (CABG) wait time definitions have been refined and standardized between Calgary and Edmonton to ensure accurate reporting and consistency of data..

Only scheduled CABG surgeries on adults 18 years of age and older are included in this measure; emergency procedures are not included. 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. Access in combination with a high quality of service delivery will help ensure optimal patient outcomes.

### WHAT IS THE TARGET?

The provincial/territorial benchmark for Urgency II CABG surgeries is within six weeks. The AHS 90<sup>th</sup> percentile target for 2011/12 is two weeks for semi-urgent CABG surgeries.

### HOW ARE WE DOING?

While there was a small increase in wait time for semi-urgent CABG surgery, the year to date value remains higher than the pro-rated target.

 <b>PERFORMANCE STATUS</b> Performance is outside acceptable range, take action and monitor progress.	<b>2011/12 TARGET:</b> 2 week
	<b>YTD TARGET:</b> 3.1 weeks <b>ACTUAL:</b> 6.4 weeks (Apr-Dec)

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Work is being done in relation to definitions for the Adult Access Targets for Surgery (aCATs) Scoring system. Cardiac surgery will follow the pilot surgical specialties in implementing aCats. Meeting with surgeons to identify and explore potential strategies for improving wait times for CABG patients while not impacting the wait for other Open Heart procedure patients. Strategies are being developed to redistribute elective CABG waitlisted patients among surgeons. There has been a 13% increase in the number of semi-urgent CABG surgeries performed year-to-date (April to December, 2011), over the same period last year.

**Subsequent actions planned:** Calgary Zone to complete approximately 20 additional CABG cases in 2011/12 and Edmonton Zone to complete approximately 45 additional CABG cases in 2011/12. This will assist all 3 categories of CABG wait lists. Additional OR capacity to become available in January 2012. Continue to monitor surgical wait time database, identifying strategies for continuous improvement. Implement Process Improvement initiative to improve patient access and flow and reduce/eliminate system inefficiencies by March 31 2012

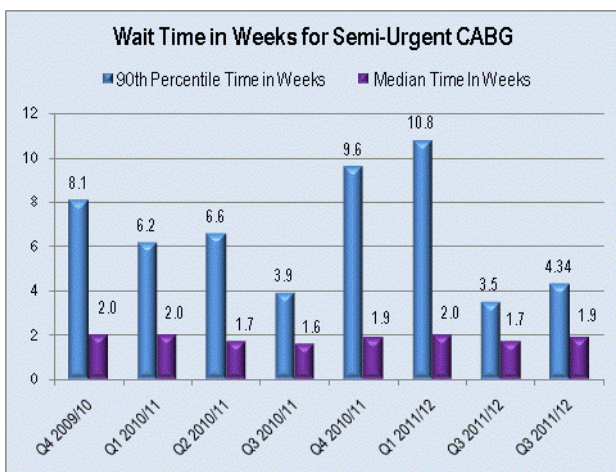
### WHAT ELSE DO WE KNOW?

All patient conditions are carefully reviewed to ensure patients are assigned an appropriate urgency level. Patients are reassessed and re-prioritized should their condition change while awaiting their surgical procedure.

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 and APPROACH (Calgary)



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

Data updated quarterly  
Most current data is Q3 2011/12  
Next data update expected for Q4 report

### WHAT IS BEING MEASURED?

Since 2010, coronary artery bypass graft (CABG) wait time definitions have been refined and standardized between Calgary and Edmonton to ensure accurate and consistent reporting of data.

Only scheduled CABG surgeries on adults 18 years of age and older are included in this measure; emergency procedures are not included.

Patients whose urgency level changed are excluded.

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

Detailed indicator [definition](#) is available.

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

### WHY IS THIS IMPORTANT?

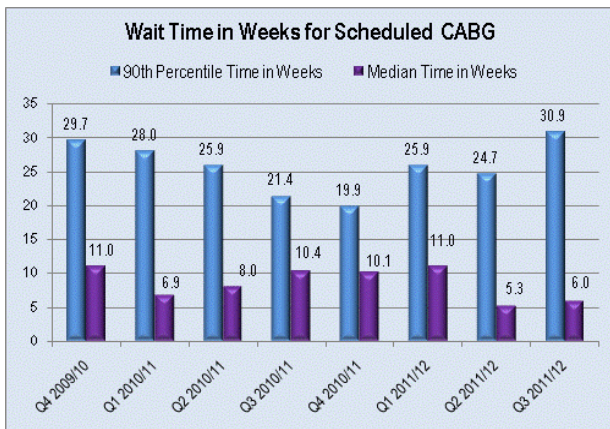
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources. Access in combination with a high quality of service delivery will help ensure optimal patient outcomes.

### WHAT IS THE TARGET?

The provincial/territorial benchmark for Urgency III CABG surgeries is within 26 weeks. The 2011/12 AHS 90<sup>th</sup> percentile target is 6 weeks.

### HOW ARE WE DOING?

The wait time for scheduled CABG surgery has deteriorated quarter over quarter and the year to date wait time remains significantly worse than target.



Source: AHS Open Heart Waitlist Database (Edmonton), VELOS and APPROACH (Calgary)

### PERFORMANCE STATUS

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

2011/12 TARGET:  
6 weeks

YTD TARGET: 10.5 weeks  
ACTUAL: 27.8 weeks  
(Apr-Dec)

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Work is being done in relation to definitions for the Adult Access Targets for Surgery (aCATs) Scoring system. Cardiac surgery will follow the pilot surgical specialties in implementing aCats. Meeting with surgeons to identify and explore potential strategies for improving wait times for CABG patients while not impacting the wait for other Open Heart procedure patients. Strategies are being developed to redistribute elective CABG waitlisted patients among surgeons. There has been a 3% increase in the number of scheduled CABG surgeries performed year-to-date (April to December, 2011), over the same period last year.

**Subsequent actions planned:** Calgary Zone to complete approximately 20 additional CABG cases in 2011/12 and Edmonton Zone to complete approximately 45 additional CABG cases in 2011/12. This will assist all 3 categories of CABG wait lists. Additional OR capacity to become available in January 2012. Continue to monitor surgical wait time database, identifying strategies for continuous improvement. Implement Process Improvement initiative to improve patient access and flow and reduce/eliminate system inefficiencies by March 31 2012

### WHAT ELSE DO WE KNOW?

All patient conditions are carefully reviewed to ensure patients are assigned an appropriate urgency level. Patients are reassessed and re-prioritized should their condition change while awaiting their surgical procedure.

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 Q3 2011/12  
Next data update expected for Q4 Report

# Performance Measure Update

## Hip Replacement Wait Time

### WHAT IS BEING MEASURED?

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

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

An in-depth data quality review on the hip surgery wait times revealed that the data are accurate within 1.0 per cent 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 Q3 2011/12 was 35.7 weeks which is slightly better than Q2, but the Year to Date (YTD) wait time was 39.9 weeks, which is longer than the target.



### PERFORMANCE STATUS

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

2011/12 TARGET:  
27 weeks

YTD TARGET: 30.0  
ACTUAL: 39.9  
(Apr – Dec)

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Zones are on target to complete the additional 1,000 approved hip and knee replacement surgeries within the Fiscal year. There have been more than 350 hip replacement surgeries year-to-date (April to December, 2011), over the same period last year. This is an increase of 16% in hip replacement surgery volume. There is a focused approach to clearing up existing wait lists in an effort to ensure that the existing waitlists are accurate and patients are receiving the appropriate care. Additional details are available at the [zone](#) level.

**Subsequent actions planned:** Process changes are being looked at on a zone by zone basis to increase efficiencies. This includes items such as establishing new referral programs, better reporting within the zone, reporting and working with the Alberta Bone and Joint Health Institute and recruitment of additional staff. Activities will continue to be monitored to keep on track to meet targets including the additional surgeries. Implement post operative care standards as per Provincial hip and knee care pathway. Additional details are available at the [zone](#) level.

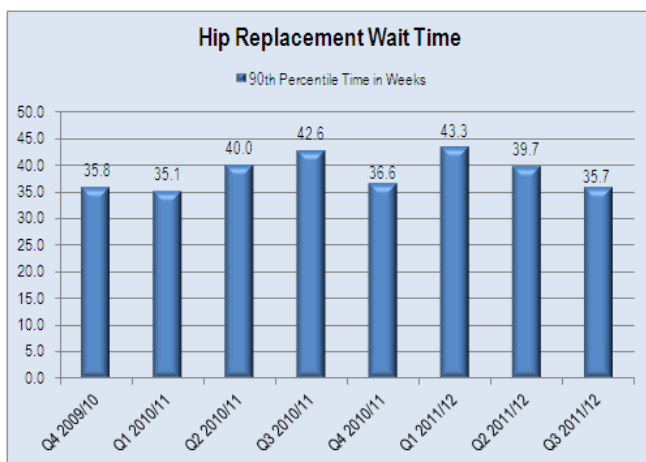
### WHAT ELSE DO WE KNOW?

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 Q3 2011/12  
Data update expected for Q4 Report

# Performance Measure Update

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

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

An in-depth data quality review on the knee surgery wait times revealed that the data are accurate within 2.7 per cent or  $\pm 1.3$  weeks in the current quarter.

### WHY IS THIS IMPORTANT?

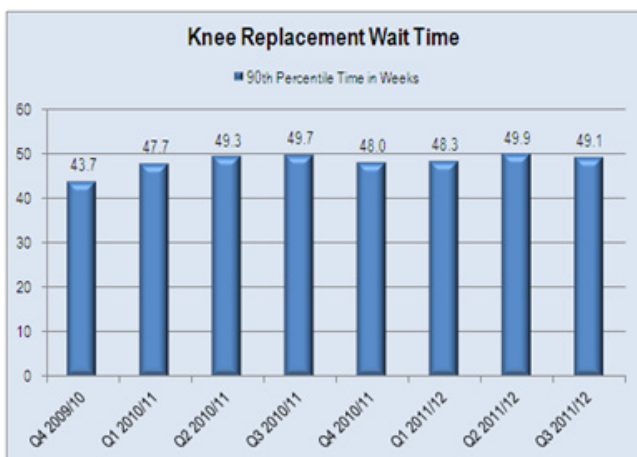
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

### 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 Q3 2011/12 was 49.1 weeks which is slightly better than the prior quarter. The Year to Date (YTD) wait time was 49.1 weeks which is longer than the target.



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



### PERFORMANCE STATUS

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

2011/12 TARGET:  
35 weeks

YTD TARGET: 38.5  
ACTUAL: 49.1  
(Apr – Dec)

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Zones are on target to complete the additional 1,000 approved hip and knee replacement surgeries within the Fiscal year. There have been more than 500 knee replacement surgeries year-to-date (April to December, 2011), over the same period last year. This is an increase of 15% in knee replacement surgery volume. There is a focused approach to clearing up existing wait lists in an effort to ensure that the existing waitlists are accurate and patients are receiving the appropriate care. Additional details are available at the [zone](#) level.

**Subsequent actions planned:** Process changes are being looked at on a zone by zone basis to increase efficiencies. This includes items such as establishing new referral programs, better reporting within the zone, reporting and working with the Alberta Bone and Joint Health Institute and recruitment of additional staff. Implement post operative care standards as per Provincial hip and knee care pathway. Additional details are available at the [zone](#) level.

### 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)

Data updated quarterly.  
Most current data is Q3 2011/12  
Next data update expected for Q4 Report

### WHAT IS BEING MEASURED?

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

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

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

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a questionable level of confidence with 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 high risk cataract surgeries is within 16 weeks. The target for 2011/12 is 30 weeks.

## Performance Measure Update

### Cataract Surgery Wait Time

 <b>PERFORMANCE STATUS</b> Performance is within acceptable range, monitor and take action as appropriate.	<b>2011/12 TARGET:</b> 30 weeks
	<b>YTD TARGET: 34.2</b> <b>ACTUAL: 36.6 weeks</b> (Apr – Dec)

### HOW ARE WE DOING?

The 90<sup>th</sup> percentile wait time for Cataract Surgery for Q3 2011/12 was 30.7 weeks which is better than the prior quarter. There has been a steady decline in the Cataract wait times over the past two years. The Year to Date (YTD) wait time was 36.6 weeks which is longer than the target.

