Alberta Health Services

Q4 Performance Report

2011/12

Prepared by

Data Integration, Measurement and Reporting

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Introduction

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

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

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

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

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

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

- In support of health promotion and health maintenance, actions underway include increasing access to and promotion of seasonal influenza immunization, obesity prevention initiatives and cancer screening capacity increases and awareness programs. Continued expansion and promotion of primary care networks and delivery of chronic disease management programs are aimed at maintaining health and managing disease.
- To support our Seniors, over one thousand Long Term Care and Supportive Living (SL) options beds were added in 2011/2012, bringing the total number of continuing care beds in the province to nearly 21,700. Further capacity will be added in 2012/2013. Home Care client numbers are increasing as Home Care services continue to be expanded across the province.
- Access and wait times are being targeted by capacity and process improvements in key areas. Priority surgical procedures have seen increased volume this year. Initiatives are ongoing to improve management of referred surgical patient lists to ensure care delivery is aligned to highest need and patients waiting are provided with care options. Radiation therapy services are targeting further access improvement with facilities planned to open in both Central and North Zones. A comprehensive wait times policy and measurement approach continues to be developed in collaboration with AHW.
- Emergency Department wait time improvement efforts continue with focused attention on new capacity and process improvements in each Zone.

Reporting our performance: January 1, 2012 – March 31, 2012

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

AHS has purposefully set aggressive performance targets within the five year health plan. This was done in a fundamental belief that these targets will translate into the type of Health Care System performance demanded by and deserved for Albertans. We remain committed to working towards these targets and striving for improvements.

Many of the performance measures focus on improving access to important services. The table below highlights some of the important increases in capacity that have been added to support performance measures.

Changes in Throughput

Volumes	Volume 2010/11	Volume 2011/12	Per cent change
Number of Coronary Artery Bypass Graft Surgeries (All).	1,286	1,345	4.6%
Number of Elective Hip Replacement Surgeries.	3,235	3,613	11.6%
Number of Elective Knee Replacement Surgeries.	4,895	5,716	16.8%
Number of Cataract Surgeries.	33,781	36,457	7.9%
Number of Other Scheduled Surgeries.	112,612	113,797	1.1%
Number of Patients receiving Radiation Therapy First Consult.	4,784	5,193	8.6%
Number of Patients Discharged from Emergency Department or Urgent Care Centre (16 Higher Volume EDs).	716,105,	778,237	8.7%
Number of Patients Discharged from Emergency Department or Urgent Care Centre (All Sites).	1,879,761	1,976,471	5.1%
Number of Patients Admitted from Emergency Department (15 Higher Volume EDs).	113,762,	122,478	7.7%
Number of Patients Admitted from Emergency Department (All Sites).	156,550	165,751	5.9%
Number of People in Acute / Sub-Acute Beds Placed into Continuing Care.	4,951	5,337	7.80%
Number of People Waiting in Community Placed into Continuing Care.	2,087	2,323	11.3%

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

- Cataract Surgery wait times have seen an improvement from 30.7 weeks to 29.3 weeks from Q3 to Q4. Notably fiscal year 2010/11 performance of 46.9 weeks has improved in 2011/12 to 35.1 for 90th percentile wait times, an improvement of 25%.
- Radiation Therapy Access (ready to treat to first therapy) has shown significant improvement and has surpassed target reaching 3.1 weeks overall for 2011/12 and 3.0 weeks for Q4.
- Colorectal screening participation rates are reported at 57% for 2011, surpassing target. Key initiatives to improve access and awareness have been successful and ongoing improvements are underway to ensure improvements are sustained.
- The Wait Times for Admissions to the Top 15 Emergency Department sites has been reduced by 9.8% over the prior year while throughput was increased by 7.7%. In addition, throughput was increased by 8.7% for Patients Discharged from the Top 16 Emergency Departments or Urgent Care Centers while Wait Times were reduced by 2%.
- Per cent of Patients placed in Continuing Care within 30 days of being assessed showed significant gains this year from 55% in 2010/11 to 64% in 2011/12 and 71% when measuring Q4 alone. Similarly the Average Wait Time in Acute/Sub-Acute Care for Continuing Care Placement has decreased from 54 days in 2010/11 to 41 days in 2011/12 overall and 32 days in Q4 alone. Though the snapshot measures of number waiting at a point in time have not reached target, they have dropped or maintained and the improvements associated with the other measures indicate significant throughput improvement.
- The number of Home Care Clients has increased from 100,277 in 2010/11 to 104,704 in 2011/12, a 4.4% increase. This exceeds the target of increasing by 3,000.
- Seasonal influenza immunization rates are higher for target populations of seniors and children.
- Workforce measures of Headcount to FTE Ratio (1.57 in 2010/11 vs. 1.55 in 2011/12) and Absenteeism (12.19 in 2010/11 vs. 12.04 in 2011/12) showed improvement over the year.
- Health Indicators of Life Expectancy and Potential Years Life Lost newly reporting for 2011 have seen ongoing improvements.
- Patient Satisfaction with Heathcare Services Personally Received improved from a reported 61% in 2010 to 67% in 2011 – a 10% improvement.
- Staff and Physician Engagement, which measures the per cent of employees and physicians who report that they are favourably engaged at work has seen a 50% increase since the previous survey.
- The number of Health Care professionals using the Provincial Netcare system has increased by 23.6% over last year.

Looking at indicators with both a current annual result and a prior year annual result on the Provincial dashboard, 74 per cent of the indicators show improvement over the prior year and of those, 42 per cent show improvement of more than 5 per cent.

Highlights of actions underway to improve performance in priority areas:

- Hip and Knee replacement surgery wait times are being targeted through various efforts including increases in surgeries completed, centralized and improved wait list management enabling prioritization and referral efficiencies, process and care improvements, and physician and staff recruitment where needed. At this time reduction in the wait lists for arthroplasty procedures are evident such that reductions in waiting times are expected for procedures completed in the coming months.
- Ongoing implementation of Emergency Department (ED) surge capacity protocols to provide additional capacity when demands on Emergency and across the health system reach critical thresholds. When reached, the new protocols trigger immediate action to reduce wait times.
- Capacity increases in cancer services including Radiation Therapy clinics built or with planning underway as well as capacity for colorectal screening procedures.
- AHS continues to add continuing care beds. In 2011/12 over one thousand beds were added to the system and a further 1,133 beds planned for the coming fiscal year.
    - This additional capacity allows us to free up hospital beds currently occupied by Albertans whose health needs would be better met outside of the hospital. More open hospital beds will help improve ED length of stay for many patients requiring admission.
- Efforts to expand Home Care services in an effort to keep seniors safe, healthy and independent in their homes and reduce the number of avoidable ED visits are ongoing to further build on the increase in these clients seen in 2011/12.

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

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

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

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

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

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

What's being measured?

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

Assessment of data quality

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

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

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

How to read this report

This report contains a high level system (provincial) dashboard which offers a summary view of AHS performance against the targets we have established for 2011/12. This provincial dashboard shows the target for the 2011/12 year and the actual performance for the fiscal year ending March, 2012. The dashboard also compares performance over the last two quarters and compares this years performance against last year's performance. If the 'stretch' target has been missed, we would still seek to demonstrate improvement from one period to another enabling us to confidently make the right changes to our health system. Each of these three comparisons uses a common "traffic light" method to illustrate how we are doing, as follows:

1. **Annual Actual to Target Comparison:** For this final report of the fiscal year, we compare the annual results against the annual target. A green square is used when actual performance is at or is better than the target, a yellow triangle represents performance within an acceptable range of the target (we are within 10% of target), and a red circle shows where performance is beyond an acceptable range.

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

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

3. **Prior Annual Comparison:** Here we compare each measure's annual value to the previous year's value. In this quarter four report, we are comparing the Fiscal 2010/11 result to the Fiscal 2011/12 result. A green square indicates we are doing better, a dashed line indicates no significant change (within 5 per cent), and a red circle indicates we are not doing as well.

