



Alberta Health Services

Q1 Performance Report

2012/13

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**Data Integration, Measurement and
Reporting**

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Introduction

This performance report has been constructed to demonstrate the progress of Alberta Health Services (AHS) towards meeting the targets and 5-year priorities as outlined in the [2012-2015 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, adults 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.

We want to acknowledge efforts of AHS physicians, staff and volunteers in driving improvements to our service delivery. Improvements have been identified in a number of areas when comparing performance year over year. We remain committed to building on these improvements through quality improvement and innovation to strive towards the goal of delivering within AHS the type of health care system performance demanded by, and deserved for Albertans.

The targets – how far and how fast – were set in consultation with clinical leaders, Alberta Health (AH), 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.

Reporting our performance: April 1, 2012 – June 30, 2012

Designed to gauge performance and drive improvement, this report provides a snapshot in time and enables us to demonstrate where we are improving, where we have met or not met predetermined targets and provides highlights of actions underway and planned as we work towards ongoing improvement and service delivery aimed at meeting the health care needs of Albertans. Reporting our performance and monitoring outcomes has helped both AHS and Albertans to understand the efforts underway and the challenges to achieve the targets set out in our Health Plan

AHS continues to increase throughputs in many areas. The table below provides insight into capacity changes that have occurred in support of the targeted performance measures.

Changes in Throughput			
Volumes	Volume Q1 2011/12	Volume Q1 2012/13	Per cent change
Number of Coronary Artery Bypass Graft Surgeries (All).	363	364	0.28%
Number of Total Hip Replacement Surgeries.	1,206	1,361	12.85%
Number of Total Knee Replacement Surgeries.	1,436	1,604	11.70%
Number of Cataract Surgeries.	8,545	9,449	10.58%
Number of Other Scheduled Surgeries.	31,126	30,371	-2.43%
Number of Patients receiving Radiation Therapy First Consult.	1,279	1,254	-1.95%
Number of Emergency Department Visits.	502,987	524,332	4.24%
Number of People in Acute / Sub-Acute Beds Placed into Continuing Care.	1,223	1,358	11.04%
Number of People Waiting in Community Placed into Continuing Care.	624	538	-13.78%

When looking at performance reported this quarter and comparing it to the performance one year ago, many measures are demonstrating improvement since last year with some measures demonstrating significant improvement. These include:

- Both Hip and Knee replacement wait times have decreased over the past quarter to the lowest level in over two years while seeing an increase in volume. Hip Replacement wait time is currently at 34.9 weeks, down from 39.5 weeks in Q4 2011/12 (a 12% improvement).
- Radiation Therapy Access (ready-to-treat to first therapy) continues to maintain wait times at 3.1 weeks which surpasses the target of 4.0 weeks for 2012/13.
- Radiation Therapy Wait Time Referral to First Consultation continues to show quarter over quarter improvement with the wait time dropping from 4.6 weeks in Q4 2011/12 to 4.4 weeks in Q1 2012/13 (4.3% improvement).
- The number of people being admitted into Emergency Departments within 8 hours has increased by 6.5% for the top 15 sites, and 3.7% for all sites. The number of people being discharged within 4 hours has also increased, by 6.9% for the 16 higher volume EDs and 3.9% for all sites. All while the total number of ED visits has increased by over 4%.
- The percent of patients placed in continuing care within 30 days continues to show gains quarter over quarter with a 1.4% increase in Q1 2012/13. The number of people waiting in Acute / Sub-Acute Care for Continuing Care and the number of people waiting in Community for Continuing Care have continued to drop as well. The number of persons waiting in Acute / Sub-Acute Care has dropped from 467 to 459 (a 1.7% drop) and the number of people waiting in Community has dropped from 1002 to 907 (a 9.5% drop).
- The number of Registered Nurses Hired by AHS has increased over this quarter compared to Q1 2011/12. Of the total estimated RN Graduates for 2012/13 (1,637), AHS has hired a total of 943 (56%). This represents a 10% increase over the percentage hired in Q1 last year.

- Cataract Surgery wait times have seen an improvement from 43.1 weeks in Q1 2011/12 to 32.1 weeks in Q1 of 2012/13 (26% improvement) while seeing a volume increase of over 10%.
- The workforce measure of Headcount to FTE Ratio (1.58 in Q1 2011/12 vs. 1.54 in Q1 2012/13) has shown improvement and is better than the target of 1.61.

Looking at indicators with both a current annual result and a prior year annual result on the provincial dashboard, 67% of the indicators show improvement over the prior year and of those, 42% show improvement of more than 5%.

Highlights of actions underway to improve performance in priority areas:

- Hip and Knee replacement surgery wait times are being targeted through various efforts including increases in surgeries completed, centralized and improved wait list management enabling prioritization and referral efficiencies, process and care improvements, and physician and staff recruitment where needed. At this time, reduction in the wait lists for arthroplasty procedures are evident; reductions in wait times are expected for procedures completed in the coming months.
- 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.
- Capacity increases in cancer services including Radiation Therapy clinics built or with planning underway as well as capacity for colorectal screening procedures.
- AHS continues to add continuing care beds. In 2011/12 over 1,000 were added to the system and a further 1,000 beds planned for the coming fiscal year.
 - This additional capacity allows us to free up hospital beds currently occupied by Albertans whose health needs would be better met outside of the hospital. More open hospital beds will help improve ED length of stay for many patients requiring admission.
- Efforts to expand Home Care services in an effort to keep seniors safe, healthy and independent in their homes and reduce the number of avoidable ED visits are ongoing to further build on the increase in these clients seen in 2011/12.

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-performing publicly-funded health care system in Canada.

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

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

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

What's being measured?

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

Assessment of data quality

AHS has initiated a formal process to assess the quality of the performance measures listed in this report, with priority given to the Tier 1 measures highlighted in the [2012-2015 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 2012/13. This provincial dashboard shows the target for the 2012/13 year and the actual performance for the first quarter ending June 30, 2012. The dashboard also compares performance between the last two quarters and compares this quarter's performance against the performance from the same quarter last 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. **Quarter One Actual to Target Comparison:** For this first report of the fiscal year, we compare the quarterly results against the prorated target. The prorated target is where we would expect to be as we move from the prior year's target to the current year's target at the end of the year.

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 (the result has moved at least 75 per cent of the way towards where it is 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 Quarterly Comparison:** Here we compare each measure's quarterly value to the previous year's quarterly value for quarter one. 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 six of the quarterly performance measures in this report are updated to the first quarter (April – June, 2012). For those indicators reporting fourth quarter 2011/12 data (January – March 2012), the following table explains the reasons for the one quarter reporting lag:

Quarterly Measures with a One Quarter Reporting Lag	Data Timeline Clarification
<ul style="list-style-type: none"> • Patient Satisfaction – Acute Care 	<p>This measure is generated from survey data, where patients are called up to six weeks after they leave the hospital. Data is then prepared and analyzed for reporting. This results in data being available approximately two months after the end of each quarter.</p>
<ul style="list-style-type: none"> • Patient Satisfaction – Emergency Department 	<p>This measure is generated from survey data, where patients are called up to six weeks after their Emergency Department visit. Data is then prepared and analyzed for reporting. This results in data being available approximately two months after the end of each quarter.</p>
<ul style="list-style-type: none"> • Central Venous Catheter Bloodstream Infection Rate 	<p>As the first of four Infection Prevention and Control measures to be reported publicly, this measure currently undergoes a more rigorous internal review process at both the zone and provincial level prior to results being released.</p>
<ul style="list-style-type: none"> • Hospital-acquired Methicillin-Resistant <i>Staphylococcus aureus</i> (MRSA) bloodstream infections (BSI) 	<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"> • <i>Clostridium difficile</i> Infection 	<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"> • 30 Day All Cause Unplanned Readmission Rate 	<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, 2012/13
• Potential Years of Life Lost	Annual	Q4, 2012/13
• Colorectal Cancer Screening Rate	Annual	Q4, 2012/13
• Breast Cancer Screening Participation Rate	Annual	Q3, 2012/13
• Cervical Cancer Screening Participation Rate	Annual	Q3, 2012/13
• Seniors Influenza Immunization Rate	Annual	Q4, 2012/13
• Children's Influenza Immunization Rate	Annual	Q4, 2012/13
• Childhood Immunization Rate for DTaP *	Annual	Q4, 2012/13
• Childhood Immunization Rate for MMR *	Annual	Q4, 2012/13
• Albertans Enrolled in a Primary Care Network	Semi-annual	Q4, 2012/13
• Rating of Care Nursing Home – Family	Every 3 years	2014/15
• Staff Overall Engagement	Every 2 years	2014
• Physician Overall Engagement	Every 2 years	2014
• Patient Satisfaction – Addiction and Mental Health	Annual	Q4, 2012/13
• 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 come from Alberta Health Services, Alberta Health, Health Quality Council of Alberta, and Statistics Canada.

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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
Staying Healthy / Improving Population Health										
◇ Life Expectancy	81.6 2010	Improvement		81.9 2011	■				81.6 2010	■
◇ Potential Years Life Lost (per 1,000 population)	44.8 2010	Improvement		43.3 2011	■				44.8 2010	■
Colorectal Cancer Screening Participation Rate	43.0% 2009	55% 2015		57.0% 2011	■				43.0% 2009	■
Breast Cancer Screening Participation Rate	57.3% 2009-2010	55% - 62% 2010-2015		54.8% 2010-2011	▲				57.3% 2009-2010	■
Cervical Cancer Screening Participation Rate	67.9% 2008-2010	70% - 75% 2010-2015		65.0% 2009-2011	▲				67.9% 2008-2010	■
Immunization and Primary Care										
◇ Seniors (65+) Influenza Immunization Rate	59% 2010-2011	75%		61% 2011-2012	●				59% 2010-2011	■
◇ Children (6 to 23 Months) Influenza Immunization Rate	27% 2010-2011	75%		30% 2011-2012	●				27% 2010-2011	■
◇ Childhood Immunization Rates for DTaP	77.0% 2009	97%		73.1% 2010	●				77.0% 2009	●
◇ Childhood Immunization Rates for MMR	86.7% 2009	98%		85.7% 2010	●				86.7% 2009	■
Albertans Enrolled in a Primary Care Network (%)	72% Apr 2011	tbd		75% Apr 2012	na	75% Apr 2012	74% Oct 2011	■	72% Apr 2011	■
◇ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	278 2011/12	282 annual	71	70 Q1 YTD 2012/13	■	70 Q1 2012/13	74 Q4 2011/12	■	75% Q1 YTD 2011/12	■
◇ Family Practice Sensitive Conditions (% of ED visits)	26.4% 2011/12	23%	24.5%	25.6% Q1 YTD 2012/13	▲	25.6% Q1 2012/13	26.5% Q4 2011/12	■	26.7% Q1 YTD 2011/12	■
Health Link Wait Time (% answered within 2 minutes)	81.0% 2011/12	80%	80%	82.6% Q1 YTD 2012/13	■	82.6% Q1 2012/13	78.5% Q4 2011/12	■	81.6% Q1 YTD 2011/12	■
◇ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	76% 2011/12	92%	91%	75% Q1 YTD 2012/13	●	75% Q1 2012/13	77% Q4 2011/12	■	72% Q1 YTD 2011/12	■
Improve Access and Reduce Wait Times										
◇ Urgent CABG Wait Time (90th percentile in weeks)	1.9 2011/12	1	1.0	1.6 Q1 YTD 2012/13	●	1.6 Q1 2012/13	1.9 Q4 2011/12	■	1.9 Q1 YTD 2011/12	■
◇ Semi-urgent CABG Wait Time (90th percentile in weeks)	6.2 2011/12	2	2.0	3.6 Q1 YTD 2012/13	●	3.6 Q1 2012/13	5.6 Q4 2011/12	■	10.8 Q1 YTD 2011/12	■
◇ Scheduled CABG Wait Time (90th percentile in weeks)	28.8 2011/12	6	6.0	31.0 Q1 YTD 2012/13	●	31.0 Q1 2012/13	30.9 Q4 2011/12	■	25.9 Q1 YTD 2011/12	●
Notes										
◇ Indicates "Tier 1" measures attached to the 2012 – 2015 Health Plan.										

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	39.8 2011/12	22.0	25.8	34.9 Q1 YTD 2012/13	●	34.9 Q1 2012/13	39.5 Q4 2011/12	■	43.3 Q1 YTD 2011/12	■
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	48.0 2011/12	28.0	33.3	44.5 Q1 YTD 2012/13	●	44.5 Q1 2012/13	44.7 Q4 2011/12	■	48.3 Q1 YTD 2011/12	■
◊ Cataract Surgery Wait Time (90th percentile in weeks)	35.1 2011/12	25.0	28.8	32.1 Q1 YTD 2012/13	●	32.1 Q1 2012/13	29.3 Q4 2011/12	●	43.1 Q1 YTD 2011/12	■
Other Scheduled Surgery Wait Time (90th percentile in weeks)	25.9 2011/12	tbd	na	26.1 Q1 YTD 2012/13	na	26.1 Q1 2012/13	24.9 Q4 2011/12	■	26.1 Q1 YTD 2011/12	■
◊ Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	5.3 2011/12	3.0	3.8	4.4 Q1 YTD 2012/13	●	4.4 Q1 2012/13	4.6 Q4 2011/12	■	5.6 Q1 YTD 2011/12	■
◊ Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks) £	3.1 2011/12	4.0	4.0	3.1 Q1 YTD 2012/13	■	3.1 Q1 2012/13	3.0 Q4 2011/12	■	3.6 Q1 YTD 2011/12	■
◊ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	65% 2011/12	80%	76%	65% Q1 YTD 2012/13	●	65% Q1 2012/13	63% Q4 2011/12	■	66% Q1 YTD 2011/12	■
◊ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	80% 2011/12	86%	85%	80% Q1 YTD 2012/13	▲	80% Q1 2012/13	79% Q4 2011/12	■	81% Q1 YTD 2011/12	■
◊ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	45% 2011/12	75%	64%	48% Q1 YTD 2012/13	●	48% Q1 2012/13	43% Q4 2011/12	■	46% Q1 YTD 2011/12	■
◊ Patients Admitted from ED within 8 hours (%) (All Sites) £	55% 2011/12	75%	68%	58% Q1 YTD 2012/13	●	58% Q1 2012/13	54% Q4 2011/12	■	57% Q1 YTD 2011/12	■
Provide More Choice for Continuing Care										
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	467 Mar 2012	350	369	459 Jun 2012	●	459 Jun 2012	467 Mar 2012	■	511 Jun 2011	■
◊ People Waiting in Community for Continuing Care Placement	1,002 Mar 2012	850	888	907 Jun 2012	▲	907 Jun 2012	1,002 Mar 2012	■	1,150 Jun 2011	■
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	41 2011/12	tbd	na	34 Q1 YTD 2012/13	na	34 Q1 2012/13	32 Q4 2011/12	●	42 Q1 YTD 2011/12	■
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	64% 2011/12	tbd	na	72% Q1 YTD 2012/13	na	72% Q1 2012/13	71% Q4 2011/12	■	65% Q1 YTD 2011/12	■
◊ Number of Home Care Clients	104,704 2011/12	tbd	na	68,728 Q1 YTD 2012/13	na	68,728 Q1 2012/13	67,709 Q4 2011/12	■	66,025 Q1 YTD 2011/12	■
◊ Rating of Care Nursing Home - Family	71.0% 2009/10	tbd	na	73.4% 2010/11	na				71.0% 2009/10	■
Notes ◊ Indicates "Tier 1" measures attached to the 2012 – 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%. ¢ Cataract Surgery Wait Time data for Q4 and 2011/12 are preliminary pending validation.										

Q1 2012/13 AHS Performance Dashboard

(continued)

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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
Build One Health System										
◊ Head Count to FTE Ratio	1.55 2011/12	1.61	1.61	1.54 Q1 YTD 2012/13	■	1.54 Jun 2012	1.53 Mar 2012	■	1.58 Jun 2011	■
◊ Registered Nurse Graduates Hired by AHS (%) - Total - Non-Casual	88% 41% 2010/11	70%	48%	56% 28% Jun 2012	■ ●				49% 17% Jun 2011	■ ■
◊ Disabling Injury Rate	3.87 2011	1.80	1.80	3.54 2012 CY Projected	●	na 2012 CY Q2 (Apr-Jun)	0.94 2012 CY Q1 (Jan-Mar)	na	3.39 2011 CY (Jan-Jun) Annualized	■
◊ Staff Overall Engagement (%)	35% 2009/10	54% 2011/12		52% 2011/12	▲				35% 2009/10	■
◊ Physician Overall Engagement (%)	26% 2009/10	54% 2011/12		39% 2011/12	●				26% 2009/10	■
Direct Nursing Average Full Time Equivalency	0.60 2011/12	0.65	0.65	0.60 Q1 YTD 2012/13	▲	0.60 Jun 2012	0.60 Mar 2012	■	0.59 Jun 2011	■
Absenteeism	12.04 2011/12	11.95	11.95	12.10 Q1 YTD 2012/13	▲	12.10 Q1 2012/13	13.06 Q4 2011/12	■	12.18 Q1 YTD 2011/12	■
Overtime Hours to Paid Hours Ratio	1.98% 2011/12	1.67%	1.67%	2.16% Q1 YTD 2012/13	●	2.16% Q1 2012/13	2.15% Q4 2011/12	■	1.91% Q1 YTD 2011/12	●
Labour Cost per Worked Hour	\$51.44 2011/12	tbd	na	\$54.80 Q1 YTD 2012/13	na	\$54.80 Q1 2012/13	\$51.39 Q4 2011/12	●	\$50.98 Q1 YTD 2011/12	●
◊ Number of Netcare Users	14,605 2011/12	tbd	tbd	na	na	na	14,605 Q4 2011/12	na	12,708 Q1 YTD 2011/12	na
On Budget: Year to Date	\$82M Surplus 2011/12	\$29M	na	\$85M Surplus Jun 2012	■	\$85M Jun 2012	\$82M Mar 2012	na	\$175M Jun 2011	na
◊ Adherence to 5 Year Budgeted Government Funding	9.5% 2010/11	Less than 1.5%	na	0.9% 2011/12	■				9.5% 2010/11	■
Notes ◊ Indicates "Tier 1" measures attached to the 2012 – 2015 Health Plan.										

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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
Quality and Patient Safety										
◊ Patient Satisfaction – Adult Acute Care	81.4% 2010/11	tbd	na	83.6% 2011/12	na	82.3% Q4 2011/12	83.8% Q3 2011/12	—	81.4% 2010/11	—
◊ Patient Satisfaction - Addictions and Mental Health (AHS)	93.0% 2010/11	tbd		92.3% 2011/12	na				93.0% 2010/11	—
Percentage of Patient Feedback as Commendations	10.28% 2011/12	tbd		10.59% Q1YTD (Apr-Jun)	na	10.59% Q1 2012/13	9.86% Q4 2011/12	—	8.5% Q1 YTD 2011/12	■
Percentage of Patient Concerns Escalated to Patient Concerns Officer	0.52% 2011/12	tbd		0.96% Q1YTD (Apr-Jun)	na	0.96% Q1 2012/13	0.39% Q4 2011/12	●	0.63% Q1 YTD 2011/12	●
◊ Albertans Reporting Unexpected Harm	% 2010	9%		12.2% 2011	●				9% 2010	●
Patient Satisfaction Emergency Department (15 Higher Volume)	Adult	tbd	na	na	na	na	67%	na	66%	na
	Pediatric	tbd	na	na	na	na	87%	na	77% 2010/11	na
◊ Patient Satisfaction Health Care Services Personally Received	62% 2010	68%		67% 2011	■				62% 2010	■
Central Venous Catheter Bloodstream Infection Rate	1.26 2010/11	tbd	na	0.93 Q4 YTD 2011/12	na	0.73 Q4 2011/12	0.82 Q3 2011/12	■	1.26 2010/11	■
◊ Methicillin-Resistant Staphylococcus aureus – Bloodstream Infection	0.19 2010/11	tbd	na	0.18 Q4 YTD 2011/12	na	0.11 Q4 2011/12	0.15 Q3 2011/12	■	0.19 2010/11	■
C-Difficile Infection Rate – Hospital Acquired	na 2010/11	tbd	na	4.1 Q4 YTD 2011/12	na	4.4 Q4 2011/12	4.2 Q3 2011/12	—	na 2010/11	na
30 Day Unplanned Readmission Rate	7.8% 2010/11	tbd	na	8.1% Q4 YTD 2011/12	na	8.2% Q4 2011/12	8.0% Q3 2011/12	—	7.8% 2010/11	—
◊ Surgical Site Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13									
Notes ◊ Indicates "Tier 1" measures attached to the 2012 – 2015 Health Plan.										
Status ■ Performance is at or better than target, continue to monitor ▲ Performance is within acceptable range of target, monitor and take action as appropriate ● Performance is outside acceptable range of target, take action and monitor progress					Period Comparative Performance ■ Current period performance is better than comparative period — Current period performance is within 5% of comparative period ● Current period performance is worse than comparative period					

Zone Comparison Dashboard 2012/13

Year to Date (Apr-Jun)

Performance Measure	Zone 1 - South	Zone 2 - Calgary	Zone 3 - Central	Zone 4 - Edmonton	Zone 5 - North	AHS	YTD Prorated Target (Apr-Jun 2012/13)	AHS Annual Target 2012/13
Staying Healthy / Improving Population Health								
Life Expectancy	81.1 2011	83.4 2011	80.5 2011	81.9 2011	79.4 2011	81.9 2011		Improvement
Potential Years of Life Lost (per 1,000 Population)	48.7 2011	33.9 2011	50.2 2011	44.7 2011	57.6 2011	43.3 2011		Improvement
Colorectal Cancer Screening Participation Rate	Measure not reported at Zone level.					57.0% 2011		55% 2015
Breast Cancer Screening Participation Rate	58.4% 2010-2011	55.3% 2010-2011	52.0% 2010-2011	54.5% 2010-2011	52.6% 2010-2011	54.8% 2010-2011		55% - 62% 2010-2015
Cervical Cancer Screening Participation Rate	69.4% 2009-2011	60.7% 2009-2011	66.1% 2009-2011	58.2% 2009-2011	62.6% 2009-2011	65.0% 2009-2011		70% - 75% 2010-2015
Strengthen Primary Health Care								
Seniors (65+) Influenza Immunization Rate	62.3% 2011-2012	63.4% 2011-2012	53.4% 2011-2012	63.8% 2011-2012	51.5% 2011-2012	60.6% 2011-2012		75%
Children (6 to 23 Months) Influenza Immunization Rate	28.5% 2011-2012	37.6% 2011-2012	26.9% 2011-2012	26.9% 2011-2012	20.2% 2011-2012	29.9% 2011-2012		75%
Childhood Immunization Rates for DTaP	67.1% 2010	77.6% 2010	65.0% 2010	74.6% 2010	66.7% 2010	73.1% 2010		97%
Childhood Immunization Rates for MMR	83.9% 2010	86.5% 2010	83.3% 2010	88.0% 2010	81.0% 2010	85.7% 2010		98%
Albertans Enrolled in a Primary Care Network (%)	82% Apr 2012	80% Apr 2012	69% Apr 2012	72% Apr 2012	68% Apr 2012	75% Apr 2012		tbd
Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	95 YTD (Apr-Jun)	52 YTD (Apr-Jun)	96 YTD (Apr-Jun)	58 YTD (Apr-Jun)	117 YTD (Apr-Jun)	70 YTD (Apr-Jun)	71	282 (annual)
Family Practice Sensitive Conditions (% of ED visits)	27.6% YTD (Apr-Jun)	19.3% YTD (Apr-Jun)	31.2% YTD (Apr-Jun)	14.3% YTD (Apr-Jun)	37.8% YTD (Apr-Jun)	25.6% YTD (Apr-Jun)	24.5%	23%
Health Link Wait Time (% answered within 2 minutes)	Measure not reported at Zone level.					82.6% YTD (Apr-Jun)		80%
Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	93% YTD (Apr-Jun)	62% YTD (Apr-Jun)	92% YTD (Apr-Jun)	55% YTD (Apr-Jun)	75% YTD (Apr-Jun)	75% YTD (Apr-Jun)	91%	92%
Improve Access and Reduce Wait Times								
Urgent CABG Wait Time (90th percentile in weeks)	np	1.6 YTD (Apr-Jun)	np	1.4 YTD (Apr-Jun)	np	1.6 YTD (Apr-Jun)	1.0	1
Semi-urgent CABG Wait Time (90th percentile in weeks)	np	3.6 YTD (Apr-Jun)	np	6.8 YTD (Apr-Jun)	np	3.6 YTD (Apr-Jun)	2.0	2
Scheduled CABG Wait Time (90th percentile in weeks)	np	34.6 YTD (Apr-Jun)	np	18.4 YTD (Apr-Jun)	np	31.0 YTD (Apr-Jun)	6.0	6
Hip Replacement Surgery Wait Time (90th percentile in weeks)	35.2 YTD (Apr-Jun)	34.1 YTD (Apr-Jun)	19.7 YTD (Apr-Jun)	35.3 YTD (Apr-Jun)	44.3 YTD (Apr-Jun)	34.9 YTD (Apr-Jun)	25.8	22
Knee Replacement Surgery Wait Time (90th percentile in weeks)	46.6 YTD (Apr-Jun)	34.7 YTD (Apr-Jun)	26.7 YTD (Apr-Jun)	45.6 YTD (Apr-Jun)	49.7 YTD (Apr-Jun)	44.5 YTD (Apr-Jun)	33.3	28
Cataract Surgery Wait Time (90th percentile in weeks)	43.4 YTD (Apr-Jun)	32.1 YTD (Apr-Jun)	21.6 YTD (Apr-Jun)	30.3 YTD (Apr-Jun)	46.1 YTD (Apr-Jun)	32.1 YTD (Apr-Jun)	28.8	25

