Alberta Health Services

Performance Report

December 2010

Prepared by

Data Integration, Measurement and Reporting

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Choice and Quality for Seniors

Enabling Our People / Enabling One Health System

Introduction

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

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

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

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

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

Reporting our performance: July 1 – September 30, 2010

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

A few areas where AHS is on track to reaching the annual target include: Health Link Alberta call answer wait times, patient satisfaction rates in hospitals, and the percentage of children receiving community-based mental health treatment within 30 days.

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

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

- Implementing new Emergency Department (ED) surge capacity protocols to provide additional capacity when demands on Emergency and across the health system reach critical thresholds. When reached, the new protocols trigger immediate action to reduce wait times. To support the new protocols, AHS is creating new surge capacity and opening 49 additional beds in Edmonton and 32 in Calgary. These beds, opening by March 2011, will help ensure that ED physicians and staff have back-up beds and resources to quickly ease capacity pressures.

- Adding more than 200 new hospital beds by March 2011. This is in addition to the surge capacity beds which are part of the new Emergency Department protocols. More open hospital beds will reduce emergency department lengths of stay for many patients requiring admission.

- Informing Albertans about their care options. Many Albertans visit emergency for illness and injuries that could be treated by a family doctor, at a drop-in clinic or an urgent care centre.

- Adding 1,300 continuing care beds by the end of March 2011. 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 emergency department lengths of stay for many patients requiring admission.

- Increasing home care spending in an effort to keep seniors safe, healthy and independent in their homes and reduce the number of avoidable emergency visits.

- Implementing a care pathway for patients requiring hip replacement. This involves a central intake of referrals and offering a "next available surgeon and site" option to interested patients. The project is now underway in all 12 facilities performing hip replacements.

- Increasing cataract surgeries: funding allocation to complete 1,400 additional cataract procedures from July to October 2010 will directly address wait times.

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

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

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

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

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

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

What's being measured?

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

How to read this report

This report is easier to understand, easier to use, streamlines information and is aligned with the 2010-2015 Health Plan and other AHS reports such as the Quality and Patient Safety Dashboard and the Human Resources Dashboard.

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

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

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

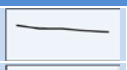
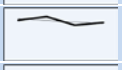
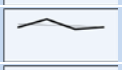
A "green light" is used when actual performance is at or better than the prorated target; a "yellow light" represents performance within an acceptable range of the target (we are at least within 75 per cent of where we were expected to be), and a "red light" shows performance is beyond an acceptable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

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

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

AHS Performance Dashboard

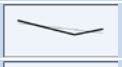
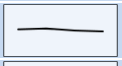
Status	
■	Performance is at or better than target, continue to monitor
△	Performance is within acceptable range of target, monitor and take action as appropriate
●	Performance is outside acceptable range of target, take action and monitor progress

Tier 1◊	Performance Measure	Reporting Period	Actual Performance	Year to Date Target	Status	Trend	Annual Target
	Staying Healthy / Improving Population Health						
◊	Life Expectancy	2009	81.1	na	na		na
◊	Potential Years of Life Lost (per 1,000 Population)	2009	47.3	na	na		na
	Colorectal Cancer Screening Participation Rate	2008	35.5%	na	△ ǂ	na*	37% ǂ 2010
	Breast Cancer Screening Participation Rate	2008 - 2009	55.9%	na	△ ǂ	na*	57% ǂ 2009-10
	Cervical Cancer Screening Participation Rate	Jan 07- Dec 09	70.70%	na	△ ǂ	na*	72% ǂ 2008-10
	Building a Primary Care Foundation						
◊	Seniors (65+) Influenza Immunization Rate	2009/10	56%	na	●		75%
◊	Children (6 to 23 Months) Influenza Immunization Rate	2009/10	16%	na	●		75%
◊	Childhood Immunization Rates for DTaP	2008	83.8%	na	●		95%
◊	Childhood Immunization Rates for MMR	2008	89.3%	na	△		95%
	Albertans Enrolled in a Primary Care Network (%)	Apr 2010	64%	na	●		75%
◊	Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)	Q1 2010/11	72 ✓	76 (quarterly)	■		304 (annually)
◊	Family Practice Sensitive Conditions (% of ED visits)	Q1 2010/11	27.1% ✓	27.8%	■		27%
	Health Link Wait Time (% answered within 2 minutes)	Q2 2010/11	83.7% ✓	72.5%	■		80%
◊	Children Receiving Community Mental Health Treatment within 30 Days (%)	Q2 2010/11	85%	80.5%	■		85%
	Improving Access, Reducing Wait Times						
◊	Urgent CABG Wait Time (90th percentile in weeks)	Q2 2010/11	2.1 ✓	1.95	●		1.5
◊	Semi-urgent CABG Wait Time (90th percentile in weeks)	Q2 2010/11	6.6 ✓	6.0	●		5.0
◊	Scheduled CABG Wait Time (90th percentile in weeks)	Q2 2010/11	25.9 ✓	23	●		15.0

◊Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.
* Trend for these measures cannot be determined until subsequent data is available.
✓Indicates data points that have been updated since the previous report.

AHS Performance Dashboard (continued)

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

Tier 1◊	Performance Measure	Reporting Period	Actual Performance	Year to Date Target	Status	Trend	Annual Target
◊	Hip Replacement Surgery Wait Time (90th percentile in weeks)	Q2 2010/11	40.0 ✓	32.6	●		28
◊	Knee Replacement Surgery Wait Time (90th percentile in weeks)	Q2 2010/11	47.7 ✓	46.6	▲		42
◊	Cataract Surgery Wait Time (90th percentile in weeks)	Q2 2010/11	43.6 ✓	38.5	●		36
◊	Other Scheduled Surgery Wait Time (90th percentile in weeks)	Q2 2010/11	25.0 ✓	tbd	na		tbd
◊	Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	Q2 2010/11	6.3 ✓	5.7	●		4
◊	Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks)	Q2 2010/11	3.7 ✓	4.7	■		4
◊	Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume EDs) £	Q1 2010/11	62% ✓	64%	●		70%
◊	Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	Q1 2010/11	79% ✓	81%	●		82%
◊	Patients Admitted from ED within 8 hours (%) (15 Higher Volume EDs) £	Q1 2010/11	39% ✓	38%	●		45%
◊	Patients Admitted from ED within 8 hours (%) (All Sites) £	Q1 2010/11	52% ✓	50%	●		55%
◊	Never (Adverse) Events	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q3 2010/11					
◊	Hospital Acquired MRSA Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q4 2010/11					
◊	Surgical Site Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13					
	Central Venous Catheter Bloodstream Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q4 2010/11					
	Choice and Quality for Seniors						
◊	People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	Q2 2010/11	759 ✓	581	●		400
◊	People Waiting in Community for Continuing Care Placement	Q2 2010/11	1,109 ✓	998	●		975
◊	Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	Q2 2010/11	59	tbd	na		tbd
◊	Number of Home Care Clients	Q1 2010/11	51,073	na	na	na*	tbd

◊Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.
* Trend for these measures cannot be determined until subsequent data is available.
✓Indicates data points that have been updated since the previous report.
£The Weekly ED Length of Stay (LOS) being published are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%. Status has been set to RED as risk of not achieving 2010/11 target assessed as high.

AHS Performance Dashboard (continued)

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

Tier 1◊	Performance Measure	Reporting Period	Actual Performance	Year to Date Target	Status	Trend	Annual Target
	Enabling Our People / Enabling One Health System						
◊	Headcount to FTE Ratio	Q2 2010/11	1.58 ✓	na	■		1.63
◊	Registered Nurse Graduates Hired by AHS (%)	Q2 2010/11	60% ✓	35%	■	na	70% by year end
◊	Disabling Injury Rate	Jan to Sep 2010	2.23 ✓	na	●	na	2.41
◊	Staff Overall Engagement (%)	2009/10	35%	na	●	na*	43%
◊	Physician Overall Engagement (%)	2009/10	26%	na	●	na*	43%
	Full-time to Part-time Clinical Worker Ratio	Q2 2010/11	0.93 ✓	na	na	na*	tbd
	Employee Absenteeism Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q4 2010/11					
	Overtime Hours to Paid Hours Ratio	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q4 2010/11					
◊	Number of Netcare Users	Q2 2010/11	10,864 ✓	10,821	■		11,575
◊	Patient Satisfaction - Acute Care	Q1 2010/11	84.5% ✓	na	■	na*	80%
◊	Patient Satisfaction - Addictions and Mental Health	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q1 2011/12					
	Patient Commendations	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q4 2010/11					
	Patient Concerns Open with Patient Concerns Office	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q4 2010/11					

◊Indicates "Tier 1" measures that are attached to the 2010 – 2015 Health Plan.
* Trend for these measures cannot be determined until subsequent data is available.
✓Indicates data points that have been updated since the previous report.

Treatment Level Activity Report

Activity Measure	2008/09 Fiscal Year	2009/10 Q1	2009/10 Q2	2009/10 Q3	2009/10 Q4	2009/10 Fiscal Year	2010/11 Q1	2010/11 Q2	2010/11 Q3	2010/11 Q4	2010/11 Fiscal Year
Number of Hospital Discharges[1] (by Site)	357,392	92,920	89,642	89,683	90,069	362,314	92,600*	88,500*			
Average Hospital Length of Stay (Days) [1,2] (by Site)	6.9	6.9	6.8	7.1	7.1	7.0	6.8*	7.0*			
Per Cent of Alternate Level of Care (ALC) [1,3] Days	8.4%	8.2%	8.9%	10.9%	9.2%	9.3%	8.2%				
Number of Hospital Births[1]	50,227	13,085	13,440	12,230	11,983	50,738	12,882				
Number of Emergency Department Visits[4] (by Site)	1,921,151	501,681	494,295	482,636	474,181	1,952,793	491,800*	492,800*			
Number of Urgent Care Service (UCS) Visits[5]	103,519	29,638	29,850	29,376	36,550	125,414	39,725				
Number of Health Link Calls	864,240	205,649	190,883	433,586	200,074	1,030,192	175,319	167,602			
Number of Total Primary Hip Replacements[6]	2,749	774	640	806	909	3,129	832				
Number of Total Primary Knee Replacements[6]	3,811	1,078	871	1,059	1,118	4,126	1,225				
Number of Cataract Surgeries	27,669	7,313	6,024	5,900	8,390	27,627					
Number of MRI Exams[7]	157,724	41,302	40,432	38,960	45,254	165,948	44,871	43,111			
Number of Lab Tests[8]	56,506,010	15,143,422	14,401,121	14,382,996	15,207,661	59,135,200					

Notes:

* Q2 2010/11 figures are preliminary, rounded to nearest 100 for all sites pending data verification.
* Q1 2010/11 figure is preliminary pending data verification for Killam Health Care Centre, Lamont Health Care Centre, St. Joseph's General Hospital, and Whitecourt Healthcare Centre.