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

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

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

Data lag

Data availability for quarterly updates varies due to data source differences. All but five of the quarterly performance measures in this report are updated to the third quarter (July-December, 2011). For those indicators reporting 1st quarter data (April-September, 2011), the following table explains the reasons for the one quarter reporting lag:

Quarterly Measures with a One Quarter Reporting Lag	Data Timeline Clarification
• Patient Satisfaction – Acute Care	This measure is generated from survey data, where patients are called up to six weeks after they leave the hospital. Data is then prepared and analyzed for reporting. This results in data being available approximately two months after the end of each quarter.
• Patient Satisfaction – Emergency Department	This measure is generated from survey data, where patients are called up to six weeks after their Emergency Department visit. Data is then prepared and analyzed for reporting. This results in data being available approximately two months after the end of each quarter.
• Central Venous Catheter Bloodstream Infection Rate	As the first of four Infection Prevention and Control measures to be reported publicly, this measure currently undergoes a more rigorous internal review process at both the Zone and Provincial level prior to results being released.
• Hospital-acquired Methicillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections (BSI)	As the second of four Infection Prevention and Control measures to be reported publicly, this measure also undergoes a more rigorous internal review process at both the Zone and Provincial level prior to results being released
• *Clostridium difficile* Infection	As the third of four Infection Prevention and Control measures to be reported publicly, this measure also undergoes a more rigorous internal review process at both the Zone and Provincial level prior to results being released
• 30 Day All Cause Unplanned Readmission Rate	Readmission rates are attributed to the quarter in which a patient is originally discharged from a hospital. This requires that patients be tracked for readmission 30 days after the end of a quarter. Data are lagged by quarter for this reason

Data updates

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

Performance Measure	Reporting Frequency	Next Update
• Life Expectancy	Annual	Q4, 2012/13
• Potential Years of Life Lost	Annual	Q4, 2012/13
• Colorectal Cancer Screening Rate	Annual	Q4, 2012/13
• Breast Cancer Screening Participation Rate	Annual	Q3, 2012/13
• Cervical Cancer Screening Participation Rate	Annual	Q3, 2012/13
• Seniors Influenza Immunization Rate	Annual	Q4, 2012/13
• Children's Influenza Immunization Rate	Annual	Q4, 2012/13
• Childhood Immunization Rate for DTaP *	Annual	Q1, 2012/13
• Childhood Immunization Rate for MMR *	Annual	Q1, 2012/13
• Albertans Enrolled in a Primary Care Network	Semi-annual	Q4, 2012/13
• Rating of Care Nursing Home – Family	Every 3 years	2014/15
• Staff Overall Engagement	Every 2 years	2012
• Physician Overall Engagement	Every 2 years	2012
• Patient Satisfaction – Addiction and Mental Health	Annual	Q4, 2012/13
• Patient Satisfaction – Health Care Services Personally Received *****	Annual	2012
• Albertans Reporting Unexpected Harm *****	Annual	2012
• Patient Satisfaction – Emergency Department (All)	Every 2 years	2012
• Patient Satisfaction – Health Care Personally Received	Annual	2012

***** The next survey being conducted by Alberta Health and Wellness is currently underway. Once complete, finalized results are available they will be reported within the Quarterly Performance Report.

Data sources

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

AHS Performance Dashboard Q4 2011/12

Provincial Dashboard

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
Staying Healthy / Improving Population Health								
◊Life Expectancy	Improvement	81.9 2011	■				81.6 2010	–
◊Potential Years Life Lost (per 1,000 population)	Improvement	43.3 2011	■				44.8 2010	–
Colorectal Cancer Screening Participation Rate	55% 2015	57.0% 2011	■				43.0% 2009	■
Breast Cancer Screening Participation Rate	55% - 62% 2010-2015	54.8% 2010-2011	△				57.3% 2009-2010	–
Cervical Cancer Screening Participation Rate	70% - 75% 2010-2015	65.0% 2009-2011	△				67.9% 2008-2010	–
Strengthen Primary Health Care								
◊Seniors (65+) Influenza Immunization Rate	75%	61% 2011-2012	●				59% 2010-2011	■
◊Children (6 to 23 Months) Influenza Immunization Rate	75%	30% 2011-2012	●				27% 2010-2011	■
◊Childhood Immunization Rates for DTaP	97%	na	na				na	na
◊Childhood Immunization Rates for MMR	98%	na	na				na	na
Albertans Enrolled in a Primary Care Network (%)	tbd	75% Apr 2012	na	75% Apr 2012	74% Oct 2011	–	72% Apr 2011	–
◊Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	297 annual	278 2011/12	■	74 Q4 2011/12	68 Q3 2011/12	●	282 2010/11	–
◊Family Practice Sensitive Conditions (% of ED visits)	25%	26.4% 2011/12	△	26.5% Q4 2011/12	26.6% Q3 2011/12	–	27.5% 2010/11	–
Health Link Wait Time (% answered within 2 minutes)	85%	81.0% 2011/12	△	78.5% Q4 2011/12	79.4% Q3 2011/12	–	77.7% 2010/11	–
◊Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	90%	76% 2011/12	●	77% Q4 2011/12	83% Q3 2011/12	●	75% 2010/11	–
Improve Access and Reduce Wait Times								
◊ Urgent CABG Wait Time (90th percentile in weeks)	1.0	1.9 2011/12	●	1.9 Q4 2011/12	1.8 Q3 2011/12	–	2.1 2010/11	■
◊ Semi-urgent CABG Wait Time (90th percentile in weeks)	2.0	6.2 2011/12	●	5.6 Q4 2011/12	4.3 Q3 2011/12	●	6.4 2010/11	–
◊ Scheduled CABG Wait Time (90th percentile in weeks)	6.0	28.8 2011/12	●	30.9 Q4 2011/12	30.9 Q3 2011/12	–	24.0 2010/11	●

Notes
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.
╪ Interim target pending confirmation. Status based on interim target.

Q4 2011/12 AHS Performance Dashboard
(continued)

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	27.0	39.8 2011/12	🔴	39.5 Q4 2011/12	35.7 Q3 2011/12	🔴	38.9 2010/11	▬
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	35.0	48.0 2011/12	🔴	44.7 Q4 2011/12	49.1 Q3 2011/12	🟩	48.9 2010/11	▬
◊ Cataract Surgery Wait Time (90th percentile in weeks)	30.0	35.1 [a] 2011/12	🔴	29.3 [a] Q4 2011/12	30.7 Q3 2011/12	▬	46.9 2010/11	🟩
Other Scheduled Surgery Wait Time (90th percentile in weeks)	tbd	25.9 2011/12	na	24.9 Q4 2011/12	26.9 Q3 2011/12	🟩	25.7 2010/11	▬
◊ Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	4.0	5.3 2011/12	🔴	4.6 Q4 2011/12	4.9 Q3 2011/12	🟩	6.0 2010/11	🟩
◊ Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks)	4.0	3.1 2011/12	🟩	3.0 Q4 2011/12	3.0 Q3 2011/12	▬	3.6 2010/11	🟩
◊ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	75%	65% 2011/12	🔴	63% Q4 2011/12	66% Q3 2011/12	▬	64% 2010/11	▬
◊ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	84%	80% 2011/12	🔺	79% Q4 2011/12	81% Q3 2011/12	▬	80% 2010/11	▬
◊ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	60%	45% 2011/12	🔴	43% Q4 2011/12	44% Q3 2011/12	▬	41% 2010/11	🟩
◊ Patients Admitted from ED within 8 hours (%) (All Sites) £	65%	55% 2011/12	🔴	54% Q4 2011/12	54% Q3 2011/12	▬	53% 2010/11	▬
Provide More Choice for Continuing Care								
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	375	467 Mar 2012	🔴	467 Mar 2012	489 Dec 2011	▬	471 2010/11	▬
◊ People Waiting in Community for Continuing Care Placement	900	1,002 Mar 2012	🔴	1,002 Mar 2012	1,038 Dec 2011	▬	1,115 2010/11	🟩
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	tbd	41 2011/12	na	32 Q4 2011/12	49 Q3 2011/12	🟩	54 2010/11	🟩
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	tbd	64% 2011/12	na	71% Q4 2011/12	60% Q3 2011/12	🟩	55% [b] 2010/11	🟩
◊ Number of Home Care Clients	+3,000	104,704 2011/12	🟩				100,277 2010/11	🟩
◊ Rating of Care Nursing Home - Family	tbd	73.4% 2010/11	na				71.0% 2007/08	▬

Notes

◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.

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

[a] Cataract Surgery Wait Time data for Q4 and 2011/12 are preliminary pending validation.

[b] Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed – data for this measure are reportable as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).

The Number of Home Care Clients Measure now reports reports the cumulative number of unique home care clients thus ensuring that when a person moves in and out of home care multiple times, they are only counted once.