‡ 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 Prorated Target (Apr-Jun 2012/13)	AHS Annual Target 2012/13
Other Scheduled Surgery Wait Time (90th percentile in weeks)	24.1 YTD (Apr-Jun)	26.9 YTD (Apr-Jun)	23.4 YTD (Apr-Jun)	26.4 YTD (Apr-Jun)	26.9 YTD (Apr-Jun)	26.1 YTD (Apr-Jun)	na	tbd
Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	3.1 YTD (Apr-Jun)	5.1 YTD (Apr-Jun)	np	3.9 YTD (Apr-Jun)	np	4.4 YTD (Apr-Jun)	3.8	3
Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks)	1.0 YTD (Apr-Jun)	3.7 YTD (Apr-Jun)	np	2.9 YTD (Apr-Jun)	np	3.1 YTD (Apr-Jun)	4.0	4
Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume EDs) £	79% YTD (Apr-Jun)	63% YTD (Apr-Jun)	70% YTD (Apr-Jun)	59% YTD (Apr-Jun)	79% YTD (Apr-Jun)	65% YTD (Apr-Jun)	76%	80%
Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	88% YTD (Apr-Jun)	75% YTD (Apr-Jun)	90% YTD (Apr-Jun)	65% YTD (Apr-Jun)	95% YTD (Apr-Jun)	80% YTD (Apr-Jun)	85%	86%
Patients Admitted from ED within 8 hours (%) (15 Higher Volume EDs) £	87% YTD (Apr-Jun)	49% YTD (Apr-Jun)	42% YTD (Apr-Jun)	39% YTD (Apr-Jun)	61% YTD (Apr-Jun)	48% YTD (Apr-Jun)	64%	75%
Patients Admitted from ED within 8 hours (%) (All Sites) £	88% YTD (Apr-Jun)	50% YTD (Apr-Jun)	71% YTD (Apr-Jun)	39% YTD (Apr-Jun)	83% YTD (Apr-Jun)	58% YTD (Apr-Jun)	68%	75%
Provide More Choice for Continuing Care								
People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	26 Jun 2012 (Target = 13)	166 Jun 2012 (Target = 119)	36 Jun 2012 (Target = 48)	166 Jun 2012 (Target = 115)	65 Jun 2012 (Target = 56)	459 Jun 2012	na	350
People Waiting in Community for Continuing Care Placement	63 Jun 2012 (Target = 50)	448 Jun 2012 (Target = 384)	107 Jun 2012 (Target = 105)	193 Jun 2012 (Target = 230)	96 Jun 2012 (Target = 82)	907 Jun 2012	na	850
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	13 YTD (Apr-Jun)	49 YTD (Apr-Jun)	27 YTD (Apr-Jun)	23 YTD (Apr-Jun)	76 YTD (Apr-Jun)	34 YTD (Apr-Jun)	na	tbd
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	89% YTD (Apr-Jun)	67% YTD (Apr-Jun)	62% YTD (Apr-Jun)	80% YTD (Apr-Jun)	48% YTD (Apr-Jun)	72% YTD (Apr-Jun)	na	tbd
Number of Home Care Clients	7,073 YTD (Apr-Jun)	20,128 YTD (Apr-Jun)	10,311 YTD (Apr-Jun)	23,560 YTD (Apr-Jun)	7,656 YTD (Apr-Jun)	68,728 YTD (Apr-Jun)	na	tbd
Rating of Care Nursing Home Family	Measure not reported at Zone level.					73.4% 2010/11	na	tbd
Build One Health System								
Head Count to FTE Ratio	Measure not reported at Zone level.					1.54 YTD (Apr-Jun)	1.61	1.61
Registered Nurse Graduates Hired by AHS (%)	- All Hires	Measure not reported at Zone level.				56% Jun 2012	48%	70%
	- Non-Casual	Measure not reported at Zone level.				28% Jun 2012		
Disabling Injury Rate	Measure not reported at Zone level.					3.54 2012 CY Projected	1.8	1.8
Staff Overall Engagement (%)	na 2011/12	na 2011/12	na 2011/12	na 2011/12	na 2011/12	52% 2011/12		68%
Physician Overall Engagement (%)	na 2011/12	na 2011/12	na 2011/12	na 2011/12	na 2011/12	39% 2011/12		68%
Direct Nursing Average Full Time Equivalency	Measure not reported at Zone level.					0.60 YTD (Apr-Jun)	0.65	0.65
Absenteeism	Measure not reported at Zone level.					12.10 Apr-Jun 2012 (annualized)	na	11.95
Overtime Hours to Paid Hours Ratio	Measure not reported at Zone level.					2.16% YTD (Apr-Jun)	na	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 Prorated Target (Apr-Jun 2012/13)	AHS Annual Target 2012/13
Labour Cost per Worked Hour	Measure not reported at Zone level.					\$54.80 YTD (Apr-Jun)	na	tbd
Number of Netcare Users	Measure not reported at Zone level.					na YTD (Apr-Jun)	na	na
On Budget: Year to Date	Measure not reported at Zone level.					\$85M YTD (Apr-Jun) ■	na	\$29M
Adherence to 5 Year Budgeted Government Funding	Measure not reported at Zone level.					0.9% 2011/12 ■	na	Less than 1.5% 2011/12
Quality and Patient Safety								
Patient Satisfaction – Adult Acute Care	84.4% 2011/12	83.5% 2011/12	85.6% 2011/12	83.2% 2011/12	82.0% 2011/12	83.6% 2011/12	na	tbd
Patient Satisfaction – Addictions and Mental Health	Measure not reported at Zone level.					92.3% 2011/12	na	tbd
Percentage of Patient Feedback as Commendations	7.44% YTD (Apr-Jun)	9.30% YTD (Apr-Jun)	13.78% YTD (Apr-Jun)	12.40% YTD (Apr-Jun)	5.49% YTD (Apr-Jun)	10.59% YTD (Apr-Jun)	na	tbd
Percentage of Patient Concerns Escalated to Patient Concerns Officer	4.81% YTD (Apr-Jun)	1.40% YTD (Apr-Jun)	0.00% YTD (Apr-Jun)	0.31% YTD (Apr-Jun)	0.70% YTD (Apr-Jun)	0.96% YTD (Apr-Jun)	na	tbd
Albertans Reporting Unexpected Harm	na 2011	na 2011	na 2011	na 2011	na 2011	12.2% 2011 ●		9%
Patient Satisfaction Emergency Department	na 2011/12	na 2011/12	na 2011/12	na 2011/12	na 2011/12	na 2011/12		tbd
Patient Satisfaction Health Care Services Personally Received	na 2011	na 2011	na 2011	na 2011	na 2011	67% 2011 ■		68%
Central Venous Catheter Bloodstream Infection Rate	Measure not reported at Zone level.					0.93 2011/12	na	tbd
Methicillin-Resistant Staphylococcus aureus – Bloodstream Infection	Measure not reported at Zone level.					0.18 2011/12	na	tbd
C-Difficile Infection Rate – Hospital Acquired	Measure not reported at Zone level.					4.1 2011/12	na	tbd
30 Day Unplanned Readmission Rate	8.58% 2011/12	7.09% 2011/12	9.74% 2011/12	8.09% 2011/12	9.48% 2011/12	8.14% 2011/12	na	tbd
Status								
■ Performance is at or better than target, continue to monitor ▲ Performance is within acceptable range of target, monitor and take action as appropriate ● Performance is outside acceptable range of target, take action and monitor progress								

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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
Staying Healthy / Improving Population Health										
◊ Life Expectancy	81.1 2011	improve		81.1 2011	na				80.3 2010	■
◊ Potential Years Life Lost (per 1,000 population)	48.7 2011	improve		48.7 2011	na				49.6 2010	■
Breast Cancer Screening Participation Rate	58.4% 2010-2011	55-62% 2010-2015		58.4% 2010-2011	■				59.2% 2009-2010	■
Cervical Cancer Screening Participation Rate	69.4% Jan 2009 - Dec 2011	70-75% 2010-2015		69.4% Jan 2009 - Dec 2011	▲				64.2% Jan 2008 - Dec 2010	■
Strengthen Primary Health Care										
◊ Seniors (65+) Influenza Immunization Rate	62.3% 2011-2012	75.0%		62.3% 2011-2012	●				55.7% 2009-2010	■
◊ Children (6 to 23 Months) Influenza Immunization Rate	28.5% 2011-2012	75.0%		28.5% 2011-2012	●				22.0% 2009-2010	■
◊ Childhood Immunization Rates for DTaP	80.5% 2009	97.0%		67.1% 2010	●				86.2% 2008	●
◊ Childhood Immunization Rates for MMR	86.7% 2009	98.0%		83.9% 2010	●				87.8% 2008	▲
Albertans Enrolled in a Primary Care Network (%)	82% Apr 2012	tbd		82% Apr 2012	na	82% Apr 2012	82% Oct 2011	■	74% Apr 2011	■
◊ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	362 2011/12	282	71	95 Q1 YTD 2012/13	●	95 Q1 2012/13	100 Q4 2011/12	■	100 Q1 YTD 2011/12	■
◊ Family Practice Sensitive Conditions (% of ED visits)	28.5% 2011/12	23.0%	24.5%	27.6% Q1 YTD 2012/13	●	27.6% Q1 2012/13	29.1% Q4 2011/12	■	29.1% Q1 YTD 2011/12	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	94.0%	92%	91%	93%	■	93%	93%	■	93% Q4 YTD 2010/11	■
Improve Access and Reduce Wait Times										
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	38.6 2011/12	22.0	25.8	35.2 Q1 YTD 2012/13	●	35.2 Q1 2012/13	37.1 Q4 2011/12	■	35.4 Q1 YTD 2011/12	■
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	50.6 2011/12	28.0	33.3	46.6 Q1 YTD 2012/13	●	46.6 Q1 2012/13	47.6 Q4 2011/12	■	50.7 Q1 YTD 2011/12	■
◊ Cataract Surgery Wait Time (90th percentile in weeks)	43.0 2011/12	25.0	28.8	43.4 Q1 YTD 2012/13	●	43.4 Q1 2012/13	43.6 Q4 2011/12	■	47.1 Q1 YTD 2011/12	■
Other Scheduled Surgery Wait Time (90th percentile in weeks)	23.6 2011/12	tbd	na	24.1 Q1 YTD 2012/13	na	24.1 Q1 2012/13	22.1 Q4 2011/12	●	24.9 Q1 YTD 2011/12	■
Notes ◊ Indicates "Tier 1" measures attached to the 2012 – 2015 Health Plan.										










Q1 2012/13 AHS Performance Dashboard

South Zone (continued)

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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 st consult) (90 th percentile in weeks)	3.9 2011/12	3.0	3.8	3.1 Q1 YTD 2012/13	■	3.1 Q1 2012/13	4.3 Q4 2011/12	■	3.0 Q1 YTD 2011/12	■
◇ Radiation Therapy Access (ready to treat to first therapy) (90 th percentile in weeks) £	1.4 2011/12	4.0	4.0	1.0 Q1 YTD 2012/13	■	1.0 Q1 2012/13	0.7 Q4 2011/12	●	2.1 Q1 YTD 2011/12	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	82% 2011/12	80%	76%	79% Q1 YTD 2012/13	■	79% Q1 2012/13	79% Q4 2011/12	■	83% Q1 YTD 2011/12	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	89% 2011/12	86%	85%	88% Q1 YTD 2012/13	■	88% Q1 2012/13	87% Q4 2011/12	■	91% Q1 YTD 2011/12	■
◇ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	89% 2011/12	75%	64%	87% Q1 YTD 2012/13	■	87% Q1 2012/13	86% Q4 2011/12	■	91% Q1 YTD 2011/12	■
◇ Patients Admitted from ED within 8 hours (%) (All Sites) £	89% 2011/12	75%	68%	88% Q1 YTD 2012/13	■	88% Q1 2012/13	87% Q4 2011/12	■	91% Q1 YTD 2011/12	■
Provide More Choice for Continuing Care										
◇ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	11 Mar 2012	13	13	26 Jun 2012	●	26 Jun 2012	11 Mar 2012	●	15 Jun 2011	●
◇ People Waiting in Community for Continuing Care Placement	71 Mar 2012	50	52	63 Jun 2012	●	63 Jun 2012	71 Mar 2012	■	73 Jun 2011	■
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	13 2011/12	tbd	31	13 Q1 YTD 2012/13	na	13 Q1 2012/13	11 Q4 2011/12	●	13 Q1 YTD 2011/12	■
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	80% 2011/12	tbd	na	89% Q1 YTD 2012/13	na	89% Q1 2012/13	90% Q4 2011/12	■	86% Q1 YTD 2011/12	■
◇ Number of Home Care Clients	11,107 2011/12	tbd	na	7,073 Q1 YTD 2012/13	na	7,073 Q1 2012/13	7,221 Q4 2011/12	■	7,097 Q1 YTD 2011/12	■
Build One Health System										
◇ Staff Overall Engagement (%)	35% 2009/10	68%		na	na				35% 2009/10	na
◇ Physician Overall Engagement (%)	20% 2009/10	68%		na	na				20% 2009/10	na
Notes ◇ Indicates "Tier 1" measures attached to the 2012 – 2015 Health Plan. £The Weekly ED Length of Stay (LOS) being published separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.										

Q1 2012/13 AHS Performance Dashboard

South Zone (continued)

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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
Quality and Patient Safety										
◊ Patient Satisfaction – Adult Acute Care	77.7% 2010/11	tbd	na	84.4% Q4 YTD 2011/12	na	80.3% Q4 2011/12	85.3% Q3 2011/12		77.7% Q4 YTD 2010/11	
◊ Patient Satisfaction - Addictions and Mental Health (AHS)	0.0% 2011/12	tbd		na	na	na	na 2011/12	na	na	na
Percentage of Patient Feedback as Commendations	0.00% 2011/12	tbd	na	7.44% Q1 YTD 2012/13	na	7.40% Q1 2012/13	2.86% Q4 2011/12	na	11.2% Q1 YTD 2011/12	
Percentage of Patient Concerns Escalated to Patient Concerns Officer	1.24% 2011/12	tbd	na	4.81% Q1 YTD 2012/13	na	4.81% Q1 2012/13	0.76% Q4 2011/12		1.0% Q1 YTD 2011/12	
◊ Albertans Reporting Unexpected Harm	0% 2011	9%		na	na				8% 2010	na
◊ Patient Satisfaction Emergency Department	na	tbd		na	na				59% 2010	
◊ Patient Satisfaction Health Care Services Personally Received	66% 2010	68%		na 2011	na				66% 2010	
30 Day Unplanned Readmission Rate	8.2% 2010/11	tbd	na	8.6% Q4 YTD 2011/12	na	8.7% Q4 2011/12	8.9% Q3 2011/12		8.2% Q4 YTD 2010/11	
Notes ◊ Indicates "Tier 1" measures attached to the 2012 – 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  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
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Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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
Staying Healthy / Improving Population Health										
◊ Life Expectancy	83.4 2011	tbd		83.4 2011	na				82.9 2010	—
◊ Potential Years Life Lost (per 1,000 population)	33.9 2011	tbd		33.9 2011	na				37.0 2010	■
Breast Cancer Screening Participation Rate	55.3% 2010-2011	55-62% 2010-2015		55.3% 2010-2011	■				58.5% 2009-2010	●
Cervical Cancer Screening Participation Rate	60.7% Jan 2009 - Dec 2011	70-75% 2010-2015		60.7% Jan 2009 - Dec 2011	●				72.7% Jan 2008 - Dec 2010	●
Strengthen Primary Health Care										
◊ Seniors (65+) Influenza Immunization Rate	63.4% 2011-2012	75%		63.4% 2011-2012	●				56.5% 2009-2010	■
◊ Children (6 to 23 Months) Influenza Immunization Rate	37.6% 2011-2012	75%		37.6% 2011-2012	●				19.0% 2009-2010	■
◊ Childhood Immunization Rates for DTaP	80.5% 2009	97%		77.6% 2010	●				86.2 2008	●
◊ Childhood Immunization Rates for MMR	86.7% 2009	98%		86.5% 2010	●				87.8 2008	▲
Albertans Enrolled in a Primary Care Network (%)	80% Apr 2012	tbd		80% Apr 2012	na	80% Apr 2012	80% Oct 2011	—	77% Apr 2011	—
◊ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	214 2011/12	282	71	52 Q1 YTD 2012/13	■	52 Q1 2012/13	57 Q4 2011/12	■	55 Q1 YTD 2011/12	■
◊ Family Practice Sensitive Conditions (% of ED visits)	20.2% 2011/12	23.0%	24.5%	19.3% Q1 YTD 2012/13	■	19.3% Q1 2012/13	20.4 Q4 2011/12	■	20.6% Q1 YTD 2011/12	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	71.0% 2011/12	92%	91%	62% Q1 YTD 2012/13	●	62% Q1 2012/13	70% Q4 2011/12	●	74% Q4 YTD 2010/11	●
Notes ◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. * Trend for these measures cannot be determined until subsequent data is available										

Q1 2012/13 AHS Performance Dashboard Calgary Zone (continued)

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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
Improve Access and Reduce Wait Times										
◇ Urgent CABG Wait Time (90 th percentile in weeks)	2.0 2011/12	1.0	1.0	1.6 Q1 YTD 2012/13	●	1.6 Q1 2012/13	1.8 Q4 2011/12	■	1.7 Q1 YTD 2011/12	■
◇ Semi-urgent CABG Wait Time (90 th percentile in weeks)	3.9 2011/12	2.0	2.0	3.6 Q1 YTD 2012/13	●	3.6 Q1 2012/13	4.1 Q4 2011/12	■	8.6 Q1 YTD 2011/12	■
◇ Scheduled CABG Wait Time (90 th percentile in weeks)	33.8 2011/12	6.0	6.0	34.6 Q1 YTD 2012/13	●	34.6 Q1 2012/13	35.0 Q4 2011/12	■	30.8 Q1 YTD 2011/12	●
◇ Hip Replacement Surgery Wait Time (90 th percentile in weeks)	30.1 2011/12	22.0	25.8	34.1 Q1 YTD 2012/13	●	34.1 Q1 2012/13	34.3 Q4 2011/12	■	30.6 Q1 YTD 2011/12	●
◇ Knee Replacement Surgery Wait Time (90 th percentile in weeks)	34.9 2011/12	28.0	33.3	34.7 Q1 YTD 2012/13	▲	34.7 Q1 2012/13	34.5 Q4 2011/12	■	34.9 Q1 YTD 2011/12	■
◇ Cataract Surgery Wait Time (90 th percentile in weeks)	38.3 2011/12	25.0	28.8	32.1 Q1 YTD 2012/13	●	32.1 Q1 2012/13	26.9 Q4 2011/12	●	49.6 Q1 YTD 2011/12	■
Other Scheduled Surgery Wait Time (90 th percentile in weeks)	26.4 2011/12	tbd	na	26.9 Q1 YTD 2012/13	na	26.9 Q1 2012/13	24.7 Q4 2011/12	●	27.6 Q1 YTD 2011/12	■
◇ Radiation Therapy Access (referral to 1 st consult) (90 th percentile in weeks)	6.3 2011/12	3.0	3.8	5.1 Q1 YTD 2012/13	●	5.1 Q1 2012/13	4.3 Q4 2011/12	●	6.3 Q1 YTD 2011/12	■
◇ Radiation Therapy Access (ready to treat to first therapy) (90 th percentile in weeks) £	3.4 2011/12	4.0	4.0	3.7 Q1 YTD 2012/13	■	3.7 Q1 2012/13	3.4 Q4 2011/12	●	3.7 Q1 YTD 2011/12	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	62% 2011/12	80%	76%	63% Q1 YTD 2012/13	●	63% Q1 2012/13	60% Q4 2011/12	■	63% Q1 YTD 2011/12	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	74% 2011/12	86%	85%	75% Q1 YTD 2012/13	●	75% Q1 2012/13	72% Q4 2011/12	■	75% Q1 YTD 2011/12	■
◇ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	44% 2011/12	75%	64%	49% Q1 YTD 2012/13	●	49% Q1 2012/13	41% Q4 2011/12	■	45% Q1 YTD 2011/12	■
◇ Patients Admitted from ED within 8 hours (%) (All Sites) £	46% 2011/12	75%	68%	50% Q1 YTD 2012/13	●	50% Q1 2012/13	43% Q4 2011/12	■	47% Q1 YTD 2011/12	■
Notes ◇ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan. £The Weekly ED Length of Stay (LOS) being published separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.										