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Increases to the number of cataract surgeries have continued to bring wait times down. There have been more than 2,800 cataract surgeries year-to-date (April to December, 2011), over the same period last year. This is an increase of 20% in cataract surgery volume. Further Zone-specific actions completed are available [here](#).

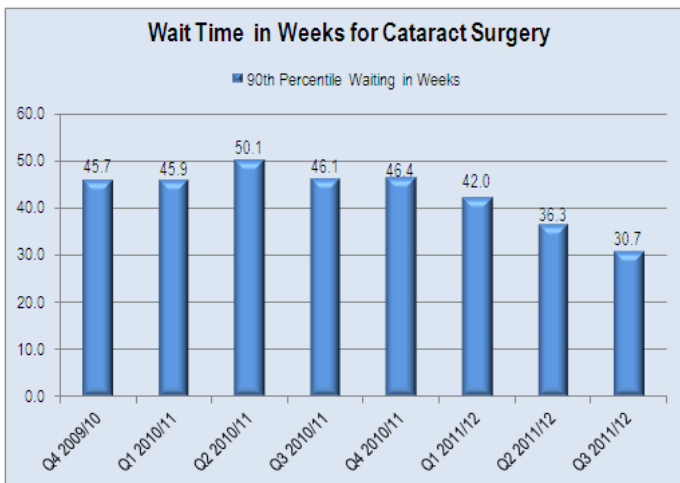
**Subsequent actions planned:** Completion of allocated cataract surgeries will continue across the province throughout 2011/12. Additional Zone-specific actions planned are available [here](#).

### 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 Q3 2011/12  
Next data update expected for Q4 Report

# Performance Measure Update

## Other Scheduled Surgery Wait Time

### WHAT IS BEING MEASURED?

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

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

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

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

Detailed indicator [definition](#) is available.

An internal review of the data quality indicates a questionable level of confidence with 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?

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.

**2011/12 TARGET:**  
(to be developed)

**YTD TARGET:** tbd  
**ACTUAL:** 26.0 weeks  
(Apr – Dec)

### HOW ARE WE DOING?

Using latest developed measurement methodology (under review) 90<sup>th</sup> percentile wait times for other surgeries was 26.9 weeks for Q3 2011/12. This is slightly better than the prior quarter. Taking all quarters into account, the year to date wait time is 26.0 weeks.

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Surgical expansion at four South Zone rural sites will potentially decrease waiting times for orthopaedic, general and podiatry surgeries. Also included are endoscopy, screening and diagnostic procedures. Additional Cancer surgeries are being performed in most zones. As well there are increases in other surgeries including spine and other orthopaedic surgery cases, bariatric, urology and thoracic surgery. There have been more than 1,900 other scheduled surgeries year-to-date (April to December, 2011), over the same period last year. This is an increase of 2% in other scheduled surgery volume.

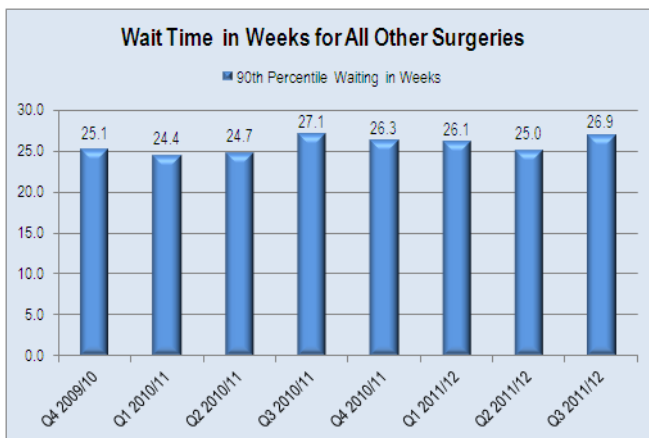
**Subsequent actions planned:** Continue with additional surgical volumes and monitor volumes to keep on track to meet expanded targets. Define current wait lists and determine urgent versus emergent cases where applicable.

### 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 Q3 2011/12  
Next data update expected for Q4 Report

## Performance Measure Update

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

#### WHAT IS BEING MEASURED?

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

Currently this data is collected on patients referred to a tertiary cancer facility (Cross Cancer Institute in Edmonton, Tom Baker Cancer Centre or Holy Cross in Calgary). As of Q3 2010/11, data is also 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 90<sup>th</sup> percentile is the time it takes in weeks for 90 per cent of patients to have had their first consult.

Detailed indicator [definition](#) is available.

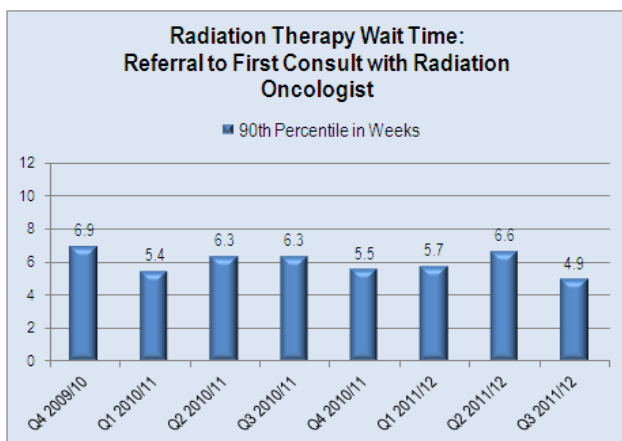
An internal review of the data quality indicates a high level of confidence with limited issues.

#### 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 (AHS) to meet the needs of cancer patients.


#### WHAT IS THE TARGET?

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



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.

 <b>PERFORMANCE STATUS</b> Performance is outside acceptable range, take action and monitor progress.	<b>2011/12 TARGET:</b> 4 weeks
	<b>YTD TARGET:</b> 5.0 weeks <b>ACTUAL:</b> 5.7 weeks (Apr-Dec)

#### 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:** There have been more than 275 radiation oncology consultations year-to-date (April to December, 2011), over the same period last year. This is an increase of 8% in consultation volume. AHS Improvement Way (AIW) training has been initiated and is ongoing. There has also been the development of Steering Committees at all three centers to ensure that appropriate communication and decision making can occur. Review of the current scheduling of patients within the Outpatient Department (OPD) is in progress.

**Subsequent actions planned:** Continue working on the AIW project during phase one and two. Phase 3 will be initiated once phase one and two are completed. This will be the evaluation of the changes and the potential increase in resources that are needed to maintain the changes and to decrease the wait times further. Continue with training of staff.

#### 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 70 per cent of patients are seen within this target (Cancer Care Ontario, October 2011).

Data updated quarterly  
Most current data is Q3 2011/12  
Next data update expected for Q4 Report

### 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.

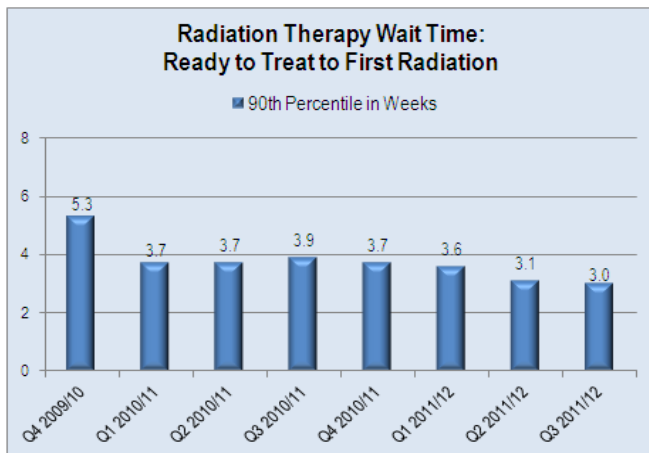
An internal review of the data quality indicates a very high level of confidence with no known issues.

### 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 (AHS) to meet the needs of cancer patients.

### WHAT IS THE TARGET?


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



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 Measure Update

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

 <b>PERFORMANCE STATUS</b> Performance is at or better than target, continue to monitor.	<b>2011/12 TARGET:</b> 4 weeks
	<b>YTD TARGET:</b> 4.0 weeks <b>ACTUAL:</b> 3.1 weeks (Apr-Dec)

### HOW ARE WE DOING?

The proportion of patients receiving radiation therapy within the expected time period is better than the target. The Q3 2011/12 90<sup>th</sup> percentile time was 3.0 weeks, however the year to date 90<sup>th</sup> percentile time is 3.1 weeks.

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Benchmark for this measure is 4 weeks; currently the provincial average is 3.0 weeks. Cancer care is below the target and will continue to work to maintain this wait time.

**Subsequent actions planned:** Opening of two new cancer centers (Central Alberta Cancer Center (2013) and Grande Prairie Cancer Center (2015)) that will provide radiation services to the province. The continuing of AHS Improvement Way processes to ensure that effective use of resources is maintained.

### WHAT ELSE DO WE KNOW?

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

The increased number of facilities may initially have a small impact in the overall wait items since we have seen an unmet population with the Lethbridge center opening and no corresponding decrease in numbers or wait times in Calgary

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 Q3 2011/12.  
Next data update expected for Q4 Report

# Performance Measure Update

## 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.

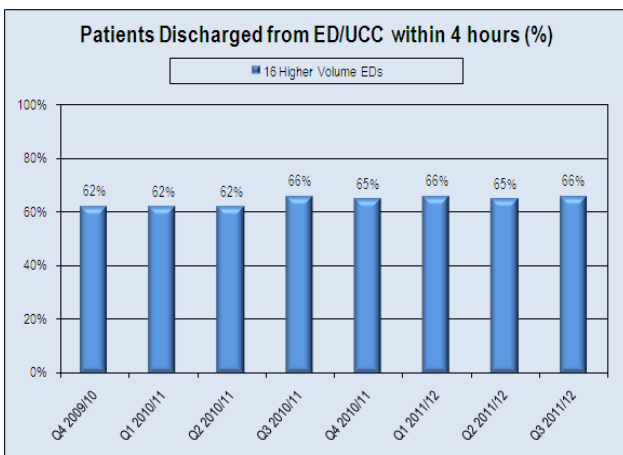
An internal review of the data quality indicates an acceptable level of confidence with known issues. A more formal internal Data Quality and Operational Readiness review is being conducted.

### 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 (AHS) 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.

2011/12 TARGET: 75%

YTD TARGET: 72%  
ACTUAL: 66%  
(Apr – Dec)

### HOW ARE WE DOING?

In Q3 2011/12, 66 per cent of patients at the 16 higher volume EDs were discharged within four hours. This is below the target which is 72 per cent.

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** There have been more than 46,600 visits at the 16 higher volume ED/UCC sites year-to-date (April to December, 2011), over the same period last year. This is an increase of 9% in ED/UCC volume. Enhanced methods to provide capacity are being implemented in all zones. Detailed Zone-specific actions completed are available [here](#).

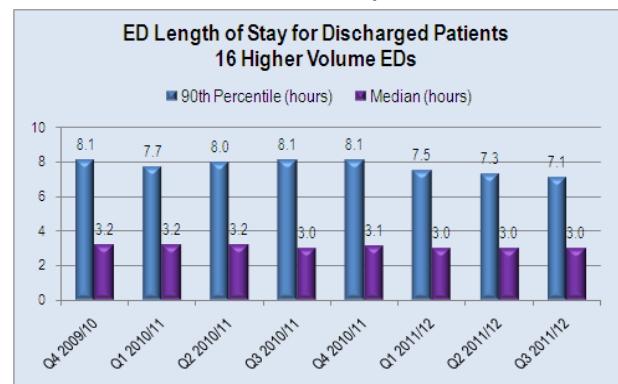
**Subsequent actions planned:** Process improvement efforts will continue across all Zones to continue to provide capacity and have overcapacity protocols in place. Detailed Zone-specific actions planned are available [here](#).

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

### HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

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

Data updated quarterly.  
Most current data is Q3 2011/12.  
Next data update expected for Q4 report.

### 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 2011/12 of 84 per cent of patients discharged within four hours for all sites.