Q4 2011/12 AHS Performance Dashboard

(continued)

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
Build One Health System								
◊ Head Count to FTE Ratio	1.62	1.55 2011/12	■	1.53 Mar 2012	1.54 Dec 2011	▬	1.57 2010/11	▬
◊ Registered Nurse Graduates Hired by AHS (%) - Total - Non-Casual	70%	98%+ 67% 2011/12	■ ▲				88% 41% 2010/11	■ ■
◊ Disabling Injury Rate	2.20	3.87 2012 CY ANNUALIZED	●				3.32 2011 CY	●
◊ Staff Overall Engagement (%)	54% 2011/12	52% 2011/12	▲				35% 2009/10	■
◊ Physician Overall Engagement (%)	54% 2011/12	39% 2011/12	●				26% 2009/10	■
Direct Nursing Average Full Time Equivalency	0.62	0.60 2011/12	▲	0.60 Mar 2012	0.60 Dec 2011	▬	0.59 2010/11	▬
Absenteeism	11.95	12.04 2011/12	▲				12.19 2010/11	■
Overtime Hours to Paid Hours Ratio	1.67%	1.98% 2011/12	●	2.15% Q4 2011/12	1.98% Q3 2011/12	▬	1.70% 2010/11	●
Labour Cost per Worked Hour	$48.55	$51.39 2011/12	▲	$51.39 2011/12	$50.76 Q3 2011/12 (Apr-Dec)	▬	$49.54 2010/11	▬
◊ Number of Netcare Users	12,998	14,605 2011/12	■	14,605 Q4 2011/12	14,066 Q3 2011/12	▬	11,816 2010/11	■
On Budget: Year to Date	$36M	$82M 2011/12	■	$82M Mar 2012	$252M Dec 2011	na	$99M Mar 2011	na
◊ Adherence to 5 Year Budgeted Government Funding	1.5%	0.9% 2011/12	■				9.5% 2010/11	na

Notes

◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.

Mar 2011 On-Budget:: Year to Date has been restated (from $116M to $99M)

Q4 2011/12 AHS Performance Dashboard

(continued)

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
Quality and Patient Safety								
◊ Patient Satisfaction – Adult Acute Care	tbd	84.1% YTD (Apr-Dec)	na	83.8% Q3 2011/12	83.7% Q2 2011/12	▬	82% Q3 2010/11 YTD	■
◊ Patient Satisfaction - Addictions and Mental Health (AHS)	tbd	92.3% 2011/12	na				93.0% 2010/11	▬
Percentage of Patient Feedback as Commendations	tbd	10.28% 2011/12	na	9.86% Q4 2011/12	12.28% Q3 2011/12	●	na	na
Percentage of Patient Concerns Escalated to Patient Concerns Officer	tbd	0.52% 2011/12	na	0.39% Q4 2011/12	0.45% Q3 2011/12	■	na	na
◊ Albertans Reporting Unexpected Harm	9%	12.2% 2011	●				9.0% 2010	●
Patient Satisfaction Emergency Department (15 Higher Volume) Adult	tbd	68%	na	67%	68%	▬	66%	▬
Pediatric	tbd	82% YTD (Apr-Dec)	na	87% Q3 2011/12	81% Q2 2011/12	▬	77% Q2 – Q4 2010/11 YTD	■
◊ Patient Satisfaction Health Care Services Personally Received	66% 2011/12	67% 2011	■				61% 2010	■
Central Venous Catheter Bloodstream Infection Rate	tbd	1.00 YTD (Apr-Dec)	na	0.82 Q3 2011/12	0.63 Q2 2011/12	●	1.02 Q3 2010/11 YTD	▬
◊ Methicillin-Resistant Staphylococcus aureus – Bloodstream Infection	tbd	0.18 YTD (Apr-Dec)	na	0.15 Q3 2011/12	0.22 Q2 2011/12	■	na	na
C-Difficile Infection Rate	tbd	4.0 YTD (Apr-Dec)	na	4.2 Q3 2011/12	3.9 Q2 2011/12	●	na	na
30 Day Unplanned Readmission Rate	tbd	8.1% YTD (Apr-Dec)	na	8.0% Q3 2011/12	8.2% Q2 2011/12	▬	7.7% Q3 2010/11 YTD	▬
◊Surgical Site Infection Rate	Measurement strategy and targets under development. Reporting for this indicator is anticipated to begin in Q2 2012/13							

Notes
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.
^ Patient Satisfaction – Adult Acute Care – sampling strategy changed as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).

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

Period Comparative Performance
■ Current period performance is better than comparative period
▬ Current period performance is within 5% of comparative period
● Current period performance is worse than comparative period

Zone Comparison Dashboard 2011/12

Fiscal Year

Performance Measure	Zone 1 - South	Zone 2 - Calgary	Zone 3 - Central	Zone 4 - Edmonton	Zone 5 - North	AHS	AHS Annual Target 2011/12
Staying Healthy / Improving Population Health							
Life Expectancy	81.1 2011	83.4 2011	80.5 2011	81.9 2011	79.4 2011	81.9 2011	Improvement
Potential Years of Life Lost (per 1,000 Population)	48.7 2011	33.9 2011	50.2 2011	44.7 2011	57.6 2011	43.3 2011	Improvement
Colorectal Cancer Screening Participation Rate	Measure not reported at Zone level.					57.0% 2011	37%ǂ 2010
Breast Cancer Screening Participation Rate	58.4% 2010-2011	55.3% 2010-2011	52.0% 2010-2011	54.5% 2010-2011	52.6% 2010-2011	54.8% 2010-2011	55% - 62% 2010-2015
Cervical Cancer Screening Participation Rate	69.4% 2009-2011	60.7% 2009-2011	66.1% 2009-2011	58.2% 2009-2011	62.6% 2009-2011	65.0% 2009-2011	70% - 75% 2010-2015
Strengthen Primary Health Care							
Seniors (65+) Influenza Immunization Rate	62% 2011-2012	63% 2011-2012	53% 2011-2012	64% 2011-2012	52% 2011-2012	61% 2011-2012	75%
Children (6 to 23 Months) Influenza Immunization Rate	29% 2011-2012	38% 2011-2012	27% 2011-2012	27% 2011-2012	20% 2011-2012	30% 2011-2012	75%
Childhood Immunization Rates for DTaP	na	na	na	na	na	na	97%
Childhood Immunization Rates for MMR	na	na	na	na	na	na	98%
Albertans Enrolled in a Primary Care Network (%)	82% Apr 2012	80% Apr 2012	69% Apr 2012	72% Apr 2012	68% Apr 2012	75% Apr 2012	tbd
Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	362 2011/12	214 2011/12	344 2011/12	241 2011/12	468 2011/12	278 2011/12	297 (annual)
Family Practice Sensitive Conditions (% of ED visits)	28.5% 2011/12	20.2% 2011/12	32.0% 2011/12	14.5% 2011/12	38.2% 2011/12	26.4% 2011/12	25%
Health Link Wait Time (% answered within 2 minutes)	Measure not reported at Zone level.					81.0% 2011/12	85%
Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	94% 2011/12	71% 2011/12	95% 2011/12	53% 2011/12	68% 2011/12	76% 2011/12	90%
Improve Access and Reduce Wait Times							
Urgent CABG Wait Time (90th percentile in weeks)	np	2.0 2011/12	np	1.9 2011/12	np	1.9 2011/12	1.0
Semi-urgent CABG Wait Time (90th percentile in weeks)	np	3.9 2011/12	np	7.5 2011/12	np	6.2 2011/12	2.0
Scheduled CABG Wait Time (90th percentile in weeks)	np	33.8 2011/12	np	18.9 2011/12	np	28.8 2011/12	6.0
Hip Replacement Surgery Wait Time (90th percentile in weeks)	38.6 2011/12	30.1 2011/12	31.4 2011/12	48.0 2011/12	49.7 2011/12	39.8 2011/12	27.0
Knee Replacement Surgery Wait Time (90th percentile in weeks)	50.6 2011/12	34.9 2011/12	32.7 2011/12	55.6 2011/12	51.9 2011/12	48.0 2011/12	35.0
Cataract Surgery Wait Time (90th percentile in weeks)	43.0 2011/12	38.3 2011/12	24.4 2011/12	32.6[a] 2011/12	55.7 2011/12	35.1[a] 2011/12	30.0

ǂ Interim target pending confirmation. Status based on interim target.
np - service not provided. CABG procedures not currently provided in South, Central and North Zones; Radiation Therapy not currently provided in Central and North Zones.
[a] Cataract Surgery Wait Time data are preliminary pending validation.