1. The above figures exclude Grimshaw/Berwyn and District Community Health Centre as inpatient data abstracts are not submitted.
2. Average Hospital Length of Stay (Days) includes acute, subacute and Alternate Level of Care (ALC) days.
3. Alternate Level of Care (ALC) Days is the per cent of total hospital days. Use with caution as classification of ALC days is not standardized throughout the province.
4. Number of Emergency Department Visits excludes the following facilities: Breton Health Centre, Coaldale Health Centre, Rainbow Lake Health Centre, St. Mary's Health Care Centre (Trochu).
5. Number of Urgent Care Service (UCS) Visits: Figures are based on the certification effective dates below.
   Airdrie Regional Health Centre 18-Dec-2009
   Health First Strathcona 01-May-2008
   Okotoks Health and Wellness Centre 17-Mar-2010
   Sheldon M Chumir Centre 01-Apr-2008
   South Calgary Health Centre 01-May-2008
6. Number of Total Primary Hip Replacements and Number of Total Primary Knee Replacements data source is inpatient data abstracts reported as of discharge date.
7. Number of MRI Exams: Figures include exams performed by Covenant Health DI sites and outsourced exams.
8. Lab Tests: Volumes are not comparable to numbers reported in previous periods (prior to April 2009). Figures include tests performed in non-AHS facilities.

Performance Measure Update

Life Expectancy

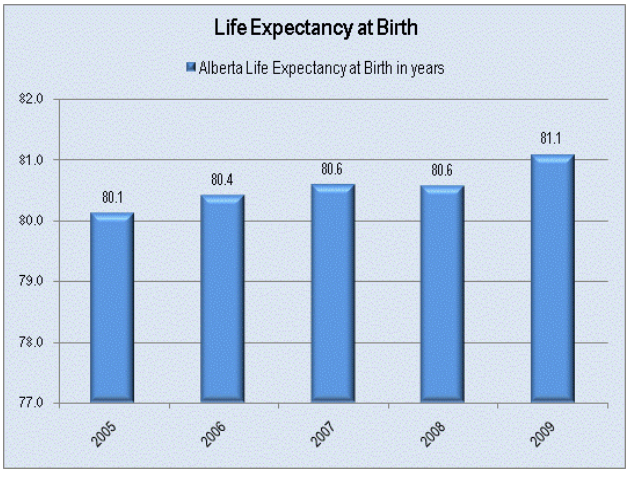
WHAT IS BEING MEASURED?
Life expectancy is the number of years from birth a person would be expected to live based on mortality statistics.

Detailed indicator definition is available.

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

WHAT IS THE TARGET?
Alberta Health Services targets an increase in life expectancy in a manner consistent with the Canadian average, with the goal of being above the national average.

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



Source: Alberta Health & Wellness

PERFORMANCE STATUS

Performance improvement observed since last reported period.

TARGET: Not Specified

ACTUAL: 81.1 years

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

WHAT ACTIONS ARE WE TAKING?
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 co-ordination 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.

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

Performance Measure Update

Potential Years of Life Lost

WHAT IS BEING MEASURED?

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

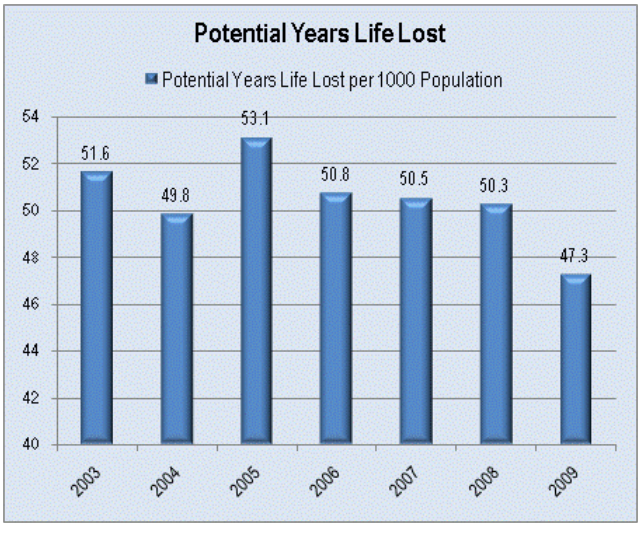
Detailed indicator definition will be available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



Source: Alberta Health & Wellness

PERFORMANCE STATUS

Performance improvement observed since last reported period.

TARGET: Not Specified

ACTUAL: 47.3 years

HOW ARE WE DOING?

In 2009, there was an improvement in PYLL with a drop from 50.3 years per 1,000 population in 2008 to 47.3 years per 1,000 population in 2009.

WHAT ACTIONS ARE WE TAKING?

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 will be made available by zone.

HOW DO WE COMPARE?

Using a similar definition, Alberta ranked third among the 10 provinces for PYLL. Alberta = 52.3, Best Performing Province = 47.6 (Ontario), Canada = 51.0 (Statistics Canada, 2001)

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.

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 individuals to have had 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. The 2010 target is 37 per cent. A target of 67 per cent has been set for 2020.

HOW ARE WE DOING?

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

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

Province	Screening Rate (%)
Alberta	35.5%

Source: Canadian Community Health Survey (CCHS) 2008

PERFORMANCE STATUS

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

2010 TARGET: 37% (to be confirmed)

ACTUAL (2007-09): 35.5%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Resources and education to healthcare providers to promote cancer screening is ongoing. Culturally appropriate and translated public educational resources have been developed to reduce the disparity in screening participation rates, and the burden of colorectal cancer among the population.

Subsequent actions planned: Development and early implementation of a long-term social marketing campaign and community action strategy to enhance public knowledge, attitudes and behaviours towards cancer screening participation.

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 would provide more meaningful information.

As with other population surveys, CCHS provides cross-sectional data with information self-reported and/or recalled. Data quality issues from survey methodology may exist.

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, Canada = 39.7 per cent (Statistics Canada, 2008).

Performance Measure Update

Breast Cancer Screening Participation Rate

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.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

The Alberta target is for 70 per cent of eligible women 50 to 69 years of age to have a screening mammogram at least biennially by 2020. The 2009-10 target is 57 per cent.

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

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

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

PERFORMANCE STATUS

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

2009/10 TARGET: 57%
(to be confirmed)

ACTUAL: 55.9%
(2008 – 2009)

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Resources and education to healthcare providers to promote cancer screening is ongoing. Culturally appropriate and translated public educational resources have been developed to reduce the disparity in screening participation rates, and the burden of breast cancer among the population.

Subsequent actions planned: Development and early implementation of a long-term social marketing campaign and community action strategy to enhance public knowledge, attitudes and behaviours towards cancer screening participation.

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 (Canadian Breast Cancer Screening Initiative) 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

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.

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 Alberta target is for 70 per cent of eligible women 21 to 69 years of age to have a Pap test every three years. The target for 2008-10 is 72 per cent.

HOW ARE WE DOING?

During the three-year period between January 2007 and December 2009, 70.7 per cent of eligible women aged 21 to 69 years received a screening Pap test. This screening rate meets the Alberta Health Services target rate of 70 per cent.

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

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

Source: Extracted from AHW FFS data

PERFORMANCE STATUS

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

2008-10 TARGET: 72%
(to be confirmed)

ACTUAL (2007-09): 70.7%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Resources and education to healthcare providers to promote cancer screening is ongoing. Culturally appropriate and translated public educational resources have been developed to reduce the disparity in screening participation rates, and the burden of cervical cancer among the population. In addition, the Alberta Cervical Cancer Screening Program (ACCSP) continues its work to enhance screening (e.g. mailing Pap test results, sending reminder letters if women are overdue for their next Pap test).

Subsequent actions planned: Development and early implementation of a long-term social marketing campaign and community action strategy to enhance public knowledge, attitudes and behaviours towards cancer screening participation. Expansion of the ACCSP throughout the province is also planned.

WHAT ELSE DO WE KNOW?

Pap test coverage tends not to be evenly distributed, with coverage rates of less than 40 per cent in some communities.

Information is available by zone.

HOW DO WE COMPARE?

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

Seniors (65+) Influenza Immunization Rate

WHAT IS BEING MEASURED?

The percentage of seniors aged 65 and older who have received the seasonal influenza vaccine during the previous influenza season (Oct 2009 through Apr 2010).

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

WHY IS THIS IMPORTANT?

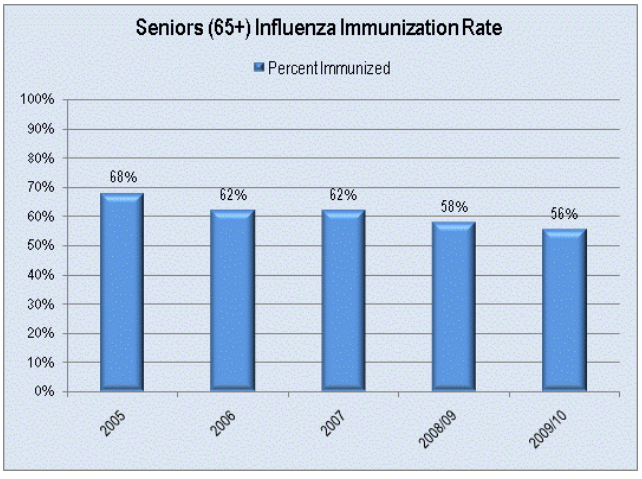
A high rate of seasonal influenza immunization among seniors will reduce the incidence of complications and death associated with influenza disease in this population.

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

Detailed indicator definition is available.

WHAT IS THE TARGET?

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



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

PERFORMANCE STATUS

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

2010/11 TARGET: 75%

2009/10 ACTUAL: 56%

HOW ARE WE DOING?

The Alberta Health Services seasonal influenza immunization rate for seniors aged 65 and older is 56 per cent. The rate is below the Alberta Health and Wellness target of 75 per cent.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Targeted clinics where seniors live or meet were opened in early October, 2010. A seasonal influenza plan has also been developed to address issues related to barriers to influenza immunization. Specific actions include: (1) improving access to immunization clinics through additional locations/times; (2) communicating the benefits of immunization to the public; (3) issuing standard training/orientation to immunizers; and (4) expanding the number of community providers who are able to offer the vaccine (e.g. pharmacists and physicians).

Subsequent actions planned: Administration of the vaccine will be offered via home visits for home-bound seniors. Newsletter inserts and posters will also be distributed to Senior's centres/residences.

WHAT ELSE DO WE KNOW?

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

HOW DO WE COMPARE?

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

Performance Measure Update

Children (6 to 23 Months) Influenza Immunization Rate

PERFORMANCE STATUS

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

2010/11 TARGET: 75%

2009/10 ACTUAL: 16%

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.

Immunization data is representative of four Alberta Health Services Zones (South, Calgary, Central and Edmonton). Data is not complete for 2009/10 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.

Detailed indicator definition is available.