 <b>PERFORMANCE STATUS</b> Performance is within acceptable range, monitor and take action as appropriate.	<b>2011/12 TARGET:</b> 84%
	<b>YTD TARGET:</b> 83% <b>ACTUAL:</b> 81% (Apr –Dec)

### HOW ARE WE DOING?

In Q3 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:** Enhanced methods to provide capacity are being implemented in all zones. There have been more than 70,500 visits at all ED/UCC sites year-to-date (April to December, 2011), over the same period last year. This is an increase of 5% in ED/UCC volume. Detailed Zone-specific actions completed are available [here](#).

**Subsequent actions planned:** Process improvement efforts will continue across all Zones to continue to provide capacity and have overcapacity protocols in place. Detailed Zone-specific actions planned are available [here](#).

### WHAT ELSE DO WE KNOW?

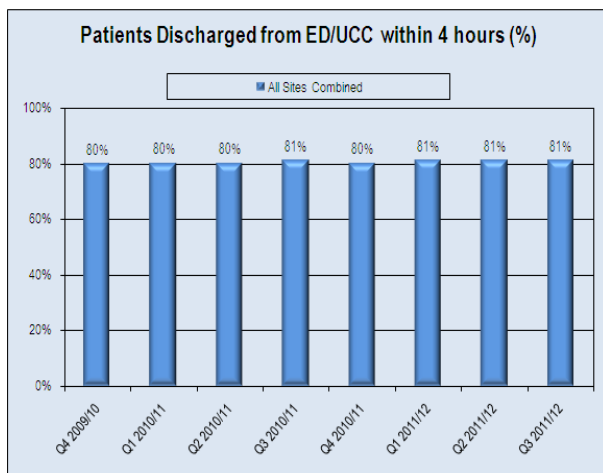
There are many reasons why ED/UCC length of stay may vary across sites, including complexity of patients, limitations (treatment spaces, staffing), operational efficiency and access to other primary care options (family physicians, walk-in clinics).

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 Q3 2011/12.  
Next data update expected for Q4 Report

# Performance Measure Update

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

### WHAT IS BEING MEASURED?

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

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

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

Detailed indicator [definition](#) is available.

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?

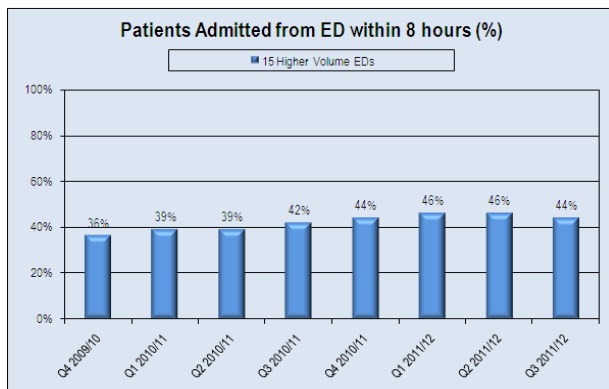
ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent can be a measure of access to the health care system and a reflection of efficient use of resources.

### WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target of 60 per cent of patients admitted leaving the ED within eight hours for the 15 higher volume EDs for 2011/12.

### HOW ARE WE DOING?

In Q3 2011/12, 44 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)

### PERFORMANCE STATUS

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

2011/12 TARGET: 60%

YTD TARGET: 55%  
ACTUAL: 45%  
(Apr - Dec)

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** There have been more than 6,900 ED inpatient admissions at the 15 higher volume ED sites year-to-date (April to December, 2011), over the same period last year. This is an increase of 8% in ED inpatient admissions volume. Enhanced methods to provide capacity are being implemented in all zones. Additional Zone-specific actions completed to date are available [here](#).

**Subsequent actions planned:** Process improvement efforts will continue across all Zones to continue to provide capacity and have overcapacity protocols in place.

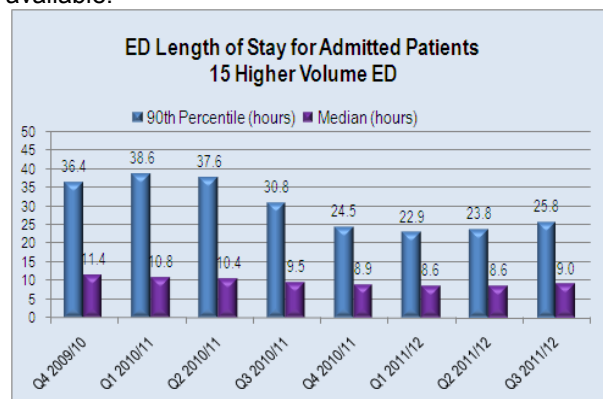
Additional Zone-specific actions planned are available [here](#).

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

### HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

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

Data updated quarterly  
Most current data is Q3 2011/12  
Next data update expected for Q4 Report.

### 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?

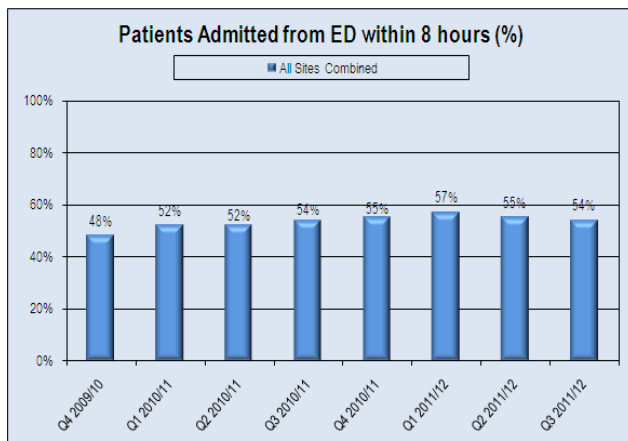
ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent by a patient in an ED can be a measure of access to the health care system and a reflection of efficient use of resources.

### 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 for 2011/12.

### HOW ARE WE DOING?

In Q3 2011/12, 54 per cent of admitted patients left the ED within eight hours and the YTD target was 62 per cent.



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.

2011/12 TARGET:  
65%

YTD TARGET: 62%  
ACTUAL: 56%  
(Apr – Dec)

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Enhanced methods to provide capacity are being implemented in all zones. Additional Zone-specific actions completed to date are available [here](#).

**Subsequent actions planned:** Process improvement efforts will continue across all Zones to continue to provide capacity and have overcapacity protocols in place. There have been more than 7,200 ED inpatient admissions at all ED sites year-to-date (April to December, 2011), over the same period last year. This is an increase of 6% in ED inpatient admissions volume.

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 available.

### HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

Data updated quarterly  
Most current data is Q3 2011/12  
Next data update expected for Q4 Report

## Performance Measure Update

### 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.

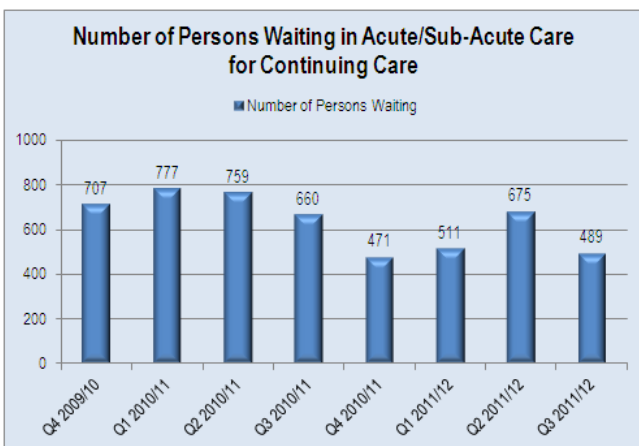
#### WHY IS THIS IMPORTANT?

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 report period.



#### PERFORMANCE STATUS

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

2011/12 TARGET:  
375

YTD TARGET: 399  
ACTUAL: 489  
(Dec 2011)

#### HOW ARE WE DOING?

At the end of Q3 2011/12, 489 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:** Additional beds are now available including new Supportive Living (SL) facilities. AHS continues to add continuing care beds. In 2010/11, 1,155 beds were added to the system and a further 1,000 beds will be added this fiscal year. As of Dec. 31, 2011, 868 beds were opened, which reflects 87% of target, bringing the total number of continuing care beds in the province to nearly 21,800. AHS is on track to add more than 5,300 beds between 2010 and 2015. Home Care services continue to be expanded across the province. Zone-specific actions completed to date are available [here](#).

**Subsequent actions planned:** Continue to add new beds in zones. 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 (AHS) website for reference by case managers.

Information is available by [zone](#).

#### HOW DO WE COMPARE?

Relevant national comparisons will be included as available.



Data updated quarterly  
 Most current data is Q3 2011/12  
 Next data update expected for Q4 Report.

## 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 Q3 2011/12, 1,038 people were waiting in the community (at home) for continuing care placement, which is above the target.

 **PERFORMANCE STATUS**

Performance is outside acceptable range, take action and monitor progress

**2011/12 TARGET:**  
900

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**YTD TARGET: 954**  
**ACTUAL: 1,038**  
(Dec 2011)

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Additional beds are now available including new Supportive Living (SL) facilities. AHS continues to add continuing care beds. In 2010/11, 1,155 beds were added to the system and a further 1,000 beds will be added this fiscal year. As of Dec. 31, 2011, 868 beds were opened, which reflects 87% of target, bringing the total number of continuing care beds in the province to nearly 21,800. AHS is on track to add more than 5,300 beds between 2010 and 2015. Home Care services continue to be expanded across the province. Detailed Zone-specific actions completed to date are available [here](#).

**Subsequent actions planned:** Continue to add new beds in zones. Further expansion of Home Care services will continue to occur. Detailed Zone-specific actions planned are available [here](#).

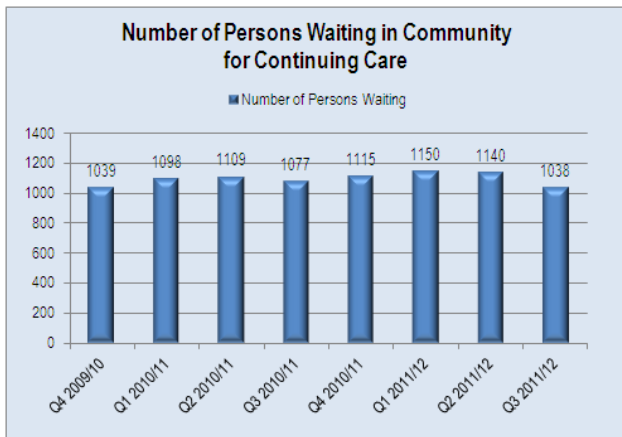
### WHAT ELSE DO WE KNOW?

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.



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

Data updated quarterly  
Most current data is Q3 2011/12  
Next data update expected for Q4 Report

## Performance Measure Update

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

#### WHAT IS BEING MEASURED?

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

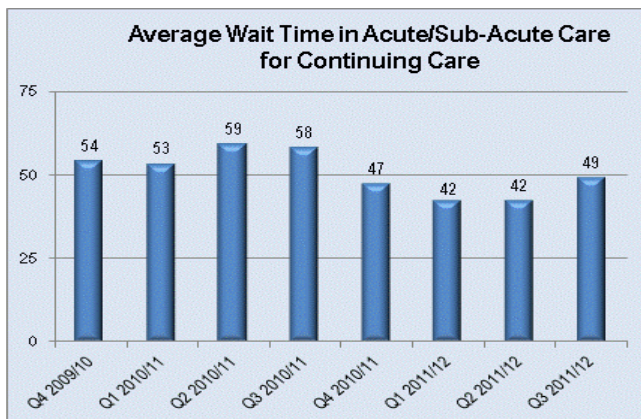
An internal review of the data quality indicates an acceptable level of confidence with known issues.

#### 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 2011/12 has not been established for comparison.

2011/12 TARGET:  
TBD

YTD Target TBD  
ACTUAL 45  
(Apr – Dec)

#### HOW ARE WE DOING?

The average wait time in acute/sub-acute care for continuing care was 49 days in Q3 of 2011/12. The year to date average wait time was 45 days.

#### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** AHS continues to add continuing care beds. In 2010/11, 1,155 beds were added to the system and a further 1,000 beds will be added this fiscal year. As of Dec. 31, 2011, 868 beds were opened, which reflects 87% of target. 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.

**Subsequent actions planned:** Continue to add new beds in zones. Roll-out of the ED2Home program will be expanded to other cities/communities. Further expansion of Home Care services will also occur.