Zone Comparison Dashboard 2011/12 Fiscal Year

(continued)

Performance Measure	Zone 1 - South	Zone 2 - Calgary	Zone 3 - Central	Zone 4 - Edmonton	Zone 5 - North	AHS	AHS Annual Target 2011/12
Other Scheduled Surgery Wait Time (90th percentile in weeks)	23.6 2011/12	26.4 2011/12	25.1 2011/12	25.7 2011/12	25.4 2011/12	25.9 2011/12	tbd
Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	3.9 2011/12 ■	6.3 2011/12 ●	np	4.9 2011/12 ●	np	5.3 2011/12 ●	4
Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks)	1.4 2011/12 ■	3.4 2011/12 ■	np	3.0 2011/12 ■	np	3.1 2011/12 ■	4
Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume EDs) £	82% 2011/12 ■	62% 2011/12 ●	69% 2011/12 ▲	58% 2011/12 ●	79% 2011/12 ■	65% 2011/12 ●	75%
Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	89% 2011/12 ■	74% 2011/12 ●	90% 2011/12 ■	65% 2011/12 ●	90% 2011/12 ■	80% 2011/12 ▲	84%
Patients Admitted from ED within 8 hours (%) (15 Higher Volume EDs) £	89% 2011/12 ■	44% 2011/12 ●	43% 2011/12 ●	31% 2011/12 ●	66% 2011/12 ■	45% 2011/12 ●	60%
Patients Admitted from ED within 8 hours (%) (All Sites) £	89% 2011/12 ■	46% 2011/12 ●	71% 2011/12 ■	32% 2011/12 ●	84% 2011/12 ■	55% 2011/12 ●	65%
Provide More Choice for Continuing Care							
People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	11 Mar 2012 (Target = 10) ▲	188 Mar 2012 (Target = 138) ●	48 Mar 2012 (Target = 52) ■	143 Mar 2012 (Target = 127) ●	77 Mar 2012 (Target = 52) ●	467 Mar 2012 ●	375
People Waiting in Community for Continuing Care Placement	71 Mar 2012 (Target = 52) ●	519 Mar 2012 (Target = 404) ●	104 Mar 2012 (Target = 118) ■	202 Mar 2012 (Target = 235) ■	106 Mar 2012 (Target = 92) ●	1,002 Mar 2012 ●	900
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	13 2011/12	55 2011/12	35 2011/12	32 2011/12	87 2011/12	41 2011/12	tbd
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	80% 2011/12	58% 2011/12	66% 2011/12	66% 2011/12	49% 2011/12	64% 2011/12	tbd
Number of Home Care Clients	11,107 2011/12	29,503 2011/12	16,379 2011/12	36,485 2011/12	11,230 2011/12	104,704 2011/12	tbd
Rating of Care Nursing Home Family	Measure not reported at Zone level.					73.4% 2010/11	tbd
Build One Health System							
Head Count to FTE Ratio	Measure not reported at Zone level.					1.55 2011/12 ■	1.62
Registered Nurse Graduates Hired by AHS (%) - All Hires - Non-Casual	Measure not reported at Zone level.					98+% ■ 67% ▲ Mar 2012	70%
Disabling Injury Rate	Measure not reported at Zone level.					3.87 2012 CY ANNUALIZED ●	2.20
Staff Overall Engagement (%)	35% 2009/10	33% 2009/10	35% 2009/10	37% 2009/10	41% 2009/10	52% 2011/12 ▲	54% 2011/12
Physician Overall Engagement (%)	20% 2009/10	27% 2009/10	27% 2009/10	25% 2009/10	27% 2009/10	38% 2011/12 ●	54% 2011/12
Direct Nursing Average Full Time Equivalency	Measure not reported at Zone level.					0.60 2011/12 ▲	0.62
Absenteeism	Measure not reported at Zone level.					12.04 2011/12 ▲	11.95

np - service not provided. CABG procedures not currently provided in South, Central and North Zones; Radiation Therapy not currently provided in Central and North Zones.
£The Weekly ED Length of Stay (LOS) being published separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. Data are accurate to ±2%.

Zone Comparison Dashboard 2011/12 Fiscal Year

(continued)

Performance Measure	Zone 1 - South	Zone 2 - Calgary	Zone 3 - Central	Zone 4 - Edmonton	Zone 5 - North	AHS	AHS Annual Target 2011/12
Overtime Hours to Paid Hours Ratio	Measure not reported at Zone level.					1.98% 2011/12 ●	1.67%
Total Labour Cost per Worked Hour	Measure not reported at Zone level.					$ 51.39 2011/12 ▲	$48.55
Number of Netcare Users	Measure not reported at Zone level.					14,605 2011/12 ■	12,998
On Budget: Year to Date	Measure not reported at Zone level.					update pending 2011/12	$36M
Adherence to 5 Year Budgeted Government Funding	Update Pending						
Quality and Patient Safety							
Patient Satisfaction – Adult Acute Care	85.7% YTD (Apr-Dec)	83.4% YTD (Apr-Dec)	86.3% YTD (Apr-Dec)	83.8% YTD (Apr-Dec)	82.1% YTD (Apr-Dec)	84.1% YTD (Apr-Dec)	tbd
Patient Satisfaction – Addictions and Mental Health	Measure not reported at Zone level.					92.3% 2011/12	tbd
Percentage of Patient Feedback as Commendations	na 2011/12	na 2011/12	na 2011/12	na 2011/12	na 2011/12	10.28% 2011/12	tbd
Percentage of Patient Concerns Escalated to Patient Concerns Officer	1.24% 2011/12	0.80% 2011/12	0.54% 2011/12	0.35% 2011/12	0.16% 2011/12	0.52% 2011/12	tbd
Albertans Reporting Unexpected Harm	na 2011	na 2011	na 2011	na 2011	na 2011	12.2% 2011 ●	9%
Patient Satisfaction Emergency Department - Adult	59% 2010 ●	61% 2010 ●	63% 2010 ▲	55% 2010 ●	58% 2010 ●	68% 2011/12 ●	70%
Patient Satisfaction Health Care Services Personally Received	na 2011/12	na 2011/12	na 2011/12	na 2011/12	na 2011/12	67% 2011	tbd
Central Venous Catheter Bloodstream Infection Rate	Measure not reported at Zone level.					1.00 YTD (Apr-Dec)	tbd
Methicillin-Resistant Staphylococcus aureus – Bloodstream Infection	Measure not reported at Zone level.					0.18 YTD (Apr-Dec)	tbd
C-Difficile Infection Rate – Hospital Acquired	Measure not reported at Zone level.					4.0 YTD (Apr-Dec)	tbd
30 Day Unplanned Readmission Rate	8.5% YTD (Apr-Dec)	7.0% YTD (Apr-Dec)	9.7% YTD (Apr-Dec)	8.0% YTD (Apr-Dec)	9.5% YTD (Apr-Dec)	8.1% YTD (Apr-Dec)	tbd

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

AHS Performance Dashboard Q4 2011/12

South Zone

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
Staying Healthy / Improving Population Health								
◊Life Expectancy	tbd	81.1 2011	na				80.3 2010	▬
◊Potential Years Life Lost (per 1,000 population)	tbd	48.7 2011	na				49.6 2010	▬
Breast Cancer Screening Participation Rate	55% - 62% 2010-2015	58.4% 2010-2011	■				56.9% 2007-2008	▬
Cervical Cancer Screening Participation Rate	70% - 75% 2010-2015	69.4% 2009 - 2011	▲				64.7% 2006 – 2008	▬
Strengthen Primary Health Care								
◊Seniors (65+) Influenza Immunization Rate	75%	62% 2011-2012	●				60% 2010-2011	
◊Children (6 to 23 Months) Influenza Immunization Rate	75%	29% 2011-2012	●				21% 2010-2011	
◊Childhood Immunization Rates for DTaP	97%	na	na				na	na
◊Childhood Immunization Rates for MMR	98%	na	na				na	na
Albertans Enrolled in a Primary Care Network (%)	tbd	82% Apr 2012	na	82% Apr 2012	82% Oct 2011	▬	74% Apr 2011	■
◊Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	297 Annual	362 2011/12	●	100 Q4011/12	93 Q3011/12	●	390 2010/11	■
◊Family Practice Sensitive Conditions (% of ED visits)	25%	28.5% 2011/12	●	29.1% Q4 2011/12	27.8% Q3 2011/12	▬	29.2% 2010/11	▬
◊Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	90%	94% 2011/12	■	93% Q4 2011/12	96% Q3 2011/12	▬	na 2010/11	na
Improve Access and Reduce Wait Times								
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	27.0	38.6 2011/12	●	37.1 Q4 2011/12	34.1 Q3 2011/12	■	43.4 2010/11	■
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	35.0	50.6 2011/12	●	47.6 Q4 2011/12	57.4 Q3 2011/12	●	57.5 2010/11	■
◊ Cataract Surgery Wait Time (90th percentile in weeks)	30.0	43.0 2011/12	●	43.6 Q4 2011/12	33.3 Q3 2011/12	■	44.3 2010/11	■
Other Scheduled Surgery Wait Time (90th percentile in weeks)	tbd	23.6 2011/12	na	22.1 Q4 2011/12	24.1 Q3 2011/12	▬	26.1 2010/11	■

Notes
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.
╪ Interim target pending confirmation. Status based on interim target.