Q1 2012/13 AHS Performance Dashboard Calgary Zone (continued)

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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
Provide More Choice for Continuing Care										
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	188 Mar 2012	119	133	166 Jun 2012	●	166 Jun 2012	188 Mar 2012	■	199 Jun 2011	■
◊ People Waiting in Community for Continuing Care Placement	519 Mar 2012	384	399	448 Jun 2012	●	448 Jun 2012	519 Mar 2012	■	517 Jun 2011	■
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	55 2011/12	tdb	na	49 Q1 YTD 2012/13	na	49 Q1 2012/13	44 Q4 2011/12	●	50 Q1 YTD 2011/12	■
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	58% 2011/12	tdb	na	67% Q1 YTD 2012/13	na	67% Q1 2012/13	63% Q4 2011/12	■	64% Q1 YTD 2011/12	■
◊ Number of Home Care Clients	29,503 2011/12	tdb	na	20,128 Q1 YTD 2012/13	na	20,128 Q1 2012/13	19,862 Q4 2011/12	■	18,952 Q1 YTD 2011/12	●
Build One Health System										
◊ Staff Overall Engagement (%)	33% 2009/10	68%		na	na				33% 2009/10	na
◊ Physician Overall Engagement (%)	27% 2009/10	68%		na	na				27% 2009/10	na
Quality and Patient Safety										
◊ Patient Satisfaction – Adult Acute Care	83.1% 2010/11	tdb	na	83.5% Q4 YTD 2011/12	na	na	83.7% Q3 2011/12	na	83.1% Q1 YTD 2011/11	■
◊ Patient Satisfaction - Addictions and Mental Health (AHS)	na	tdb		na	na			na	na	na
Percentage of Patient Feedback as Commendations	na	tdb	na	9.30% Q1 YTD 2012/13	na	9.30% Q1 2012/13	10.43% Q4 2011/12	na	9.9% Q1 YTD 2011/12	●
Percentage of Patient Concerns Escalated to Patient Concerns Officer	0.80% 2011/12	tdb	na	1.40% Q1 YTD 2012/13	na	1.40% Q1 2012/13	0.44% Q4 2011/12	●	1.1% Q1 YTD 2011/12	●
◊ Albertans Reporting Unexpected Harm	na	9%		na 2011	na				10% 2010	na
◊ Patient Satisfaction Emergency Department	na	tdb	na	na	na				61% 2010	●
◊ Patient Satisfaction Health Care Services Personally Received	60% 2010	68%		na 2011	na				60% 2010	na
30 Day Unplanned Readmission Rate	6.8% 2010/11	tdb	na	7.1% Q4 YTD 2011/12	na	7.2% Q1 2012/13	7.0% Q3 2011/12	■	6.8% Q4 YTD 2011/12	■
Notes ◊ 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	
		2012/13 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
Staying Healthy / Improving Population Health										
◊ Life Expectancy	80.5 2011	tbd		80.5 2011	na				80.7 2010	■
◊ Potential Years Life Lost (per 1,000 population)	50.2 2011	tbd		50.2 2011	na				51.4 2010	■
Breast Cancer Screening Participation Rate	52.0% 2010-2011	55 - 62% 2010-2015		52.0% 2010-2011	▲				53.4% 2009-2010	■
Cervical Cancer Screening Participation Rate	66.1% Jan 2009 - Dec 2011	70 - 75% 2010-2015		66.1% 2009 - 2011	▲				62.3% Jan 2008 - Dec 2010	■
Strengthen Primary Health Care										
◊ Seniors (65+) Influenza Immunization Rate	53.4% 2011-2012	75.0%		53.4% 2011-2012	●				43.8% 2009-2010	■
◊ Children (6 to 23 Months) Influenza Immunization Rate	26.9% 2011-2012	75.0%		26.9% 2011-2012	●				9% 2009-2010	■
◊ Childhood Immunization Rates for DTaP	72.0% 2009	97.0%		65.0% 2010	●				75.1% 2008	●
◊ Childhood Immunization Rates for MMR	85.2% 2009	98.0%		83.3% 2010	●				86.8% 2008	▲
Albertans Enrolled in a Primary Care Network (%)	69% Apr 2012	tbd		69% Apr 2012	na	69% Apr 2012	69% Oct 2011	■	66% Apr 2011	■
◊ Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)	344 2011/12	282	71	96 Q1 YTD 2012/13	●	96 Q1 2012/13	92 Q4 2011/12	■	92 Q1 YTD 2011/12	■
◊ Family Practice Sensitive Conditions (% of ED visits)	32.0% 2011/12	23.0%	24.5%	31.2% Q1 YTD 2012/13	●	31.2% Q1 2012/13	32.3% Q4 2011/12	■	32.2% Q1 YTD 2011/12	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	95.0% 2011/12	92%	91%	92% Q1 YTD 2012/13	■	92% Q1 2012/13	94% Q4 2011/12	■	95% Q4 YTD 2010/11	■
Notes ◊ Indicates "Tier 1" measures attached to the 2012 – 2015 Health Plan. * 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	
		2012/13 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
Improve Access and Reduce Wait Times										
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	31.4 2011/12	22.0	25.8	19.7 Q1 YTD 2012/13	■	19.7 Q1 2012/13	33.4 Q4 2011/12	■	32.7 Q1 YTD 2011/12	■
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	32.7 2011/12	28.0	33.3	26.7 Q1 YTD 2012/13	■	26.7 Q1 2012/13	29.4 Q4 2011/12	■	32.7 Q1 YTD 2011/12	■
◊ Cataract Surgery Wait Time (90th percentile in weeks)	24.4 2011/12	25.0	28.8	21.6 Q1 YTD 2012/13	■	21.6 Q1 2012/13	22.9 Q4 2011/12	■	28.5 Q1 YTD 2011/12	■
Other Scheduled Surgery Wait Time (90th percentile in weeks)	25.1 2011/12	tbd	na	23.4 Q1 YTD 2012/13	na	23.4 Q1 2012/13	25.4 Q4 2011/12	■	24.6 Q1 YTD 2011/12	■
◊ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	69% 2011/12	80%	76%	70% Q1 YTD 2012/13	●	70% Q1 2012/13	67% Q4 2011/12	■	72% Q1 YTD 2011/12	■
◊ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	90% 2011/12	86%	85%	90% Q1 YTD 2012/13	■	90% Q1 2012/13	89% Q4 2011/12	■	90% Q1 YTD 2011/12	■
◊ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	43% 2011/12	75%	64%	42% Q1 YTD 2012/13	●	42% Q1 2012/13	37% Q4 2011/12	■	51% Q1 YTD 2011/12	●
◊ Patients Admitted from ED within 8 hours (%) (All Sites) £	71% 2011/12	75%	68%	71% Q1 YTD 2012/13	■	71% Q1 2012/13	68% Q4 2011/12	■	75% Q1 YTD 2011/12	●
Provide More Choice for Continuing Care										
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	48 Mar 2012	48	48	36 Jun 2012	■	36 Jun 2012	48 Mar 2012	■	57 Jun 2011	■
◊ People Waiting in Community for Continuing Care Placement	104 Mar 2012	105	105	107 Jun 2012	▲	107 Jun 2012	104 Mar 2012	■	169 Jun 2011	■
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	35 2011/12	tbd	na	27 Q1 YTD 2012/13	na	27 Q1 2012/13	26 Q4 2011/12	■	35 Q1 YTD 2011/12	■
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	66% 2011/12	tbd	na	62% Q1 YTD 2012/13	na	62% Q1 2012/13	69% Q4 2011/12	●	70%* Q1 YTD 2011/12	●
◊ Number of Home Care Clients	16,379 2011/12	tbd	na	10,311 Q1 2012/13	na	10,311 Q1 2012/13	10,222 Q4 2011/12	■	9,795 Q1 YTD 2011/12	●
Enabling Our People / Enabling One Health System										
◊ Staff Overall Engagement (%)	35% 2009/10	68%		na	na				35% 2009/10	na
◊ Physician Overall Engagement (%)	27% 2009/10	68%		na	na				27% 2009/10	na
Notes ◊ Indicates "Tier 1" measures attached to the 2012 – 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%.										





















Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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
Quality and Patient Safety										
◇ Patient Satisfaction – Adult Acute Care	81.7% 2010/11	tbd	na	85.6% Q4 YTD 2011/12	na	83.6% Q4 2011/12	85.6% Q3 2011/12	■	81.7% Q4 YTD 2010/11	■
◇ Patient Satisfaction - Addictions and Mental Health (AHS)	na	tbd		na	na				na	na
Percentage of Patient Feedback as Commendations	na	na	na	13.80% Q1 YTD 2012/13	na	13.80% Q1 2012/13	5.73% Q4 2011/12	■	6.0% Q1 YTD 2011/12	■
Percentage of Patient Concerns Escalated to Patient Concerns Officer	0.54% 2011/12	na	na	0.00%	na	na	0.61% Q4 2011/12	■	na	na
◇ Albertans Reporting Unexpected Harm	na	9%		na	na				8% 2010	na
◇ Patient Satisfaction Emergency Department	na	tbd		na	na	na	na	na	na	na
◇ Patient Satisfaction Health Care Services Personally Received	na	68%		na	na				66% 2010	na
30 Day Unplanned Readmission Rate	9.1% 2010/11	tbd	na	9.7% Q4 YTD 2011/12	na	9.6 Q4 2011/12	9.8% Q3 2011/12	■	9.1% Q4 YTD 2010/11	●
Notes ◇ Indicates "Tier 1" measures attached to the 2012 – 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

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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
Staying Healthy / Improving Population Health										
◊ Life Expectancy	81.9 2011	tbd		81.9 2011	na				81.8 2010	—
◊ Potential Years Life Lost (per 1,000 population)	44.7 2011	tbd		44.7 2011	na				45.7 2010	—
Breast Cancer Screening Participation Rate	54.5% 2010-2011	55 - 62% 2010-2015		54.5% 2010-2011	▲				56.6% 2009-2010	—
Cervical Cancer Screening Participation Rate	58.2% 2009-2011	70 - 75% 2010-2015		58.2% 2009 - 2011	●				67.9% 2008 - 2010	●
Strengthen Primary Health Care										
◊ Seniors (65+) Influenza Immunization Rate	63.8% 2011-2012	75.0%		63.8% 2011-2012	●				61.0% 2009/10	—
◊ Children (6 to 23 Months) Influenza Immunization Rate	26.9% 2011-2012	75.0%		26.9% 2011-2012	●				14.0% 2009-2010	■
◊ Childhood Immunization Rates for DTaP	77.2% 2009	97.0%		74.6% 2010	●				87.0% 2010	●
◊ Childhood Immunization Rates for MMR	88.8% 2009	98.0%		88.0% 2010	●				92.5% 2010	▲
Albertans Enrolled in a Primary Care Network (%)	72% Apr 2012	tbd		72% Apr 2012	na	72% Apr 2011	72% Oct 2011	—	70% Apr 2011	—
◊ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	241 2011/12	282	71	58 Q1 YTD 2012/13	■	58 Q1 2012/13	63 Q4 2011/12	■	63 Q1 YTD 2011/12	■
◊ Family Practice Sensitive Conditions (% of ED visits)	14.5% 2011/12	23%	24.5%	14.3% Q1 YTD 2012/13	■	14.3% Q1 2012/13	14.7% Q4 2011/12	—	14.7% Q1 YTD 2011/12	—
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	53% 2011/12	92%	91%	55% Q1 YTD 2012/13	●	55% Q1 2012/13	64% Q4 2011/12	●	34% Q1 YTD 2011/12	■
Notes ◊ Indicates "Tier 1" measures attached to the 2012 – 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	
		2012/13 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
Improve Access and Reduce Wait Times										
◇ Urgent CABG Wait Time (90th percentile in weeks)	1.9 2011/12	1.0	1.0	1.4 Q1 YTD 2012/13	●	1.4 Q1 2012/13	1.9 Q4 2011/12	■	1.9 Q1 YTD 2011/12	■
◇ Semi-urgent CABG Wait Time (90th percentile in weeks)	7.5 2011/12	2.0	2.0	6.8 Q1 YTD 2012/13	●	6.8 Q1 2012/13	7.0 Q4 2011/12	■	13.0 Q1 YTD 2011/12	■
◇ Scheduled CABG Wait Time (90th percentile in weeks)	18.9 2011/12	6.0	6.0	18.4 Q1 YTD 2012/13	●	18.4 Q1 2012/13	14.1 Q4 2011/12	●	20.6 Q1 YTD 2011/12	■
◇ Hip Replacement Surgery Wait Time (90th percentile in weeks)	48.0 2011/12	22.0	25.8	35.3 Q1 YTD 2012/13	●	35.3 Q1 2012/13	42.9 Q4 2011/12	■	54.0 Q1 YTD 2011/12	■
◇ Knee Replacement Surgery Wait Time (90th percentile in weeks)	55.6 2011/12	28.0	33.3	45.6 Q1 YTD 2012/13	●	45.6 Q1 2012/13	49.3 Q4 2011/12	■	57.9 Q1 YTD 2011/12	■
◇ Cataract Surgery Wait Time (90th percentile in weeks)	32.6 2011/12	25.0	28.8	30.3 Q1 YTD 2012/13	▲	30.3 Q1 2012/13	27.6 Q4 2011/12	●	37.6 Q1 YTD 2011/12	■
Other Scheduled Surgery Wait Time (90th percentile in weeks)	25.7 2011/12	tbd	na	26.4 Q1 YTD 2012/13	na	26.4 Q1 2012/13	25.3 Q4 2011/12	■	26.0 Q1 YTD 2011/12	■
◇ Radiation Therapy Access (referral to 1 st consult) (90th percentile in weeks)	4.9 2011/12	3.0	3.8	3.9 Q1 YTD 2012/13	▲	3.9 Q1 2012/13	4.9 Q4 2011/12	■	4.9 Q1 YTD 2011/12	■
◇ Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks) £	3.0 2011/12	4.0	4.0	2.9 Q1 YTD 2012/13	■	2.9 Q1 2012/13	2.7 Q4 2011/12	●	3.6 Q1 YTD 2011/12	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	58% 2011/12	80%	76%	59% Q1 YTD 2012/13	●	59% Q1 2012/13	56% Q4 2011/12	■	60% Q1 YTD 2011/12	■
◇ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	65% 2011/12	86%	85%	65% Q1 YTD 2012/13	●	65% Q1 2012/13	62% Q4 2011/12	■	66% Q1 YTD 2011/12	■
◇ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	31% 2011/12	75%	64%	39% Q1 YTD 2012/13	●	39% Q1 2012/13	33% Q4 2011/12	■	31% Q1 YTD 2011/12	■
◇ Patients Admitted from ED within 8 hours (%) (All Sites) £	32% 2011/12	75%	68%	39% Q1 YTD 2012/13	●	39% Q1 2012/13	34% Q4 2011/12	■	32% Q1 YTD 2011/12	■
Notes ◇ Indicates "Tier 1" measures attached to the 2012 – 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	
		2012/13 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
Provide More Choice for Continuing Care										
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	143 Mar 2012	115	124	166 Jun 2012		166 Jun 2012	143 Mar 2012		165 Jun 2011	
◊ People Waiting in Community for Continuing Care Placement	202 Mar 2012	230	230	193 Jun 2012		193 Jun 2012	202 Mar 2012		284 Jun 2011	
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	32 2011/12	tbd	na	23 Q1 YTD 2012/13	na	23 Q1 2012/13	24 Q4 2011/12		33 Q1 YTD 2011/12	
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	66% 2011/12	tbd	na	80% Q1 YTD 2012/13	na	80% Q1 2012/13	75% Q4 2011/12		61% Q1 YTD 2011/12	
◊ Number of Home Care Clients	36,485 2011/12	tbd	na	23,560 Q1 YTD 2012/13	na	23,560 Q1 2012/13	22,655 Q4 2011/12		22,462 Q1 YTD 2011/12	
Build One Health System										
◊ Staff Overall Engagement (%)	37% 2009/10	68%		na	na				37% 2009/10	na
◊ Physician Overall Engagement (%)	25% 2009/10	68%		na	na				25% 2009/10	na
◊ Patient Satisfaction – Adult Acute Care	80.3%^ 2010/11	tbd	na	83.2% 2011/12	na	81.4% Q4 2011/12	82.6% Q3 2011/12		80.3%^ 2010/11	
◊ Patient Satisfaction - Addictions and Mental Health (AHS)	na 2010/11	tbd		na	na	na	na	na	na	na
Percentage of Patient Feedback as Commendations	na 2011/12	tbd	na	12.40% Q1 YTD 2012/13	na	12.40% Q1 2012/13	11.58% Q4 2011/12		7.9% Q1 YTD 2011/12	
Percentage of Patient Concerns Escalated to Patient Concerns Officer	0.35% 2011/12	tbd	na	0.31% Q1 YTD 2012/13	na	0.31% Q1 2012/13	0.21% Q4 2011/12		0.3% Q1 YTD 2011/12	
◊ Albertans Reporting Unexpected Harm	na 2011	9%		na 2011	na				9% 2010	na
◊ Patient Satisfaction Emergency Department	na	tbd	na	na	na	na	na	na	na	na
◊ Patient Satisfaction Health Care Services Personally Received	na	tbd	na	na 2011	na				65% 2010	na
30 Day Unplanned Readmission Rate	7.8% 2010/11	tbd	na	8.1% Q4 YTD 2011/12	na	8.3% Q4 2011/12	7.9% Q3 2011/12		7.8% 2010/11	
Notes ◊ Indicates "Tier 1" measures attached to the 2012 – 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

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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
Staying Healthy / Improving Population Health										
◊ Life Expectancy	79.4 2011	tbd		79.4 2011	na				79.8 2010	■
◊ Potential Years Life Lost (per 1,000 population)	57.6 2011	tbd		57.6 2011	na				56.8 2010	■
Breast Cancer Screening Participation Rate	52.6% 2010-2011	55 - 62% 2010-2015		52.6% 2010-2011	▲				54.7% 2009-2010	■
Cervical Cancer Screening Participation Rate	62.6% Jan 2009 - Dec 2011	70 - 75% 2010-2015		62.6% Jan 2009 - Dec 2011	●				59.5% Jan 2008 - Dec 2010	■
Strengthen Primary Health Care										
◊ Seniors (65+) Influenza Immunization Rate	51.5% 2011-2012	75.0%		51.5% 2011-2012	●				51.5% 2009-2010	■
◊ Children (6 to 23 Months) Influenza Immunization Rate	20.2% 2011-2012	75.0%		20.2% 2011-2012	●				18.0% 2010-2011	▲
◊ Childhood Immunization Rates for DTaP	72.6% 2009	97.0%		66.7% 2010	●				78.2% 2008	●
◊ Childhood Immunization Rates for MMR	83.5% 2009	98.0%		81.0% 2010	●				89.2 2008	●
Albertans Enrolled in a Primary Care Network (%)	68% Apr 2012	tbd		68% Apr 2012	na	68% Apr 2012	66% Oct 2011	■	63% Apr 2011	■
◊ Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	468 2011/12	282	71	117 Q1 YTD 2012/13	●	117 Q1 2012/13	124 Q4 2011/12	■	136 Q1 YTD 2011/12	■
◊ Family Practice Sensitive Conditions (% of ED visits)	38.2% 2011/12	23.0%	24.5%	37.8% Q1 YTD 2012/13	●	37.8% Q1 2012/13	37.7% Q4 2011/12	■	38.5% Q1 YTD 2011/12	■
◊ Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	68.0% 2011/12	92%	91%	75% Q1 YTD 2012/13	●	75% Q1 2012/13	67% Q4 2011/12	■	68% Q4 YTD 2010/11	■
Improve Access and Reduce Wait Times										
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	49.7 2011/12	22.0	25.8	44.3 Q1 YTD 2012/13	●	44.3 Q1 2012/13	45.2 Q4 2011/12	■	49.6	■
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	51.9 2011/12	28.0	33.3	49.7 Q1 YTD 2012/13	●	49.7 Q1 2012/13	54.8 Q4 2011/12	■	50.9	■
◊ Cataract Surgery Wait Time (90th percentile in weeks)	55.7 2011/12	25.0	28.8	46.1 Q1 YTD 2012/13	●	46.1 Q1 2012/13	64.0 Q4 2011/12	■	53.6	■
Other Scheduled Surgery Wait Time (90th percentile in weeks)	25.4 2011/12	tbd	na	26.9 Q1 YTD 2012/13	na	26.9 Q1 2012/13	24.6 Q4 2011/12	●	23.6	●
Notes ◊ Indicates "Tier 1" measures attached to the 2012 – 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.										

Q1 2012/13 AHS Performance Dashboard

North Zone (continued)

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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) £	79% 2011/12	80%	76%	79% Q1 YTD 2012/13	■	79% Q1 2012/13	76% Q4 2012/13	■	78% Q1 YTD 2011/12	■
◊ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	90% 2011/12	86%	85%	95% Q1 YTD 2012/13	■	95% Q1 2012/13	89% Q4 2012/13	■	90% Q1 YTD 2011/12	■
◊ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	66% 2011/12	75%	64%	61% Q1 YTD 2012/13	▲	61% Q1 2012/13	62% Q4 2012/13	■	67% Q1 YTD 2011/12	●
◊ Patients Admitted from ED within 8 hours (%) (All Sites) £	84% 2011/12	75%	68%	83% Q1 YTD 2012/13	■	83% Q1 2012/13	83% Q4 2012/13	■	85% Q1 YTD 2011/12	■
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	77 Mar 2012	56	53	65 Jun 2012	●	65 Jun 2012	77 Mar 2012	■	75 Jun 2011	■
◊ People Waiting in Community for Continuing Care Placement	106 Mar 2012	82	90	96 Jun 2012	●	96 Jun 2012	106 Mar 2012	■	107 Jun 2011	■
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	87 2011/12	tbd	na	76 Q1 YTD 2012/13	na	76 Q1 2012/13	75 Q4 2012/13	■	118 Q1 YTD 2011/12	■
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	49% 2011/12	tbd	na	48% Q1 YTD 2012/13	na	48% Q1 2012/13	54% Q4 2012/13	●	38% Q1 YTD 2011/12	■
◊ Number of Home Care Clients	11,230 2011/12	tbd	na	7,656 Q1 YTD 2012/13	na	7,656 Q1 2012/13	7,749 Q4 2012/13	■	7,719 Q1 YTD 2011/12	■
◊ Staff Overall Engagement (%)	41% 2009/10	68%		na	na				41% 2009/10	na
◊ Physician Overall Engagement (%)	27% 2009/10	68%		na	na				27% 2009/10	na
Notes ◊ Indicates "Tier 1" measures attached to the 2012 – 2015 Health Plan. £The Weekly ED Length of Stay (LOS) being published separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.										

Q1 2012/13 AHS Performance Dashboard

North Zone (continued)

Performance Measure	Previous Year Results	Year to Date Actual to Target Comparison				Consecutive Period Comparison			Prior Year Comparison	
		2012/13 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
Quality and Patient Safety										
◇ Patient Satisfaction – Adult Acute Care	82.4% 2010/11	tbd	na	82.0% Q4 YTD 2011/12	na	81.7% Q4 2011/12	84.1% Q3 2011/12	■	82.4% [^] Q4 2010/11 YTD	■
◇ Patient Satisfaction - Addictions and Mental Health (AHS)	na 2011/12	tbd		na	na				na 2010/11	na
Percentage of Patient Feedback as Commendations	na 2010/12	tbd	na	5.50% Q1 YTD 2012/13	na	5.50% Q1 2012/13	6.07% Q4 2011/12	na	3.2% Q1 YTD 2011/12	■
Percentage of Patient Concerns Escalated to Patient Concerns Officer	na 2010/12	tbd	na	0.70% Q1 YTD 2012/13	na	0.70% Q1 2012/13	0.54% Q4 2011/12	●	na 2010/11	na
◇ Albertans Reporting Unexpected Harm	na	9%		na 2011	na				8% 2010	na
◇ Patient Satisfaction Emergency Department	na	tbd		na	na	na	na	na	na	na
◇ Patient Satisfaction Health Care Services Personally Received	na	68%		na 2011	na				53% 2010	na
30 Day Unplanned Readmission Rate	9.6% 2010/11	tbd	na	9.5% Q4 YTD 2011/12	na	9.2% Q4 2011/12	9.1% Q3 2011/12	■	9.6% Q4 YTD 2010/11	■
Notes ◇ Indicates "Tier 1" measures attached to the 2012 – 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					

Quick Facts

Activity Measure	2010/11 Fiscal Year	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4	2011/12 Fiscal Year	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4	2012/13 Fiscal Year
Number of Hospital Discharges ¹ (by Site)	364,041	95,600	92,582	92,690	95,254	376,126	96,919				
Average Hospital Length of Stay (Days) ^{1,2} (by Site)	7.0	6.8	6.7	7.1	7.0	6.9	6.8				
Per Cent of Alternate Level of Care (ALC) ^{1,3} Days	9.0%	7.1%	7.4%	8.3%	7.2%	7.5%	9.9%				
Number of Hospital Births ¹	49,756	12,894	13,104	12,007	12,095	50,101	12,890				
Number of Emergency Department Visits ⁴ (by Site)	1,942,003	502,987	508,802	502,931	514,505	2,029,225	524,332				
Number of Urgent Care Service (UCS) Visits ⁵	177,297	49,913	49,152	47,984	49,219	196,268	50,779				
Number of Health Link Calls	758,971	189,135	174,190	203,008	199,813	766,146	180,592				
Number of Total Hip Replacements ⁶	4,466	1,206	1,033	1,309	1,321	4,869	1,361				
Number of Elective Hip Replacements ⁷	3,235	900	773	925	1,015	3,613	1,045				
Number of Total Knee Replacements ⁶	4,990	1,436	1,221	1,488	1,651	5,796	1,604				
Number of Elective Knee Replacements ⁷	4,895	1,434	1,217	1,406	1,659	5,716	1,589				
Number of Cataract Surgeries ⁸	33,781	8,545	8,163	10,296	9,555	36,559	9,449				
Number of MRI Exams ⁹	177,422	41,016	40,642	40,787	44,200	166,645	42,957				
Number of CT Exams ¹⁰	333,163	82,878	84,653	82,543	84,540	334,614	87,059				
Number of Lab Tests ¹¹	61,357,627	16,483,608	15,743,839	16,092,350	16,928,228	65,248,025	17,283,794				
Number of EMS Events ¹²	377,280	96,500	99,696	98,760	99,008	393,964	96,346				

Access notes for interpretation [here](#).

Life Expectancy

Data updated annually.
Most current data are 2011.
Next data update expected for 2012/13 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.

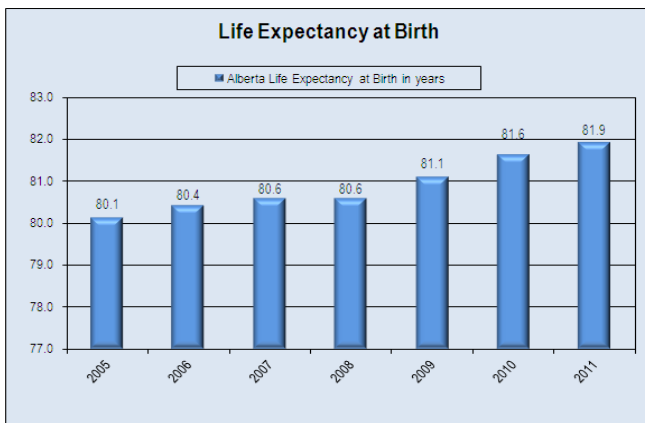
WHAT IS THE TARGET?

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.

HOW ARE WE DOING?