#### 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 Q3 2011/12  
Next data update expected for Q4 report

## Performance Measure Update

### Percent of Patients Placed in Continuing Care within 30 Days of Being Assessed

#### WHAT IS BEING MEASURED?

Wait Time for Supportive and Facility Living measures the number of days between the time an individual is assessed and approved for admission to a Continuing Care Living Option and their admission date. Wait Time = Admission Date – Assessed and Approved Date.

This specific measurement is the per cent of patients admitted to Supportive or Facility Living within 30 days.

This performance measure is used to monitor and report on access to Continuing Care Living Options in Alberta, as indicated by the wait times experienced by individuals admitted within the reporting period

Detailed indicator [definition](#) is available.

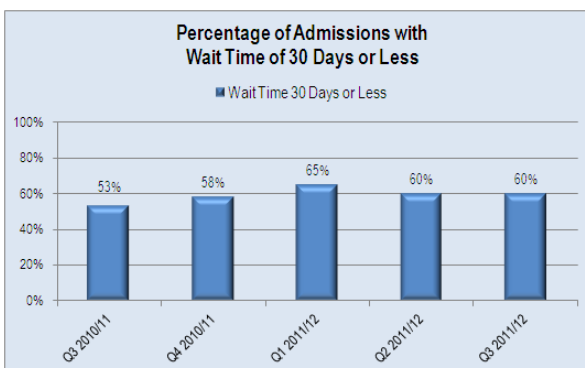
An internal review of the data quality indicates an acceptable level of confidence with known issues.

#### WHY IS THIS IMPORTANT?

**Accessibility:** Access to Supportive and Facility living options is a major issue in Alberta. *Goal 2 of Alberta's 5-Year Health Action Plan is that "All Albertans requiring continuing care will have access to an appropriate option for (continuing) care within one month (30 days) (p. 11).*

By improving access to a few key areas, Alberta Health Services (AHS) will be able to improve flow throughout the system, provide more appropriate care, decrease wait times and deliver care in a more cost effective manner.

AHS wants to offer seniors and persons with disabilities more options for quality accommodations that suit their lifestyles and service needs. In addition, AHS wants to offer short term continuing care transition options and/or increasing home care capacity to support people waiting for placement.



Source: Continuing Care Wait Time Data

#### PERFORMANCE STATUS

Performance target has not been established for comparison.

2011/12 TARGET:  
TBD

YTD TARGET: TBD  
ACTUAL: 62%  
(Apr-Dec)

#### WHAT IS THE TARGET?

AHS has not established a target for this measure.

#### HOW ARE WE DOING?

The percentage of patients placed in Supportive Living or Long Term Care within 30 days of being assessed was 60 per cent in Q3 of 2011/12. The year to date (YTD) percentage was 62 per cent for April to December 2011.

#### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** AHS continues to add continuing care beds. In 2010/11, 1,155 beds were added to the system and a further 1,000 beds will be added this fiscal year. As of Dec. 31, 2011, 868 beds were opened, which reflects 87% of target. In addition, Home Care services continue to be expanded across the province.

**Subsequent actions planned:** Continue to add new beds in zones. Further expansion of Home Care services will also occur.

#### WHAT ELSE DO WE KNOW?

Work is in process to validate the completeness and accuracy of the data.

The wait time may include days when a client was unavailable for placement due to medical reasons (aka Delay days; Hold days).

Information is available by [zone](#).

#### HOW DO WE COMPARE?

National benchmark comparisons are not available.

Data updated quarterly  
 Most current data is Q3 2011/12  
 Next data update expected for Q4 Report

## 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 available.

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

### WHY IS THIS IMPORTANT?

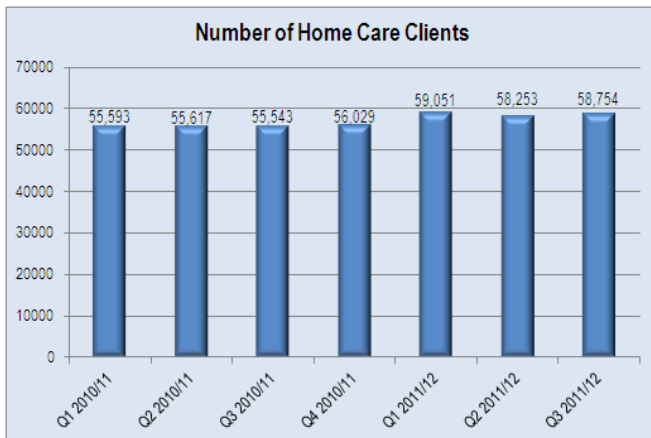
Providing seniors with access to services and supports to remain healthy and independent as long as possible is very important. Enhancing support services and offering more choice and care options to Albertans in their homes is a key strategy to enable individuals to “age in the right place”.

### 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 58,754 in Q3 of 2011/12.



### PERFORMANCE STATUS

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

2011/12 TARGET:  
TBD

YTD TARGET: TBD  
 ACTUAL: 58,754  
 (Oct-Dec)

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** More seniors and adults with disabilities are able to remain safe and independent in their own homes as AHS added nearly 4,000 home care clients year-to-date, a 5.4 per cent increase. This also exceeds our target of 3,000 additional clients by March 2012. A number of initiatives are underway to provide additional services to Home Care Clients. These initiatives range from hiring additional resources to increasing responsibilities to established new focused teams. Detailed Actions completed are available by [Zone](#).

**Subsequent actions planned:** With plans defined, hire into new positions where required, monitor other initiatives to determine their effectiveness and continue to implement new plans. Detailed Actions planned are available by [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 2010/11.  
The next survey is planned for 2013/14.

### 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 most recent report was released in 2012 and is based on a survey from November 2010 to February 2011.

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 per cent of respondents who rated overall level of care as 8, 9 or 10 on a scale of 1 to 10 is reported.

Detailed indicator [definition](#) is available.

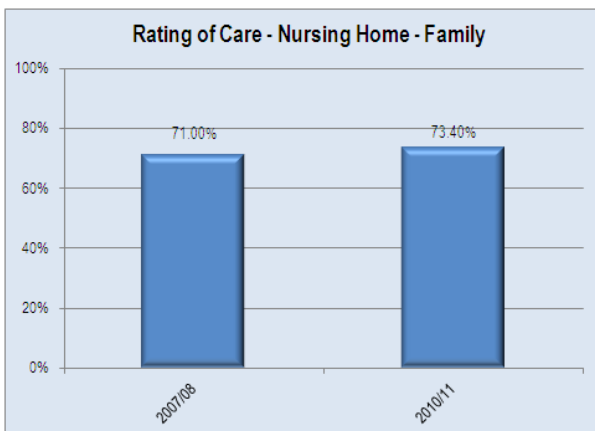
An internal review of the data quality indicates a very high level of confidence with no known issues.

### 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 (AHS) has not yet established a 2011/12 target for the average overall family rating of care at Alberta nursing homes.



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

### PERFORMANCE STATUS

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

2011/12 TARGET:  
TBD

2010/11 ACTUAL:  
73.4%

### HOW ARE WE DOING?

In 2010/11 the average overall family rating of care at Alberta nursing homes was 73.4 per cent, a very modest but statistically significant improvement from 71 per cent in 2007/08.

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Facility specific reports and highlights sent to all providers. AHS received technical report. Comparative results by facility and zones being analyzed.

**Subsequent actions planned:** Each LTC facility will be required to provide an action plan based on their results as part of 2012-13 Quality Incentives Funding and Accountabilities. Zones will review results in their Quality Councils and discuss strengths and opportunities for improvement. Public report from HQCA expected Jan. 2012. Communication Plan is being developed.

### 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 rural 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.

Information is available by [zone](#).

### 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



Data updated quarterly  
Most current data is Q3 2011/12  
Next data update expected for Q4 report

### WHAT IS BEING MEASURED?

The Head Count to Full-Time Equivalent (FTE) 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?

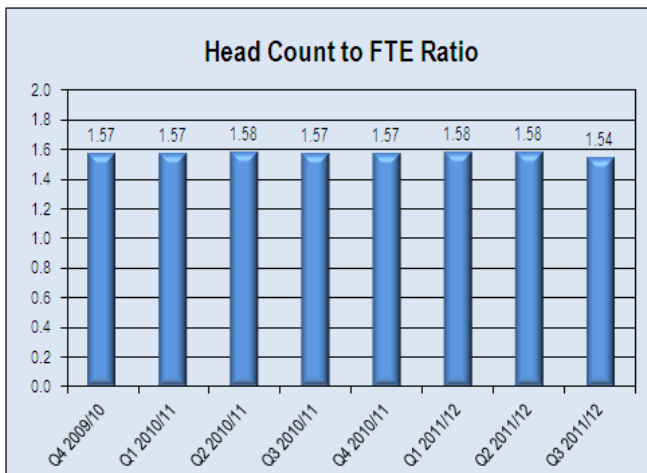
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

### WHAT IS THE TARGET?

A target of 1.62 head count to FTE ratio has been established for 2011/12. 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 Q3 2011/12, the ratio was 1.54.




Source: Alberta Health Services Human Resources

Note: Data are point in time calculations as of the end of each reporting period.

## Performance Measure Update

### Head Count to FTE Ratio

 <b>PERFORMANCE STATUS</b> Performance is at or better than target, continue to monitor.	<b>2011/12 TARGET :</b> 1.62
	<b>YTD Target: 1.62</b> <b>ACTUAL 1.54</b> (Apr-Dec)

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** AHS is working to increase existing employees' Full Time Equivalency (FTE) level as well as hire at higher FTE levels and to move Casual employees to fuller employment. Managers' Workforce Report is distributed monthly to all AHS managers. This report and associated handbook provides managers with better data to build awareness and information regarding existing workforce demographics and FTE.

**Subsequent actions planned:** Version 2 of the Tools for Operational Managers will have a section on increasing FTEs (to be published February 2012). This will increase overall awareness of the plans to hire more FTE personnel.

The Manager Workforce Report will continue to be refined to provide managers with effective information to support better workforce decision making.

### 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.

### HOW DO WE COMPARE?

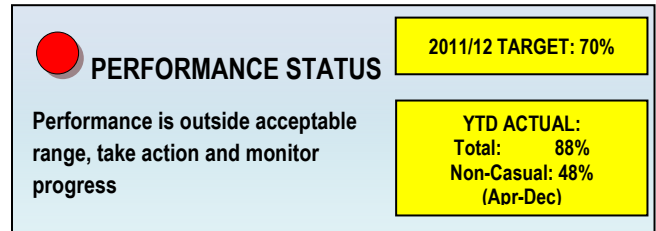
This measure is not benchmarked externally.



Data updated quarterly  
Most current data is Q3 2011/12  
Next data update expected for Q4 report

## Performance Measure Update

### Registered Nurse Graduates Hired by AHS (%)



#### WHAT IS BEING MEASURED?

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

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 AHS to sustain the delivery of nursing care services, by utilizing a locally educated nursing workforce.

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

#### WHAT IS THE TARGET?

Consistent with the UNA Collective Agreement, AHS has established a target of 70 per cent of Alberta graduates hired into non-casual in 2011/12.

#### HOW ARE WE DOING?

At end of third quarter of 2011/12, Alberta Health Services has hired 1,364 (88%) of Alberta nursing graduates available this year. Of these, 752 (48%) were hired into non-casual positions. These represent an improvement over AHS hiring of RN graduates last year at this time.

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.

The total estimated RN graduates for 2011/12 is 1,552. This total is comprised of three graduating periods throughout the fiscal year; April, August and December. At Q3, only the April and August graduates are available. This is estimated at 1,263 potential graduates. Using this as a denominator, AHS has hired 108% of Alberta nursing graduates available at this time. Of these, 60% were hired into non casual positions.

#### 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. Targeted recruitment of the December 2011 nursing graduate cohort yielded a favourable response; dates in place for targeted recruitment of the April 2012 cohort. Supports for new grad nurses and managers developed to support the successful transition into the workplace.

**Subsequent actions planned:** Negotiations with UA to improve and revitalize the Transitional Graduate Nurse Recruitment Program (TGNRP) as a proven mechanism for recruiting and retaining new grads have been successfully concluded. Recruitment to commence in January 2012 for up to 100 positions in the TGNRP. As well, AHS is considering initiatives to cover expected growth; expected replacement; and time to bring in external candidates continues to improve.