Q4 2011/12 AHS Performance Dashboard

South Zone (continued)

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
◊ Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	4.0	3.9 2011/12	■	4.3 Q4 2011/12	2.6 Q3 2011/12	■	4.5 2010/11	■
◊ Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks) £	4.0	1.4 2011/12	■	0.7 Q4 2011/12	1.0 Q3 2011/12	■	2.1 2010/11	■
◊ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	75%	82% 2011/12	■	79% Q4 2011/12	82% Q3 2011/12	▬	83% 2010/11	▬
◊ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	84%	89% 2011/12	■	87% Q4 2011/12	90% Q3 2011/12	▬	90% 2010/11	▬
◊ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	60%	89% 2011/12	■	86% Q4 2011/12	89% Q3 2011/12	▬	89% 2010/11	▬
◊ Patients Admitted from ED within 8 hours (%) (All Sites) £	65%	89% 2011/12	■	87% Q4 2011/12	89% Q3 2011/12	▬	90% 2010/11	▬
Provide More Choice for Continuing Care								
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	10	11 Mar 2012	▲	11 Mar 2012	9 Dec 2011	■	22 2010/11	■
◊ People Waiting in Community for Continuing Care Placement	52	71 Mar 2012	●	71 Mar 2012	46 Dec 2011	■	67 2010/11	■
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	tbd	13 2011/12	na	11 Q4 2011/12	14 Q3 2011/12	■	21 2010/11	■
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	tbd	80% 2011/12	na	90% Q4 2011/12	83% Q3 2011/12	na	68%* 2010/11	na
◊ Number of Home Care Clients	tbd	11,107 2011/12	na	7,221 Q4 2011/12	7,232 Q3 2011/12	▬	10,220 2010/11	na
Build One Health System								
◊ Staff Overall Engagement (%)	43% 2010/11	35% 2009/10	●					
◊ Physician Overall Engagement (%)	43% 2010/11	20% 2009/10	●					

Notes

◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.

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

* Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed – data for this measure are reportable as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).

Q4 2011/12 AHS Performance Dashboard

South Zone (continued)

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
Quality and Patient Safety								
◊ Patient Satisfaction – Adult Acute Care	tbd	85.7% YTD (Apr-Dec)	na	85.3% Q3 2011/12	85.7% Q2 2011/12	▬	82.6%^ Q3 2010/11 YTD	na
◊ Patient Satisfaction - Addictions and Mental Health (AHS)	85% 2010/11	na	na	na	na	na	na 2010/11	na
Percentage of Patient Feedback as Commendations	tbd	na	na	7.58% Q3 2011/12	13.21% Q2 2011/12	●	na 2010/11	na
Percentage of Patient Concerns Escalated to Patient Concerns Officer	tbd	1.24% 2011/12	na	0.76% Q4 2011/12	0.00% Q3 2011/12	■	na 2010/11	na
◊ Albertans Reporting Unexpected Harm	9%	na 2011	na				8% 2010	na
◊ Patient Satisfaction Emergency Department	70%	59% 2010	●				62% 2008	▬
◊ Patient Satisfaction Health Care Services Personally Received	tbd	na 2011	na				66% 2010	na
30 Day Unplanned Readmission Rate	tbd	8.5% YTD (Apr-Dec)	na	8.9% Q3 2011/12	8.4% Q2 2011/12	▬	8.2% Q3 2010/11 YTD	▬

Notes
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.
£The Weekly ED Length of Stay (LOS) being published separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.
^ Patient Satisfaction – Adult Acute Care – sampling strategy changed as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).

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

Comparative Performance
■ Current period performance is better than comparative period
▬ Current period performance is within 5% of comparative period
● Current period performance is worse than comparative period

AHS Performance Dashboard Q4 2011/12

Calgary Zone

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
Staying Healthy / Improving Population Health								
◊Life Expectancy	tbd	83.4 2011	na				81.6 2010	▬
◊Potential Years Life Lost (per 1,000 population)	tbd	33.9 2011	na				44.8 2010	▬
Breast Cancer Screening Participation Rate	55% - 62% 2010-2015	55.3% 2010-2011	■				57.2% 2008-2009	■
Cervical Cancer Screening Participation Rate	70% - 75% 2010-2015	60.7% Jan 2009 – Dec 2011	●				74.8% Jan 2007 - Dec 2009	▬
Strengthen Primary Health Care								
◊Seniors (65+) Influenza Immunization Rate	75%	63% 2011-2012	●				62% 2010-2011	▬
◊Children (6 to 23 Months) Influenza Immunization Rate	75%	38% 2011-2012	●				39% 2010-2011	▬
◊Childhood Immunization Rates for DTaP	97%	na	na				86.2% 2008	na
◊Childhood Immunization Rates for MMR	98%	na	na				87.8% 2008	na
Albertans Enrolled in a Primary Care Network (%)	tbd	80% Apr 2012	na	80% Apr 2012	80% Oct 2011	▬	77% Apr 2011	■
◊Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	297 annual	214 2011/12	■	57 Q4 2011/12	52 Q3 2011/12	●	221 2010/11	■
◊Family Practice Sensitive Conditions (% of ED visits)	25%	20.2% 2011/12	■	20.4% Q4 2011/12	20.4% Q3 2011/12	▬	21.3% 2010/11	▬
◊Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	90%	71% 2011/12	●	70% Q4 2011/12	77% Q3 2011/12	▬	73% 2010/11	na

Notes
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.
╪ Interim target pending confirmation. Status based on interim target.
* Trend for these measures cannot be determined until subsequent data is available

Q4 2011/12 AHS Performance Dashboard
Calgary Zone (continued)

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
Improve Access and Reduce Wait Times								
◊ Urgent CABG Wait Time (90th percentile in weeks)	1.0	2.0 2011/12	🔴	1.8 Q4 2011/12	2.0 Q3 2011/12	▬	1.6 2010/11	🔴
◊ Semi-urgent CABG Wait Time (90th percentile in weeks)	2.0	3.9 2011/12	🔴	4.1 Q4 2011/12	3.2 Q3 2011/12	🔴	3.2 2010/11	🔴
◊ Scheduled CABG Wait Time (90th percentile in weeks)	6.0	33.8 2011/12	🔴	35.0 Q4 2011/12	34.1 Q3 2011/12	🔴	28.0 2010/11	🔴
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	27.0	30.1 2011/12	🔴	34.3 Q4 2011/12	28.3 Q3 2011/12	▬	30.4 2010/11	▬
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	35.0	34.9 2011/12	🟩	34.5 Q4 2011/12	39.1 Q3 2011/12	🔴	34.3 2010/11	▬
◊ Cataract Surgery Wait Time (90th percentile in weeks)	30.0	38.3 2011/12	🔴	26.9 Q4 2011/12	30.9 Q3 2011/12	🟩	61.9 2010/11	🟩
Other Scheduled Surgery Wait Time (90th percentile in weeks)	tbd	26.4 2011/12	na	24.7 Q4 2011/12	28.1 Q3 2011/12	🔴	26.7 2010/11	▬
◊ Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	4.0	6.3 2011/12	🔴	4.3 Q4 2011/12	5.4 Q3 2011/12	🟩	6.0 2010/11	🔴
◊ Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks) £	4.0	3.4 2011/12	🟩	3.4 Q4 2011/12	3.1 Q3 2011/12	🟩	3.7 2010/11	🟩
◊ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	75%	62% 2011/12	🔴	60% Q4 2011/12	63% Q3 2011/12	🟩	57.0% 2010/11	🟩
◊ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	84%	74% 2011/12	🔴	72% Q4 2011/12	75% Q3 2011/12	▬	72.0% 2010/11	▬
◊ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	60%	44% 2011/12	🔴	41% Q4 2011/12	44% Q3 2011/12	▬	35.0% 2010/11	🟩
◊ Patients Admitted from ED within 8 hours (%) (All Sites) £	65%	46% 2011/12	🔴	43% Q4 2011/12	46% Q3 2011/12	▬	37.0% 2010/11	🟩

Notes
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.
£The Weekly ED Length of Stay (LOS) being published separate from this report are based upon a subset of the sites identified in the current ED LOS data definitions where more timely data is readily available. There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.