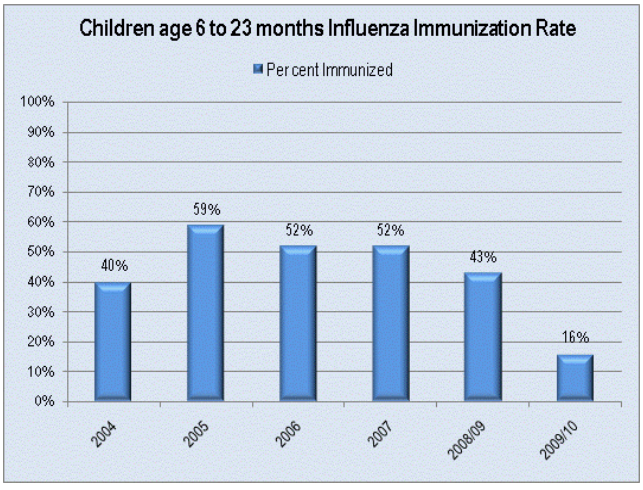
WHY IS THIS IMPORTANT?

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

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

WHAT IS THE TARGET?

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



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

HOW ARE WE DOING?

The influenza immunization rate for children between the ages of 6-23 months was 16 per cent for 2009/10, well below target.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A seasonal influenza plan has been developed to address issues related to barriers to influenza immunization. Specific actions include: (1) improving access to immunization clinics through additional locations/times; (2) communicating the benefits of immunization to the public; (3) issuing standard training/orientation to immunizers; and (4) expanding the distribution of influenza immunization to pediatricians to administer to their clients.

Subsequent actions planned: Influenza immunization will be offered to children (and other household contacts) as they present for routine immunizations in child health clinics. Posters and newsletter inserts will also be distributed to targeted groups (e.g. day-cares, day-homes).

WHAT ELSE DO WE KNOW?

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

HOW DO WE COMPARE?

Limited comparable data is available. In 2007, Manitoba reported 22 per cent of children were complete for their influenza vaccination by the age of two years.

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

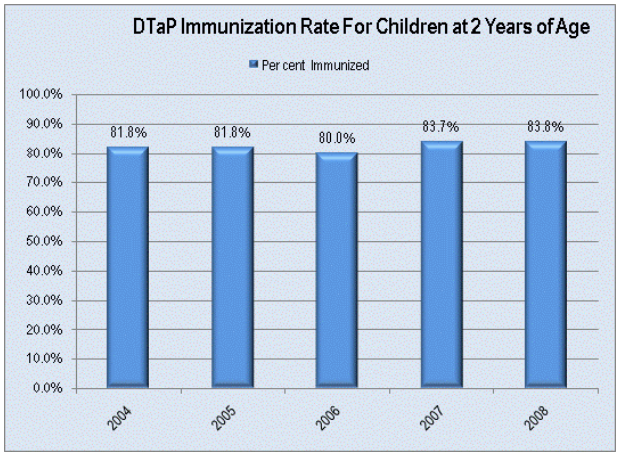
Detailed indicator definition is available.

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. A high rate of coverage is needed to protect the entire community from outbreaks of the disease.

WHAT IS THE TARGET?

The Alberta Health and Wellness Business Plan target is for 95 per cent of children to have received the required number of doses of DTap-IPV-Hib vaccine by two years of age.



Source: Alberta Health & Wellness and Alberta Health Services

PERFORMANCE STATUS

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

2010/11 TARGET: 95%

2008 ACTUAL: 83.8%

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: An environmental scan of immunization reporting capacity within each zone was completed.

Subsequent actions planned: A plan will be developed to explore evidence-based strategies to address immunization. Consultations will also be held with public health directors to identify: (1) the barriers to immunization; (2) the barriers to access immunization clinics; (3) the need for parent education/consultation; and (4) the consistently-delayed immunization data collection across the province.

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

Limited comparable data is available. In 2007, Manitoba reported 73.3 per cent of children were complete for DTaP, 88.0 per cent for Polio and 79.3 per cent for Hib by the age of two years.

Performance Measure Update

Childhood Immunization Rate for Measles, Mumps, Rubella

WHAT IS BEING MEASURED?

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

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

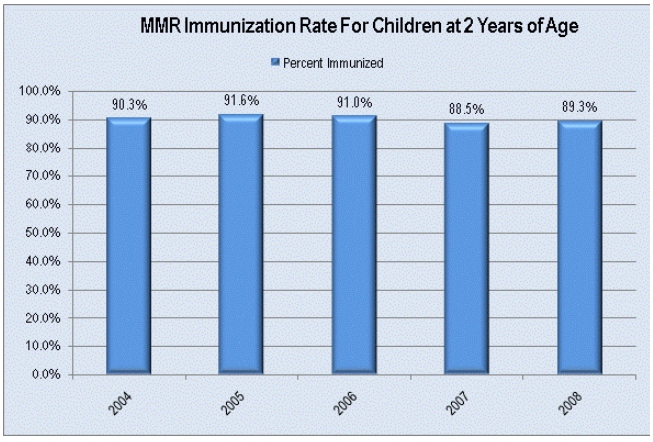
Detailed indicator definition is available.

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. Providing immunizations for childhood diseases is a major activity of the public health system. Immunizations protect children and adults from a number of diseases, some of which can be fatal or produce permanent disabilities. A high rate of coverage is needed to protect the entire community from outbreaks of the disease.

WHAT IS THE TARGET?

The Alberta Health and Wellness Business Plan target is for 95 per cent of children to have received the required number of doses of MMR vaccine by two years of age.



Source: Alberta Health & Wellness and Alberta Health Services

PERFORMANCE STATUS

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

2010/11 TARGET: 95%

2008 ACTUAL: 89.3%

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: An environmental scan of immunization reporting capacity within each zone was completed.

Subsequent actions planned: A plan will be developed to explore evidence-based strategies to address immunization. Consultations will also be held with public health directors to identify: (1) the barriers to immunization; (2) the barriers to access immunization clinics; (3) the need for parent education/consultation; and (4) the consistently-delayed immunization data collection across the province.

WHAT ELSE DO WE KNOW?

The decrease in immunization coverage from the previous year is very serious. There are pockets of low immunization across the province. Specific strategies need to be developed to increase immunization rates closer to the target by identifying why some children are not immunized, to increase access and modify existing immunization delivery programs to best suit the local population.

Information is available by zone.

HOW DO WE COMPARE?

Limited comparable data is available. In 2007, Manitoba reported 86.5 per cent of children were complete for Measles, 86.4 per cent for Mumps and 86.4 per cent for Rubella by two years.

Performance Measure Update

Albertans Enrolled in a Primary Care Network (%)

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

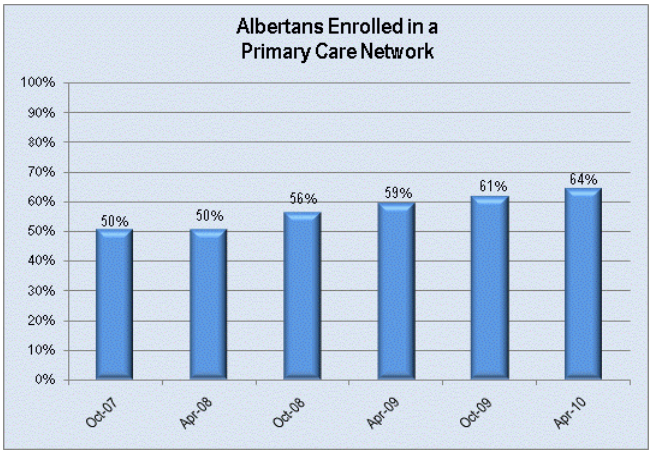
A PCN is an arrangement between a group of family physicians and Alberta Health Services to provide and coordinate a comprehensive set of primary health care services to patients. Primary Care is the care individuals receive at the first point of contact with the healthcare system. Patients receive care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

WHAT IS THE TARGET?

Alberta Health Services has established a target of 75 per cent of Albertans enrolled in a PCN for 2010/11. The target for this metric is currently under review.

HOW ARE WE DOING?

The percentage of Albertans enrolled in a PCN is 64 per cent as of April 2010, this is below the 2010/11 target of 75 per cent.



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

PERFORMANCE STATUS

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

2010/11 TARGET: 75%

ACTUAL: 64%
April 2010

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Early stages in the development of a Primary Health Care Strategy have been completed to advance a patient-focused model for primary care that offers care in the community by way of a team-based provider approach (literature search and environmental scan for best practices, two separate consultation and planning sessions with over 250 representatives from the public health, primary care and community care sectors).

Subsequent actions planned: Work will continue across the province to attach additional family physicians to PCNs, with efforts concentrated in the North and Central Zones. Focus groups and interviews will occur across the province to gain further input on the Primary Health Care Strategy and develop implementation plans.

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

Reference: Primary Care Initiative Program Office

HOW DO WE COMPARE?

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

Admissions for Ambulatory Care Sensitive Conditions

WHAT IS BEING MEASURED?

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

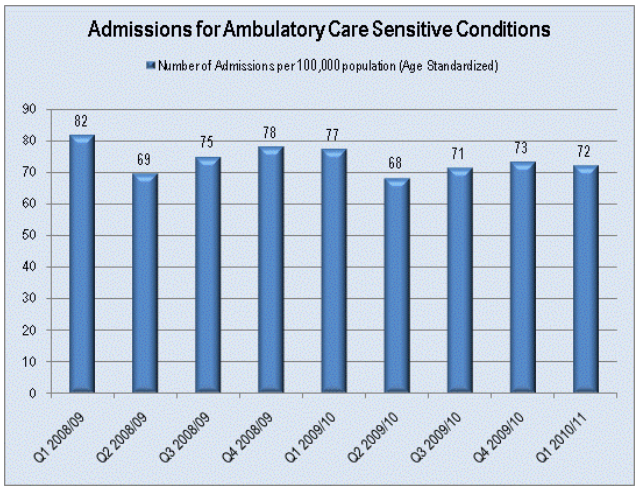
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



Source: AHS Discharge Abstract Database

PERFORMANCE STATUS

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

2010/11 TARGET: 304
admissions per 100,000
Q1 TARGET: 76

Q1 ACTUAL: 72
admissions per 100,000

HOW ARE WE DOING?

While there has been a slight increase in overall ACSC admissions in the most recent quarter, performance is better than target. The rate has been better than target over the last three quarters. This improvement has been noticed most markedly in the North, Central and South Zones. The annual ACSC rate for the 2009/10 fiscal year is 285 per 100,000 population under age 75 years.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Development of a long-term provincial registry system has been initiated to provide better access to information about chronic disease and better manage care for those patients.

Subsequent actions planned: In addition to next steps on the provincial chronic disease registry project, a quality improvement plan to reduce diabetes hospital admissions by one-third is planned. New public education materials will also be developed for prevention of the most common chronic diseases.

WHAT ELSE DO WE KNOW?

Participation from Patient Care Networks in the Alberta Access, Improvement, Measures (AIM) program is expected to reduce wait times and increase access to primary care.

Information is available by zone.

HOW DO WE COMPARE?