#### 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 Q4  
Next data update expected for Q4 report

### 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 AHS by the Workers' Compensation Board (WCB) in Alberta multiplied by 100 and divided by AHS person-years.

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

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

### WHAT IS THE TARGET?

AHS has established a 2011 target of 2.20 disabling injury claims per 100 workers. This is an 8.7 per cent reduction in the disabling injury target (2.41) set for 2010 and represents a 31 per cent 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 per cent increase in the disabling injury rate. For 2011 Q4, the actual disabling injury rate was 3.30 (cumulative Jan – Dec). If this rate continues through WCB's 2011 final reconciliation (a 15 month period), the DIR annual rate is projected to be 3.32. This will be 50% higher than target.



Source: Alberta Health Services and Alberta Workers' Compensation Board  
Notes: \* 2011 figure is annualized Calendar year to date (projected to year end).



### PERFORMANCE STATUS

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

2011 Calendar Year (CY) TARGET: 2.20

2011 CY Q4 (Jan-Dec) ACTUAL: 3.30  
2011 CY ANNUALIZED: 3.32

### WHAT ACTIONS ARE WE TAKING?

The three goals of the AHS Occupational Injury Action Plan are to prevent injuries, respond appropriately to injuries and support sustainable return to work for injured employees. Foundational components now in place include AHS commitment to a Safety "Value", the WHS Policy and Management System, the Shared Responsibility Framework, Hazard identification and Control, Incident Investigation program and a Job Demands Summary system. The "It's Your Move" safe client handling program continued across the province and has trained 4,130 staff to date. "Move Safe" manual materials handling beta testing was completed and the training program drafted. \$5M of Ergonomic Equipment was approved for procurement. The Modified Work Standard and program was launched in the Edmonton and North Zones. Timely reporting to WCB is being monitored through portfolio Health and Safety Improvement Plans. A standard process for resolving long term WCB cases was put in place in all Zones. Quarterly reporting of injury data at the Zone and VP levels was inaugurated.

### 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).

### HOW DO WE COMPARE?

In 2009, the DIR for AHS was slightly better than the industry average. In 2010, the disabling injury rate for AHS was slightly worse than all Alberta industries. (2.70). [See Workers' Compensation Board – Alberta 2010 Annual Report.](#)

## Staff Overall Engagement (%)

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

### WHAT IS BEING MEASURED?

Staff overall engagement measures the per cent of Alberta Health Services (AHS) 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.

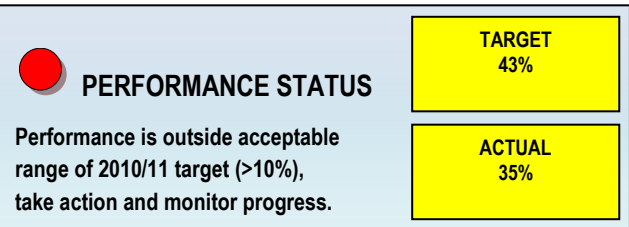
### WHAT IS THE TARGET?

AHS 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.



### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** AHS is collaborating with the Health Quality Council of Canada (HQCA) in creating a framework document and toolkits designed to enhance the healthcare workplace with respect to intimidation and bullying. Completed a survey for staff, physicians, and external stakeholders to obtain input on adding new AHS values on Learning, Safety, and Performance. Focus groups on the People Value Proposition for staff completed. Learning and Leadership have implemented multiple programs including; "Learning and Professional Development Fund", "Learning Management System", "Management Essentials and Leadership Development", "My AHS" and "Delegation of Authority Improvements".

**Subsequent actions planned:** The HQCA document will be provided for AHS review by Jan 2012. Engagement survey for staff, physicians, and volunteers will be completed by early 2012. Development of AHS President's Awards for 2012. Implementation of frontline managers engagement committee to advise the President and CEO of AHS.

### 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 AHS' 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 AHS employee engagement survey result.

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

## Physician Overall Engagement (%)

 <b>PERFORMANCE STATUS</b> Performance outside acceptable range of 2010/11 target (>10%), take action and monitor progress.	<b>TARGET</b> 43%
	<b>ACTUAL</b> 26%

### WHAT IS BEING MEASURED?

Physician overall engagement measures the per cent of physicians associated with Alberta Health Services (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 AHS 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?

AHS 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.

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** A Practitioner Advocacy Working Group has developed Terms of Reference and a three month work plan to provide advice and guidance on the following:

- Implementation of a "Hotline" that would be initially used by physicians for advocacy and or description of intimidation.
- Informational materials that provide advice to clinical physicians on the process of advocating.
- Description of current process for physician advocacy.
- Survey of Physician Groups.
- Education & Training programs.

**Subsequent actions planned:** Implementation of Physician Advocacy Assistance Line by January 31<sup>st</sup>. Draft materials to be reviewed by Working Group in January. Working Group to host Physician Advocacy Planning Session in late January or early February with invitations to UofC, UofA medical schools, Professional Association of Resident Physicians of Alberta (PARA), AMA, to jointly identify current activities and future programs that support Physician Advocacy.

### 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 AHS 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 AHS physician engagement survey result



## Direct Nursing Average Full Time Equivalency

Data updated quarterly.  
Most current data is Q3 2011/12.  
Next data update expected for Q4 report.

### WHAT IS BEING MEASURED?

The direct nursing average Full-Time Equivalency (FTE) is the assigned Direct Nursing Full Time Equivalents divided by the functional bargaining unit head count (including casuals).

Direct Nursing includes all those employees for whom nursing training is a prerequisite. It applies to those employed in nursing care or instruction in nursing care. The unit could contain graduate and registered nurses, psychiatric nurses and nursing instructors when instructing. (Source: Information Bulletin #10, Alberta Labour Relations Board).

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?

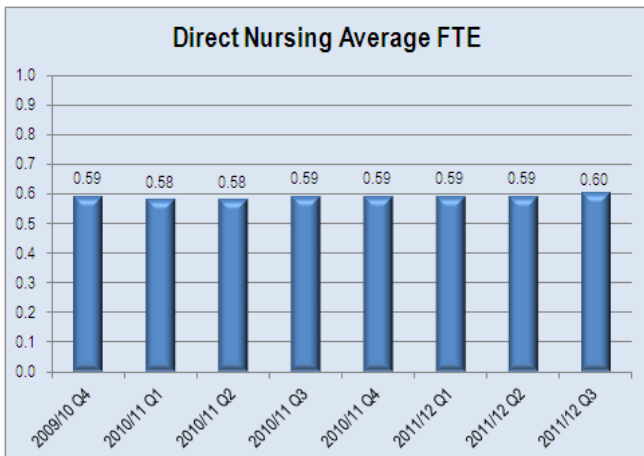
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure supports the clinical workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

### WHAT IS THE TARGET?


A target of 0.62 has been established for 2011/12. This represents a 3 per cent increase over 2010/11.

### HOW ARE WE DOING?

In 2010/11 the Direct Nursing (DN) average FTE was 0.59. In Q3 2011/12 the ratio is at 0.60.



Source: Alberta Health Services Human Resources  
Note: Data are point in time calculations as of the end of each reporting period.



**PERFORMANCE STATUS**

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

**2011/12 TARGET:**  
0.62

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**Q3 2011/12 ACTUAL:**  
0.60

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Initiatives 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, part time positions with higher FTE and increased full time positions. Support for managers has been provided in the Tools for Operational Managers (Supporting Effective Management of Labour Costs) document issued August 31, 2011 and further updates are expected for January/February 2012

Negotiations successfully concluded with UNA to amend and revitalize the Transitional Graduate Nurse Recruitment Program (TGNPR).

**Subsequent actions planned:** Targeted recruitment of the December 2011 cohort of new grads during the final courses of their formal programs, to ensure all available grads are hired into regular or casual positions, and/or were attached to a recruiter to assist with matching jobs and preferences.

Planning in place to hire up to 100 new nursing grads into the TGNPR programs in January/February 2012. These will be full-time positions.

### WHAT ELSE DO WE KNOW?

This measure was substituted for the previous measure Full-Time to Part-Time Clinical Worker Ratio in September 2011.

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

Information is available by [portfolio](#)

### HOW DO WE COMPARE?

This measure is not benchmarked externally.

Data updated quarterly  
Most current data is Q3 2011/12  
Next data update expected for Q4 report

# Performance Measure Update

## Absenteeism (#Days/FTE)

### 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?

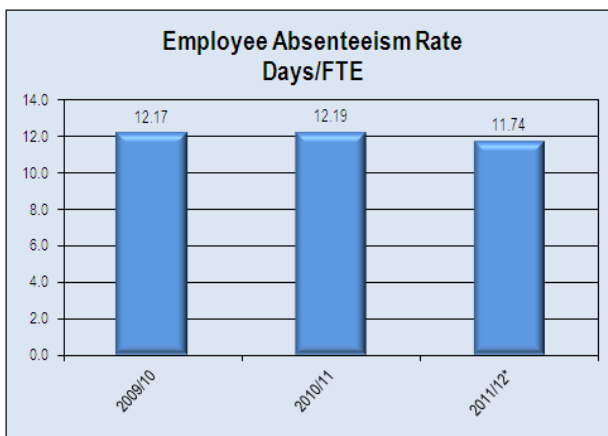
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

### WHAT IS THE TARGET?

The 2011/12 target has been set at 11.95 days per FTE which is a 2 per cent decrease from the 2010/11 year end actual of 12.19 days per FTE.

### HOW ARE WE DOING?

Days taken per FTE have remained fairly constant throughout 2009/10 and 2010/11 fiscal years. In Q2 2011/12, the AHS employee absenteeism rate decreased but has increased slightly in Q3 resulting in an annualized absenteeism of 11.74 days per FTE.



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



### PERFORMANCE STATUS

Performance is within an acceptable range, continue to monitor.

2011/12 TARGET:  
11.95 days/FTE

YTD ACTUAL (annualized):  
11.74 days/FTE

### WHAT ACTIONS ARE WE TAKING?

Collection and analysis of attendance awareness programs from former health entities has been completed to identify effective practices.

Tools and resources to assist front line managers in managing attendance are provided in the Tools for Operational managers (Supporting Effective Management of Labour Costs) document that was distributed to managers August 31, 2011, with further updates to be provided in the planned January/February, 2012 version.

### WHAT ELSE DO WE KNOW?

The reason an employee may access sick leave is confidential and not provided by employees and therefore is not reported.

The nature of services provided, the service delivery model, age distribution and unionization of the workforce as well as the terms and conditions of employment may influence this measure.

Information is available by [portfolio](#).

### HOW DO WE COMPARE?

In 2009/10, AHS had one of the lowest sick hour levels of the eight western provinces' health regions participating in the Western CEO Performance and Benchmarking Project:

	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 Q3 2011/12.  
Next data update expected for Q4 report

### 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?

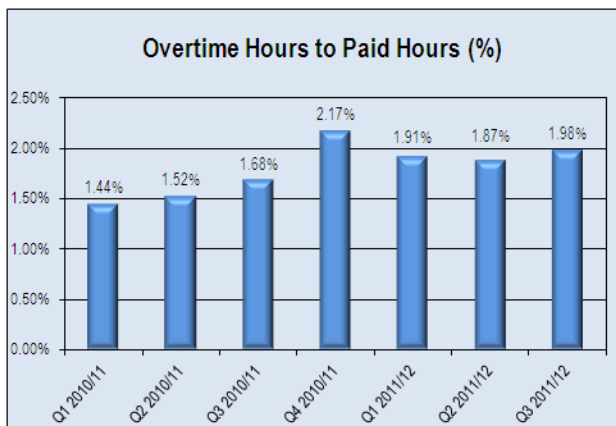
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

### WHAT IS THE TARGET?

The 2011/12 target has been set at 1.67 per cent which is a 2 per cent decrease from the 2010/11 year end actual of 1.70 per cent.

### HOW ARE WE DOING?

Overtime hours accounted for only 1.62 per cent of total paid hours in 2009/10. This increased slightly in 2010/11 to 1.70 per cent. Overtime hours accounted for 1.98 per cent of total paid hours in Q3 2011/12 while on a Year to Date (YTD) basis, 1.92 per cent of total paid hours were overtime hours.