Q4 2011/12 AHS Performance Dashboard
Calgary Zone (continued)

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
Provide More Choice for Continuing Care								
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	138	188 Mar 2012	●	188 Mar 2012	162 Dec 2011	■	146 2010/11	■
◊ People Waiting in Community for Continuing Care Placement	404	519 Mar 2012	●	519 Mar 2012	545 Dec 2011	■	504 2010/11	●
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	tbd	55 2011/12	na	55 Q4 2011/12	69 Q3 2011/12	●	55 2010/11	▲
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	tbd	58% 2011/12	na	58% Q4 2011/12	48% Q3 2011/12	●	59%* 2010/11	na
◊ Number of Home Care Clients	tbd	29,503 2011/12	na	19,862 Q4 2011/12	19,524 Q3 2011/12	▬	28,248 2010/11	na
Build One Health System								
◊ Staff Overall Engagement (%)	43% 2010/11	33% 2009/10	●					
◊ Physician Overall Engagement (%)	43% 2010/11	27% 2009/10	●					
Quality and Patient Safety								
◊ Patient Satisfaction – Adult Acute Care	tbd	83.4% YTD (Apr-Dec)	na	83.7% Q3 2011/12	82.9% Q2 2011/12	▬	78.5% Q3 2010/11 YTD	■
◊ Patient Satisfaction - Addictions and Mental Health (AHS)	85% 2010/11	na	na				na	na
Percentage of Patient Feedback as Commendations	tbd	na	na	10.43% Q4 2011/12	13.71% Q3 2011/12	■	na Q3 2010/11 YTD	na
Percentage of Patient Concerns Escalated to Patient Concerns Officer	tbd	0.80% 2011/12	na	0.44% Q4 2011/12	0.50% Q3 2011/12	■	na Q3 2010/11 YTD	na
◊ Albertans Reporting Unexpected Harm	9%	na 2011	na				10% 2010	na
◊ Patient Satisfaction Emergency Department	70%	61% 2010	●				58% 2008	■
◊ Patient Satisfaction Health Care Services Personally Received	tbd	na 2011	na				60% 2010	na
30 Day Unplanned Readmission Rate	tbd	7.0% YTD (Apr-Dec)	na	7.0% Q3 2011/12	7.0% Q2 2011/12	▬	6.7% Q3 2010/11 YTD	●

Notes
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.
* Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed – data for this measure are reportable as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).
^ Patient Satisfaction – Adult Acute Care – sampling strategy changed as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).

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

Period Comparative Performance
■ Current period performance is better than comparative period
▬ Current period performance is within 5% of comparative period
● Current period performance is worse than comparative period

AHS Performance Dashboard Q4 2011/12

Central Zone

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
Staying Healthy / Improving Population Health								
◊Life Expectancy	tbd	80.5 2011	na				81.6 2010	▬
◊Potential Years Life Lost (per 1,000 population)	tbd	50.2 2011	na				44.8 2010	▬
Breast Cancer Screening Participation Rate	55% - 62% 2010-2015	52.0% 2010-2011	△				53.4% 2009-2010	▬
Cervical Cancer Screening Participation Rate	70% - 75% 2010-2015	66.1% Jan 2009 - Dec 2011	△				62.3% Jan 2008 - Dec 2010	■
Strengthen Primary Health Care								
◊Seniors (65+) Influenza Immunization Rate	75%	53% 2011-2012	●				54% 2010-2011	▬
◊Children (6 to 23 Months) Influenza Immunization Rate	75%	27% 2011-2012	●				22% 2010-2011	■
◊Childhood Immunization Rates for DTaP	97%	na	na				na	na
◊Childhood Immunization Rates for MMR	98%	na	na				na	na
Albertans Enrolled in a Primary Care Network (%)	tbd	69% Apr 2012	na	69% Apr 2012	69% Oct 2011	▬	66% Apr 2011	▬
◊Admissions for Ambulatory Care Sensitive Conditions (rate per 100,000 Population)	297 annual	344 2011/12	●	92 Q4 2011/12	81 Q3 2011/12	●	352 2010/11	■
◊Family Practice Sensitive Conditions (% of ED visits)	25%	32.0% 2011/12	●	32.3% Q4 2011/12	32.4% Q3 2011/12	▬	32.6% 2010/11	▬
◊Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	90%	95% 2011/12	■	94% Q4 2011/12	96% Q3 2011/12	▬	89% 2010/11	na

Notes
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.
╪ Interim target pending confirmation. Status based on interim target.
* Trend for these measures cannot be determined until subsequent data is available

Q4 2011/12 AHS Performance Dashboard
Central Zone (continued)

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
Improve Access and Reduce Wait Times								
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	27.0	31.4 2011/12	🔴	33.4 Q4 2011/12	27.0 Q3 2011/12	🔴	26.4 2010/11	🔴
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	35.0	32.7 2011/12	🟩	29.4 Q4 2011/12	33.1 Q3 2011/12	🟩	30.2 2010/11	▬
◊ Cataract Surgery Wait Time (90th percentile in weeks)	30.0	24.4 2011/12	🟩	22.9 Q4 2011/12	23.1 Q3 2011/12	🟩	28.6 2010/11	🟩
Other Scheduled Surgery Wait Time (90th percentile in weeks)	tbd	25.1 2011/12	na	25.4 Q4 2011/12	25.3 Q3 2011/12	🔴	25.1 2010/11	▬
◊ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	75%	69% 2011/12	🔺	67% Q4 2011/12	67% Q3 2011/12	▬	74% 2010/11	🔴
◊ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	84%	90% 2011/12	🟩	89% Q4 2011/12	90% Q3 2011/12	▬	91% 2010/11	▬
◊ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	60%	43% 2011/12	🔴	37% Q4 2011/12	40% Q3 2011/12	🔴	47% 2010/11	🔴
◊ Patients Admitted from ED within 8 hours (%) (All Sites) £	65%	71% 2011/12	🟩	68% Q4 2011/12	71% Q3 2011/12	▬	74% 2010/11	▬
Provide More Choice for Continuing Care								
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	52	48 Mar 2012	🟩	48 Mar 2012	71 Dec 2011	🟩	65 2010/11	🟩
◊ People Waiting in Community for Continuing Care Placement	118	104 Mar 2012	🟩	104 Mar 2012	103 Dec 2011	▬	128 2010/11	🟩
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	tbd	35 2011/12	na	26 Q4 2011/12	40 Q3 2011/12	🟩	57 2010/11	🟩
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	tbd	66% 2011/12	na	69% Q4 2011/12	63% Q3 2011/12	🟩	57%* 2010/11	na
◊ Number of Home Care Clients	tbd	16,379 2011/12	na	10,222 Q4 2011/12	10,025 Q3 2011/12	▬	19,224 2010/11	🔴
Enabling Our People / Enabling One Health System								
◊ Staff Overall Engagement (%)	43% 2010/11	35% 2009/10	🔴					
◊ Physician Overall Engagement (%)	43% 2010/11	27% 2009/10	🔴					

Notes

◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.

£ There is currently a three month time lag in obtaining information from alternate data sources that allow for a more complete provincial picture. AHS is currently working on integrating the data to support these measures using more timely data sources. Data are accurate to ±2%.

* Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed – data for this measure are reportable as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).