There has been significant improvement in Life Expectancy for Albertans as a whole with Life Expectancy steadily increasing since 2005. There is significant disparity in life expectancy between urban and rural zones. Life expectancy in the North is about two and a half years less than for the average Albertan. A child born in the Edmonton Zone can expect to live a year and a half less than a child born in Calgary. Differences in health status and determinants of health are also evident between rural and urban areas.



Source: Alberta Health

PERFORMANCE STATUS

Performance improvement observed since last reported period.

TARGET:
Improvement

2011 ACTUAL:
81.9 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?

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 = 80.7, Best Performing Province = 81.7 (British Columbia), Canada = 81.1 (Statistics Canada 2007/2009).

Data updated annually.
Most current data are 2011.
Next data update expected for 2012/13 Q4 report.

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?

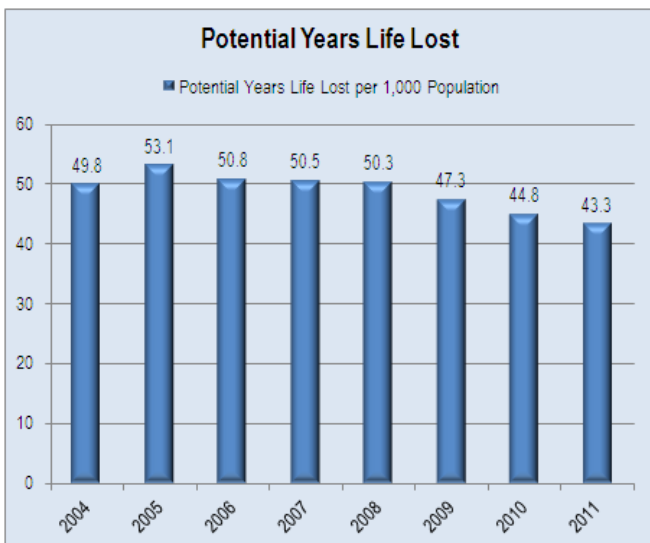
PYLL is an indicator of premature mortality that gives greater weight to causes of death that occur at a younger age than to those at older ages. It emphasizes the loss of life at an early age and the causes of early deaths such as cancer, injury and cardiovascular disease. For example, the death of 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?

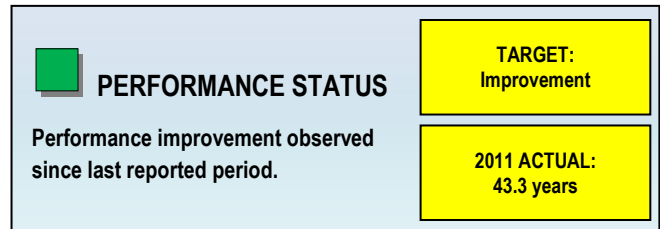
In 2011, there was an improvement in PYLL with a drop from 44.8 years per 1,000 population in 2010 to 43.3 years per 1,000 population in 2011.



Source: Alberta Health

Performance Measure Update

Potential Years of Life Lost



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).

Data updated annually.
Most current data are 2011.
Next data update expected for 2012.

Performance Measure Update

Colorectal Cancer Screening Participation Rate

WHAT IS BEING MEASURED?

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

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

Detailed indicator [definition](#) is available.

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

WHY IS THIS IMPORTANT?


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

WHAT IS THE TARGET?

The Alberta 2015 target is for 55 per cent of targeted individuals to have had a FOBT within the last two years, a flexible sigmoidoscopy within the last five years, or a colonoscopy within the last ten years. A target of 67 per cent has been set for 2020.

HOW ARE WE DOING?

The 2011 Colon Cancer Screening in Canada Survey by Canadian Partnership Against Cancer (CPAC) showed 57 per cent of Albertans between the ages of 50 and 74 years are up to date for

 PERFORMANCE STATUS Performance is at or better than target, continue to monitor.	2015 TARGET: 55%
	2011 ACTUAL: 57%

colorectal cancer screening. This is a substantial improvement over the 2009 rate of 43%.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Continue to develop access, infrastructure and capacity for comprehensive colorectal cancer screening programs including expanding screening-related colonoscopy capacity across the province. Fecal Immunochemical Test (FIT) pilot project completed

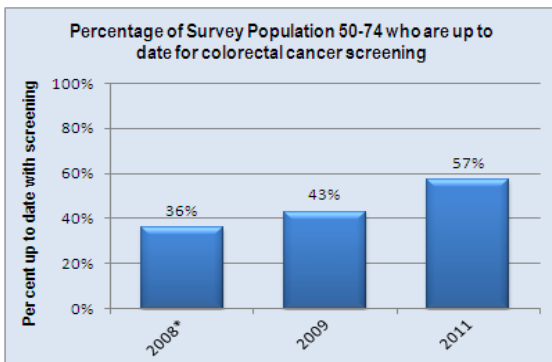
Subsequent actions planned: Detailed implementation plan for FIT initiated.

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).



* Source: Canadian Community Health Survey (CCHS) 2008.
Source: Colon Cancer Screening in Canada Survey by Canadian Partnership Against Cancer (CPAC).

Breast Cancer Screening Participation Rate

Data updated annually.
Most current data are 2010/11.
Next data update expected for 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 62 per cent of eligible women, 50 to 69 years of age, to have a screening mammogram at least biennially by 2015.



PERFORMANCE STATUS

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

2010 - 2015
TARGET:
55% - 62%%

2010-2011 ACTUAL:
54.8%

HOW ARE WE DOING?

During the two-year period between January 2010 and December 2011, 54.8 per cent of women aged 50 to 69 years received a screening mammogram. This result is just short of the lower end of the 2010 – 2015 target range.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Incorporate a full spectrum of screening program activities within the Alberta Breast Cancer Screening Program. Enhancements to the Alberta Breast Cancer Screening Program completed to enable Reminders to physicians and women when follow-up of abnormal results is overdue and Reminders to women who are overdue for breast cancer screening.

Subsequent actions planned: Continue to incorporate a full spectrum of screening program activities within the Alberta Breast Cancer Screening Program.

WHAT ELSE DO WE KNOW?

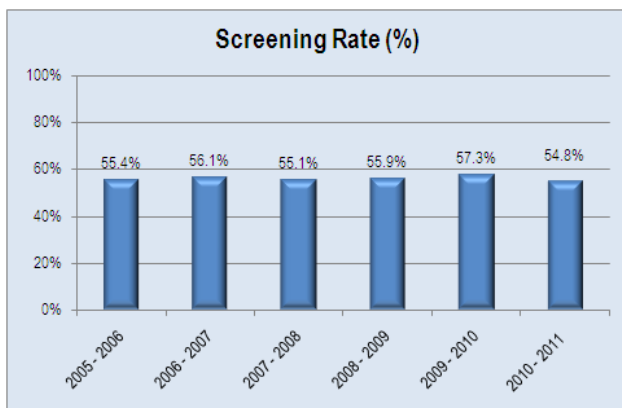
In order to more accurately reflect the way in which the population receives screening mammography, the Alberta Breast Cancer Screening Program is working with the Public Health Agency of Canada to evaluate a biennial mammography utilization indicator that might include bilateral diagnostic mammograms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

Data updated annually.
Most current data are 2009/11.
Next data update expected for 2012/13 report.

Performance Measure Update

Cervical Cancer Screening Participation Rate

WHAT IS BEING MEASURED?

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

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

Detailed indicator [definition](#) is available.

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

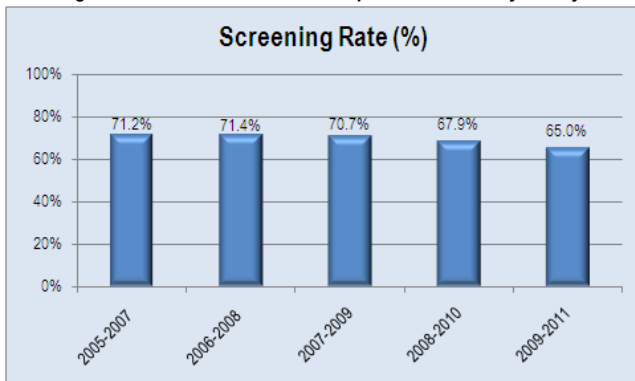
WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

The target for 2010 - 2015 is 70 per cent to 75 per cent.

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



Source: Extracted from AH 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.

2010-2015
TARGET:
70% - 75%

2009-2011 ACTUAL:
65.0%

HOW ARE WE DOING?

During the three-year period between January 2009 and December 2011, 65.0 per cent of eligible women aged 21 to 69 years received a screening Pap test. While this is 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: Continue expansion of the Alberta Cervical Cancer Screening Program correspondence components province wide.

Subsequent actions planned: AHS Alberta Cervical Cancer Screening Program reminder system expanded province wide as of April 2012 to include reminders to physicians and women when follow-up of abnormal cervical cancer screening results is overdue.

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 seventh among the 10 provinces for self-reported cervical cancer screening. Alberta = 80.3 per cent, Best Performing Province = 83.2 per cent (Manitoba), Canada = 78.5 per cent (Statistics Canada, 2008).

Data updated annually.
Most current data are 2011/12
Next data update expected for 2012/13.

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 (October 2011 to end of season).

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?

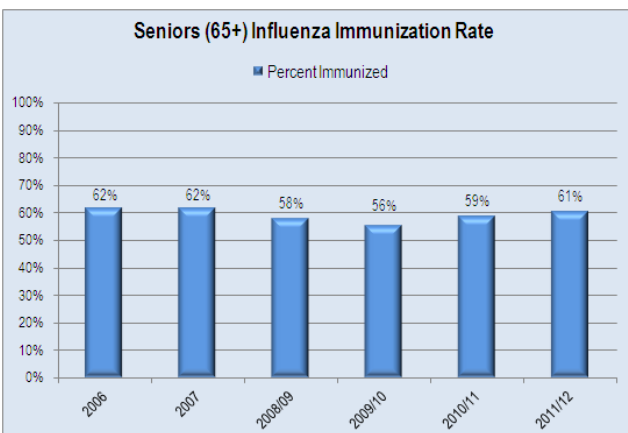
A high rate of seasonal influenza immunization among seniors will reduce the incidence of complications and death associated with influenza disease in this population. A high rate of coverage will reduce the impact of disease on the health care system.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

The seasonal influenza immunization rate for seniors aged 65 and older for 2011/12 is 60.8 per cent as of May 26, 2012. While slightly better than the 2010/11 rate of 58.9 per cent, it is below the overall target of 75 per cent. There has been steady improvement since 2009/10.



Source: Alberta Health and Alberta Health Services.

Note: The lower immunization rate for 2009/10 may be due to seniors opting for the pandemic H1N1 vaccine component as it was the circulating strain.

PERFORMANCE STATUS

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

2012/13 TARGET:
75%

2011/12 ACTUAL:
60.8%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Venues for public clinics have been selected and booked for fall 2012 in the South Zone. Planning meeting for 2012/13 took place in June for the Central Zone with most venues and dates for mass clinics having been booked, supplies ordered and managers beginning to post and hire staff for the influenza program. Within the Edmonton Zone, sites for mass clinics are currently in the process of being secured and the staff recruitment and program planning is in process for the annual fall campaign. Within the North Zone, planning for 2012/13 is underway: committee has been formed and first meeting held; steering committee will meet monthly.

Subsequent actions planned: Continue to execute against the 2012/13 plans within each zone including identifying and securing mass clinic sites and securing necessary staff.

WHAT ELSE DO WE KNOW?

A high rate of coverage will reduce the impact of disease on the health care system during influenza season, including physician and emergency department visits, and hospitalizations.

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 the end of season. Due to late outbreaks this year, doses continued to be delivered into May so the figures reported here reflect an end of season of May 26.

HOW DO WE COMPARE?

Using a separate definition, determined to be similar across provinces, Alberta ranked third among the 10 provinces for self-reported influenza immunization. Alberta = 67.6 per cent, Best Performing Province = 75.0 per cent (Nova Scotia), Canada = 64.4 per cent (Statistics Canada, 2011).

Children (6 to 23 Months) Influenza Immunization Rate

Data updated annually.
Most current data are 2011/12.
Next data update expected for 2012/13.

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?

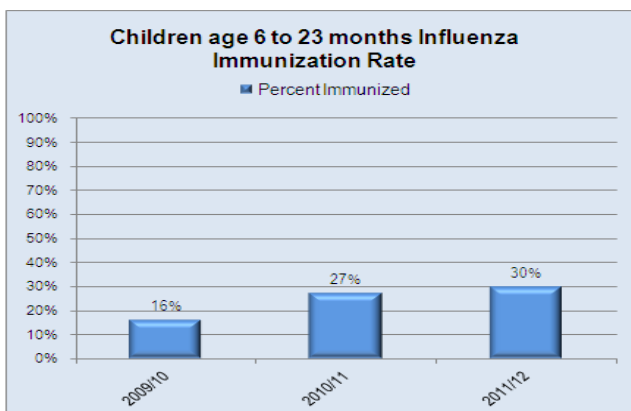
A high rate of seasonal influenza immunization among children reduces the incidence of complications and death associated with influenza disease and reduces the spread of disease to older age groups during the influenza season. A high rate of coverage will reduce the impact of disease on the health care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

WHAT IS THE TARGET?

The Alberta Health (AH) 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 29.9 per cent for 2011/12, as of May 26, 2012 which while better than the 2010/11 rate of 27.2 per cent, remains below target of 75 per cent. Over the past 2 years, since 2009/10, the immunization rate has nearly doubled.



Source: Alberta Health and Alberta Health Services

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.

The 2009/10 rate may be lower as many parents chose to have their children receive only the pandemic H1N1 vaccine.



PERFORMANCE STATUS

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

2012/13 TARGET:
75%

2011/12 ACTUAL:
29.9%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Planning is underway for the 2012/13 influenza season. Venues for public clinics have been selected and booked for fall 2012 in the South Zone. Planning meeting for 2012/13 took place in June for the Central Zone with most venues and dates for mass clinics having been booked, supplies ordered and managers beginning to post and hire staff for the influenza program. Within the Edmonton Zone, sites for mass clinics are currently in the process of being secured and the staff recruitment and program planning is in process for the annual fall campaign. Within the North Zone, planning for 2012/13 is underway: committee has been formed and first meeting held; steering committee will meet monthly.

Subsequent actions planned: Continue to execute against the 2012/13 plans within each zone including identifying and securing mass clinic sites and securing necessary staff.

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. 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 end of season. For 2011/12 end of season was up until May 26.

HOW DO WE COMPARE?

Limited comparable data is available.

Data updated annually.
Most current data are 2010.
Next data update expected for Q4 2012/13 report.

Performance Measure Update

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 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?

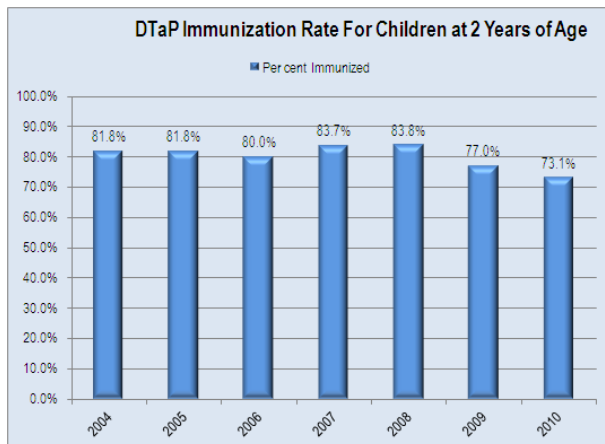
A high rate of immunization for a population reduces the incidence of vaccine preventable childhood diseases, and controls outbreaks. Immunizations protect children and adults from a number of preventable diseases, some of which can be fatal or produce permanent disabilities.

WHAT IS THE TARGET?

The Alberta Health (AH) 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.

HOW ARE WE DOING?

The DTaP immunization rate for children up to two years of age for 2010 was 73.1 per cent (below target). This is a decrease from previous years.



Source: Alberta Health and Alberta Health Services
<http://www.health.alberta.ca/health-info/IHDA.html>



PERFORMANCE STATUS

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

2012/13 TARGET:
97%

2010 ACTUAL:
73.1%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Have begun to identify common barriers that AHS immunizers feel are influencing decisions regarding the choice to immunize. Have begun to identify and document current and common strategies that can be implemented across the province, the zone and specific geographic area to address barriers to immunization.

Subsequent actions planned: Barriers to immunization survey developed and distributed to zone public health and province-wide immunization program staff with timeline for response set for August 2012.

WHAT ELSE DO WE KNOW?

There are pockets of low immunization across the province.

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 75 per cent of children born in 2009 were up-to-date by two years of age for D/T/aP/IPV/HIB (BC Centre for Disease Control 2012).

Data updated annually.
Most current data are 2010.
Next data update expected for Q4 2012/13 report.

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.

Individual immunization events are reported by AHS Zones to Alberta Health. First Nations Alberta Region reports aggregate data to Alberta Health.

Detailed indicator [definition](#) is available.

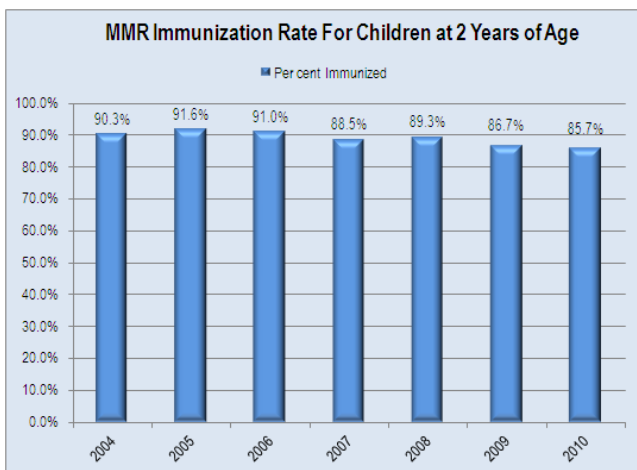
A data quality assessment is not available for this data at this time.

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?

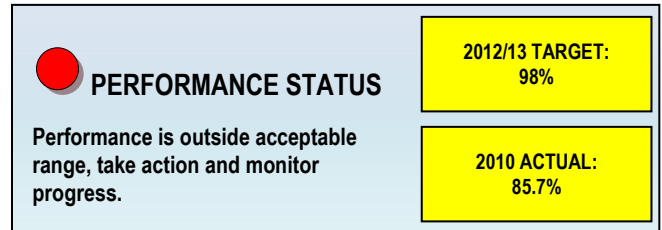
The Alberta Health (AH) Business Plan target is for 98 per cent of children to have received the required number of doses of MMR vaccine by two years of age.



Source: Alberta Health and Alberta Health Services
<http://www.health.alberta.ca/health-info/IHDA.html>

Performance Measure Update

Childhood Immunization Rate for Measles, Mumps, Rubella



HOW ARE WE DOING?

The 2010 MMR immunization rate for children at two years of age is 85.7 per cent, below target.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Have begun to identify common barriers that AHS immunizers feel are influencing decisions regarding the choice to immunize. Have begun to identify and document current and common strategies that can be implemented across the province, the zone and specific geographic area to address barriers to immunization.

Subsequent actions planned: Barriers to immunization survey developed and distributed to zone public health and province-wide immunization program staff with timeline for response set for August 2012.

WHAT ELSE DO WE KNOW?

There are pockets of low immunization across the province.

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 75 per cent of children born in 2009 were up-to-date by two years of age for MMR (BC Centre for Disease Control 2012).

Data updated twice yearly
Most current data are April 2012
Next data update expected in October 2012.

Albertans Enrolled in a Primary Care Network (%)

WHAT IS BEING MEASURED?

Access to primary care through Primary Care Networks is defined as the percentage of Albertans informally enrolled in a Primary Care Network as at March 31 of a given year.

The percentage of Albertans enrolled in a Primary Care Network is determined by calculating the number of Albertans who are informally enrolled in a Primary Care Network (numerator) in a given fiscal year as a proportion of the total population covered by the Alberta Health Care Insurance Plan (denominator) as at March 31 of that year.

The measure definition and methodology used to calculate this measure have been reviewed and agreed upon by both AH and AHS and future reporting will align to this single methodology for reporting consistency.

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 health care 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.

PERFORMANCE STATUS

Status to be determined.

2012/13 TARGET:
tbd

ACTUAL: 75%
(April 2012)

HOW ARE WE DOING?

The percentage of Albertans enrolled in a PCN is 75 per cent as of April 2012.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Over the past year, more than 30 nurse practitioner-led outpatient clinics have opened in the province, improving access to wide range of primary care services, from diabetes management to spinal injury care. Nurse practitioners are advanced practice nurses who, through additional education, are licensed to diagnose and manage chronic illnesses, order diagnostic tests, and prescribe treatments and medications. They can manage independent clinics and carry their own patient caseload. AHS worked with Family Care Clinics (FCCs) prior to their launch and implementation phases to ensure that Primary Health Care multi-disciplinary provider teams are in place and supported so that the providers in FCCs work in a collaborative way and to their full scopes of practice.

Subsequent actions planned: Nurse practitioners are being recruited into the FCCs, with a target of 14 FTEs.

WHAT ELSE DO WE KNOW?

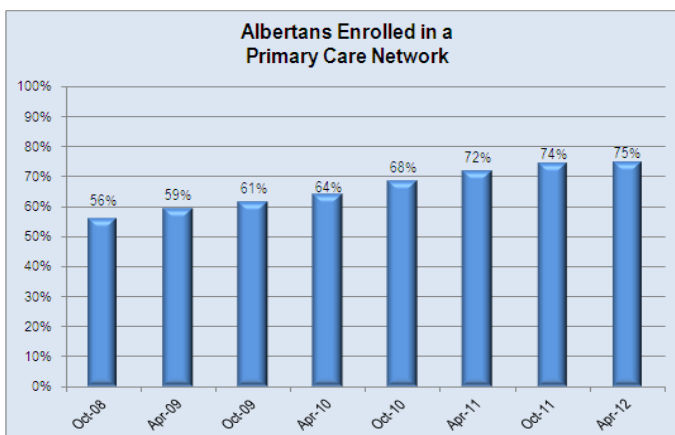
AHS is working to apply and advance a patient-focused model of primary health care that offers care in the community, and provides a team-based health care provider approach.

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 = 79.7 per cent, Best Performing Province = 93.5 per cent (Nova Scotia), Canada = 84.7 per cent (Statistics Canada, 2011). Alberta ranked tied for fifth among the 10 provinces in terms of number of family physicians per 100,000 population. Alberta = 109, Best Performing Province = 119 (British Columbia), Canada = 104 (Canadian Institute for Health Information, 2010).



Source: Alberta Health; April 2010 figure is a preliminary calculation from AHS.

Data updated quarterly.
Most current data are Q1 2012/13
Next data update expected for Q2 Report

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.

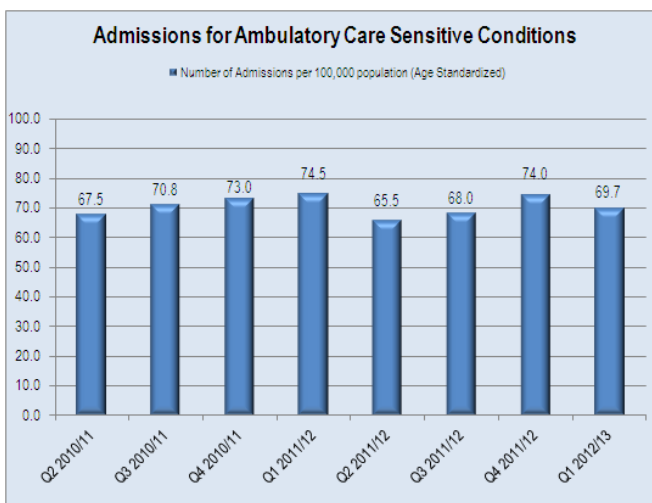
An internal review of the data quality indicates a high level of confidence with limited issues.

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 282 ACSC admissions per 100,000 population under age 75 years, has been established for 2012/13. As large variations exist in the rate of hospitalization for these conditions across Canada, the “most appropriate” target is not yet known ([CIHI Health Indicators 2009](#)).



Source: AHS Discharge Abstract Database

Performance Measure Update

Admissions for Ambulatory Care Sensitive Conditions

 PERFORMANCE STATUS Performance is at or better than target, continue to monitor.	2012/13 TARGET: 282 admissions per 100,000
	YTD TARGET: 71 ACTUAL: 70 admissions per 100,000 (Apr-Jun)

HOW ARE WE DOING?