Source: Labour Cost Forecasting System (LCFS)

**PERFORMANCE STATUS**

Performance is outside acceptable range of target, take action and monitor progress

2011/12 TARGET:  
1.67%

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YTD TARGET: 1.69%  
ACTUAL: 1.92%  
(Apr – Dec)

### 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.

The Tools for Operational Managers (Supporting Effective Management of Labour Costs) document issued August 31, 2011 provides managers with supporting tools and resources to effectively manage labour costs, including, reducing overtime, the 2 per cent productivity goal and improved utilization of management rights..

**Subsequent actions planned:** An updated version of Tools for Operational Managers to be released in February 2012. Refinements are being made to the Managers' Workforce Report based on feedback from the August pilot.

### WHAT ELSE DO WE KNOW?

Measuring Overtime as a percentage of time worked helps Alberta Health Services (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.

Information is available by [portfolio](#)

### 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 Q3 2011/12.  
Next data update expected for Q4 report.

## Performance Measure Update

### Labour Cost per Worked Hour (\$/hr)

#### 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?


The 2011/12 target has been set at \$48.55. This is a 2 per cent reduction over the 2010/11 actual..

#### HOW ARE WE DOING?

For the third quarter of 2011/12, the Labour Cost per worked hour was \$50.76.

Time Period	Labour Cost (Billions)	Worked Hours	Labour Cost Per Worked Hour
2008/09	\$5.02	N/A	N/A
2009/10	\$5.48	113,230,155	\$48.43
2010/11	\$5.67	114,401,543	\$49.54
2011/12 Q1	\$1.48	28,970,210	\$50.98
2011/12 Q2	\$2.91	56,902,320	\$51.07
2011/12 Q3	\$4.44	87,384,992	\$50.76

Source: AHS Financial Services.

 <b>PERFORMANCE STATUS</b> Performance is within acceptable range, monitor and take action as appropriate.	<b>2011/12 TARGET:</b> \$48.55
	<b>YTD TARGET: \$48.80</b> <b>ACTUAL: \$50.76</b> (Apr – Dec)

#### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** AHS works to ensure quality, accessible health care is provided in a cost effective manner.

The Tools for Operational Managers (Supporting Effective Management of Labour Costs) document issued August 31, 2011 provides managers with a variety of options and supporting tools and resources to effectively manage labour costs, including the 2 per cent productivity goal and improved utilization of management rights.

**Subsequent actions planned:** Productivity metrics similar to this are being refined to support the implementation of the Clinical Workforce Strategy.

The Managers' Workforce Report provides managers with effective information to support better workforce (labour cost) decision making.

#### WHAT ELSE DO WE KNOW?

Figures include the following wholly owned subsidiaries of AHS:

- Calgary Laboratory Services Ltd. (CLS), who provides medical diagnostic services in Calgary and Southern Alberta.
- Capital Care Group Inc. (CCGI), who manages continuing care programs and facilities in the Edmonton area.
- Carewest, who manages continuing care programs and facilities in the Calgary area.
- 1115399 Alberta Inc. (operating as Chemical Exposure Support Services), Capital Health Tele-Ophthalmology Inc., and Edmonton Heart Systems Inc. were amalgamated into AHS effective December 31, 2009.

#### HOW DO WE COMPARE?

National benchmark comparisons are not available.

## Number of Netcare Users

Data updated quarterly.  
Most current data is Q3 2011/12  
Next data update expected for Q4 report

### 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.

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

### WHY IS THIS IMPORTANT?


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

### WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target of a 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 14,066 in Q3 of 2011/12. This represents an 8 per cent increase over the previous quarter.

 <b>PERFORMANCE STATUS</b> Performance is at or better than target, continue to monitor.	<b>2011/12 TARGET:</b> 12,998
	<b>YTD TARGET: 12,703</b> <b>ACTUAL: 14,066</b> (Apr – Dec)

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Homecare providers are using Drug Summaries for Medication Reconciliation, in order to improve Patient Safety. Overall there were 123,403 drug summaries accessed through Netcare in Nov 2011, up from 53,500 when it was first implemented in Oct 2010. Additional information was made available in Dec. 2011 in Netcare from a number of AHS and privately operated healthcare groups.

**Subsequent actions planned:** Additional Education from Netcare delivery team could be provided during Home Care Orientation days. AHS will work with Home care leaders to choose and deliver the most appropriate knowledge for the use of Netcare for Medication reconciliation. Patient admission events from Calgary, North, Central and South Zones planned for April 2012. Transcribed reports from University of Calgary Medical Clinic tentatively planned for Apr. 2012. Transcribed reports from community hospitals in Calgary zone tentatively planned for Nov. 2012. Public Health Immunization information from North / Central / South Zones tentatively planned for Nov. 2012.

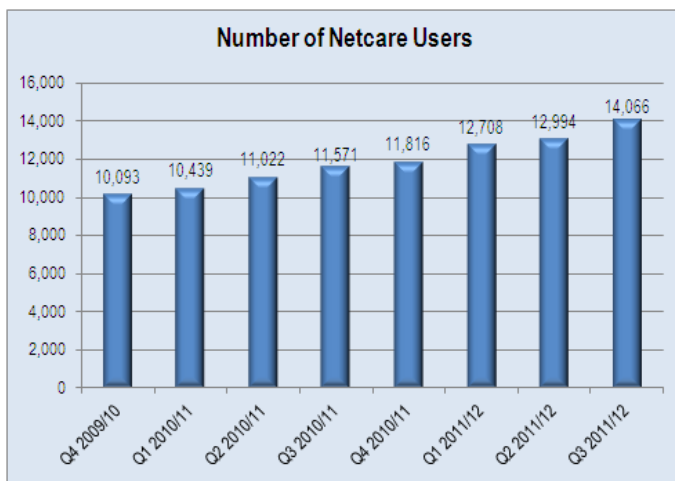
### WHAT ELSE DO WE KNOW?

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

Information is available by [zone](#).

### HOW DO WE COMPARE?

National benchmark comparisons are not available.



Source: Alberta Netcare Portal

Data updated quarterly.  
Most current data is Q3 2011/12.  
Next data update Q4 report.

# Performance Measure Update

## On Budget: Year To Date

### 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?

By way of the five year funding agreement, 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. This targeted surplus results from the March 31, 2011 actual accumulated surplus of \$116M being reduced for the budgeted operating deficit of \$20M, the net change in internally funded capital assets of \$75M, and the repayment of \$19M of long term debt; these reductions are offset by the utilization of \$34M of other internally restricted net assets for the South Health Campus and parkades.

Table: Accumulated surplus in \$Millions as at:

	Actual
March 31, 2011	116
June 30, 2011	175
September 30, 2011	194
December 31, 2011	252

Source: Unaudited Quarterly Financial Statements for the period ended December 31, 2011.



### PERFORMANCE STATUS

Performance is better than annual target, continue to monitor.

2011/12 TARGET  
ACCUMULATED  
SURPLUS: \$36M

Q3 ACTUAL  
ACCUMULATED  
SURPLUS: \$252M

### HOW ARE WE DOING?

At December 31, 2011, the third quarter accumulated surplus was \$252M and is forecast at January 25, 2012 to be \$128M at year end which is \$92M 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 tool is also in progress.

### WHAT ELSE DO WE KNOW?

The third quarter accumulated surplus has increased from March 31, 2011 by \$136M primarily due to an operating surplus of \$172M offset by a net decrease in internally funded capital assets of \$31M and the long term debt repayment of \$5M. The operating surplus is higher than target primarily due to delayed implementation of new initiatives and difficulties in recruitment for staff vacancies. Spending on internally funded capital assets is lower than targeted as the majority of the spending on these assets is expected to occur in the fourth quarter or in the next fiscal year. The AHS financial reporting documents can be obtained from the [www.albertahealthservices.ca](http://www.albertahealthservices.ca) website.

### HOW DO WE COMPARE?

National benchmark comparisons are not applicable.

## Patient Satisfaction Adult Acute Care

Data updated quarterly with one quarter lag.  
Most current data is Q2 2011/12.  
Next data update expected for Q4 report.

### 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?

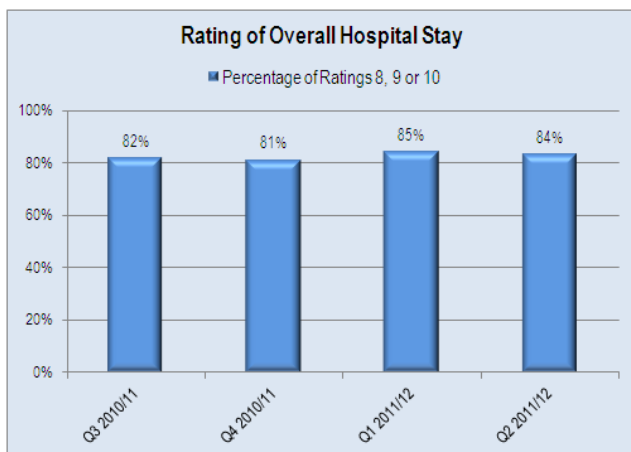
Gathering perceptions and feedback from individuals who use hospital acute care services is a critical aspect of measuring progress and improving the health system. This measure reflects overall patient perceptions associated with the hospital where they received care and is derived from a well-established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

### WHAT IS THE TARGET?

Alberta Health Services has not established a target of for 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 better in Q2 than it was in Q1.



Source: AHS HCAHPS Survey data

Notes: The results are based on sample surveys with standard error within 1%.

### PERFORMANCE STATUS

Performance target has not been established for comparison.

2011/12 TARGET:  
TBD

YTD TARGET: TBD  
ACTUAL: 84.2%  
(Apr-Sep)

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** H-CAHPS 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).

**Subsequent actions planned:** AHS carried out a secondary analysis of data from recent inpatients who responded to the H-CAHPS survey. This identified key drivers influencing how patients evaluate their care including communication with patients, coordinated care, pain control, and patient involvement in care decisions.

### WHAT ELSE DO WE KNOW?

The HCAHPS survey has not been validated for patients with psychiatric diagnoses.

Information is available by [zone](#), and semi-annually by [site](#).

### HOW DO WE COMPARE?

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



*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 not established a final target for the 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 show that 93 per cent of patients are 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

<b>PERFORMANCE STATUS</b>  Performance target has not been established for comparison.	2010/11 TARGET: TBD
	2010/11 ACTUAL: 93%

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 Q3 2011/12  
Next data update expected for Q4 Report

## Percentage of Patient Feedback as Commendations

### WHAT IS BEING MEASURED?

This measure calculates the number of commendations received as a percentage of all feedback received by the Patient Relations Department.

The Patient Relations Department manages Commendations and Concerns received from patients/families pertaining to AHS Programs and Services. Additionally, the Patient Relations Department tracks feedback classified as Advisements, Consultations and Non-AHS Feedback<sup>1</sup>. Provincial Commendation and Concern reporting can be further broken down by locations, programs and categories/subjects of feedback.

Detailed indicator [definition](#) is available.

### 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 percentage of commendations received of all patient feedback assists AHS in assessing the quality of our services and determining if quality improvements are having an impact on patients and families. In addition, the results allow our staff to see where their dedicated efforts are making a difference in people's lives.

### WHAT IS THE TARGET?

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

### HOW ARE WE DOING?

Of the 2,499 pieces of feedback provided to the Patient Relations Department between October 1 – December 31, 2011, (including Covenant Health), 12.28 % were commendations.

<sup>1</sup> This Feedback is defined as follows:

- Advisement is feedback received from sources external to the Patient Relations Department on the potential for receipt of a concern.
- Consultation is information sought from sources external to Patient Relations Department on the management of a concern.
- Non-AHS Feedback is for programs or services that are not provided by, or under AHS jurisdiction.
- 

### PERFORMANCE STATUS

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

2011/12 TARGET:  
TBD

YTD TARGET: TBD  
ACTUAL: 10.44%  
(Apr-Dec)

**Table 1: Total Patient Commendations for the Fiscal Year 2011-12.**

Fiscal Year 2011/12	Number of Commendations	Percentage of All Feedback
Q1	233	8.53 %
Q2	271	10.67 %
Q3	307	12.28 %
Q4		
<b>Total</b>	<b>811</b>	<b>10.44 %</b>

### 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. Once a full year's worth of data has been collected, targets will be developed (Q1 2012/13). New reporting tools will also be developed to enable more robust reporting that will separate data from Covenant Health. Processes will also be reviewed to simplify the ways for patients and families to provide AHS with direct feedback.