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

Performance Measure Update

Family Practice Sensitive Conditions

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

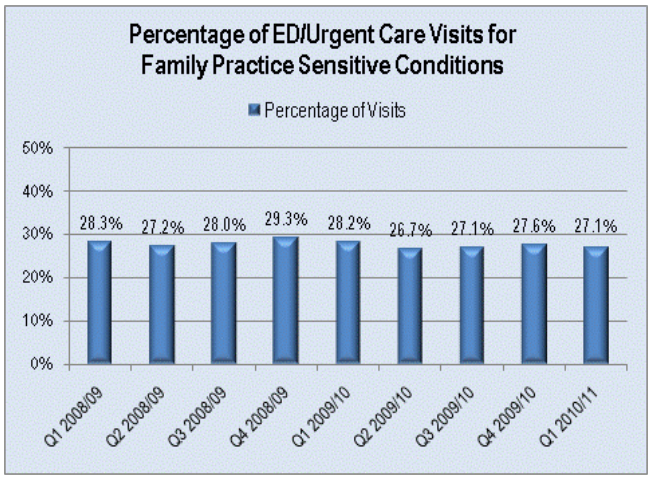
Further information on this indicator is available from the Health Quality Council of Alberta (HCQA) Measuring & Monitoring for Success report.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



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

PERFORMANCE STATUS

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

2010/11 TARGET: 27% of ED/UCC visits
Q1 TARGET: 27.8%

Q1 ACTUAL: 27.1% of ED/UCC visits

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Early stages in the development of a Primary Health Care Strategy have been completed to advance a patient-focused model for primary care that offers care in the community by way of a team-based provider approach (literature search and environmental scan for best practices, two separate consultation and planning sessions with over 250 representatives from the public health, primary care and community care sectors).

Subsequent actions planned: Focus groups and interviews will occur across the province to gain further input on the Primary Health Care Strategy and develop implementation plans.

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.

Performance Measure Update

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

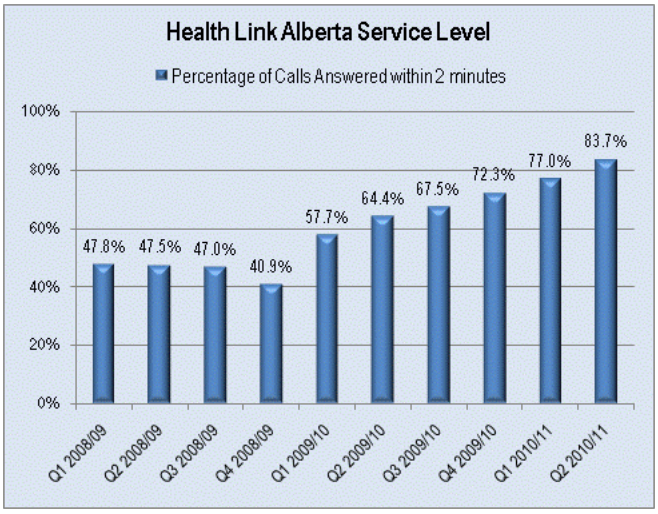
WHAT IS BEING MEASURED?
Health Link Alberta Service Level measures the percentage of calls to Health Link Alberta that are answered within two minutes.

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

Detailed indicator definition is available.

WHAT IS THE TARGET?
Alberta Health Services has established a 2010/11 annual target of 80 per cent of calls to be answered within two minutes.

HOW ARE WE DOING?
The percentage of Health Link Alberta calls answered within two minutes was 83.7 per cent for Q2 2010/11.



Source: Health Link Alberta, Nortel Contact Centre Management 6.0

PERFORMANCE STATUS

Performance is at or better than target, continue to monitor

2010/11 TARGET: 80%
Q2 TARGET: 72.5%

Q2 ACTUAL: 83.7%

WHAT ACTIONS ARE WE TAKING?
Actions completed to date: A review of the volume and types of calls placed to Health Link Alberta was completed. This review identified a need to increase the Information and Referral staff complement. The early stages of this change are currently underway.

Subsequent actions planned: The increased Information and Referral staffing plan is targeted for completion by March, 2011. As well, a plan for technology upgrades will be developed to assist with improving the Health Link Alberta wait time target.

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.

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

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

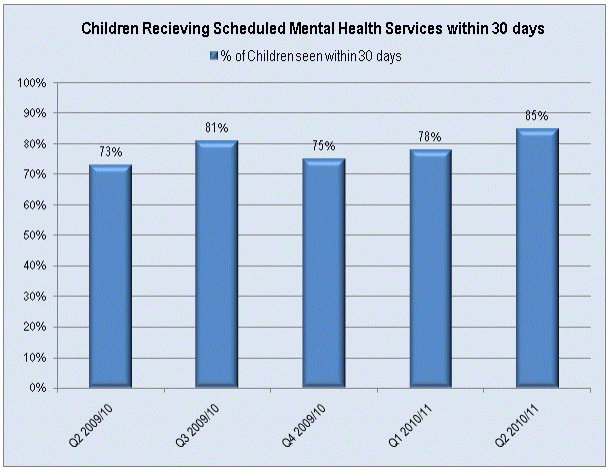
Wait times for access to community mental health treatment services are used as an indicator of patient access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

Currently, AHS is meeting the 85 per cent target of referred children receiving a face-to-face assessment within 30 days. Results are anticipated to further improve with the implementation of subsequent years of the Children's Mental Health Plan for Alberta: Three-Year Action Plan (2008/11).



Source: AHS Mental Health Services

PERFORMANCE STATUS

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

2010/11 TARGET: 85%
Q2 TARGET: 80.5%

Q2 ACTUAL: 85%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The three-year action plan has identified a host of new initiatives designed to enhance access to mental health services in schools and communities across the province. The plan seeks to recruit an additional 70 positions, with 25 having been filled thus far.

Subsequent actions planned: Recruitment efforts will continue so as to enable full implementation of the three-year action plan. Programs at all eight new project sites are also planned to begin implementation by March, 2011.

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

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

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

WHAT IS BEING MEASURED?

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

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

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

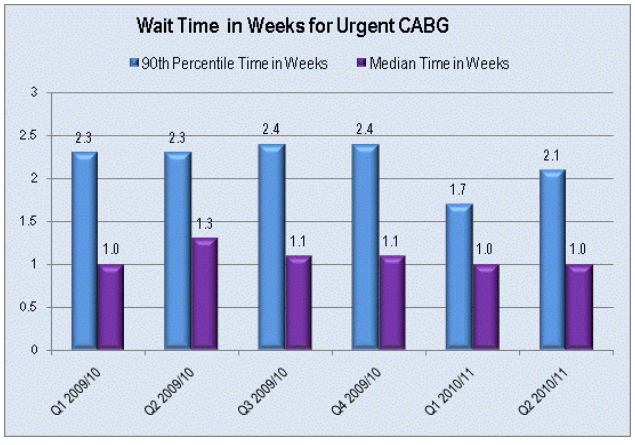
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



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

PERFORMANCE STATUS

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

2010/11 TARGET: 1.5 weeks
Q2 TARGET: 1.95

Q2 ACTUAL: 2.1 weeks

HOW ARE WE DOING?

The wait time for urgent CABG surgery is somewhat longer than target. There is still variation across the province in how definitions of urgency are applied which need to be addressed.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The Cardiac Network has formed a subgroup committee to review CABG wait times. This committee is currently looking at opportunities to reduce wait times (e.g. reviewing surgical cancellations, effectiveness in booking).

Subsequent actions planned: A plan to improve the triage and booking process for urgent cases is to be developed. A reporting system will be developed to inform surgeons as to current wait times and identify outliers currently on their list. Edmonton will recruit an additional cardiac surgeon and will also increase the number of cardiac surgeries starting January, 2011. The Cardiac Network will also continue to refine and standardize province wide wait time definitions.

WHAT ELSE DO WE KNOW?

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

Information is available for sites performing this surgery.

HOW DO WE COMPARE?

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

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

WHAT IS BEING MEASURED?

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

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

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

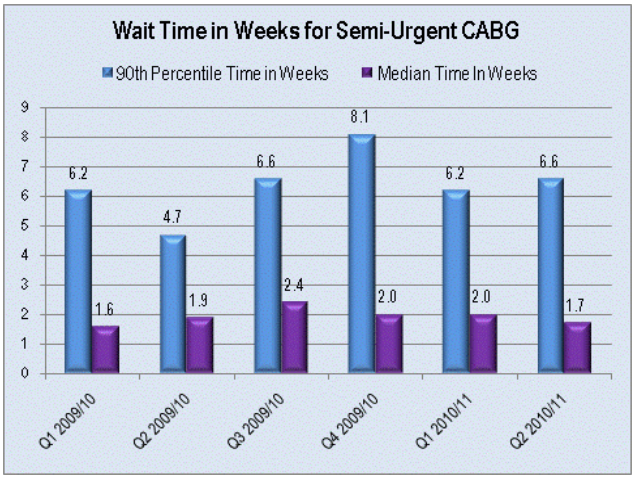
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



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

PERFORMANCE STATUS

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

2010/11 TARGET: 5.0 weeks
Q2 TARGET: 6.0

Q2 ACTUAL: 6.6 weeks

HOW ARE WE DOING?

The wait time for semi-urgent CABG surgery is longer than target. There is still variation across the province in how definitions of urgency are applied which need to be addressed.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The Cardiac Network has formed a subgroup committee to review CABG wait times. This committee is currently looking at opportunities to reduce wait times (e.g. reviewing surgical cancellations, effectiveness in booking).

Subsequent actions planned: A reporting system will be developed to inform surgeons as to current wait times and identify outliers currently on their list. Edmonton will recruit an additional cardiac surgeon and will also increase the number of cardiac surgeries starting January, 2011. The Cardiac Network will also continue to refine and standardize province wide wait time definitions.

WHAT ELSE DO WE KNOW?

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

Information is available for sites performing this surgery.

HOW DO WE COMPARE?

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

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

WHAT IS BEING MEASURED?

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

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

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

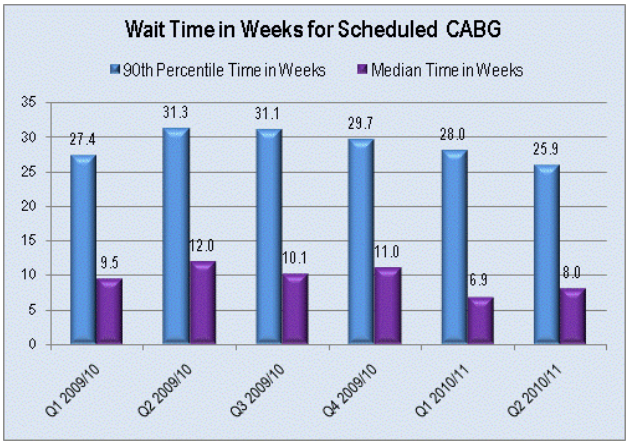
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



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

PERFORMANCE STATUS

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

20010/11 TARGET: 15 .0 weeks
Q2 TARGET: 23.0

Q2 ACTUAL: 25.9 weeks

HOW ARE WE DOING?