While there has been a slight decrease in overall ACSC admissions in the most recent quarter, actual performance is better than target.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: AHS and Patient Care Networks (PCNs) continue to work on decreasing hospital admissions and Emergency visits by focusing on chronic disease management and prevention, maximizing the use of inter-professional teams (e.g., social workers and mental health providers), and also ensuring that hospital flow and transitions with the community are appropriate. Provincial process maps that cross the continuum of care have been developed. Clinical processes for adult specialty care are under development in each Zone by the provincial Bariatric Resource team.

Subsequent actions planned: Work is ongoing to recruit patients not yet attached to a physician. In addition, all partners will continue to work collaboratively to improve efficiency, patient and provider satisfaction, and increased PCN participation within the framework of a primary care model that supports physicians, teams and best practice.

WHAT ELSE DO WE KNOW?

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 = 309, Best Performing Province = 263 (British Columbia), Canada = 299 (CIHI 2010/11).

Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 report

Performance Measure Update

Family Practice Sensitive Conditions

WHAT IS BEING MEASURED?

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

Detailed indicator [definition](#) is available.

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 23 per cent of ED or urgent care visits.

HOW ARE WE DOING?

The percentage of family practice sensitive conditions remains slightly above the target.

 PERFORMANCE STATUS Performance is within acceptable range, monitor and take action as appropriate.	2012/13 TARGET: 23% of ED/UCC visits
	YTD TARGET: 24.5% ACTUAL: 25.6% of ED/UCC visits (Apr-Jun)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: AHS zones are actively recruiting new physicians to form PCNs or to join existing PCNs. In addition, work is ongoing to increase enrolment of specific populations (e.g., palliative patients and new mothers with babies). Work is ongoing to recruit patients not yet attached to a physician. In addition, all partners will continue to work collaboratively to improve efficiency, patient and provider satisfaction, and increased PCN participation within the framework of a primary care model that supports physicians, teams and best practice.

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

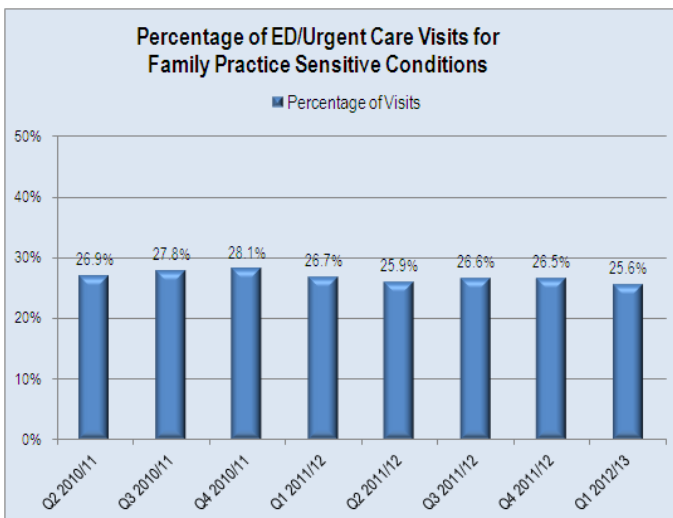
WHAT ELSE DO WE KNOW?

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

Information is available by [zone](#).

HOW DO WE COMPARE?

National benchmark comparisons are not available



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

Data updated quarterly
 Most current data are Q1 2012/13
 Next data update expected for Q2 report

Alberta Service Level (% answered within 2 minutes)

WHAT IS BEING MEASURED?

Health Link Alberta Service Level measures the percentage of calls to Health Link Alberta (HLA) 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 2012/13 annual target of 80 per cent of calls to be answered within two minutes.

HOW ARE WE DOING?

The percentage of Health Link Alberta calls answered within two minutes was 82.6 per cent for Q1 2012/13.

 **PERFORMANCE STATUS**

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

2012/13 TARGET:
80%

YTD TARGET: 82%
ACTUAL: 82.6%
(Apr-Jun)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Review of current operations for efficiencies in call management. A call referral process improvement project has been approved by the HLA provincial management team. An initial meeting has been held with web IT to discuss business requirements for look-up tools to assist with efficiency of information retrieval for staff. MyHealth.Alberta.ca has had 130 parenting and child growth and development information topics added to it. Implemented call process to refer all callers to MyHealth.Alberta.ca at the end of the HLA call, encouraging the public to access self-care/health information via the web prior to calling Health Link when appropriate.

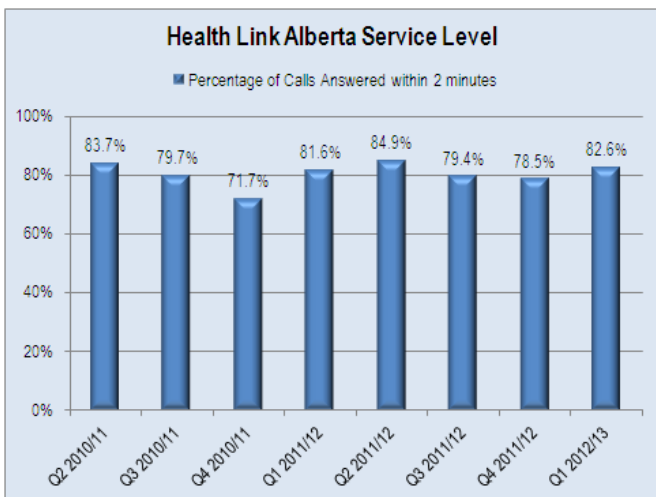
Subsequent actions planned: Expand consumer health content available on MyHealth.Alberta.ca to increase self-serve options for the public, diverting some call volume from HLA.

WHAT ELSE DO WE KNOW?

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

HOW DO WE COMPARE?

National benchmark comparisons are not available.



Source: Health Link Alberta, Nortel Contact Centre Management 6.0

Data updated quarterly.
Most current data are Q1 2012/13
Next data update expected for Q2 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.

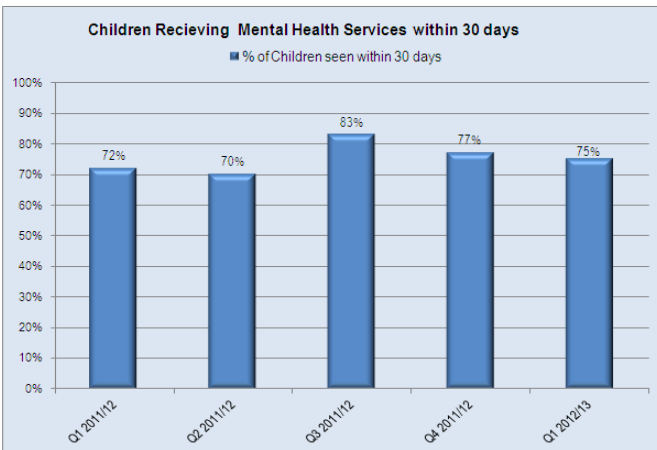
An internal review of the data quality indicates a high level of confidence with limited issues.

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 2012/13 target for children receiving community mental health treatment within 30 days is 92 per cent. Provincial wait-time standards reflect the maximum time children should wait to receive mental health services in Alberta.



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.



PERFORMANCE STATUS

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

2012/13 TARGET:
92%

YTD TARGET: 91%
ACTUAL: 75%
(Apr-Jun)

HOW ARE WE DOING?

Currently, AHS is not meeting the 92 per cent target of referred children receiving a face-to-face assessment within 30 days.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Continuing implementation of the Children's Mental Health Plan and the Positive Futures Framework, including school based mental health capacity-building approaches. Positive Futures program completed within budget (March 31, 2012); five children's mental health standards recommendations identified with work to be advanced in 2012/13. Additional zone-specific actions completed are available [here](#).

Subsequent actions planned: Implementation of the 23 Action Items continues throughout the zones and through provincial initiatives. Collaboration with school districts continues to identify local needs and implement services to improve capacity in school based settings. 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 are Q1 2012/13
Next data update expected for Q2 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 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?

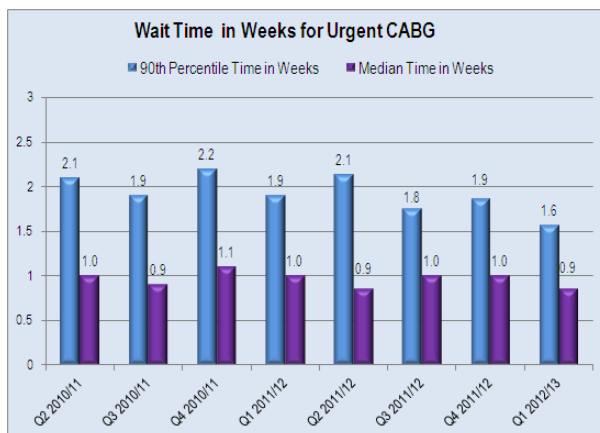
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources. Access in combination with a high quality of service delivery will help ensure optimal patient outcomes.

WHAT IS THE TARGET?

The provincial/territorial benchmark for Urgency I CABG surgeries is within two weeks. The AHS 90th percentile target for 2012/13 is one week for Urgent CABG surgeries.

HOW ARE WE DOING?


The wait time for urgent CABG surgery has decreased between Q4 2011/12 and Q1 2012/13 and the year to date wait time remains longer than the annual target.



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

Performance Measure Update

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.

2012/13 TARGET:
1 week

YTD TARGET: 1 week
ACTUAL: 1.6 weeks
(Apr-Jun)

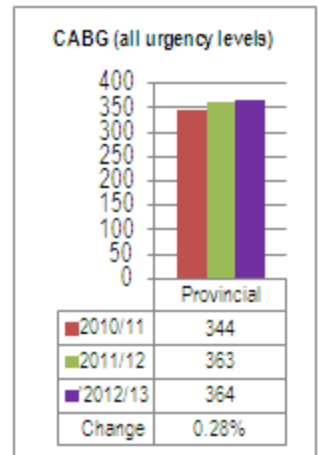
WHAT ACTIONS ARE WE TAKING?

Actions completed to date:

A Joint Working Group (with representatives from Calgary and Edmonton) continues to implement the new wait time definitions for cardiac surgery. Physician-led Quality Improvement project planning meetings are underway; project charter was approved. Continuing to monitor and improve surgical wait time database, identifying strategies for continuous improvement.

There has been an increase in the total number of CABG surgeries performed in April – June 2012, compared to the same period in 2011.

Subsequent actions planned: Review of the intake and triage process for all urgency categories. Review and implement recommendations from OR Utilization committee – focus will be to reduce postponements and increase efficiencies based on current data and resources available.



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 are Q1 2012/13
Next data update expected for Q2 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 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?

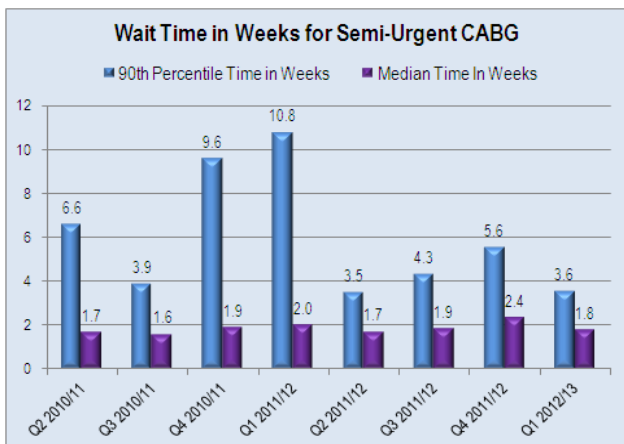
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources. Access in combination with a high quality of service delivery will help ensure optimal patient outcomes.

WHAT IS THE TARGET?

The provincial/territorial benchmark for Urgency II CABG surgeries is within six weeks. The AHS 90th percentile target for 2012/13 is two weeks for semi-urgent CABG surgeries.

HOW ARE WE DOING?

There was a decrease in wait time for semi-urgent CABG surgery in the first quarter of 2012/13 compared to fourth quarter 2011/12, however, the actual wait time remains longer than the annual target.



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

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

PERFORMANCE STATUS

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

2012/13 TARGET: 2 weeks

YTD TARGET: 2 weeks
ACTUAL: 3.6 weeks (Apr-Jun)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date:

A Joint Working Group (with representatives from Calgary and Edmonton) continues to implement the new wait time definitions for cardiac surgery. Physician-led Quality Improvement project planning meetings are underway; project charter was approved. Continuing to monitor and improve surgical wait time database, identifying strategies for continuous improvement.

There has been an increase in the total number of CABG surgeries performed in April – June 2012, compared to the same period in 2011.

Subsequent actions planned: Review of the intake and triage process for all urgency categories. Review and implement recommendations from OR Utilization committee – focus will be to reduce postponements and increase efficiencies based on current data and resources available.

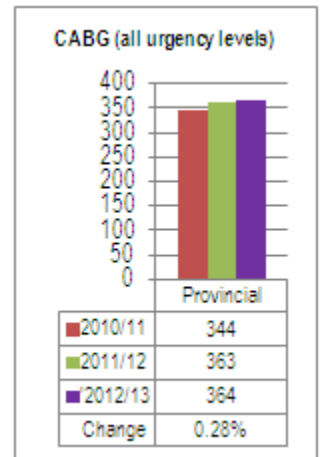
WHAT ELSE DO WE KNOW?

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.



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

Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 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 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?

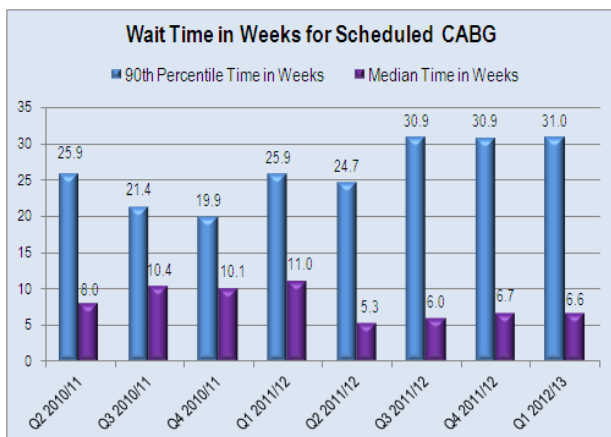
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources. Access in combination with a high quality of service delivery will help ensure optimal patient outcomes.

WHAT IS THE TARGET?

The provincial/territorial benchmark for Urgency III CABG surgeries is within 26 weeks. The 2012/13 AHS 90th percentile target is 6 weeks.

HOW ARE WE DOING?

While the wait time for scheduled CABG surgery has increased slightly to 31.0 weeks in Q1 2012/13 from 30.9 weeks previously, the actual wait time remains 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.

2012/13 TARGET:
6 weeks

YTD TARGET: 6 weeks
ACTUAL: 31.0 weeks
(Apr-Jun)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date:

A Joint Working Group (with representatives from Calgary and Edmonton) continues to implement the new wait time definitions for cardiac surgery. Physician-led Quality Improvement project planning meetings are underway; project charter was approved. Continuing to monitor and improve surgical wait time database, identifying strategies for continuous improvement.

There has been an increase in the total number of CABG surgeries performed in April – June 2012, compared to the same period in 2011.

Subsequent actions planned: Review of the intake and triage process for all urgency categories. Review and implement recommendations from OR Utilization committee – focus will be to reduce postponements and increase efficiencies based on current data and resources available.

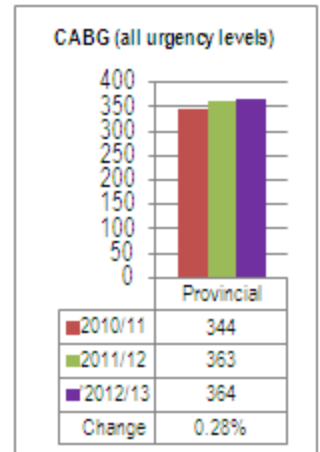
WHAT ELSE DO WE KNOW?

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 are Q1 2012/13
Next data update expected for Q2 report

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

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

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

WHY IS THIS IMPORTANT?

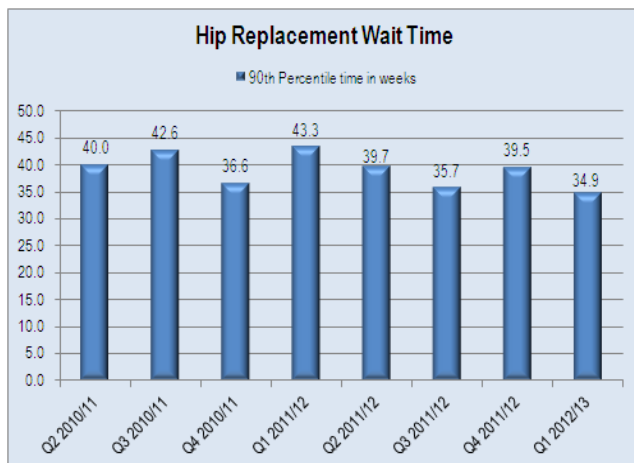
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?


The provincial/territorial benchmark for hip replacement surgeries for 2012/13 is within 22 weeks. The Alberta target for 2011/12 was 27 weeks.

HOW ARE WE DOING?

The wait time for hip replacement surgery in Q1 2012/13 was 34.9 weeks which has decreased from 2011/12 although still not at the target level.



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



PERFORMANCE STATUS

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

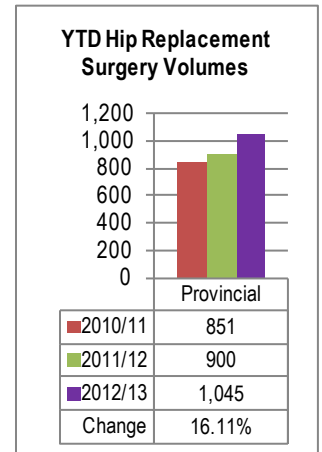
2012/13 TARGET:
22 weeks

YTD TARGET: 25.8
ACTUAL: 34.9
(Apr – Jun)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date:

Target volumes for 2012/13 have been established for all zones. More hip replacement surgeries have been done this quarter than for the same quarter over the past two fiscal years with a 16.1% increase from last quarter to this quarter in surgical volume. There is a focused approach to clearing up existing wait lists in an effort to ensure that the existing wait lists are accurate and patients are receiving the appropriate care.



Additional details area available at the [zone](#) level.

Subsequent actions planned: Process changes are being looked at on a zone by zone basis to increase efficiencies. Work continues in cleaning up surgical and referral waitlists.

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 2011, Alberta ranked fifth among the 10 provinces for hip replacement surgery wait times. Alberta = 41.1 weeks, Best Performing Province = 26.6 weeks (Ontario), Canada = 34.1 weeks (CIHI, 2011).

Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 report

WHAT IS BEING MEASURED?

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

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

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

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

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

WHY IS THIS IMPORTANT?

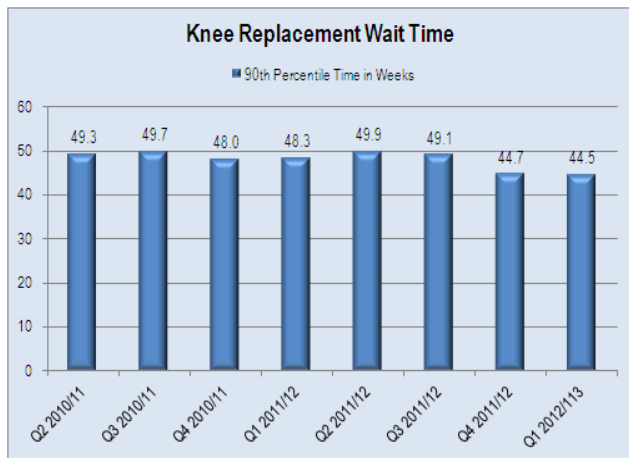
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

The provincial/territorial benchmark for knee replacement surgeries is within 26 weeks. The Alberta target for 2012/13 is 28 weeks.

HOW ARE WE DOING?


The wait time for knee replacement surgery in Q1 2012/13 was 44.5 weeks which has improved since the prior year.



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

Performance Measure Update

Knee Replacement Wait Time



PERFORMANCE STATUS

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

2012/13 TARGET:
28 weeks

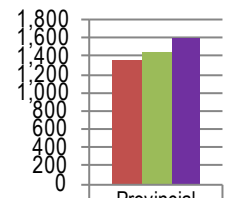
YTD TARGET: 33.3
ACTUAL: 44.5 weeks
(Apr – Jun)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date:

Target volumes for 2012/13 have been established for all zones. More knee replacement surgeries have been done this quarter than for the same quarter over the past two fiscal years with a 10.8% increase from last quarter to this quarter in surgical 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.

YTD Knee Replacement Surgery Volumes



2010/11	1,357
2011/12	1,434
2012/13	1,589
Change	10.81%

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. Post operative care standards are being implemented 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 2011, Alberta ranked fifth among the 10 provinces for knee replacement surgery wait times. Alberta = 49.1 weeks, Best Performing Province = 31.3 weeks (Ontario), Canada = 39.7 weeks (CIHI, 2011).

Cataract Surgery Wait Time

Data updated quarterly.
Most current data are Q1 2012/13
Next data update expected for Q2 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 90th percentile is the time it takes in weeks for 90 per cent of patients to have had their surgery.

Detailed indicator [definition](#) is available.

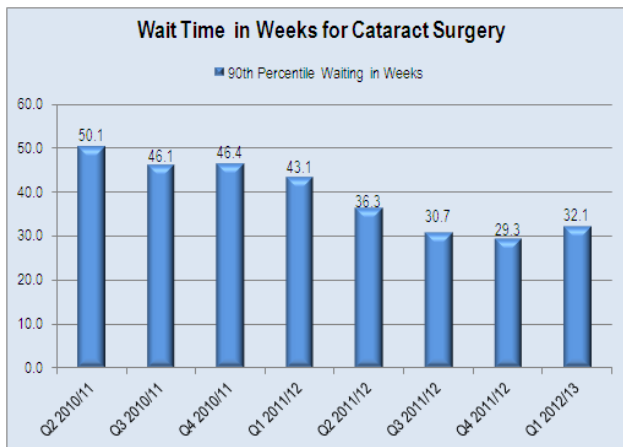
An internal review of the data quality indicates a questionable level of confidence with known issues.

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 2012/13 is 25 weeks, down from the 30-week target for 2011/12.



Source: Alberta Health.

PERFORMANCE STATUS

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

2012/13 TARGET:
25 weeks

YTD TARGET: 28.8
ACTUAL: 32.1 weeks
(Apr – Jun)

HOW ARE WE DOING?

The 90th percentile wait time for cataract surgery for Q1 2012/13 was 32.1 weeks which is slightly worse than the prior quarter and longer than the target. There has been a steady decline in the cataract wait times over the past two years.

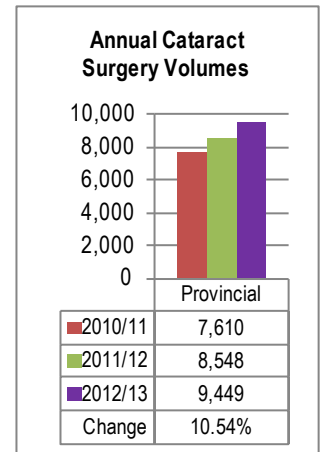
WHAT ACTIONS ARE WE TAKING?

Actions completed to date:

Increases to the number of cataract surgeries have continued to bring wait times down. . There have been more than 9,000 cataract surgeries in this quarter which represents an increase of 10.5% in cataract surgery volume over the first quarter last year. Further zone-specific actions completed are available [here](#).

Subsequent actions

planned: Completion of allocated cataract surgeries will continue across the province throughout 2012/13. 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 in 2011, Alberta ranked tenth among the 10 provinces for cataract surgery wait times. Alberta = 39.3 weeks, Best Performing Province = 17.3 weeks (Ontario), Canada = 21.1 weeks (CIHI, 2011).

Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 report

WHAT IS BEING MEASURED?

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

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

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

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

Detailed indicator [definition](#) is available.

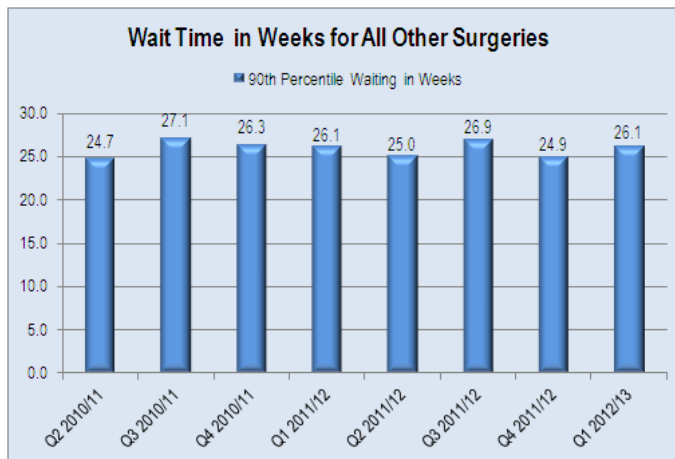
An internal review of the data quality indicates a questionable level of confidence with known issues.