### WHAT ELSE DO WE KNOW?

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

Information is available by [zone](#).

### HOW DO WE COMPARE?

This measure is not benchmarked externally.

Data updated quarterly.  
Most current data is Q3 2011/12  
Next data update expected for Q4

## Performance Measure Update

### Percentage of Patient Concerns Escalated to Patient Concerns Officer

#### WHAT IS BEING MEASURED?

This measure calculates the per cent of concerns referred to the 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.

#### 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 1, 2010 with the implementation of a new provincial database. The Feedback and Concerns Tracking (FACT) tool provides for consistent documentation and reporting of patient feedback.

#### HOW ARE WE DOING?

During the period October 1 to December 31, 2011, 9 files were reviewed by the Patient Concerns Officer that had been managed first by the Patient Relations Department. These files represent a total of 0.45 per cent for Quarter 3.

The number of concerns escalated to the Patient Concerns Officer has decreased from 13 in the previous quarter to 9 this quarter.

<b>PERFORMANCE STATUS</b> Performance Target for 2011/12 has not been established for comparison	<b>2011/12 TARGET:</b> TBD
	<b>YTD TARGET:</b> TBD <b>ACTUAL:</b> 0.57% (Apr-Dec)

Table 1 - Patient Concerns Officer Reviews Initiated

Fiscal Year 2011/12	Concerns		
	Total Managed by PR*	PCO Reviews Initiated	%
Q1 (Apr-Jun)	2216	14	0.63%
Q2 (Jul-Sep)	2114	13	0.61%
Q3 (Oct-Dec)	1988	9	0.45%
Q4 (Jan-Mar)			
<b>Total YTD</b>	<b>6318</b>	<b>36</b>	<b>0.57%</b>

\*AHS, EMS & Covenant Health PR Offices  
Data Source: FACT (Feedback and Concerns Tracking)

#### 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 patient feedback will continue. Once a full year's worth of data has been collected, targets will be developed (Q1 2012/13). 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.

Data updated Annually.  
Most current data is 2011  
The next survey is anticipated for 2012.

### 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. As well, the Provincial Survey about Health and the Health System in Alberta is conducted on an annual basis and reported within the AHW Annual Report. [The most recent annual report is for 2010 – 2011.](#)

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.

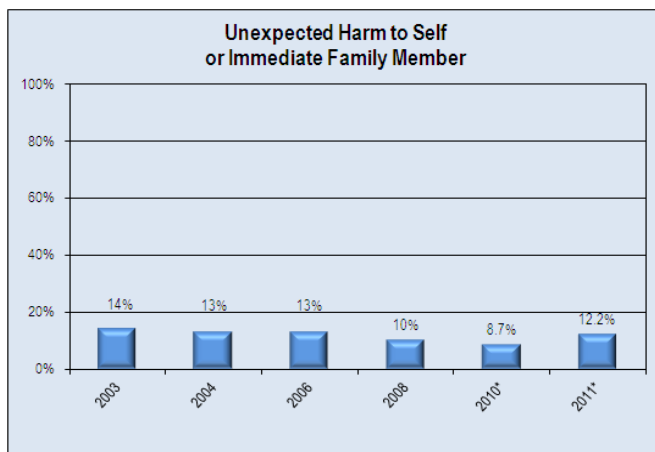
An internal review of the data quality indicates a very high level of confidence with no known issues.

### 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.




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.

\* 2010 error rate of +/- 1.2; 2011 error rate of +/- 2.1.

## Performance Measure Update

### Albertans Reporting Unexpected Harm

 <b>PERFORMANCE STATUS</b> Performance is outside acceptable range, take action and monitor progress.	<b>2011/12 TARGET:</b> 9%
	<b>2011 ACTUAL:</b> 12.2%

### 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 below the target of 9 per cent.

### WHAT ACTIONS ARE WE TAKING?

**Actions completed to date:** Implementation of AHS provincial Reporting and Learning System (RLS) across AHS is fully deployed across Alberta Health Services. A Quality Assurance Committee Structure was implemented to ensure a formal process is in place to investigate incidents when they occur.

**Subsequent actions planned:** Adaptation and implementation of a HQCA recommended Life Cycle Model will support effective development and implementation of recommendations for system improvements. Prioritization of Quality Assurance Review Recommendations for action through targeted risk reduction strategies will be done and a follow-up evaluation of the effectiveness of these actions will be undertaken.

### 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

## Patient Satisfaction Emergency Department (Top 15)

Data updated quarterly with a one quarter lag  
Most current data is Q2 2011/12  
Next update is anticipated for Q4 report

### WHAT IS BEING MEASURED?

Patient experience emergency department (ED) measures the patients (16+) who responded “Excellent” or “Very Good” to the question “Overall, how would you rate the care you received in the emergency department?” on a scale with six response categories from “Very Poor” to “Excellent”.

This performance measure is used to track progress toward improving patient satisfaction with the quality of emergency department services received during the past year in Alberta.

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?

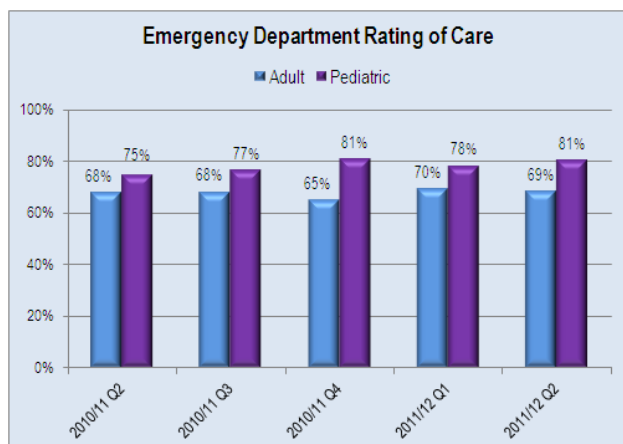
Patient satisfaction with emergency department services is a crucial and critical dimension of quality; it is a high level indicator of the structure, process and outcome of care in emergency departments. The information provides insights into the consequences of policy and strategic changes from the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

### WHAT IS THE TARGET?

No targets have been defined. Baseline for Alberta Health Services (AHS) will be established and confirmed in 2011/12. A target will be set in early 2012/13.

### HOW ARE WE DOING?

In Q2 2011/12 69 per cent of Adult and 81 per cent of Pediatric ED Satisfaction surveys resulted in High Satisfaction Ratings (score of 8, 9, or 10).



Source: AHS H-CAHPS Survey data

Notes: The results are based on sample surveys with standard error within 3%.

### PERFORMANCE STATUS

Performance target has not been established for comparison.

2011/12 TARGET:  
TBD

YTD ACTUAL: 69% Adult  
78% Pediatric  
(Apr-Sep)

### 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) hired. In addition, “over capacity” protocols and escalation plans continue to be used to manage periods of peak pressures in EDs.

**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 ED users identified public expectations of ED care. These included: staff communication with patients; appropriate wait 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 ED 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](#), and semi-annually by [site](#).

### HOW DO WE COMPARE?

Limited comparable data is available. BC reports publicly on a very similar measure of overall quality of ED care. In 2009/10 63.3% of all responses in BC were Excellent or Very Good, while 59.7% of the responses for large facilities (40,000+ ED visits per year) were Excellent or Very Good. (BC Ministry of Health 2010).



## Patient Satisfaction Emergency Department

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 (ED) 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 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 ED 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?

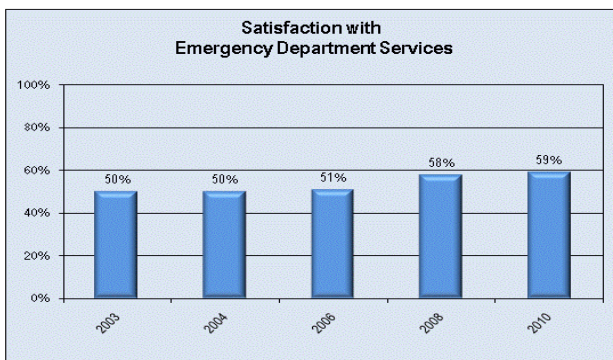
Patient satisfaction with the ED is a crucial and critical dimension of quality; it is a high level indicator of the structure, process and outcome of care in EDs. The information provides insights into the consequences of policy and strategic changes from the perspective of a key health care partner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

### WHAT IS THE TARGET?

The Alberta Health Services (AHS) 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 ED 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

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) hired. In addition, "over capacity" protocols and escalation plans continue to be used to manage periods of peak pressures in EDs.

**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 ED users identified public expectations of ED care. These included: staff communication with patients; appropriate wait 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 ED 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?

Using a similar measure, 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 Annually.  
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. As well, the Provincial Survey about Health and the Health System in Alberta is conducted on an annual basis and reported within the AHW Annual Report. [The most recent annual report is for 2010 – 2011](#).

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.

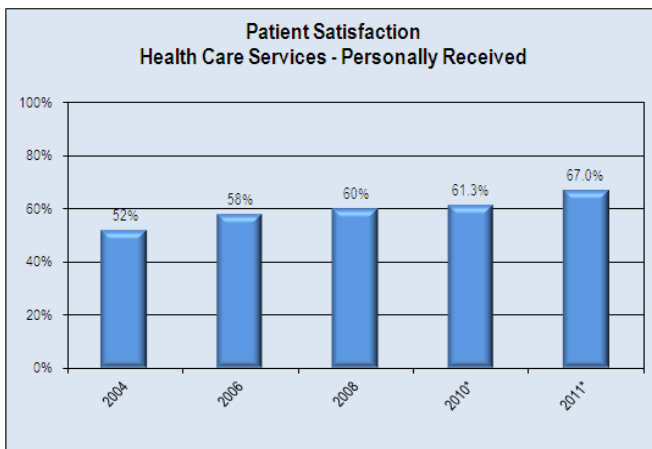
Health care services include personal family doctor, other health care professionals at family doctor's office, community walk-in clinics, specialists, MRI, other diagnostic imaging, pharmacists, emergency departments, inpatient hospital services, outpatient hospital services and mental health services.

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



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.

\* 2010 error rate of +/- 2%; 2011 error rate of +/- 3%.

<b>PERFORMANCE STATUS</b> Performance Target for 2011/12 has not been established for comparison.	<b>2011/12 TARGET:</b> TBD
	<b>2011 ACTUAL:</b> 67%

the perspective of a key health care partner - Albertans.

### WHAT IS THE TARGET?

Alberta Health Services (AHS) 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 67 per cent.

### WHAT ACTIONS ARE WE TAKING?

AHS 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)



## Central Venous Catheter Bloodstream Infection Rate

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

### 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.<sup>(1-4)</sup>

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

YTD 2011/12  
ACTUAL: 1.05  
(Apr-Sep)

### HOW ARE WE DOING?

The central venous catheter bloodstream infection rate for adult sites was 0.67 per 1,000 line-days in Q2 2011/12 and the year to date (Apr-Sep) rate was 1.05 per 1,000..