Q4 2011/12 AHS Performance Dashboard
Central Zone (continued)

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
Quality and Patient Safety								
◊ Patient Satisfaction – Adult Acute Care	tbd	86.3% YTD (Apr-Dec)	na	85.6% Q3 2011/12	85.8% Q2 2011/12	▬	na Q3 2010/11 YTD	
◊ Patient Satisfaction - Addictions and Mental Health (AHS)	85% 2010/11	na 2011/12	na				na 2010/11	na
Percentage of Patient Feedback as Commendations	na	na 2011/12	na	5.73% Q4 2011/12	6.62% Q3 2011/12	●	na 2010/11	na
Percentage of Patient Concerns Escalated to Patient Concerns Officer	na	0.54% 2011/12	na	0.61% Q4 2011/12	0.82% Q3 2011/12	■	na 2010/11	na
◊ Albertans Reporting Unexpected Harm	9%	na 2011	na				8% 2010	na
◊ Patient Satisfaction Emergency Department	70%	63% 2010	△				64% 2008	■
◊ Patient Satisfaction Health Care Services Personally Received	tbd	na 2011	na				60% 2010	na
30 Day Unplanned Readmission Rate	tbd	9.7% YTD (Apr-Dec)	na	9.8% Q3 2011/12	10.0% Q2 2011/12	▬	9.1% Q3 2010/11 YTD	●

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

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

Comparative Performance
- ■ Current period performance is better than comparative period
- ▬ Current period performance is within 5% of comparative period
- ● Current period performance is worse than comparative period

AHS Performance Dashboard Q4 2011/12

Edmonton Zone

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
Staying Healthy / Improving Population Health								
◊Life Expectancy	tbd	81.9 2011	na				81.8 2010	▬
◊Potential Years Life Lost (per 1,000 population)	tbd	44.7 2011	na				45.7 2010	▬
Breast Cancer Screening Participation Rate	55% - 62% 2010-2015	54.5% 2010-2011	△				56.6% 2009-2010	▬
Cervical Cancer Screening Participation Rate	70% - 75% 2010-2015	58.2% Jan 2009 - Dec 2011	●				67.9% Jan 2008 - Dec 2010	●
Strengthen Primary Health Care								
◊Seniors (65+) Influenza Immunization Rate	75%	64% 2011-2012	●				60% 2010 - 2011	■
◊Children (6 to 23 Months) Influenza Immunization Rate	75%	27% 2011-2012	●				20% 2010-2011	■
◊Childhood Immunization Rates for DTaP	97%	na	na				na	na
◊Childhood Immunization Rates for MMR	98%	na	na				na	na
Albertans Enrolled in a Primary Care Network (%)	tbd	72% Apr 2011	na	72% Apr 2011	72% Oct 2011	▬	70% Apr 2011	▬
◊Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	297 annual	241 2011/12	■	63 Q4 2011/12	62 Q3 2011/12	▬	231 2010/11	●
◊Family Practice Sensitive Conditions (% of ED visits)	25%	14.5% 2011/12	■	14.7% Q4 2011/12	14.7% Q3 2011/12	▬	16.5% 2010/11	■
◊Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	90%	53% 2011/12	●	64% Q4 2011/12	71% Q3 2011/12	■	42% 2010/11	na

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╪ Interim target pending confirmation. Status based on interim target.
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Q4 2011/12 AHS Performance Dashboard
Edmonton Zone (continued)

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
Improve Access and Reduce Wait Times								
◊ Urgent CABG Wait Time (90th percentile in weeks)	1.0	1.9 2011/12	●	1.9 Q4 2011/12	1.5 Q3 2011/12	■	2.1 2010/11	■
◊ Semi-urgent CABG Wait Time (90th percentile in weeks)	2.0	7.5 2011/12	●	7.0 Q4 2011/12	5.3 Q3 2011/12	●	11.9 2010/11	●
◊ Scheduled CABG Wait Time (90th percentile in weeks)	6.0	18.9 2011/12	●	14.1 Q4 2011/12	17.1 Q3 2011/12	■	18.0 2010/11	●
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	27.0	48.0 2011/12	●	42.9 Q4 2011/12	45.1 Q3 2011/12	▬	48.6 2010/11	●
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	35.0	55.6 2011/12	●	49.3 Q4 2011/12	54.7 Q3 2011/12	▬	60.7 2010/11	▬
◊ Cataract Surgery Wait Time (90th percentile in weeks)	30.0	32.6 2011/12	△	27.6 Q4 2011/12	29.6 Q3 2011/12	■	40.1 2010/11	■
Other Scheduled Surgery Wait Time (90th percentile in weeks)	tbd	25.7 2011/12	na	25.3 Q4 2011/12	26.3 Q3 2011/12	●	24.6 2010/11	●
◊ Radiation Therapy Access (referral to 1st consult) (90th percentile in weeks)	4.0	4.9 2011/12	●	4.9 Q4 2011/12	4.7 Q3 2011/12	■	6.0 2010/11	■
◊ Radiation Therapy Access (ready to treat to first therapy) (90th percentile in weeks) £	4.0	3.0 2011/12	■	2.7 Q4 2011/12	2.9 Q3 2011/12	▬	3.4 2010/11	■
◊ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	75%	58% 2011/12	●	56% Q4 2011/12	59% Q3 2011/12	▬	56% 2010/11	■
◊ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	84%	65% 2011/12	●	62% Q4 2011/12	65% Q3 2011/12	▬	64% 2010/11	▬
◊ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	60%	31% 2011/12	●	33% Q4 2011/12	29% Q3 2011/12	●	29% 2010/11	■
◊ Patients Admitted from ED within 8 hours (%) (All Sites) £	65%	32% 2011/12	●	34% Q4 2011/12	31% Q3 2011/12	●	30% 2010/11	■

Notes

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Q4 2011/12 AHS Performance Dashboard
Edmonton Zone (continued)

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year to Date Performance	Comparative Performance
Provide More Choice for Continuing Care								
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	127	143 Mar 2012	🔴	143 Mar 2012	163 Dec 2011	🟩	151 2010/11	🟩
◊ People Waiting in Community for Continuing Care Placement	235	202 Mar 2012	🟩	202 Mar 2012	252 Dec 2011	▬	310 2010/11	🟩
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	tbd	32 2011/12	na	24 Q4 2011/12	35 Q3 2011/12	🟩	51 2010/11	🟩
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	tbd	66% 2011/12	na	75% Q4 2011/12	64% Q3 2011/12	▬	49%* 2010/11	na
◊ Number of Home Care Clients	tbd	36,485 2011/12	na	22,655 Q4 2011/12	21,227 Q3 2011/12	▬	35,693 2010/11	na
Build One Health System								
◊ Staff Overall Engagement (%)	43% 2010/11	37% 2009/10	🔴					
◊ Physician Overall Engagement (%)	43% 2010/11	25% 2009/10	🔴					
Quality and Patient Safety								
◊ Patient Satisfaction – Adult Acute Care	tbd	83.8% YTD (Apr-Dec)	na	82.6% Q3 2011/12	85.2% Q2 2011/12	▬	85.9% Q3 2010/11 YTD	▬
◊ Patient Satisfaction - Addictions and Mental Health (AHS)	85% 2010/11	na	na	na	na	na	na	na
Percentage of Patient Feedback as Commendations	tbd	na	na	11.58% Q4 2011/12	12.53% Q3 2011/12	🟩	na 2010/11	na
Percentage of Patient Concerns Escalated to Patient Concerns Officer	tbd	0.35% 2011/12	na	0.47% Q3 2011/12	0.43% Q2 2011/12	🔴	na 2010/11	na
◊ Albertans Reporting Unexpected Harm	9%	na 2011	na				9% 2010	na
◊ Patient Satisfaction Emergency Department	70%	55% 2010	🔴				53% 2008	▬
◊ Patient Satisfaction Health Care Services Personally Received	tbd	na 2011	na				65% 2010	na
30 Day Unplanned Readmission Rate	tbd	8.0% YTD (Apr-Dec)	na	7.9 Q3 2011/12	8.2% Q2 2011/12	▬	7.6% Q3 2010/11 YTD	🔴

Notes
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.
* Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed – data for this measure are reportable as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).
^ Patient Satisfaction – Adult Acute Care – sampling strategy changed as of Q3 2010/11; 2010/11 data represents the partial year, beginning in Q3 (Oct 2010-Mar 2011).