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.



Source: Alberta Health

Performance Measure Update

Other Scheduled Surgery Wait Time

PERFORMANCE STATUS

Performance target for 2012/13 is not yet established.

2012/13 TARGET:
TBD

YTD TARGET: tbd
ACTUAL: 26.1 weeks
(Apr – Jun)

HOW ARE WE DOING?

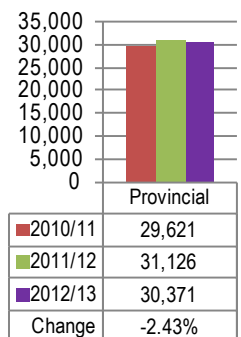
Using latest developed measurement methodology (under review) 90th percentile wait times for other surgeries was 26.1 weeks for Q1 2012/13, somewhat worse than the prior quarter.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date:

There has been a slight decrease in the number of surgeries in Q1 compared to a year ago. Continue to increase surgical capacity through increased volumes, implementation of wait time management systems, and more efficient use of operating rooms. The goal of the Adult Coding Access Targets for Surgery (aCATS) project is to develop and implement a standardized diagnosis-based priority system to book surgeries across the continuum of surgical services offered throughout the Province. The aCATS pilot went 'live' in Calgary (FMC, RGH, PLC) on May 1 with six specialties.

YTD Other Surgery Volumes



Subsequent actions planned: Going 'live' entails use of aCATS coding into the surgical booking process. This enables assignment of diagnosis and urgency access targets for all patients.

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 are Q1 2012/13
Next data update expected for Q2 report

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator [definition](#) is available.

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

WHY IS THIS IMPORTANT?

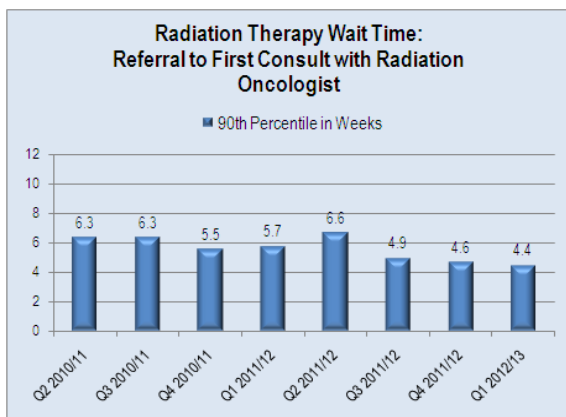
Wait times are an important measure of how quickly people are getting access to cancer care. They reflect the ability of Alberta Health Services (AHS) to meet the needs of cancer patients.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

Wait times from cancer referral to consultation by radiation oncologists are outside the target.




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.

Performance Measure Update

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



PERFORMANCE STATUS

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

2012/13 TARGET:
3.0 weeks

YTD TARGET: 3.8 weeks
ACTUAL: 4.4 weeks
(Apr-Jun)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date:

A Quality Improvement project has been initiated to address the increased wait time. The project is being completed at three centres within Alberta. The first phase of the project is a process review of the New Patient Offices looking at reducing the turnaround time. The second phase will look at scheduling and utilization of current resources.

Development of referral guidelines is being shared with referring physicians that will increase the number of complete referrals that are being submitted to New Patient Offices. There are more patients receiving a first consult visit this year than in 2010/11, although the number is down slightly from 2011/12.

Subsequent actions planned: Movement of New Patient Office into new location for the development of a cell structure to maximize efficiencies. Continue and expand the nurse practitioner clinic pilots to all tumour groups.

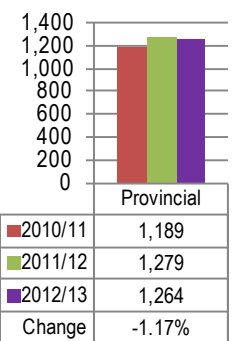
WHAT ELSE DO WE KNOW?

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 about 74 per cent of patients are seen within this target (Cancer Care Ontario, April 2012).

YTD Referral to 1st Consult Volume



Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 report

Performance Measure Update

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

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator [definition](#) is available.

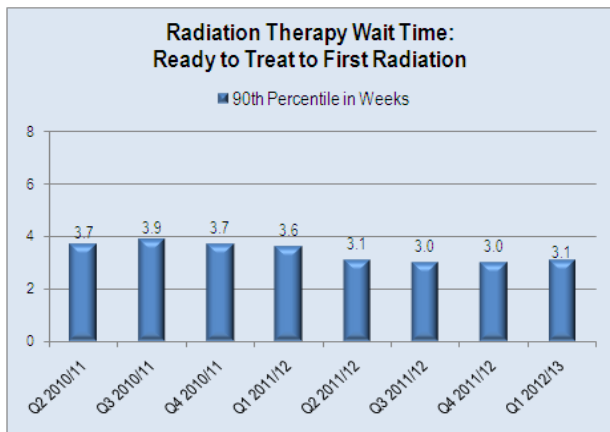
An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

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

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

2012/13 TARGET:
4.0 weeks

YTD TARGET: 4.0 weeks
ACTUAL: 3.1 weeks
(Apr-Jun)

HOW ARE WE DOING?

The proportion of patients receiving radiation therapy within the expected time period is better than the year to date target. The Q1 2012/13 90th percentile time was 3.1 weeks.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Benchmark for this measure is 4 weeks; the provincial Q1 average is 3.1 weeks and the prior year annual average was 3.1 weeks as well. Cancer care wait time is better than the target and will continue to work to maintain this wait time.

Subsequent actions planned: It is anticipated that with the new facility openings including Central Alberta Cancer Centre (2013) and the Grande Prairie Cancer Centre (2015), that the wait times may reduce even further. This will likely have a small impact in the overall wait items since we have seen an unmet population with the Lethbridge centre opening and no corresponding decrease in numbers or wait times in Calgary.

WHAT ELSE DO WE KNOW?

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

Information is available by [site](#).

HOW DO WE COMPARE?

Using a similar measure in 2011, Alberta ranked third among eight provinces for radiation therapy wait times. Alberta = 3.1 weeks, Best Performing Province = 2.4 weeks (Saskatchewan), Canada = 3.1 weeks (CIHI, 2011).

Data updated quarterly
 Most current data are Q1 2012/13
 Next data update expected for Q2 report

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.

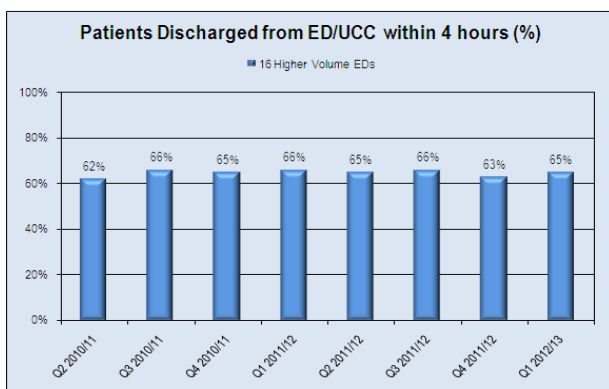
An internal review of the data quality indicates an acceptable level of confidence with known issues. A more formal internal Data Quality and Operational Readiness review is being conducted.

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 2012/13 target of 80 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.

2012/13 TARGET: 80%

YTD TARGET: 76%
 ACTUAL: 65%
 (Apr – Jun)

HOW ARE WE DOING?

In Q1 2012/13, 65 per cent of patients at the 16 higher volume EDs were discharged within four hours.

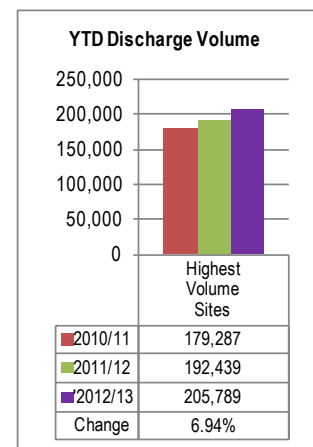
WHAT ACTIONS ARE WE TAKING?

Actions completed to date:

ED flow capacity for patients treated and subsequently discharged at the 16 higher volume EDs has increased by almost 7% over last year. 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](#).

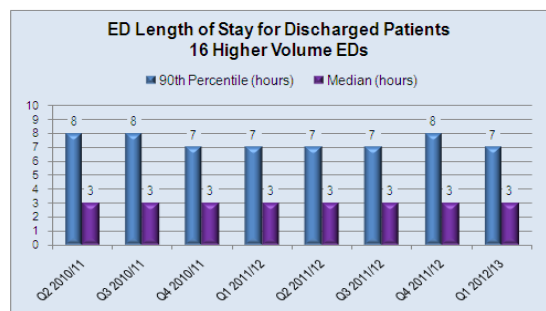


WHAT ELSE DO WE KNOW?

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 90th percentile data are available by [site](#).

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 report

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

WHAT IS BEING MEASURED?

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

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

This ED/UCC measure is presented for all sites.

Detailed indicator [definition](#) is available.

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

WHY IS THIS IMPORTANT?

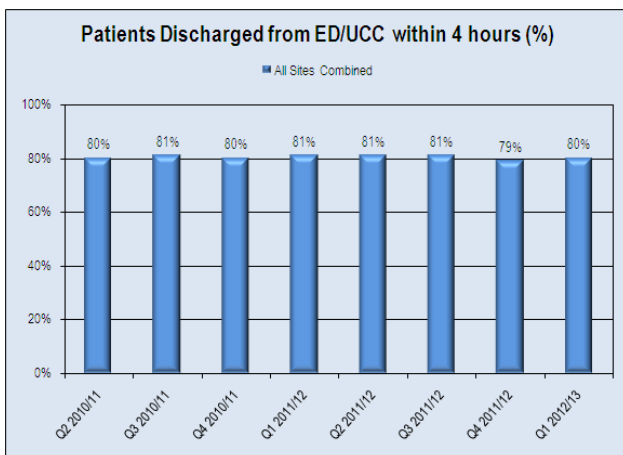
The amount of time spent waiting for treatment is a measure of access to the health care system. Patients treated in the ED/UCC should receive care in a timely fashion. Excessive wait times for care can result in treatment delays for individual patients and reduced efficiency in the flow of patients.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target for 2012/13 of 86 per cent of patients discharged within four hours for all sites.

HOW ARE WE DOING?

In Q1 2012/13, 80 per cent of patients at all EDs were discharged within four hours.



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



PERFORMANCE STATUS

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

2012/13 TARGET:
86%

YTD TARGET: 85%
ACTUAL: 80%
(Apr – Jun)

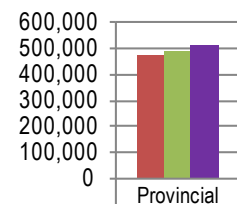
WHAT ACTIONS ARE WE TAKING?

Actions completed to date: ED flow capacity for patients treated and subsequently discharged at all ED sites has increased by just under 4% over last year. 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](#).

YTD Discharge Volume



Year	Volume
2010/11	474,764
2011/12	491,444
2012/13	510,681
Change	3.91%

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.

Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 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 (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?

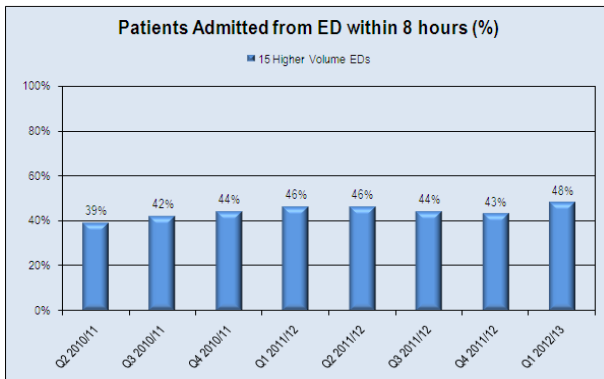
ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent can be a measure of access to the health care system and a reflection of efficient use of resources.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target of 75 per cent of patients admitted leaving the ED within eight hours for the 15 higher volume EDs for 2012/13.

HOW ARE WE DOING?


In Q1 2012/13, 48 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 Measure Update

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



PERFORMANCE STATUS

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

2012/13 TARGET:
75%

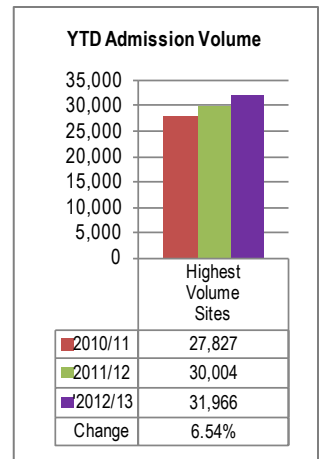
YTD TARGET: 64%
ACTUAL: 48%
(Apr – Jun)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: ED flow capacity for patients treated and subsequently admitted at the 15 higher volume EDs has increased by 6.54% over last year. 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.

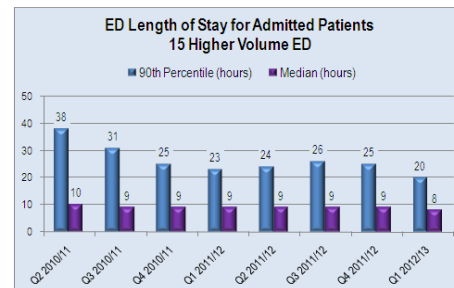
Additional zone-specific actions planned are available [here](#).



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 90th 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 are Q1 2012/13
Next data update expected for Q2 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?

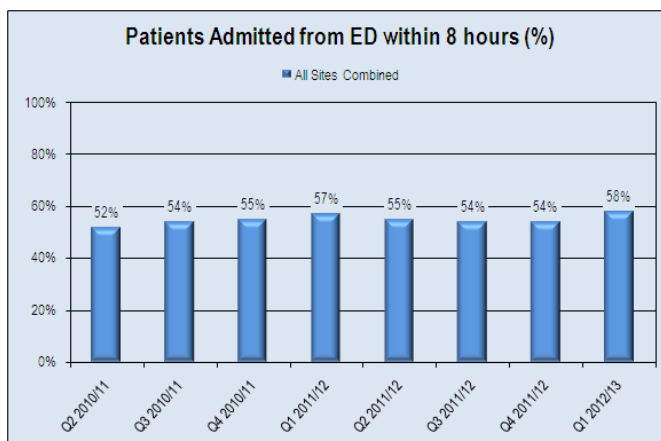
ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent by a patient in an ED can be a measure of access to the health care system and a reflection of efficient use of resources.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target for all ED sites combined of 75 per cent of patients admitted leaving the ED within eight hours for 2012/13.

HOW ARE WE DOING?

In Q1 2012/13, 58 per cent of admitted patients left the ED within eight hours which is below the target of 75 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.

2012/13 TARGET:
75%

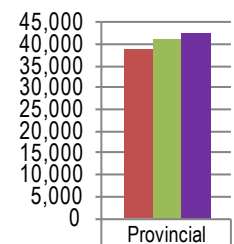
YTD TARGET: 68%
ACTUAL: 58%
(Apr – Jun)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: ED flow capacity for patients treated and subsequently admitted at all EDs has increased by just under 4% over last year. 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.

YTD Admission Volume



Year	Volume
2010/11	38,782
2011/12	41,218
2012/13	42,748
Change	3.71%

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 are Q1 2012/13
Next data update expected for Q2 report

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.

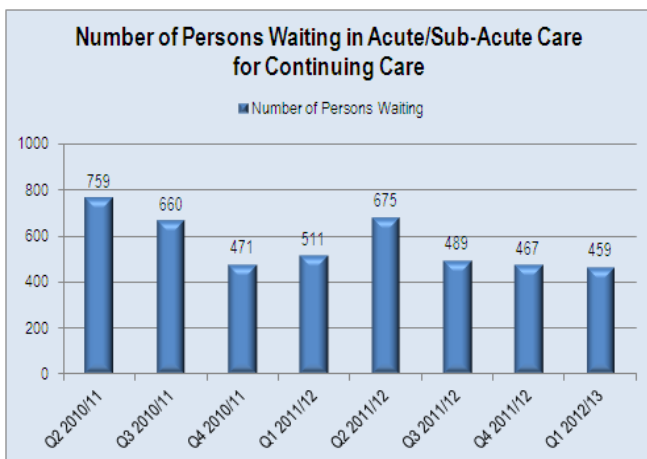
WHY IS THIS IMPORTANT?

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 2012/13 is for 350 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.

2012/13 TARGET:
350

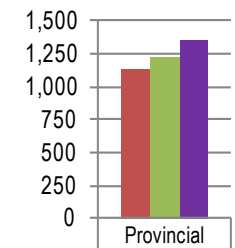
Q1 2012/13 ACTUAL:
459
(Jun 2012)

HOW ARE WE DOING?

At the end of Q1 2012/13, 459 people were waiting in acute/sub-acute (hospital) beds for continuing care placement. The number of people waiting is above target, and an improving trend has been seen over the past two years.

During Q1 of 2012/13, 1,358 individuals were placed in Continuing Care from Acute / Sub-Acute Beds, the increase in placements from Q1 of 2011/12 to Q1 of 2012/13 was 11.04%.

YTD Number Placed



Year	Number Placed
2010/11	1,126
2011/12	1,223
2012/13	1,358
Change	11.04%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: AHS continues to add continuing care beds. In 2011/12, 1,002 beds were opened which reflects 100% of the target, bringing the total number of continuing care beds in the province to nearly 21,700. AHS will continue to open more continuing care capacity in 2012/13, with 1,000 new beds. 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?

National benchmark comparisons are not applicable.

People Waiting in Community for Continuing Care Placement

Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 report

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.

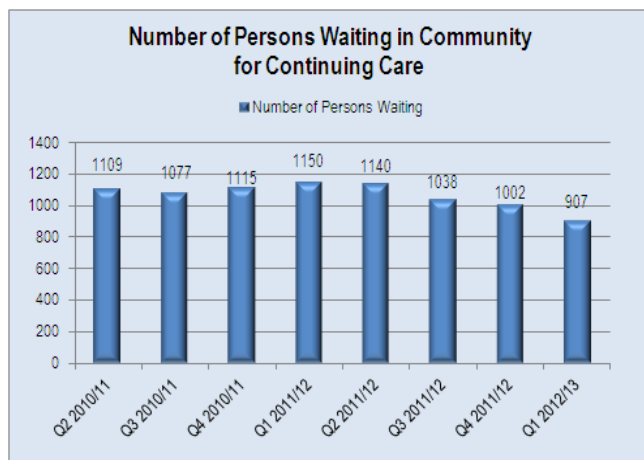
An internal review of the data quality indicates a high level of confidence with limited issues.

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 2012/13 is for 850 or fewer people to be waiting in the community (at home) for continuing care placement. This is a decrease from the target of 900 in 2011/12.



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



PERFORMANCE STATUS

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

2012/13 TARGET:
850

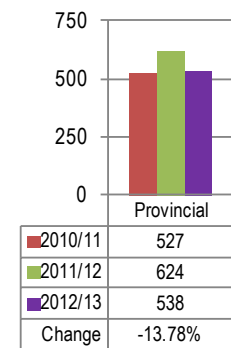
Q1 2012/13 ACTUAL:
907
(Jun 2012)

HOW ARE WE DOING?

During Q1 of 2012/13, 907 individuals were still on the wait list which is worse than the target.

During this same period, 538 individuals were placed in Continuing Care from Community. The decrease in placements from Q1 of 2011/12 to Q1 of 2012/13 was 13.78%.

YTD Number Placed



WHAT ACTIONS ARE WE TAKING?

Actions completed to date: AHS continues to add continuing care beds. In 2011/12, 1,002 beds were opened which reflects 100% of the target, bringing the total number of continuing care beds in the province to nearly 21,700. AHS will continue to open more continuing care capacity in 2012/13, with 1,000 new beds. 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?

National benchmark comparisons are not applicable.

Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 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 under development and is not available.

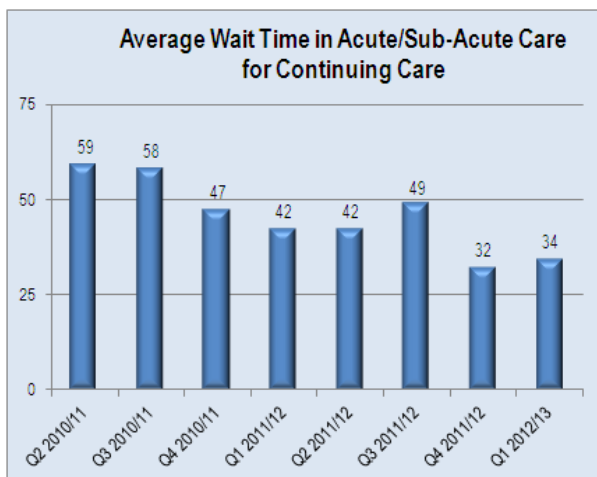
An internal review of the data quality indicates an acceptable level of confidence with known issues.

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.

2012/13 TARGET:
TBD

Q1 2012/13 ACTUAL:
34 days

HOW ARE WE DOING?

The average wait time in acute/sub-acute care for continuing care was 34 days in Q1 of 2012/13. The 2011/12 annual average wait time was 41 days.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: AHS continues to add continuing care beds. In 2011/12, 1,002 beds were opened which reflects 100% of the target, bringing the total number of continuing care beds in the province to nearly 21,700. AHS will continue to open more continuing care capacity in 2012/13, with 1,000 new beds. 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.

Subsequent actions planned: Continue to add new beds in zones. Rollout 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 are Q1 2012/13
Next data update expected for Q2 report

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.

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.

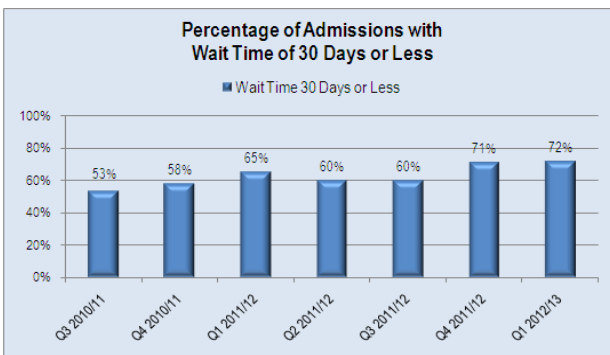
An internal review of the data quality indicates an acceptable level of confidence with known issues.

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



Source: Continuing Care Wait Time Data

Note: This measure includes individuals placed from both Acute/Sub Acute Beds, as well as Community.

Performance Measure Update

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

PERFORMANCE STATUS Performance target has not been established for comparison.	2012/13 TARGET: TBD
	YTD TARGET: TBD ACTUAL: 72% (Apr-Jun)

capacity to support people waiting for placement.

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 72 per cent in Q1 of 2012/13. The 2011/12 annual average was 64 per cent.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: AHS continues to add continuing care beds. In 2011/12, 1,002 beds were opened which reflects 100% of the target, bringing the total number of continuing care beds in the province to nearly 21,700. AHS will continue to open more continuing care capacity in 2012/13, with 1,000 new beds. 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.

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 Q1 2012/13
Next data update expected for Q2 report

Performance Measure Update

Number of Home Care Clients

PERFORMANCE STATUS Performance Target for 2012/13 has not been established for comparison.	2012/13 TARGET: TBD
	2012/13 Q1 ACTUAL: 68,728

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, receiving home care services in Home Living settings, Supportive Living Settings and Long Term Care Facility settings including Home Care Day Support Programs and Comprehensive Day Programs.

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 68,728 in Q1 of 2012/13.

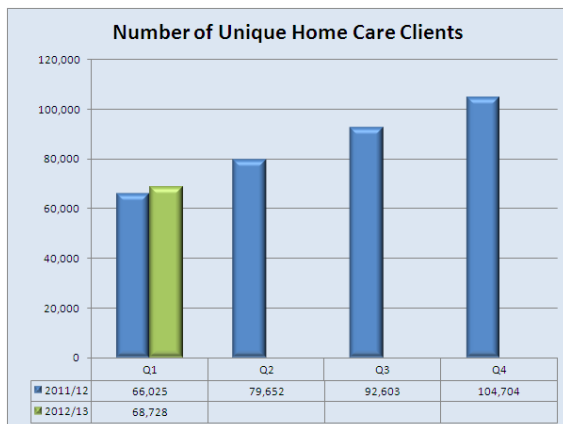


Chart represents the cumulative number of unique home care clients. For clients who come and go off the case load multiple times, they will only be counted once.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Continue to expand home care by adding more hours for those requiring short-term care, in order to prevent hospitalization or an emergency situation. Detailed Actions completed are available by [Zone](#).