Although the wait time for scheduled CABG surgery has improved over the last year, it is still significantly longer than target. There is still variation across the province in how definitions of urgency are applied which need to be addressed.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The Cardiac Network has formed a subgroup committee to review CABG wait times. This committee is currently looking at opportunities to reduce wait times (e.g. reviewing surgical cancellations, effectiveness in booking).

Subsequent actions planned: A reporting system will be developed to inform surgeons as to current wait times and identify outliers currently on their list. The referral and triage process for urgency level III cases will be reviewed to identify opportunities to improve access. Edmonton will recruit an additional cardiac surgeon and will also increase the number of cardiac surgeries starting January, 2011. The Cardiac Network will also continue to refine and standardize province wide wait time definitions.

WHAT ELSE DO WE KNOW?

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

Information is available for sites performing this surgery.

HOW DO WE COMPARE?

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

Performance Measure Update

Hip Replacement Wait Time

WHAT IS BEING MEASURED?

Hip replacement wait time is the time from the date the patient and clinician agreed to hip replacement (arthroplasty) surgery as the treatment option of choice, to the date surgery was completed. Only scheduled, elective hip replacements are included in this measure. Emergency cases are not included in the calculation. The 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.

WHY IS THIS IMPORTANT?

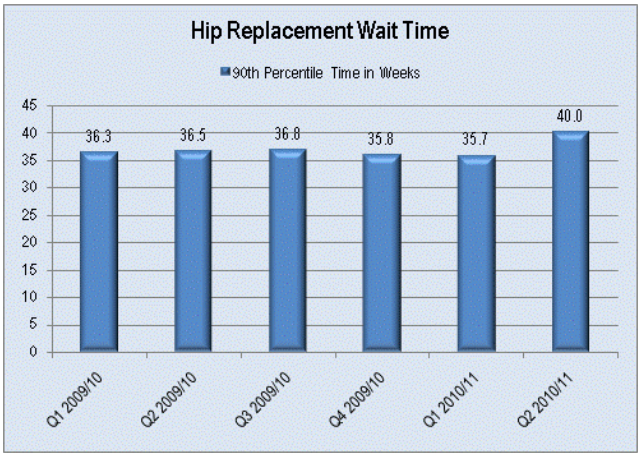
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

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



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

PERFORMANCE STATUS

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

2010/11 TARGET: 28.0 weeks
Q2 TARGET: 32.6

Q2 ACTUAL: 40.0 weeks

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A provincial plan for hip replacements looking at backlog and areas for increased volume is being modeled across the 12 hospital sites delivering hip surgery. A provincial surgical blitz to August, 2010 included an additional 130 hip replacements. The Hip Arthroplasty Care Pathway was also implemented across Alberta in August, 2010. All 12 sites have implemented their plans for reducing Length of Stay and Waiting Time in Central Intake and are measuring early improvements. A proposal for sustainable funding for all rural central intake clinics has also been completed.

Subsequent actions planned: Preliminary results from the provincial improvement plan will be shared across all teams, including reports of ongoing improvements. As part of the provincial plan, additional hip replacements will be assigned to sites with the greatest backlog. Finally, all Zones in Alberta will have stable funding for Central Intake clinics.

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 2009, Alberta ranked fifth among nine provinces for hip replacement surgery wait times. Alberta = 35.7 weeks, Best Performing Province = 22.9 weeks (Ontario) (CIHI, 2009)

Performance Measure Update

Knee Replacement Wait Time

WHAT IS BEING MEASURED?

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

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

The 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.

WHY IS THIS IMPORTANT?

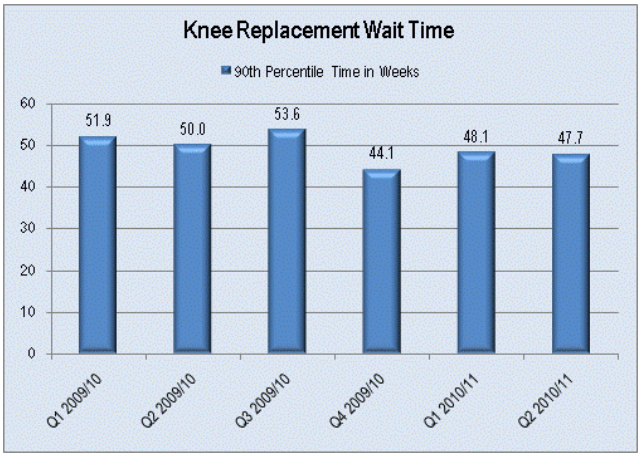
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

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



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

PERFORMANCE STATUS

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

2010/11 TARGET: 42 weeks
Q2 TARGET: 46.6

Q2 ACTUAL: 47.7 weeks

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A provincial plan for knee replacements looking at backlog and areas for increased volume is being modeled across the 12 hospital sites delivering hip surgery. A provincial surgical blitz to August, 2010 included an additional 195 knee replacements. The Knee Arthroplasty Care Pathway was also implemented across Alberta in August, 2010. All 12 sites have implemented their plans for reducing Length of Stay and Waiting Time in Central Intake and are measuring early improvements. A proposal for sustainable funding for all rural central intake clinics has also been completed.

Subsequent actions planned: Preliminary results from the provincial improvement plan will be shared across all teams, including reports of ongoing improvements. As part of the provincial plan, additional knee replacements will be assigned to sites with the greatest backlog. Finally, all Zones in Alberta will have stable funding for Central Intake clinics.

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 2009, Alberta ranked fourth among nine provinces for knee replacement surgery wait times. Alberta = 50.3 weeks, Best Performing Province = 26.3 weeks (Ontario) (CIHI, 2009)

Performance Measure Update

Cataract Surgery Wait Time

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.

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

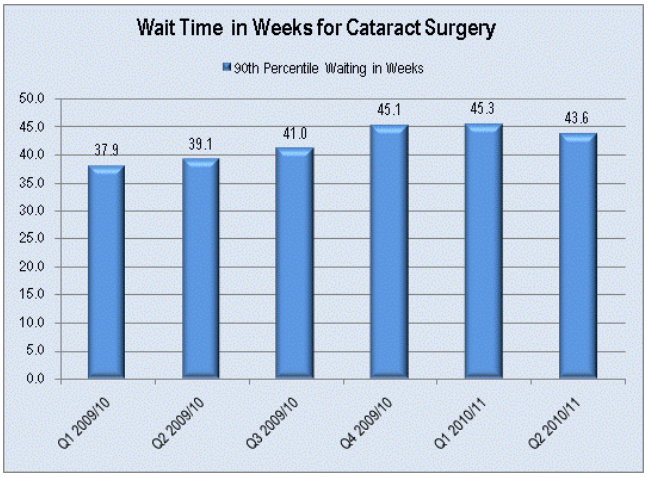
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



Source: Alberta Health & Wellness

NOTE: Q2 2010/11 reported result has been identified to contain a known data issue. The direction and magnitude of impact on the reported result cannot be determined at this time. This result will be updated when data corrections have been finalized.

PERFORMANCE STATUS

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

2010/11 TARGET: 36 weeks
Q2 TARGET: 38.5

Q2 ACTUAL: 43.6* weeks
*preliminary result

HOW ARE WE DOING?

The preliminary result for 90th percentile wait time for Cataract Surgery for Q2 2010/11 was 43.6 weeks which exceeds the target time of 36 weeks. An improvement is anticipated in Q3 for 2010/11 with additional surgeries performed as part of the surgical blitz. The result for Q2 2010/11 will be adjusted when a data correction is completed.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Expansion of cataract surgeries in Calgary from 8,500 in 2009/10 to 10,000 in 2010/11 is underway (Calgary had the highest backlog of cases). On top of this planned increase, an additional 1,000 surgeries were completed as part of a surgical blitz between July-October to further reduce cataract wait times.

Subsequent actions planned: Continued ramp-up in Calgary to meet the base target of 10,000 cataract surgeries by March 31, 2011.

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

Using a similar measure, Alberta ranked 10th among 10 provinces for cataract surgery wait times. Alberta = 38.6 weeks, Best Performing Province = 14.9 weeks (Ontario) (CIHI, 2009)

Performance Measure Update

Other Scheduled Surgery Wait Time

PERFORMANCE STATUS	2010/11 TARGET: TBD (to be developed)
Performance target for 2010/11 is not yet established.	Q2 ACTUAL: 25.0 weeks

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.

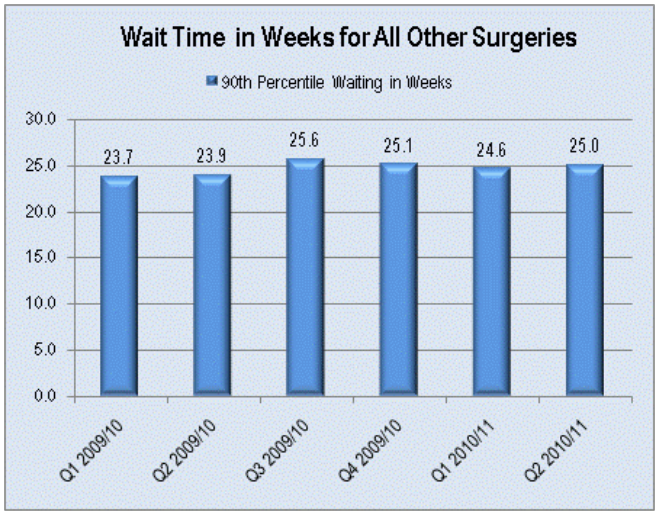
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



Source: Alberta Health & Wellness

HOW ARE WE DOING?

Using latest developed measurement methodology (under review) 90th percentile wait times for other surgeries was 25.0 weeks for Q2 2010/11. Q2 figures include incomplete contracted surgical facilities data; figures will be revised as data becomes available.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A Transformational Improvement Program (TIP) focused on improving access and reducing wait times was launched (Other Surgeries falls under the scope of this Program).

Subsequent actions planned: Additional surgeries are planned as part of an overall surgical blitz prior to March, 2011.

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Performance Measure Update

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

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

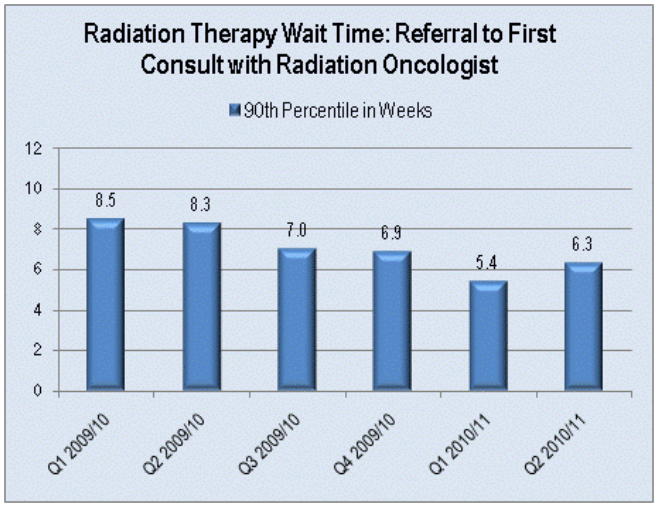
Currently this data is only collected on patients referred to a tertiary cancer facility (Cross Cancer Institute in Edmonton, Tom Baker Cancer Centre or Holy Cross in Calgary). There is a project underway to collect these data at four additional cancer centres that provide consultations to patients in Lethbridge, Medicine Hat, Red Deer, and Grand 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.