### 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?

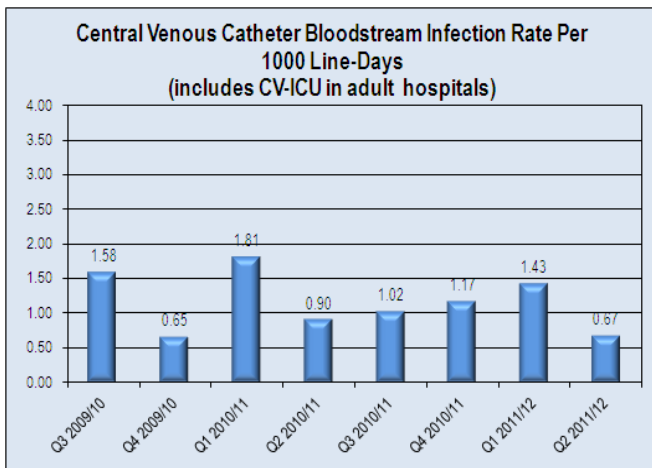
The skin is the main source of organisms causing CVC-BSI. Infection may occur because of migration of organisms from the insertion site along the percutaneous tract. Other risk factors include catheter insertion and care practices, products administered through the line, frequency of manipulation, age 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:

- Centers for Disease Control and Prevention. Guidelines for the prevention of intravascular catheter-related infections [Erratum to p. 29, Appendix B published in MMWR Vol. 51, No. 32, p. 711]. MMWR 2002;51(No. RR-10):1-32.
- Crnich CJ, Maki DG. Intravascular Device Infections. Chapter 24 In: Association for Professionals in Infection Control and Epidemiology (eds), APIC Text of Infection Control and Epidemiology. 2004 pp 24-1 – 24-26.
- Pittet D, Tarara D, Wenzel RP. Nosocomial bloodstream infection in critically ill patients. JAMA 1994;271:1598-1601.
- CVC-BSI Working Group and the Canadian Nosocomial Infection Surveillance Program (CNISP). Surveillance for Central Venous Catheter Associated Blood Stream Infections (CVC-BSI) in

## Methicillin-Resistant *Staphylococcus aureus* – Bloodstream Infection

Data updated quarterly (Year to Date (YTD)).  
Most current data is Q2 2011/12.  
Next data update expected for Q4 report

### WHAT IS BEING MEASURED?

Hospital-acquired Methicillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections (BSI) are an important cause of morbidity and mortality in severely ill patients. All patients who develop a laboratory-confirmed bloodstream infection caused by MRSA that they acquired as the result of being hospitalized are included.

Detailed indicator definition is currently in development.

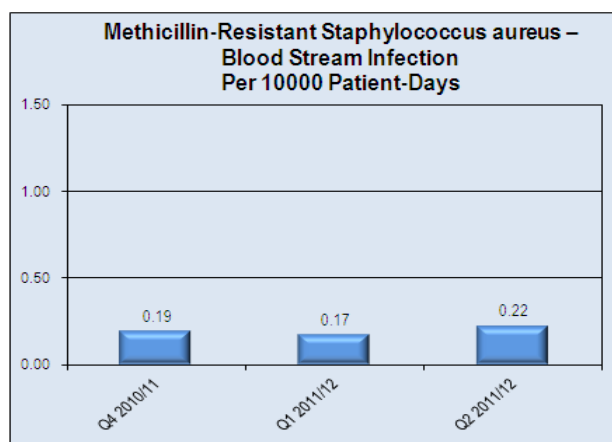
An internal review of the data quality indicates a very high level of confidence with no known issues.

### WHY IS THIS IMPORTANT?

MRSA infections constitute a significant and growing threat to patients /clients/residents in health care facilities and in our community. Bloodstream infections in hospitalized patients caused by MRSA are associated with increased morbidity and mortality, have fewer treatment options, and prolong hospital stays. The need to contain the spread of MRSA also has a significant impact on resources and costs in the health care system<sup>1,2</sup>.

### 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.



#### References

1. Association for Professionals in Infection Control and Epidemiology (APIC) Guide to the elimination of methicillin-resistant *Staphylococcus aureus* (MRSA) transmission in hospital settings. March 2007.
2. Canadian Nosocomial Infection Surveillance Program (CNISP). MRSA Surveillance Protocols. Version 2010. Public Health Agency of Canada. Nosocomial and Occupational Infections Section.

### PERFORMANCE STATUS

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

2011/12 TARGET:  
TBD

YTD 2011/12  
ACTUAL: 0.20  
(Apr-Sep)

### HOW ARE WE DOING?

The MRSA bloodstream infection rate was 0.22 per 10,000 patient days in Q2 of 2011/12 while the year to date (Apr-Sep) rate was 0.20.

### WHAT ACTIONS ARE WE TAKING?

Current best practice guidelines are employed for the prevention of MRSA and management of patients colonized or infected with MRSA. MRSA cases are routinely investigated and intervention strategies are implemented to prevent transmission in hospitals. This includes optimizing staff hand hygiene practices.

MRSA rates are provided to physicians and staff who care for patients so that they can monitor their practice. AHS' Infection Prevention and Control department works collaboratively with physicians and staff to optimize patient management and intervention programs for MRSA.

### WHAT ELSE DO WE KNOW?

Nasal and skin colonization are common sources of organisms causing MRSA. MRSA occurs when these organisms cause infections and/or migrate into the bloodstream. Risk factors for MRSA include invasive procedures such as intravenous catheters or surgery as well local skin or soft tissue infections, age, underlying disease and severity of illness of the patient.

Information is available by adult acute care [sites](#)

### HOW DO WE COMPARE?

National benchmark comparisons are not available. "The Ontario Ministry of Health and Long Term Care published an overall rate of 0.2 cases of MRSA bacteremia per 10,000 patient-days for patients admitted to a hospital for longer than 72 hours in 2009.

[http://www.health.gov.on.ca/english/media/news\\_releases/archives/nr\\_09/apr/bg\\_20090430\\_3.html](http://www.health.gov.on.ca/english/media/news_releases/archives/nr_09/apr/bg_20090430_3.html). The Alberta definition uses longer than 48 hours after admission."

Internal benchmarks will be developed over time.

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

### WHAT IS BEING MEASURED?

*Clostridium difficile* infection (CDI) causes diarrhea, and occasionally serious illness. Two CDI indicators are reported; (1) Hospital-acquired CDI - all new CDI cases that develop while the person is in an AHS or Covenant Health facility, and (2) Total CDI - all cases of *Clostridium difficile* infection diagnosed in hospital, regardless of where it was acquired.

Total CDI includes those cases acquired in hospital AND those acquired in the community that are severe enough to require hospitalization.

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.

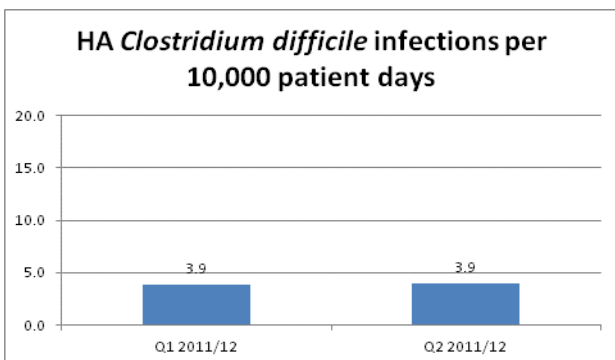
### WHY IS THIS IMPORTANT?

CDI is an important infection to monitor in health-care facilities and in our community. Some individuals carry *Clostridium difficile* in their intestines while others may acquire it while in hospital. CDI is an unpleasant illness, complicates and prolongs hospital stays and impacts resources and costs in the health-care system.

The use of antibiotics (for any reason) can cause *Clostridium difficile* to multiply and produce toxins that cause CDI. Monitoring CDI trends provide important information about effectiveness of infection prevention and control strategies and may also be impacted by antibiotic use, the population served, and seasonal variability.

### WHAT IS THE TARGET?

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



Source: AHS Infection Prevention and Control

## Performance Measure Update

### *Clostridium difficile* Infection

<b>PERFORMANCE STATUS</b>  Performance target for 2011/12 is not yet established for comparison	<b>2011/12 TARGET:</b> TBD
	<b>YTD TARGET TBD</b> <b>HA ACTUAL 3.9</b> (Apr-Sep)

### HOW ARE WE DOING?

The Hospital-Acquired (HA) CDI rate was 3.9 per 10,000 patient days in July – September 2011 and the April – September 2011 rate was 3.9 as well.

Between July and September 2011, the total number of hospitalized cases of CDI was 407.

### WHAT ACTIONS ARE WE TAKING?

Current best practice guidelines are used for the prevention and management of patients with CDI. Monitoring to prevent transmission in hospitals includes early recognition and diagnosis, isolation, optimizing housekeeping procedures, improving staff hand hygiene practices and promoting appropriate antibiotic use.

Infection Prevention and Control works collaboratively with physicians and staff in hospitals and with Public Health by providing CDI rates and assisting with intervention and control strategies.

### WHAT ELSE DO WE KNOW?

Most often, CDI is a mild disease but serious disease and relapse can occur, including the need for surgery and in extreme cases, even death. Several factors affect hospital rates of CDI including the size, physical layout and nature of services provided, type of population served and use of antibiotics. The major objective of CDI monitoring is to track trends in hospital facilities and the community in order to implement appropriate control measures as needed.

Information is available by [site](#).

### HOW DO WE COMPARE?

AHS has chosen to focus on two CDI indicators, one reflecting acquisition and/or development in hospital and total CDI, which also reflects severe community-acquired disease requiring hospitalization.

The Canadian Nosocomial Infection Surveillance Program (CNISP) reports a CDI rate of **6.3 cases per 10,000 patient-days** for hospital-acquired CDI in 2010 (CNISP personal communication). Internal AHS benchmarks will be developed over time for Hospital-acquired and Total CDI.

## 30 Day Unplanned Readmission Rate

Data updated quarterly with one quarter lag.  
Most current data is Q2 2011/12.  
Next data update expected for Q4 report.

### WHAT IS BEING MEASURED?

The 30 Day Unplanned Readmission Rate represents the proportion of occurrences of an unplanned admission to hospital within 30 days of a patient being discharged from a hospital stay. Only initial visits where the patient is discharged are included (transfers, sign-outs, and deaths are excluded). Any cause of the readmission is included.

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 risk of readmission following initial hospitalization may be related to the type of drugs prescribed at discharge, patient compliance with post-discharge therapy, the quality of follow-up care in the community, or the availability of appropriate diagnostic or therapeutic technologies during the initial hospital stay. Although readmission for medical conditions may involve factors outside the direct control of the hospital, high rates of readmission act as a signal to hospitals to look more carefully at their practices, including the risk of discharging patients too early and the relationship with community physicians and community-based care. High rates of readmissions within a short period of time may therefore be useful in monitoring quality of care.

### PERFORMANCE STATUS

Performance target has not been established for comparison.

2011/12 TARGET:  
TBD

YTD TARGET TBD  
ACTUAL: 8.07%  
(Apr-Sep)

### WHAT IS THE TARGET?

Alberta Health Services (AHS) has not established a target for this measure.

### HOW ARE WE DOING?

The rate of readmissions has remained relatively stable over the past few years. Continued monitoring and detailed investigation will be needed to determine significance of rates and expected improvement opportunities. Current measurements will provide a baseline for comparison in the future.

### WHAT ACTIONS ARE WE TAKING?

This is a new measure that AHS is producing for public reporting. At this point AHS is using the measure for monitoring purposes. More in-depth analysis is currently underway to identify opportunities for improvement. Once these analyses are complete, Zone Leaders will be engaged to identify actions for improvement and to set targets accordingly. Targets and action plans are expected to be developed by Fall 2012.

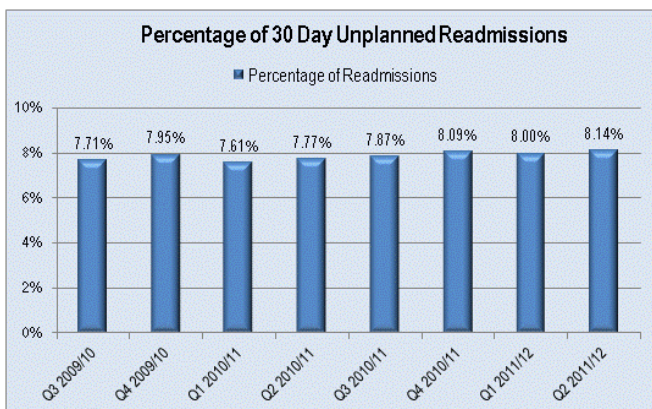
### WHAT ELSE DO WE KNOW?

Readmissions to hospital may be due to conditions unrelated to the initial discharge. This metric is most useful in monitoring changes over time. Due to a higher expected readmission rate amongst elderly patients and patients with chronic conditions, this measure will vary due to the nature of the population served by a facility. Rates can also be impacted due to different models of care and healthcare services accessibility. Therefore comparisons between zones should be approached with caution.

Information is available by [zone](#).

### HOW DO WE COMPARE?

National comparisons are not available at this time.



Source: AHS Discharge Abstract Database