Subsequent actions planned: The South Zone, Calgary Zone, Central Zone, and North Zone have received funding to implement the new service guidelines. Each Zone is at various stages of implementation with most at the stage of educating staff to the new guidelines. Implement home care services guidelines to bring long term home care clients to an average of 120 hours per year for all zones by 2014/2015. Detailed Actions planned are available by [Zone](#).

WHAT ELSE DO WE KNOW?

Information is available by [zone](#).

The [Supportive Living guide](#), published by Alberta Health offers additional information.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Most current data are 2010/11
The next survey is planned for 2013/14

Rating of Care Nursing Home – Family

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asked family members of Alberta nursing home residents about their rating of the care in the [Alberta Long Term Care Family Experience Survey](#). The 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.

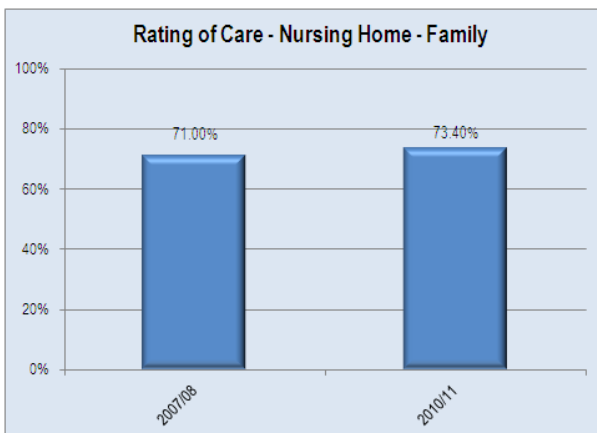
An internal review of the data quality indicates a very high level of confidence with no known issues.

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 2012/13 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 has not been established for comparison.	2012/13 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. AHS Briefing Note on comparative results by facility and zones being prepared from HQCA information.

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.

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.

Head Count to FTE Ratio

Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 report

WHAT IS BEING MEASURED?

The count of unique/discrete individuals employed by Alberta Health Services (AHS) divided by the sum of reported assigned FTE's. An FTE (full-time equivalent) is the number of hours that represent what a full time employee would work over a given time period.

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?

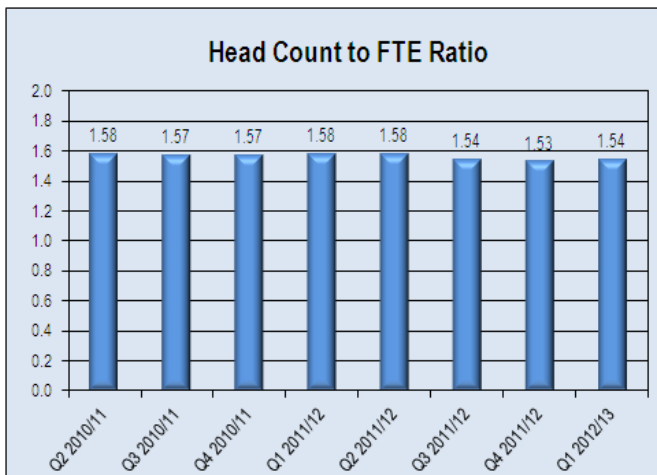
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

WHAT IS THE TARGET?

A target of 1.61 head count to FTE ratio has been established for 2012/13. This is a reduction from the 2011/12 target of 1.62.

HOW ARE WE DOING?

In 2009/10 and 2010/11, the head count to FTE ratio was 1.57. For 2011/12, the annual ratio was 1.55. As of Q1 2012/13, the ratio was 1.54.



Source: Alberta Health Services Human Resources
Note: Data reflects the average over the reporting period.



PERFORMANCE STATUS

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

2012/13 TARGET:
1.61

Q1 2012/13 ACTUAL:
1.54

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 provide 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. The new version was published May 2012. This will increase overall awareness of the plans to hire more FTE personnel.

The Manager Workforce Report continues to be refined to provide managers with effective information to support better workforce decision-making. This includes providing roll-up reports for higher-level managers.

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 are Q1 2012/13
Next data update expected for Q2 report

Registered Nurse Graduates Hired by AHS (%)

 PERFORMANCE STATUS Performance is outside acceptable range, take action and monitor progress.	2012/13 TARGET: 70%
	YTD TARGET: 48% Q1 2012/13 ACTUAL Total: 56% Non-Casual: 28%

WHAT IS BEING MEASURED?

The number of registered nurse Alberta university/college graduates hired by AHS within the fiscal year as a percent of the total estimated graduates available in the fiscal year.

Detailed indicator [definition](#) is available.

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

AHS does not monitor province of graduation so new grads from other provinces may be included in the totals. New nurses commenced at Step 1 rate of pay (equivalent to a new grad nurse) while waiting to present their portability information may also be included potentially inflating the total number of new hires identified as new grads. These issues are not expected to be material in terms of reporting this performance measure

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 2010-2013 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 2012/13.

HOW ARE WE DOING?

The total estimated RN graduates for 2012/13 is 1,687. AHS has hired a total of 943 (56%) of the 2012/13 RN graduates by the end of Q1. Of these, 465 (28%) were hired into non-casual positions. This represents a 10% increase over the percentage hired in Q1 last year.

Of the 1,687 total estimated RN graduates for 2012/13, only 1,161 new graduates were available to be hired in Q1. The 943 RN graduates AHS has hired by the end of Q1 represent 81% of the total available in the same period. Of these, 465 (49%) 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.

- 61 of the 100 full time Transitional Graduate Nurse Recruitment Program (TGNRP) positions have been filled since January 2012.
- Approval is ongoing to regularize funding for TGNRP positions within operations budgets.
- 337 Undergrad Nursing Employees (3rd year) hired for summer temporary employment.
- Pilot programs commenced to support 18 new grad nurses in Northern Lights Regional Health Centre and all new grads in Fort McMurray.

Subsequent actions planned:

- Meeting with nursing unit managers and clinical educators across the province to raise awareness of Transitional Graduate Nurse Resources and to encourage implementation of resources for all new graduate hires.
- Targeted recruitment of the University of Alberta August 2012 cohort is underway.

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 are Calendar Year (CY) 2012 Q2
Next data update expected for Q2 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.

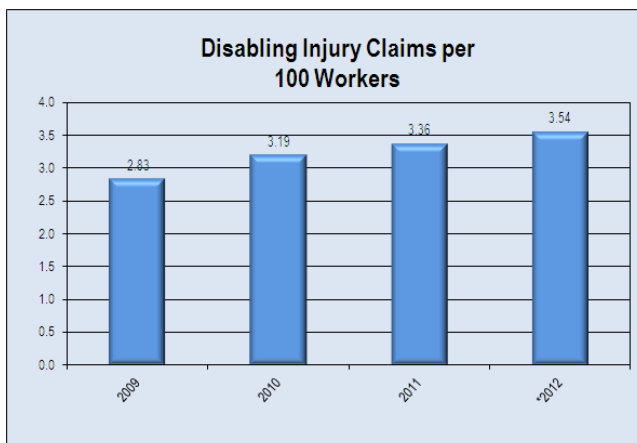
WHAT IS THE TARGET?

Alberta Health Services has established a target of 1.80 disabling injury claims per 100 workers for 2012.

HOW ARE WE DOING?

In 2011, AHS's DIR was 3.36. This represents a 5% increase in the DIR over 2010. The target DIR for 2011 was 2.20. The AHS DIR actual in 2011 was 53% higher than target.

For 2012 Q2, the actual DIR was 1.70 (cumulative Jan – Jun). If this rate continues through WCB's 2012 final reconciliation (a 15-month period), the DIR annual rate is projected to be 3.54.



Source: Alberta Health Services and Alberta Workers' Compensation Board
Notes: * 2012 figure is annualized Calendar year to date (projected to year end).



PERFORMANCE STATUS

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

2012/13 TARGET:
1.80

2012 CY Q2 (Jan-Jun)
ACTUAL: 1.70
2012 CY Projected: 3.54

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The three goals of the AHS Occupational Injury Action Plan are to prevent injuries, respond assertively to injuries and support sustainable return to work for injured employees. Foundational AHS resources available to leaders include the organization's commitment to the value of safety, the WHS Policy and Management System, the Shared Responsibility Framework, Hazard Identification and Control, Incident Investigation program, Job Demands Summary system, and Modified Work Standard. The "It's Your Move" safe client handling program continues across the province and has trained 6,100 staff to date. "Move Safe" manual materials handling pilots are due to begin. Evaluation of the \$5 M 2011 Ergonomic Equipment program is being developed. A WCB initiative specifically targeting late reporting and offers of modified work began this quarter. Daily injury tracking and the inclusion of AHS subsidiary safety statistics in the quarterly health and safety dashboard began this quarter.

Further actions planned: Continue to collaborate with operations on the Occupational Injury Action Plan and monitor performance.

WHAT ELSE DO WE KNOW?

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

Previous years are not available by quarter or other time subsets. 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.](#)

Data updated biennially
Most current data are 2011/12
The next survey is planned for 2014

Staff Overall Engagement (%)

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 and April 2012.

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

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

Detailed indicator [definition](#) is available.

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

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

Alberta Health Services has established a target of 43 per cent of employees reporting they are favourably engaged at work for 2010/11 and 54 per cent for 2011/12. The 2012/13 target is 68%.

HOW ARE WE DOING?

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

Of the employees responding to the 2011/12 engagement survey, 52 per cent reported they were favourably engaged.



PERFORMANCE STATUS

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

2011/12 TARGET:
54%

2011/12 ACTUAL:
52%

This demonstrates an increase of almost 50% over the previous survey results. An additional 17% of employees report they are favourably engaged

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: AHS is collaborating with HQCA in creating a framework document and toolkits designed to enhance the health care workplace with respect to intimidation and bullying. The 2012 AHS Workforce Engagement Survey was completed in April 2012. The survey results have been distributed to down to the manager level. A local action planning approach is being utilized to increase participation in improving engagement by involving our workforce. Managers are having open discussions with their teams on how to improve engagement at their local level, and developing Local Action Plans for their units.

Subsequent actions planned: The target date for Senior Vice-Presidents to submit a Local Action Plan for their entire portfolio is August 31, 2012, after which time integration into the overall AHS Workforce Engagement Plan will begin.

WHAT ELSE DO WE KNOW?

Both participation and engagement rates increased from the 2010 engagement survey, in all four sectors; unionized employees, non-union employees, physicians and volunteers.

Information is available by [zone](#).

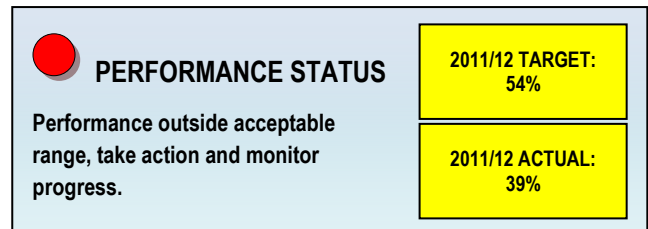
HOW DO WE COMPARE?

Using third party provider benchmark data (engagement data drawn from 28 Canadian healthcare organizations – 40 per cent from Western Canada), the health care benchmark for overall engagement is 76 per cent. This is significantly higher than the Alberta Health Services employee engagement survey result.

Data updated biennially
Most current data are 2011/12
The next survey is planned for 2014

Performance Measure Update

Physician Overall Engagement (%)



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 and April 2012.

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?

Alberta Health Services has established a target of 43 per cent of the medical staff community reporting they are favourably engaged at work for 2010/11 and 54 per cent for 2011/12. The 2012/13 target is 68%.

HOW ARE WE DOING?

Of the physicians responding to the 2011/12 engagement survey, 39 per cent reported they were favourably engaged. This demonstrates an increase of 50% over the previous survey results. An additional 13% of physicians report they are favorably engaged.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The Physician Advocacy Working Group has confirmed the next wave of initiatives to optimize advocacy and minimize intimidation. AHS has a preliminary agreement with HQCA to conduct a follow-up survey. CMO Office is consolidating all zone engagement planning initiatives. Planning meetings with AMA and CPSA (as recommended by HQCA) are ongoing to jointly identify current activities and future programs that support physician advocacy.

Subsequent actions planned: The consolidated version of the zone plans will be shared with all zone medical affairs offices and PPEC. A survey to update AHS understanding of physicians' experiences with intimidation and advocacy will be undertaken. The CMO staff and the Physician Advocacy Working Group will be implementing its work plan for 2012/13.

WHAT ELSE DO WE KNOW?

Both participation and engagement rates increased from the 2010 engagement survey, in all four sectors: unionized employees, non-union employees, physicians, and volunteers.

Information is available by [zone](#).

HOW DO WE COMPARE?

Using third party provider benchmark data (engagement data drawn from 28 Canadian health care organizations - 40 per cent from Western Canada), the health care benchmark for overall engagement is 76 per cent. While we are improving, the benchmark is still higher than the Alberta Health Services employee engagement survey result.

Direct Nursing Average Full Time Equivalency

Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 report

WHAT IS BEING MEASURED?

The direct nursing average full time equivalency (FTE) is the direct nursing (DN) functional bargaining unit head count (including casuals) divided by the assigned FTE for the same group.

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?

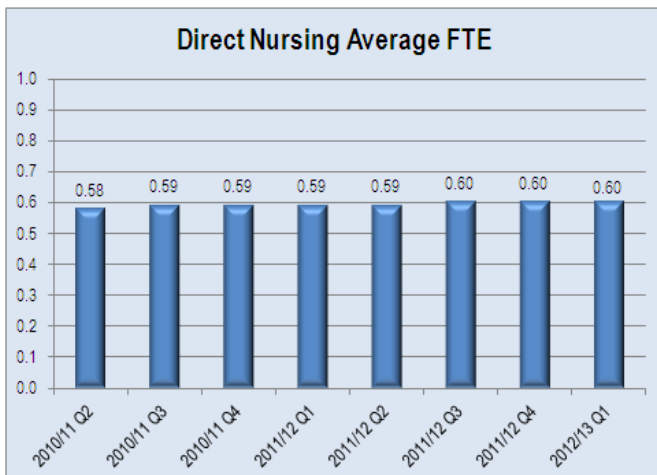
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure supports the clinical workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

WHAT IS THE TARGET?

A target of 0.65 has been established for 2012/13. This represents a 3% increase over the 2011/12 target.

HOW ARE WE DOING?

Over the past 4 years this measure has remained relatively consistent.



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.

2012/13 TARGET:
0.65

Q1 2012/13 ACTUAL:
0.60

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Workforce Regularization activity between UNA and AHS is converting some casual and part-time positions into higher FTE regular positions. Final reports and numbers are anticipated by the end of Q3. A revised "Tools for Operational Managers" with additional information and resources to support managers was completed in June 2012 and is posted internally for use. Phase 1 of the Provincial Scheduling Transformation Project includes two streams of work focused on "rotation building." A set of standardized Master Rotation Guidelines was developed by the Strategic Review Team, and is currently being tested/adapted for AHS-wide use as needed. New rotations developed show a range from 56% to 94% FT positions. The average percentage of FT positions has increased from 39% to 69% against the organizational target of 70%. Average FTE has increased to 0.85 from 0.79. An HR Transition Plan is in development to facilitate transition from current to optimized rotations for the units within Phase 1. Phase 2 rotation optimization is beginning now.

Subsequent actions planned: 21 scheduling processes are being standardized; 18 are complete and approved. The remainder scheduled for completion in August with roll out to commence in fall 2012. 66 optimized rotations have been completed for other units; an additional 176 rotations are in progress. Phase 2 implementation planning and initial rollout approved by AHS Executive Committee on July 13, 2012. Rollout to begin November 2012.

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.

HOW DO WE COMPARE?

This measure is not benchmarked externally.

Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 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?

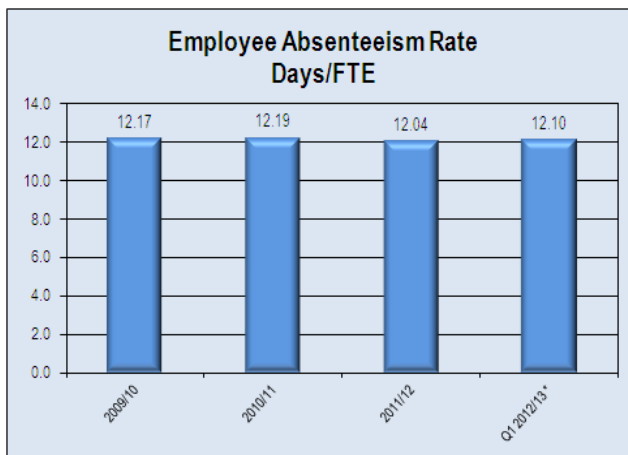
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

WHAT IS THE TARGET?

A target of 11.95 days per FTE has been established for 2012/13.

HOW ARE WE DOING?

Days taken per FTE have remained fairly constant over the past 4 years.



Source: Alberta Health Services, Labour Cost System
Notes: * 2012/13 figure is annualized fiscal year to date.



PERFORMANCE STATUS

Performance is within an acceptable range, continue to monitor.

2012/13 TARGET:
11.95 days/FTE

Q1 2012/13 ACTUAL
Annualized:
12.10 days/FTE

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The document "Tools for Operational Managers" was revised and distributed to managers in February 2012.

A draft Attendance Awareness program for AHS has been made available as a resource to Human Resources Client Services. Effective practices are being monitored informally. A pilot Attendance Program has been launched in the Central Zone and Linen and Environmental Services provincially.

Subsequent actions planned: Completion of the pilot Attendance Program and analysis of findings.

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.

HOW DO WE COMPARE?

AHS has one of the lowest sick hour levels of the 8 western provinces' health regions participating in the Western CEO Performance and Benchmarking Project.:

	Overall (n=224)	Public sector (n=76)	Private sector (n=148)
Absenteeism rate* (days per FTE)	6.0	7.8	5.1

Source: the Conference Board of Canada. *Compensation Planning Outlook 2011*

Overtime Hours to Paid Hours

Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 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?

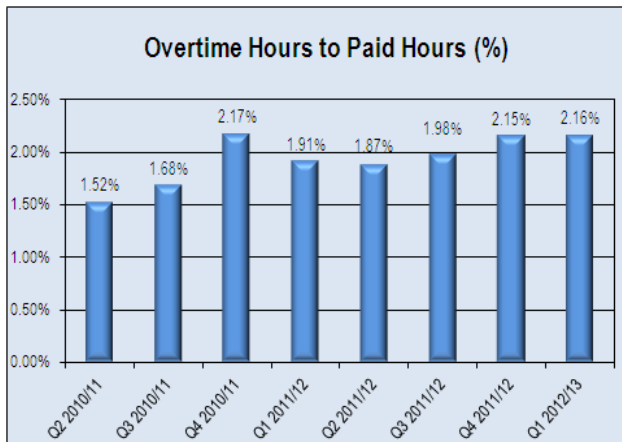
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

WHAT IS THE TARGET?

A target of 1.67% has been established for 2012/13.

HOW ARE WE DOING?

Overtime hours accounted for 2.16% of total paid hours in Q1 2012/13.



Source: Labour Cost Forecasting System (LCFS)



PERFORMANCE STATUS

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

2012/13 TARGET:
1.67%

Q1 2012/13 ACTUAL:
2.16%

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% productivity goal and improved utilization of management rights.

Subsequent actions planned: Refinements continue to be made to the Managers' Workforce Report based on feedback from managers.

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.

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% 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 5% 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 are Q1 2012/13
Next data update expected for Q2 report

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?

A target for 2012/13 has not yet been established.

HOW ARE WE DOING?

For Q1 2012/13, the labour cost per worked hour was \$54.80.

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	\$6.16	119,686,352	\$51.44
2012/13 Q1	\$1.68	30,583,588	\$54.80

Source: AHS Financial Services.

Performance Measure Update

Labour Cost per Worked Hour (\$/hr)

PERFORMANCE STATUS Performance target has not been established for comparison.	2011/12 TARGET: TBD
	Q1 2012/13 ACTUAL: \$54.80

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% productivity goal and improved utilization of management rights.

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

Subsequent actions planned: Productivity metrics similar to this indicator continue to be refined to support the implementation of the Clinical Workforce Strategy.

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 are Q4 2011/12
Next data update expected for Q2 report

PERFORMANCE STATUS

2012/13 TARGET:
TBD

2011/12 ACTUAL:
14,605

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 14,605 in Q4 of 2011/12. This represents a 4 per cent increase over the previous quarter. Due to internal system issues more recent results are not available.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Alberta is leading Canada in the successful implementation of a single, province-wide Electronic Health Record (EHR). Alberta Netcare is a program that encompasses all the projects, processes, products, and services that work together to make Alberta's EHR a reality. It has been developed by Alberta Health (AH) in cooperation and partnership with Alberta Health Services, and many other partners including the health professional colleges and associations. Most Home care areas in Zones are now actively using Netcare to access data sources already published. Netcare usage continues to rise on a monthly basis. Additional data sets were added in April of 2012 (Transcribed reports, Rural zone and Calgary zone event histories) which continue to increase the overall value of Netcare to clinicians throughout Alberta.

Subsequent actions planned: Increase the use of Netcare within the homecare settings by continuing to promote the use of Netcare especially for Medication reconciliation purposes for patients that are in transition. For the Alberta Netcare Release planned for November, 2012 the data source of "Seniors Health Community Client Profile" (a patient summary) is planned for publication from all AHS Zones (currently only published for the Edmonton Zone).

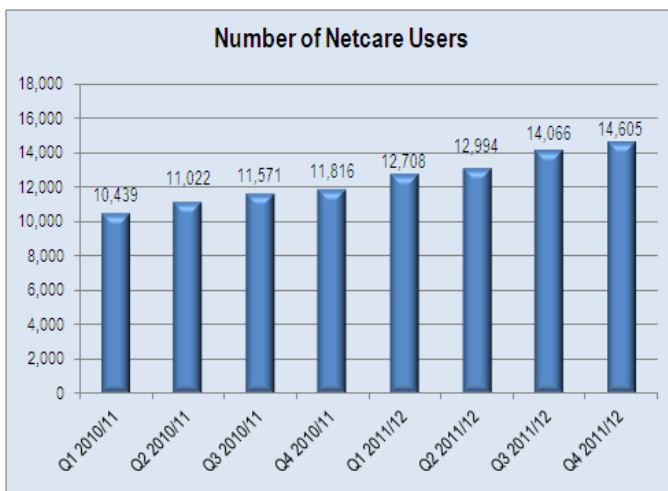
WHAT ELSE DO WE KNOW?

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 are Q1 2012/13
Next data update Q2 report

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 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 against budget 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.

The Provincial Government has provided AHS with a fixed 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. 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, 2013, the targeted accumulated surplus is \$29M. This targeted surplus results from changes to the opening budgeted accumulated surplus of \$78M, which is \$4M lower than the actual March 31, 2012 accumulated surplus of \$82M due to timing (i.e. March 31, 2013 budget was prepared prior to finalizing the March 31, 2012 financial statements). The overall change to the targeted accumulated surplus results from a budgeted change of \$nil for the operating surplus, a net decrease in internally funded capital assets of \$57M, and the repayment of \$12M of long term debt, these reductions are offset by the utilization of \$20M of

 PERFORMANCE STATUS Performance is better than annual target, continue to monitor.	2012/13 TARGET ACCUMULATED SURPLUS: \$29M
	Q1 ACTUAL ACCUMULATED SURPLUS: \$85M

other internally restricted net assets for the South Health Campus (SHC).

HOW ARE WE DOING?

At June 30, 2012, the first quarter accumulated surplus was \$85M and is forecasted at August 10, 2012 to be \$29M at year end.

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 nearly complete as at August 2012.

WHAT ELSE DO WE KNOW?

The first quarter accumulated surplus has decreased from March 31, 2012 by \$3M primarily due to an operating surplus of \$7M offset by a net decrease in internally funded capital assets of \$4M, long term debt repayment of \$1M, and net utilization of \$1M of internally funded capital assets for the SHC. The operating surplus is higher than target primarily due to recruitment issues, including staff vacancies and new initiatives starting later than planned, partially offset by increased inpatient and outpatient activity. Spending on internally funded capital assets is lower than targeted due to delays which are expected to be caught up by year end. The AHS financial reporting documents can be obtained from the www.albertahealthservices.ca website.

HOW DO WE COMPARE?

National benchmark comparisons are not applicable.

Table: Accumulated surplus in \$Millions as at:

	Actual
September 30, 2011	194
December 31, 2011	252
March 31, 2012	82
June 30, 2012	85

Source: Unaudited Annual Financial Statements for the year ended June 30, 2012.

Data updated annually
Most current data are year-end report
Next data update year end 2012/13

Performance Measure Update

Adherence to Five Year Budgeted Government Funding

WHAT IS BEING MEASURED?