WHY IS THIS IMPORTANT?
Wait times are an important measure of how quickly people are getting access to cancer care. They reflect the ability of Alberta Health Services to meet the needs of cancer patients.

WHAT IS THE TARGET?
The Alberta target for referral to radiation oncologist consultation is four weeks for 90 per cent of patients.



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

PERFORMANCE STATUS

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

2010/11 TARGET: 4 weeks
Q2 TARGET: 5.7

Q2 ACTUAL: 6.3 weeks

HOW ARE WE DOING?
Wait times from cancer referral to consultation by radiation oncologists are outside the target. However, in the majority of tumour groups, patients are seen within the target timeline. This wait time has increased from 5.4 weeks in Q1 2010/11 to 6.3 weeks in Q2 2010/11.

WHAT ACTIONS ARE WE TAKING?
Actions completed to date: A provincial strategy for cancer care is being developed in conjunction with Alberta Health and Wellness.

Subsequent actions planned: Efforts to address the current staffing challenges with radiation oncologists at the Calgary and Edmonton sites will continue. As well, a Provincial Cancer Care patient navigation system will be established by Fall/2011 to improve the coordination of care and speed up access to appropriate services.

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

Information is available by site.

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

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.

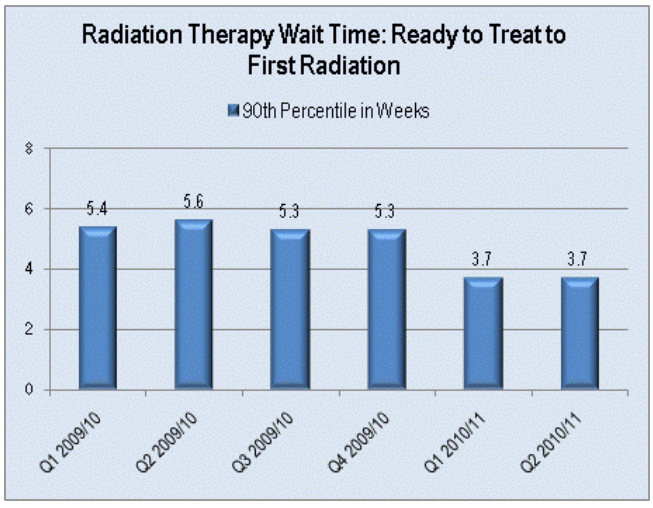
Currently this data is only reported on patients who receive radiation therapy at the Cross Cancer Institute in Edmonton and the Tom Baker Cancer Centre in Calgary. The data apply only to patients receiving external beam radiation therapy (i.e. brachytherapy is not included).

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

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?
Wait times are an important measure of how quickly people are getting access to cancer care. They reflect the ability of Alberta Health Services 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 -2009-002 Radiation Therapy Time from Ready to Treat to First Radiation Treatment by Institution

PERFORMANCE STATUS

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

2010/11 TARGET: 4 weeks
Q2 TARGET: 4.7

Q2 ACTUAL: 3.7 weeks

HOW ARE WE DOING?
The proportion of patients receiving radiation therapy within the expected time period is better than the target. Significant improvement was observed between Q4 2009/10 and Q1 2010/11.

WHAT ACTIONS ARE WE TAKING?
Actions completed to date: Process improvement techniques to improve efficiencies and increase throughput have been used to reduce wait times in the past two quarters. The first of two radiation treatment accelerators is up and running at the Lethbridge Cancer Centre (treatment initiated as of June, 2010). The second accelerator has been installed and commissioned and recruitment plans have been initiated to bring the facility to full capacity. Sod turning for another radiation therapy facility in Red Deer took place in September, 2010.

Subsequent actions planned: Complete recruitment to staff the second accelerator in Lethbridge (radiation oncologist, as well as technical and support staff). Also, continue with plans to open the Central Alberta Cancer Centre in Red Deer in 2013.

WHAT ELSE DO WE KNOW?
Alberta Health Services is reviewing benchmark work done by Provincial/Territory Governments in 2005, and reported in October 2009.

Information is available by site.

HOW DO WE COMPARE?
Using a similar measure, Alberta ranked sixth among seven provinces for radiation therapy wait times. Alberta = 5.4 weeks, Best Performing Province = 3.0 weeks (Ontario) (CIHI, 2009)

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

WHAT IS BEING MEASURED?

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

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

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

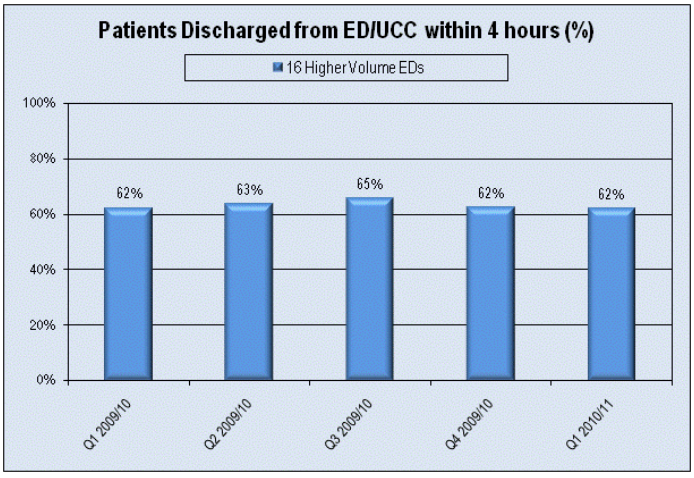
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



Source: Calgary and Edmonton Emergency Department Information System Data (REDIS, EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS). There is currently a three month time lag in NACRS data sources. AHS is working on integrating the data to support these measures using more timely data sources.

PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress. Risk of not achieving 2010/11 target assessed as high.

2010/11 TARGET: 70%
Q1 TARGET: 64%

Q1 ACTUAL: 62%

HOW ARE WE DOING?

In Q1 2010/11, 62 per cent of patients at the 16 higher volume EDs were discharged within four hours. This is below the target.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Process improvements projects are underway across the province to reduce wait times, enhance throughput and improve care quality. As well, eleven new treatment rooms were opened at the Stollery Childrens' ED in Edmonton.

Subsequent actions planned: In addition to ongoing process improvement efforts, EDs are working collaboratively with other sectors to help patients avoid unnecessary (avoidable) ED visits and return home with appropriate services so as to minimize return visits.

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).

Detailed information is available by site. In addition, for a subset of sites where more timely data is readily available, we are publicly providing more current weekly information.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

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

WHAT IS BEING MEASURED?

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

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

This ED/UCC measure is presented for all sites.

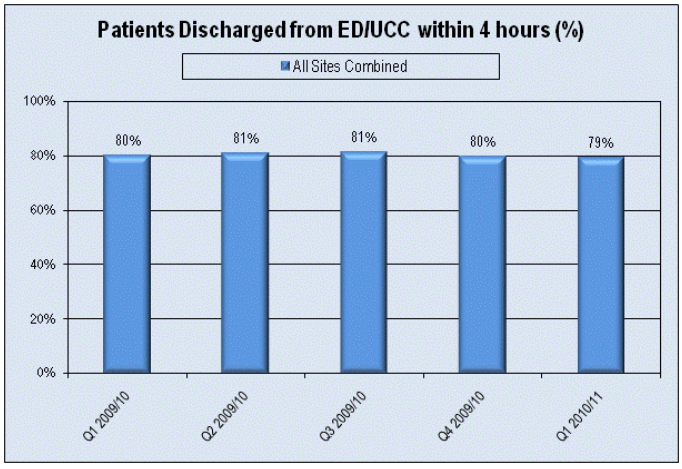
Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



Source: Calgary and Edmonton Emergency Department Information System Data (REDIS, EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS). There is currently a three month time lag in NACRS data sources. AHS is working on integrating the data to support these measures using more timely data sources.

PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress. Risk of not achieving 2010/11 target assessed as high.

2010/11 TARGET: 82%
Q1 TARGET: 81%

Q1 ACTUAL: 79%

HOW ARE WE DOING?

In Q1 2010/11, 79 per cent of patients presenting and subsequently discharged at ED/UCC sites within four hours.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Process improvements projects are underway across the province to reduce wait times, enhance throughput and improve care quality. As well, eleven new treatment rooms were opened at the Stollery Childrens' ED in Edmonton.

Subsequent actions planned: In addition to ongoing process improvement efforts, EDs are working collaboratively with other sectors to help patients avoid unnecessary (avoidable) ED visits and return home with appropriate services so as to minimize return visits.

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. In addition, for a subset of sites where more timely data is readily available, we are publicly providing more current weekly information.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

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

WHAT IS BEING MEASURED?

The total time patients spend in an Emergency Department (ED) is calculated from the first documented time after arrival at emergency until the time they enter the hospital as an inpatient (15 higher volume EDs). The percentage of admitted patients whose length of stay in ED is less than eight hours is reported. This measure does not apply to Urgent Care Centre (UCC) facilities as these facilities do not have inpatient spaces to receive admitted patients.

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

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

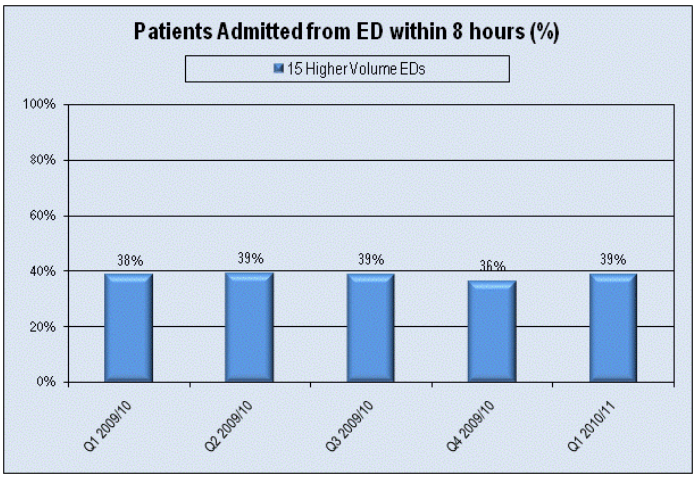
ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent can be a measure of access to the health care system and a reflection of efficient use of resources.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

In Q1 2010/11, 39 per cent of admitted patients at 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). There is currently a three month time lag in NACRS data sources. AHS is working on integrating the data to support these measures using more timely data sources.

PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress. Risk of not achieving 2010/11 target assessed as high.