Adherence to Five Year Budgeted Government Funding is an annual outcome measure that compares the AHS accumulated surplus (deficit) for the year against funding provided to AHS per the government's five year funding agreement.

This indicator is measured by the year's operating surplus (deficit) divided by the annual global funding amount, and is presented as the percent variance from global funding.

Detailed indicator [definition](#) is available.

WHY IS THIS IMPORTANT?

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.

As part of this commitment, AHS is not to run an operating deficit greater than 1.5% of annual global funding. Over this time period AHS must monitor its adherence to the agreement closely in order to ensure that the five year funding commitments are not exceeded and to ensure budget sustainability into the future.

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 ending March 31, 2012, the variance from global funding (if in deficit) is targeted to be less than 1.5%.


HOW ARE WE DOING?

For the fiscal year ending March 31st, 2012, the variance from budget measuring adherence to the funding agreement is an operating surplus of \$85M, or 0.9 % relative to the annual global Alberta Health funding of \$9,634M.

Table: Adherence to Five Year Budgeted Government Funding

	Operating Surplus (Deficit) (\$millions)	Annual Funding (\$millions)	Operating Surplus(Deficit) over Global Funding
March 31, 2011	856	9,037	+9.5%
March 31, 2012	85	9,634	+0.9%

Source: *Unaudited Annual Financial Statements for the year ended March 31, 2012.*

 PERFORMANCE STATUS Performance is at or better than quarterly target, continue to monitor.	2011/12 TARGET DEFICIT ADHERENCE RANGE: WITHIN 1.5%
	2011/12 ACTUAL ADHERENCE VALUE: SURPLUS OF 0.9%

WHAT ACTIONS ARE WE TAKING?

AHS has succeeded in achieving a surplus position with respect to our annual global funding for fiscal 2011/12, and will continue to monitor our adherence to budget going forward. Throughout the fiscal year, we continue to assess our success relative to our five year funding agreement with Alberta Health through quarterly updates regarding our accumulated surplus (deficit). For more information specific to our progress and actions, please refer to our publically reported "On Budget, Year to Date" measure in the Quarterly Performance Report.

WHAT ELSE DO WE KNOW?

The AHS financial reporting documents can be obtained from the www.albertahealthservices.ca website.

HOW DO WE COMPARE?

National benchmark comparisons are not applicable.

Data updated quarterly with one quarter lag
Most current data are Q4 2011/12
Next data update expected for Q2 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?

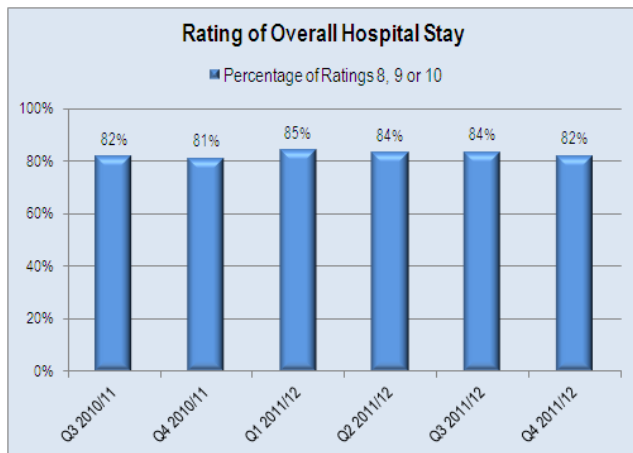
Gathering perceptions and feedback from individuals who use hospital acute care services is a critical aspect of measuring progress and improving the health system. This measure reflects overall patient perceptions associated with the hospital where they received care and is derived from a well-established 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 84% for fiscal year 2011/12. The Q4 actual value is 82%.



Source: AHS H-CAHPS Survey data

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

Performance Measure Update

Patient Satisfaction Adult Acute Care

PERFORMANCE STATUS

Performance target has not been established for comparison.

2012/13 TARGET:
TBD

2011/12
ACTUAL: 84%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A Provincial Working Group has been established to develop a plan for gathering and reporting patient feedback to organizations. A Patient-Centred Care Education Strategy has been developed and approved and an Education Strategy has been implemented.

Subsequent actions planned: Develop Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) reporting. Implement internal web page and e-learning.

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 percent (New Brunswick), Canada = 81.5 per cent (Statistics Canada, 2007). Using a similar measure Alberta ranked 10th among the 10 provinces for satisfaction with their last hospital stay for one or more nights. Alberta = 75 per cent, Best Performing Province = 90 per cent (Prince Edward Island), Canada = 79 per cent (Angus Reid 2009-2010)

Data updated annually
Most current data are 2011/12
Next data update expected for Q4 2012/13

Performance Measure Update

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 percentage of patients indicating that overall they are satisfied with the addiction and mental health services they received.

HOW ARE WE DOING?

The 2011/12 results within Addiction and Mental Health show that 92.3 per cent of patients are satisfied with the service they received.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Continued to work on standardized screening and assessment for addiction and mental health. Adult Depression: Pathway developed and pilot completed in Calgary Zone. The final evaluation of the pilot has been released with recommendations and overall outcomes are positive.

PERFORMANCE STATUS

Performance target has not been established for comparison.

2011/12 TARGET:
TBD

2011/12 ACTUAL:
92.3%

Subsequent actions planned: Adult Depression: Finish adapting the pathway in the South Zone and implement. Continue work with North, Central and Edmonton Zones as per current stages. Adolescent Depression: Components of the pathway to be tested as of end of March 2012 while pursuing opportunity to provide required education to implement remainder. Combined meeting of the Pilot Site, AHS Adolescent Depression Working Group, and the Science Policy Practice Network (SPPN) Adolescent Working Group plan to meet in April 2012 to share information and discuss next steps to an integrated pathway

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 are Q1 2012/13
Next data update expected for Q2 report

Performance Measure Update

Percentage of Patient Feedback as Commendations

WHAT IS BEING MEASURED?

This measure is the number of commendations received by the Patient Relations Department (PRD) expressed as a percentage of the total feedback.

The Patient Relations Department (PRD) manages commendations and complaints/concerns feedback received from patients/families about AHS programs and services. In addition to these, the PRD tracks feedback classified as advisements, consultations and non-AHS feedback¹.

Patients and their families must take the initiative to contact PRD either by phone, submitting an online feedback form or faxing/mailling a written letter. Patient feedback that is offered to staff at the point of service or care delivery is not captured by PRD.

Detailed indicator [definition](#) is available.

WHY IS THIS IMPORTANT?

It is important for AHS to hear about what is working well for patients and families, as well as areas for improvement. Tracking the percentage of commendations received assists AHS to assess the quality of our services and determine if improvements initiatives are having an impact on patients /families. This information also shows our staff where their dedicated efforts are making a difference in people's lives.

WHAT IS THE TARGET?

While a target has yet to be established for 2012/13, in comparison with the data from the previous fiscal year, the percentage of feedback received as commendations in Q1 has remained consistent with the previous average of 10.28%.

HOW ARE WE DOING?

Of the 2,851 pieces of feedback provided to the Patient Relations Department from April 1 to June 30, 2012, 302 were commendations.

¹ This feedback is defined as follows:

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

PERFORMANCE STATUS Performance Target for 2012/13 has not been established for comparison.	2012/13 TARGET: TBD
	Q1 ACTUAL: 10.59%

Table 1: Commendations for Fiscal Year 2012/13.

Fiscal Year 2012/13	Number of Commendations	Percentage of All Feedback
Q1	302	10.59%
Q2		
Q3		
Q4		
Total		

Feedback managed by: AHS & Covenant Health Patient Relations
Data Source: FACT (Feedback and Concerns Tracking)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Following the amalgamation of the PCO and Patient Relations Department three actions have been completed: the Patient Concerns Resolution Process (PCRP) Policy Suite was approved by Executive in May 2012 with implementation planned for September 2012; the Patient Relations Department website was updated to reflect the changes made to the PCRP as a result of the amalgamation; and, a campaign designed to educate AHS staff and physicians about what types of feedback the Patient Relations Department collects and how to direct patients or their families to provide feedback, was disseminated throughout the organization.

Subsequent actions planned: As mandated in the PCRP Policy Suite, the Patient Relations Department will provide educational support to all AHS staff and physicians concerning their role in the PCRP.

WHAT ELSE DO WE KNOW?

The Patient Relations Department recognizes the value of positive patient feedback. Commendations that are documented by the Patient Relations Department can be used as educational illustrations about the importance of a positive interaction with a patient or their families for all AHS staff.

Information is available by [zone](#).

HOW DO WE COMPARE?

This measure is not benchmarked externally.

Data updated quarterly
Most current data are Q1 2012/13
Next data update expected for Q2 report

WHAT IS BEING MEASURED?

This measure is the percent of concerns that the Patient Concerns Officer (PCO) has reviewed and provided a closure letter, signed by the PCO, and the Executive Director (ED) of the Patient Relations Department to the complainant. This letter, which also, includes the contact information for the Alberta Ombudsman, is the final step in the AHS Patient Concerns Resolution Process (PCRP).

Patients/families with service delivery concerns are encouraged to work with their health care team or with the Patient Relations Department, led by PCO / ED. However, some patients/families prefer not to work with either or are dissatisfied with the outcome of the PCRP. These patients/families are referred, by the PCO to the Alberta Ombudsman, who will conduct an independent investigation as required by provincial regulation.

Detailed indicator [definition](#) is available.

WHY IS THIS IMPORTANT?

Feedback, in the form of a concern, is an important informational tool, highlighting areas for quality improvements, and it is essential that patients/families feel there is an avenue to express their concerns.

If patients do not feel that they can express their concerns at the service delivery level, or if they feel their concerns are not adequately addressed by the Patient Concerns Resolution Process, it may indicate that there is need for AHS to better engage with patients/families and that public trust needs to be developed.

WHAT IS THE TARGET?

Ongoing tracking and reporting of concerns will continue and over the course of the next year benchmarks will be established and targets developed.

HOW ARE WE DOING?

During the period April 1 to June 30, 2012, 23 files were reviewed by the Patient Concerns Officer as the final step in the Patient Concerns Resolution Process, and the contact information for the Alberta Ombudsman was provided in the closing letter. These files represent 1% of the total number of concerns received during Q1.

Performance Measure Update

Percentage of Patient Concerns Escalated to Patient Concerns Officer

PERFORMANCE STATUS Performance Target for 2011/12 has not been established for comparison	2012/13 TARGET: TBD
	Q1 2012/13 ACTUAL: 0.96%

Table 1 - PCO Reviews Initiated (2012/13)

Fiscal Year 2012/13	Concerns		
	Total Concerns*	PCO Reviews Initiated	%
Q1	2,384	23	0.96%
Q2			
Q3			
Q4			
Total			

*Concerns managed by: AHS and Covenant Health Patient Relations Departments

Data Source: FACT (Feedback and Concerns Tracking)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Following the amalgamation of the PCO and Patient Relations Departments, three actions have been completed: the Patient Concerns Resolution Process (PCRP) Policy Suite was approved by Executive in May 2012 with implementation planned for September 2012; the Patient Relations Department website was updated to reflect the changes made to the PCRP as a result of the amalgamation; and, a campaign designed to educate AHS staff and physicians about what types of feedback the Patient Relations Department collects and how to direct patients or their families to provide feedback, was disseminated throughout the organization.

Subsequent actions planned: As mandated in the PCRP Policy Suite, the Patient Relations Department will provide educational support to all AHS staff and physicians concerning their role in the PCRP.

WHAT ELSE DO WE KNOW?

As mandated in the PCRP Policy Suite, the Patient Relations Department will provide educational support to all AHS staff and physicians concerning their role in 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 are 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 AH Annual Report. [The most recent annual report is for 2010 – 2011](#).

Unexpected harm measures the percentage 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.

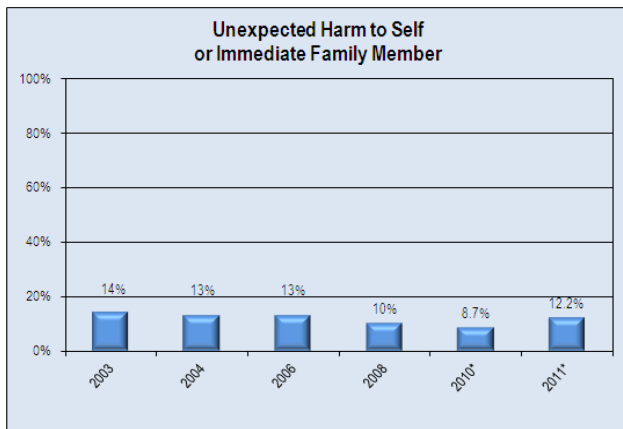
An internal review of the data quality indicates a very high level of confidence with no known issues.

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 2012/13 target of 9 per cent for the percentage 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



PERFORMANCE STATUS

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

2012/13 TARGET:
9%

2011 ACTUAL:
12.2%

HOW ARE WE DOING?

It should be noted that this metric is based upon a survey conducted by the Health Quality Council of Alberta. It is the percentage of people who respond "yes" to the question: "To the best of your knowledge, have you, or has a member of your immediate family experienced unexpected harm while receiving health care in Alberta within the past year." This includes care provided by all health providers not just those providing care on behalf of AHS. The number of Albertans surveyed in 2011 was 1,215 resulting in an error rate of $\pm 2.1\%$. The change from 2010 is not statistically significant.

The percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year is above 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. An Executive Patient Safety Committee (EPSC) has been implemented and meets regularly

Subsequent actions planned: Prioritization of Quality Assurance Review Recommendations for action through targeted risk reduction strategies. Follow-up evaluation of the effectiveness of these actions will also 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

Data updated quarterly with a one quarter lag
Most current data are Q3 2011/12
Next update is anticipated for Q2 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.

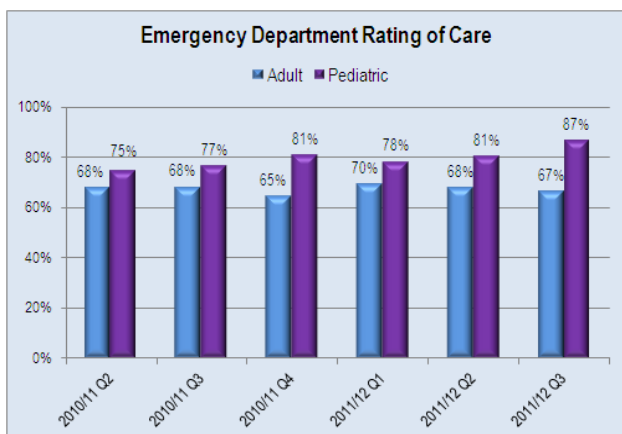
The information provides insights into the consequences of policy and strategic changes from the perspective of a key health care partner – Albertans.

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?

For Q3 Year to Date (Apr – Dec) 2011/12, 68 per cent of Adult and 82 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: 68% Adult
82% Pediatric
(Apr-Dec)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Additional facilities have been opened and others expanded (Stollery Children’s Hospital) adding new capacity to the system. Programs such as the ED2Home program which helps Seniors transition from Emergency to their homes have been implemented. EMS clients are now being transported to the most appropriate facility – ED or Urgent Care Center (UCC). Over Capacity Protocols and escalation plans continue to be used to manage periods of peak pressures in EDs.

Subsequent actions planned: There is ongoing participation in system wide improvement and flow initiatives to support inpatient bed capacity for ED patients.

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).

Data updated annually
Most current data are 2011
Next survey is anticipated for 2012

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 AH Annual Report. [The most recent annual report is for 2010/11.](#)

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

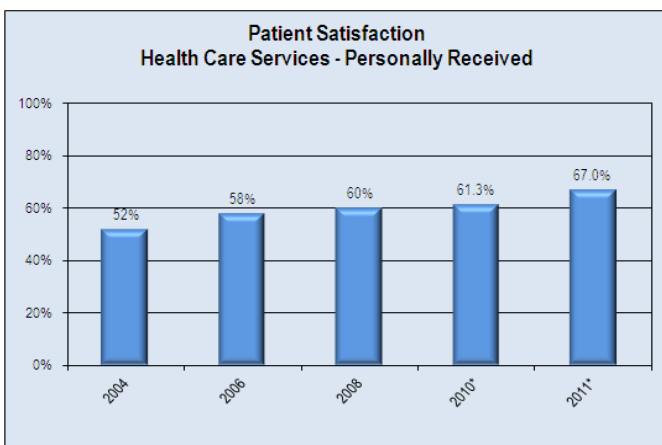
Health care services include personal family doctor, other health care professionals at family doctor's office, community walk-in clinics, specialists, MRI, other diagnostic imaging, pharmacists, emergency departments, inpatient hospital services, outpatient hospital services and mental health services.

Detailed indicator [definition](#) is available.

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

WHY IS THIS IMPORTANT?

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

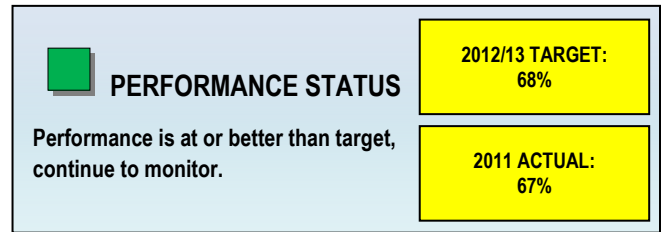


Source: Health Quality Council of Alberta (HQCA) Health Services Satisfaction Survey
Note: This measure applies only to adults aged 18 years and over who used health care services in Alberta in the past year.

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

Performance Measure Update

Patient Satisfaction Health Care Services Personally Received



WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a 2012/13 target of 68 per cent of Albertans who were satisfied with the health care services they personally received in Alberta within the past year.

HOW ARE WE DOING?

The percentage 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 works closely with HQCA (Health Quality Council of Alberta) to monitor patient satisfaction. 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).

Data updated quarterly
Most current data are Q4 2011/12
Next data update expected for Q2 report

Central Venous Catheter Bloodstream Infection Rate

WHAT IS BEING MEASURED?

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

Detailed indicator [definition](#) is available.

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 AHS following the collection of baseline data and information on infection prevention and control program activity by AHS.

HOW ARE WE DOING?

The central venous catheter bloodstream infection rate for adult sites was 0.73 per 1,000 line-days in Q4 2011/12 and the year to date (April 2011–March 2012) rate was 0.93 per 1,000 line-days.

PERFORMANCE STATUS Performance target for 2011/12 is not yet established for comparison	2012/13 TARGET: TBD
	YTD 2011/12 ACTUAL: 0.93 (Apr-Mar)

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?

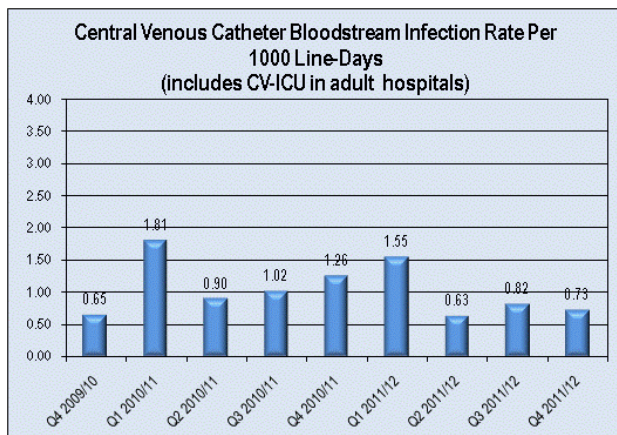
The skin is the main source of organisms causing CVC-BSI. Infection may occur because of migration of organisms from the insertion site along the percutaneous tract. Other risk factors include catheter insertion and care practices, products administered through the line, frequency of manipulation, age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



Methicillin-Resistant *Staphylococcus aureus* – Bloodstream Infection

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

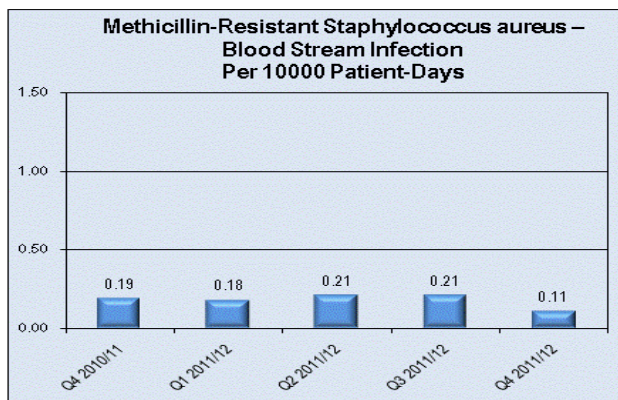
An internal review of the data quality indicates a very high level of confidence with no known issues.

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^{1,2}.

WHAT IS THE TARGET?

Targets will be set jointly by Alberta Health 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: 0.18
(Apr-Mar)

HOW ARE WE DOING?

The MRSA bloodstream infection rate was 0.11 per 10,000 patient days in Q4 of 2011/12 while the year to date (April 2011 – March 2012) rate was 0.18.

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. The Alberta definition uses longer than 48 hours after admission."

Internal benchmarks will be developed over time.

Data updated quarterly
Most current data are Q4 2011/12
Next data update expected for Q2 report

Performance Measure Update

Clostridium difficile Infection

PERFORMANCE STATUS

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

2011/12 TARGET:
TBD

YTD TARGET TBD
HA ACTUAL: 4.1
(Apr-Mar)

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 definitions are available for [Hospital-Acquired CDI](#) and [Total CDI](#).

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 AH and AHS following the collection of baseline data and information on infection prevention and control program activity by AHS.

HOW ARE WE DOING?

The hospital-acquired (HA) CDI rate was 4.4 per 10,000 patient days in January – March 2012 and the April 2011 – March 2012 rate was 4.1.

Between January and March 2012, the total number of hospitalized cases of CDI was 324.

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?

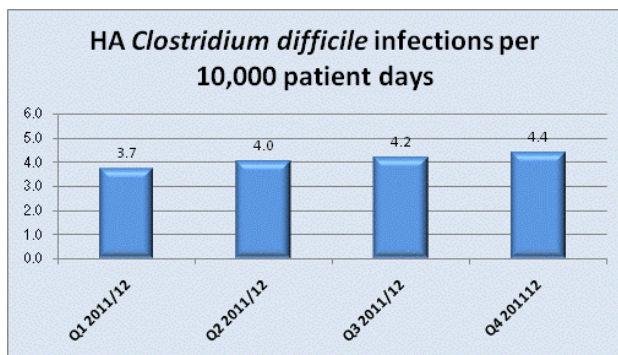
Most often, CDI is a mild disease, but serious disease and relapse can occur, including the need for surgery and, in extreme cases, even death. Several factors affect hospital rates of CDI including the size, physical layout and nature of services provided, type of population served and use of antibiotics. 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.



Source: AHS Infection Prevention and Control

Data updated quarterly with one quarter lag
Most current data are Q4 2011/12
Next data update expected for Q2 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 under development and is not available.

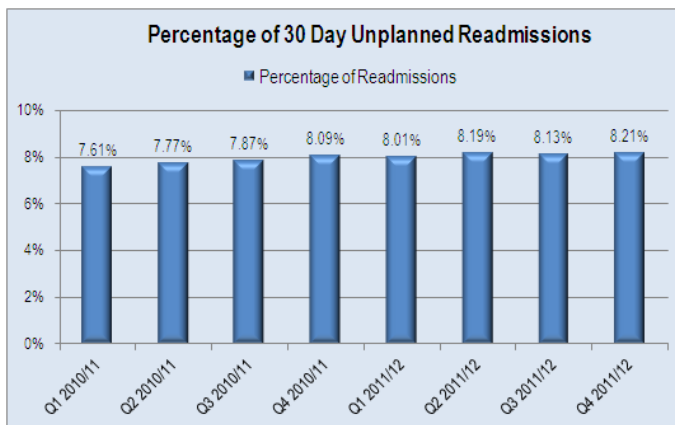
An internal review of the data quality indicates a very high level of confidence with no known issues.

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.

WHAT IS THE TARGET?

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



Source: AHS Discharge Abstract Database

Performance Measure Update

30 Day Unplanned Readmission Rate

PERFORMANCE STATUS

Performance target has not been established for comparison.

2012/13 TARGET:
TBD

2011/12 ACTUAL:
8.14%

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.

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 health care services accessibility. Therefore comparisons between zones should be made with caution.

Information is available by [zone](#).

HOW DO WE COMPARE?

Using a similar measure, Alberta ranked third among the 10 provinces for 30-day overall readmission rate. Alberta = 8.3 per cent, Best Performing Province = 7.9 per cent (Quebec), Canada = 8.4 per cent (CIHI, 2009/10).