2010/11 TARGET: 45%
Q1 TARGET: 38%

Q1 ACTUAL: 39%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Two pilot medical assessment units were opened (one at Rockyview General in Calgary, one at the Royal Alexandra in Edmonton) to initiate consultations, treatment and diagnostics sooner for admitted ED patients. Over 100 beds were opened in Calgary for Alternate Level of Care patients to facilitate care in the appropriate place thus freeing up more acute care beds. As well, 11 new treatment rooms were opened at the Stollery Childrens' ED in Edmonton.

Subsequent actions planned: Process improvement projects continue across the province to reduce wait times, enhance throughput and improve care quality. EDs are also working collaboratively with other sectors to help patients avoid unnecessary (avoidable) ED visits and return home with appropriate services so as to minimize return visits.

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. In addition, for a subset of sites where more timely data is readily available, we are publicly providing more current weekly information.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

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

WHAT IS BEING MEASURED?

The total time patients spend in an Emergency Department (ED) is calculated from the first documented time after arrival at emergency until the time they enter the hospital as an inpatient (all sites). The percentage of admitted patients whose length of stay in ED is less than eight hours is reported. The performance for the 15 highest volume teaching, large urban and regional ED sites as well as the average performance across all AHS sites combined is measured.

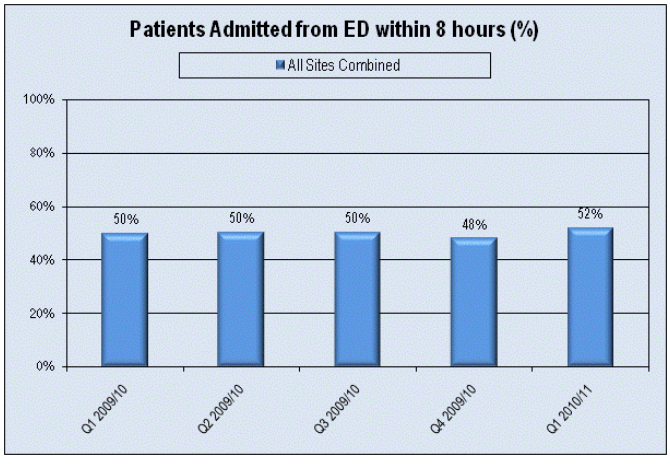
Detailed definition is available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

Alberta Health Services has established a target for all ED sites combined of 55 per cent of patients admitted leaving the ED within eight hours. This indicator may be too aggregated to clearly indicate the quality of services being provided. In the future, the indicator will be separated into three components: a) triage to ED disposition (consult request): as a measure of ED efficiency; b) consult request to bed request: as a measure of consulting service responsiveness; and c) bed request to arrival on unit: as a measure of inpatient bed access. The target for this composite indicator would be eight hours (4/2/2).



Source: Calgary and Edmonton Emergency Department Information System Data (REDIS, EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS). There is currently a three month time lag in NACRS data sources. AHS is working on integrating the data to support these measures using more timely data sources.

PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress. Risk of not achieving 2010/11 target assessed as high.

2010/11 TARGET: 55%
Q1 TARGET: 50%

Q1 ACTUAL: 52%

HOW ARE WE DOING?

In Q1 2010/11, 52 per cent of admitted patients left the ED within eight hours. This is below the 2010/11 target of 55 per cent.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Two pilot medical assessment units were opened (one at Rockyview General in Calgary, one at the Royal Alexandra in Edmonton) to initiate consultations, treatment and diagnostics sooner for admitted ED patients. Over 100 beds were opened in Calgary for Alternate Level of Care patients to facilitate care in the appropriate place thus freeing up more acute care beds. As well, 11 new treatment rooms were opened at the Stollery Childrens' ED in Edmonton.

Subsequent actions planned: Process improvement projects continue across the province to reduce wait times, enhance throughput and improve care quality. EDs are also working collaboratively with other sectors to help patients avoid unnecessary (avoidable) ED visits and return home with appropriate services so as to minimize return visits.

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. In addition, for a subset of sites where more timely data is readily available, we are publicly providing more current weekly information.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

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.

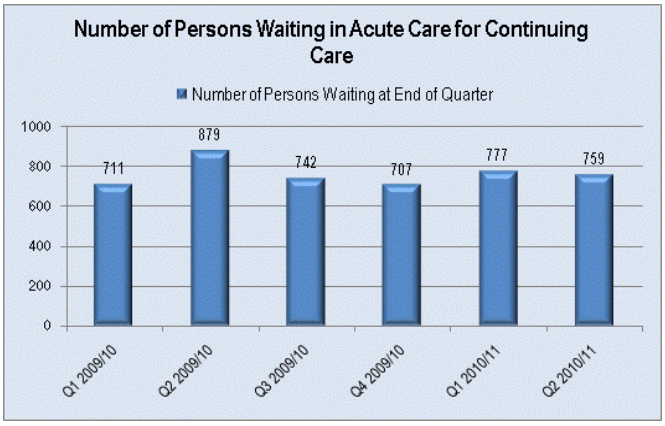
WHY IS THIS IMPORTANT?

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

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

WHAT IS THE TARGET?

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



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

PERFORMANCE STATUS

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

2010/11 TARGET: 400
Q2 TARGET: 581

Q2 ACTUAL: 759

HOW ARE WE DOING?

The number of people waiting in acute/sub-acute (hospital) beds for continuing care placement is significantly higher than the target level of 400.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: 772 new continuing care spaces were added across the province between April 1 and September 30, 2010.

Subsequent actions planned: Additional continuing care spaces will be added to meet this year's target of 1,100-1,300 new spaces by March 31, 2011. Planning is also underway to identify additional strategies to reduce the number of persons waiting in acute/sub-acute beds for continuing care.

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

Performance Measure Update

People Waiting in Community for Continuing Care Placement

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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

PERFORMANCE STATUS

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

2010/11 TARGET: 975
Q2 TARGET: 998

Q2 ACTUAL: 1,109

HOW ARE WE DOING?

The number of people waiting in the community (at home) for continuing care placement is above the target of 975 for Q2 2010/11 at 1,109.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: 772 new continuing care spaces were added across the province between April 1 and September 30, 2010.

Subsequent actions planned: Additional continuing care spaces will be added to meet this year's target of 1,100-1,300 new spaces by March 31, 2011. Planning is also underway to identify additional strategies to reduce the number of persons waiting in the community for continuing care.

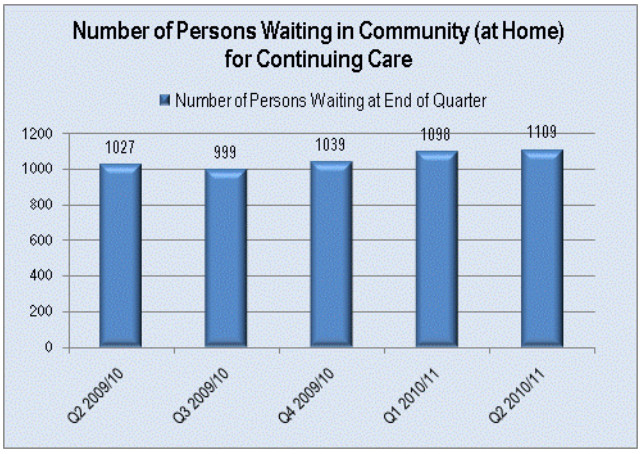
WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

No national benchmark comparisons were found.



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

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 waited, during the reporting period, by individuals who were assessed and approved and who subsequently waited in an acute or sub-acute bed prior to their admission to a Long Term Care Facility or Supportive Living space.

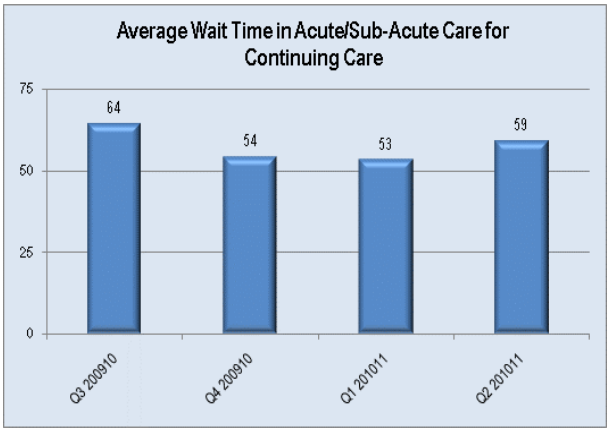
Currently the data is provided by nine former health regions and collated manually. The issues with completeness and accuracy associated with different definitions and recording methods have been recognized, and plans are underway to establish consistent measurement definitions and approaches.

Detailed indicator definition is currently in development.

WHY IS THIS IMPORTANT?

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

By reducing the length of 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, decrease wait times and deliver care in a more cost effective manner.



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

PERFORMANCE STATUS	2010/11 TARGET: TBD
Performance Target for 2010/11 has not been established for comparison.	Q2 ACTUAL: 59

WHAT IS THE TARGET?

Targets are currently being developed for this indicator.

HOW ARE WE DOING?

The average wait time in acute/sub-acute care for continuing care was 59 days in Q2 of 2010/11.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: 772 new continuing care spaces were added across the province between April 1 and September 30, 2010.

Subsequent actions planned: Additional continuing care spaces will be added to meet this year's target of 1,100-1,300 new spaces by March 31, 2011. Planning is also underway to identify additional strategies to reduce waiting time for continuing care (e.g. expanding the role of transition coordinators, facilitating advanced discharge planning with patients and their families).

WHAT ELSE DO WE KNOW?

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Performance Measure Update

Number of Home Care Clients

WHAT IS BEING MEASURED?

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

Detailed indicator definition is currently in development.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

Targets are currently being developed for this indicator.

HOW ARE WE DOING?

The number of unique / individual Home Living Clients was 51,073 in Q1 of 2010/11.

PERFORMANCE STATUS	2010/11 TARGET: TBD
Performance Target for 2010/11 has not been established for comparison.	Q1 ACTUAL: 51,073

WHAT ACTIONS ARE WE TAKING?

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

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

WHAT ELSE DO WE KNOW?

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Performance Measure Update

Head Count to FTE Ratio

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

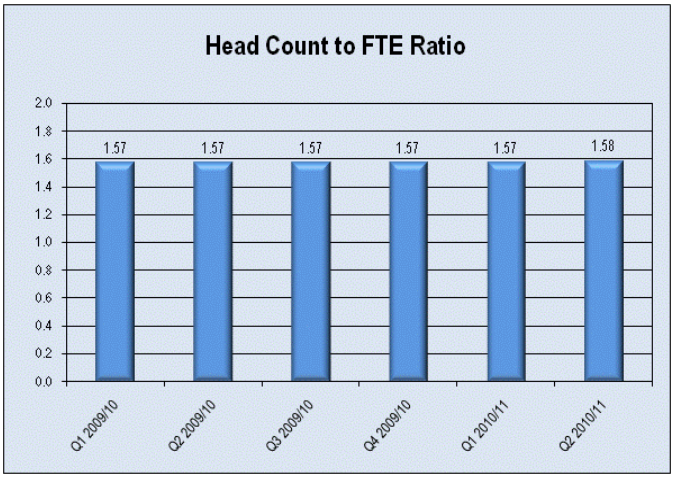
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

WHAT IS THE TARGET?

Alberta Health Services has established a 2010/11 target head count to FTE ratio of 1.63.

HOW ARE WE DOING?

In 2009/10 the head count to FTE ratio was 1.57. In Q1 2010/11 the ratio was 1.57. In Q2 2010/11 the ratio was 1.58.



Source: Alberta Health Services Human Resources

Note: A new computational methodology was introduced by Human Resources beginning with Q1 2010/11; 2009/10 quarterly figures have been recalculated using the new methodology.

PERFORMANCE STATUS

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

2010/11 TARGET: 1.63

Q2 ACTUAL: 1.58

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The early stages of a Strategic Clinical Workforce Plan have been completed with a view to recruiting the right mix of health professionals across the province. Alberta Health Services has increased awareness regarding the requisite to create higher FTE positions.

Subsequent actions planned: Stakeholder engagement and feedback will take place on a working paper to address the supply and demand issues for Registered Nursing, Licensed Practical Nurses and Health Care Aides. Output from this process will be incorporated into the Strategic Clinical Workforce Plan currently targeted for completion in March, 2011. Alberta Health Services continues to encourage higher FTE positions.

WHAT ELSE DO WE KNOW?

The head count includes full-time, part-time and casual employees. The FTE includes full-time, part-time and casual employees even though 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.

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

HOW DO WE COMPARE?

This measure is not benchmarked externally.

Performance Measure Update

Registered Nurse Graduates Hired by AHS (%)

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

A commitment has been made in the 2010/13 United Nurses of Alberta (UNA) Collective Agreement stating Alberta Health Services will hire a minimum of 70 per cent of Alberta nursing graduates annually.

WHAT IS THE TARGET?

Consistent with the UNA Collective Agreement, Alberta Health Services has established a target of 70 per cent of Alberta graduates hired in 2010/11.

HOW ARE WE DOING?

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

By the end of September 2010 (Q2 of 2010/11) Alberta Health Services hired 947 nursing graduates. This represents 60 per cent of the nursing graduates.

While the number of RN graduate hires will vary each quarter due to many factors, the goal of 70 per cent of hires would be met with an average of 17.5 per cent of graduates hired per quarter. Therefore, this metric is meeting target expectations.

PERFORMANCE STATUS

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

2010/11 TARGET: 70%
Q2 TARGET: 35%

Q2 ACTUAL: 60%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Decision rights for hiring have returned to front line managers which has resulted in a more efficient and effective hiring process for both employees and managers. Work also continues on a modeling process to identify future demand and workforce gaps to determine the necessary supply of Alberta RN graduates.

Subsequent actions planned: Recruitment plans for the winter and spring graduating classes will be developed. Recommendations for a transitional graduate nurse recruitment program will also be developed to support new graduates as they transition into the workplace.

WHAT ELSE DO WE KNOW?

Alberta Health Services does not currently track the source of new hires. This measure refers to those nurses compensated at a Step One level, and may include new grads from outside Alberta as well as RNs whose previous experience has not yet been verified for step increments. Once experience is verified, adjustments will be made. Data values will be updated as available.

HOW DO WE COMPARE?

This measure is not benchmarked externally.

Performance Measure Update

Disabling Injury Rate

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

The performance of our health care system is directly related to the health and wellness of the people who provide care and services. Alberta Health Services 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 2010 target of 2.41 disabling injury claims per 100 workers. This corresponds to a target rate of 1.81 after the first nine months of a year.

HOW ARE WE DOING?

In 2009, the disabling injury rate was 2.83 per 100 workers. In September 2009, the disabling injury rate was 2.24. In the first nine months of 2010, the disabling injury rate was 2.23 per 100 workers.

PERFORMANCE STATUS

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

2010 TARGET: 2.41
9 Month TARGET: 1.81

Jan-Sep 2010 (9 Months) ACTUAL: 2.23

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Safety Engineered Devices have been implemented. The Safe Client Handling Program for South Zone completed and the Workplace Health and Safety Improvement Plans (WHSIPs) implemented across all Divisions and initiatives.

Subsequent actions planned: The Safe Client Handling Program will be initiated in Edmonton and North Zones. The Provincial Hazard Identification and Control process will be completed and available for implementation. As well, the Ability Management redesign and Incident Management Process will be in place across all Zones. We also plan to have the Workplace Health and Safety Improvement Plans and the Ergonomic Office Equipment Upgrade project completed by fiscal year end.

WHAT ELSE DO WE KNOW?

The data for this measure is provided by WCB Alberta and is a measure of the calendar year rather than the fiscal year. Previous years are not available by quarter or other time sub-sets. From 2010 forward, WCB Alberta will provide quarterly data.

Caution must be used when comparing this measure over time as it is reported cumulatively throughout the calendar year (Q1 = 3 months of data, Q2 = 6 months, etc). Starting in 2011, quarterly intervals will be comparable.

HOW DO WE COMPARE?

In 2009, the disabling injury rate for Alberta Health Services was slightly better than the industry average. However, as an industry, healthcare's disabling injury rate is about average when compared with all Alberta industries

Performance Measure Update

Staff Overall Engagement (%)

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator definition is available.

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 2010/11 target of 43 per cent of employees reporting they are favorably engaged at work.

HOW ARE WE DOING?

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

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

PERFORMANCE STATUS

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

TARGET: 43%

ACTUAL: 35%

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: In response to the survey results and follow-up discussion with staff, a corporate Workforce Engagement Plan was developed and has identified specific actions to facilitate open, two-way communication, encourage local autonomy and decision-making, facilitate staff development, and promote a culture of appreciation. Department-specific engagement plans have also been developed and are currently being implemented across AHS.

Subsequent actions planned: Implementation of the Workforce Engagement Plan will continue in the upcoming months with a view to long-term sustainability.

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

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

Performance Measure Update

Physician Overall Engagement (%)

PERFORMANCE STATUS

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

TARGET: 43%

ACTUAL: 26%

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

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

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

WHAT ACTIONS ARE WE TAKING?

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

Subsequent actions planned: Development of a rewards and recognition program for physicians is targeted for March, 2011. As well, negotiations will continue between AHS, AHW and the AMA on the next Trilateral Master Agreement.

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

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

Performance Measure Update

Full-time to Part-time Clinical Worker Ratio

WHAT IS BEING MEASURED?

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

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

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

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

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

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

Alberta Health Services has not yet established a 2010/11 target full-time to part-time clinical worker ratio.

HOW ARE WE DOING?

In 2009/10 the full-time to part-time clinical worker ratio was 0.92. In Q1 of 2010/11, the ratio was 0.93. In Q2 of 2010/11, the ratio was 0.93.

PERFORMANCE STATUS	2010/11 TARGET: TBD
Performance Target for 2010/11 has not been established for comparison.	Q2 ACTUAL: 0.93

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The early stages of a Strategic Clinical Workforce Plan have been completed with a view to recruiting the right mix of health professionals across the province.

Subsequent actions planned: Stakeholder engagement and feedback will take place on a working paper to address the supply and demand issues for Registered Nursing, Licensed Practical Nurses and Health Care Aides. Output from this process will be incorporated into the Strategic Clinical Workforce Plan, currently targeted for completion in March, 2011.

WHAT ELSE DO WE KNOW?

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

Information will be available by zone.

HOW DO WE COMPARE?

This measure is not benchmarked externally.

Performance Measure Update

Number of Netcare Users

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

Detailed indicator definition is available.

PERFORMANCE STATUS

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

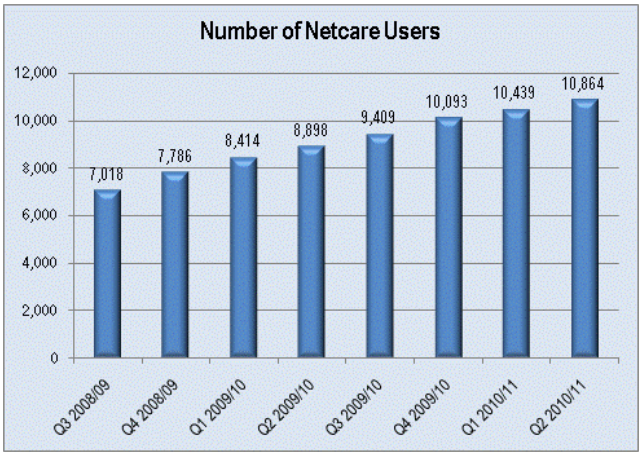
2010/11 TARGET: 11,575
Q2 TARGET: 10,821

Q2 ACTUAL: 10,864

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

WHAT IS THE TARGET?
Alberta Health Services has established a target of a 15 per cent increase in Netcare users from 2009/10 to 2010/11.

HOW ARE WE DOING?
The peak quarterly number of nurses and physicians accessing Netcare was 10,864 in Q2 of 2010/11. This represents a 4.1 per cent increase over the previous quarter.



Source: Alberta Netcare Portal

WHAT ACTIONS ARE WE TAKING?
Actions completed to date: Additional users continue to be added as new clinical information systems come online, most recently in the area of Emergency and Urgent Care.

Subsequent actions planned: Uptake of new users will be contingent on planned technical improvements and added security provisions to Netcare. Additional training resources will be applied to expand the reach of Netcare following implementation.

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.

Performance Measure Update

Patient Satisfaction
Adult Acute Care

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

Detailed indicator definition is available.

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

WHAT IS THE TARGET?
Alberta Health Services has established a target of 80 per cent of patients rating their overall hospital stay as eight, nine or ten.

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

In Q1 2010/11, 1,581 telephone HCAHPS surveys were completed with patients discharged from 29 facilities across all AHS Zones resulting in 1,573 valid answers for the question regarding overall rating of hospital experience. Of these, 84.5 per cent rated their hospital experience as eight to ten. In Q4 2009/10, 82.5 per cent of respondents rated their overall hospital experience as eight to ten.

PERFORMANCE STATUS

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

2010/11 TARGET: 80%

Q1 ACTUAL: 84.5%

WHAT ACTIONS ARE WE TAKING?
Actions completed to date: HCAHPS continues to be rolled out province-wide, which will allow AHS to report by province, zone and site. Over time data will be collected in a variety of ways to reflect patient experience and prompt actions for improvement.

Subsequent actions planned: A provincial Feedback and Concerns Tracking (FACT) system is planned for implementation by March, 2011. This system will centralize data and facilitate information sharing across the province with the potential to share learnings.

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

HOW DO WE COMPARE?
Alberta ranked ninth among the 10 provinces for satisfaction with hospital services received in 2007. Alberta = 78.5 per cent, Best Performing Province = 87.8 per cent (New Brunswick), Canada = 81.5 per cent (Statistics Canada, 2007)