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

Period Comparative Performance
- 🟩 Current period performance is better than comparative period
- ▬ Current period performance is within 5% of comparative period
- 🔴 Current period performance is worse than comparative period

AHS Performance Dashboard Q4 2011/12

North Zone

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
Staying Healthy / Improving Population Health								
◊Life Expectancy	tbd	79.4 2011	na				79.8 2010	▬
◊Potential Years Life Lost (per 1,000 population)	tbd	57.6 2011	na				56.8 2010	▬
Breast Cancer Screening Participation Rate	55% - 62% 2010-2015	52.6% 2010-2011	△				54.7% 2009-2010	▬
Cervical Cancer Screening Participation Rate	70% - 75% 2010-2015	62.6% Jan 2009 – Dec 2011	●				59.5% Jan 2008 - Dec 2010	■
Strengthen Primary Health Care								
◊Seniors (65+) Influenza Immunization Rate	75%	52% 2011-2012	●				49% 2010-2011	■
◊Children (6 to 23 Months) Influenza Immunization Rate	75%	20% 2011-2012	●				18% 2010-2011	■
◊Childhood Immunization Rates for DTaP	97%	na	na				na	na
◊Childhood Immunization Rates for MMR	98%	na	na				na	na
Albertans Enrolled in a Primary Care Network (%)	tbd	68% Apr 2012	na	68% Apr 2012	66% Oct 2011	▬	63% Apr 2011	■
◊Admissions for Ambulatory Care Sensitive Conditions (per 100,000 Population)	297 annual	468 2011/12	●	124 Q4 2011/12	105 Q3 2011/12	●	473 2010/11	▬
◊Family Practice Sensitive Conditions(% of ED visits)	25%	38.2% 2011/12	●	37.7% Q4 2011/12	38.7% Q3 2011/12	▬	39.0% 2010/11	▬
◊Children Receiving Community Mental Health Treatment within 30 Days (%) - Scheduled	90%	68% 2011/12	●	67% Q4 2011/12	77% Q3 2011/12	■	74% 2010/11	na
Improve Access and Reduce Wait Times								
◊ Hip Replacement Surgery Wait Time (90th percentile in weeks)	27.0	49.7 2011/12	●	45.2 Q4 2011/12	51.8 Q3 2011/12	■	36.6 2010/11	●
◊ Knee Replacement Surgery Wait Time (90th percentile in weeks)	35.0	51.9 2011/12	●	54.8 Q4 2011/12	50.2 Q3 2011/12	▬	40.6 2010/11	●
◊ Cataract Surgery Wait Time (90th percentile in weeks)	30.0	55.7 2011/12	●	64.0 Q4 2011/12	52.7 Q3 2011/12	▬	39.1 2010/11	●
Other Scheduled Surgery Wait Time (90th percentile in weeks)	tbd	25.4 2011/12	na	24.6 Q4 2011/12	27.9 Q3 2011/12	●	26.3 2010/11	▬

Notes
◊ Indicates "Tier 1" measures attached to the 2011 – 2015 Health Plan.
╪ Interim target pending confirmation. Status based on interim target.
* Children (6 to 23 Months) Influenza Immunization Rate – Data not available for North Zone.

Q4 2011/12 AHS Performance Dashboard
North Zone (continued)

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
◊ Patients Discharged from ED or UCC within 4 hours (%) (16 Higher Volume) £	75%	79% 2011/12	■	76% Q4 2011/12	79% Q3 2011/12	▬	82% 2010/11	▬
◊ Patients Discharged from ED or UCC within 4 hours (%) (All Sites) £	84%	90% 2011/12	■	89% Q4 2011/12	90% Q3 2011/12	▬	91% 2010/11	▬
◊ Patients Admitted from ED within 8 hours (%) (15 Higher Volume) £	60%	66% 2011/12	■	62% Q4 2011/12	66% Q3 2011/12	▬	70% 2010/11	▬
◊ Patients Admitted from ED within 8 hours (%) (All Sites) £	65%	84% 2011/12	■	83% Q4 2011/12	84% Q3 2011/12	▬	87% 2010/11	▬
Provide More Choice for Continuing Care								
◊ People Waiting in Acute/Sub-acute Beds for Continuing Care Placement	52	77 Mar 2012	●	77 Mar 2012	84 Dec 2011	●	87 2010/11	■
◊ People Waiting in Community for Continuing Care Placement	92	106 Mar 2012	●	106 Mar 2012	92 Dec 2011	■	106 2010/11	▬
Average Wait Time in Acute/Sub-Acute Care for Continuing Care (Days)	tbd	87 2011/12	na	75 Q4 2011/12	69 Q3 2011/12	■	110 2010/11	■
Per cent of Patients Placed in Continuing Care within 30 Days of Being Assessed	tbd	49% 2011/12	na	54% Q4 2011/12	51% Q3 2011/12	na	41%* 2010/11	na
◊ Number of Home Care Clients	tbd	11,230 2011/12	na	7,749 Q4 2011/12	7,772 Q3 2011/12	▬	10,849 2010/11	na
Build One Health System								
◊ Staff Overall Engagement (%)	43% 2010/11	41% 2009/10	▲					
◊ Physician Overall Engagement (%)	43% 2010/11	27% 2009/10	●					

Notes

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Q4 2011/12 AHS Performance Dashboard
North Zone (continued)

Performance Measure	Actual to Target Comparison			Consecutive Period Comparison			Prior Year Comparison	
	2011/12 Annual Target*	Current Year Performance	Status	Current Period Performance	Previous Period Performance	Comparative Performance	Previous Year Performance	Comparative Performance
Quality and Patient Safety								
◊ Patient Satisfaction – Adult Acute Care		82.1% YTD (Apr-Dec)	na	84.1% Q3 2011/12	78.2% Q2 2011/12	■	81.2%^ Q3 2010/11 YTD	▬
◊ Patient Satisfaction - Addictions and Mental Health (AHS)	85% 2010/11	na	na				na 2010/11	na
Percentage of Patient Feedback as Commendations	tbd	na	na	6.07% Q4 2011/12	9.24% Q3 2011/12	■	na 2010/11	na
Percentage of Patient Concerns Escalated to Patient Concerns Officer	tbd	0.16% 2011/12	na	0.54% Q4 2011/12	0.00% Q3 2011/12	▬	na 2010/11	na
◊ Albertans Reporting Unexpected Harm	9%	na 2011	na				8% 2010	na
◊ Patient Satisfaction Emergency Department	70%	58% 2010	●				58% 2008	▬
◊ Patient Satisfaction Health Care Services Personally Received	tbd	na 2011	na				53% 2010	●
30 Day Unplanned Readmission Rate	tbd	9.5% YTD (Apr-Dec)	na	9.1% Q3 2011/12	9.7% Q2 2011/12	▬	9.7% Q3 2010/11 YTD	▬

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

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Period Comparative Performance
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Quick Facts

Activity Measure	2009/10 Fiscal Year	2010/11 Q1	2010/11 Q2	2010/11 Q3	2010/11 Q4	2010/11 Fiscal Year	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4	2011/12 Fiscal Year
Number of Hospital Discharges[1] (by Site)	362,314	92,641	89,135	89,960	92,305	364,041	95,597	92,579	92,687	95,252	376,115
Average Hospital Length of Stay (Days)[1,2] (by Site)	6.9	6.8	6.9	7.1	7.1	7.0	6.8	6.7	7.1	7.0	6.9
Per Cent of Alternate Level of Care (ALC)[1,3] Days	9.4%	8.2%	9.9%	10.0%	8.0%	9.0%	7.1%	7.4%	8.3%	7.2%	7.5%
Number of Hospital Births[1]	50,738	12,882	12,985	11,952	11,937	49,756	12,894	13,103	12,006	12,096	50,099
Number of Emergency Department Visits[4] (by Site)	1,952,803	491,934	491,155	472,121	486,793	1,942,003	502,973	508,793	502,929	514,496	2,029,191
Number of Urgent Care Service (UCS) Visits[5]	125,916	44,189	44,238	42,428	46,442	177,297	49,909	49,110	47,951	49,167	196,137
Number of Health Link Calls	1,030,192	175,319	167,602	203,281	212,769	758,971	189,135	174,190	203,008	199,813	766,146
Number of Total Hip Replacements[6]	4,482	1,146	976	1,125	1,220	4,466	1,206	1,033	1,309	1,320	4,868
Number of Elective Hip Replacements[7]	3,244	851	686	779	919	3,235	900	773	925	1,015	3,613
Number of Total Knee Replacements[6]	4,723	1,408	1,003	1,288	1,291	4,990	1,436	1,221	1,487	1,651	5,795
Number of Elective Knee Replacements[7]	4,692	1,357	1,031	1,194	1,313	4,895	1,434	1,217	1,406	1,659	5,716
Number of Cataract Surgeries[8]	28,601	7,610	7,230	8,024	10,915	33,781	8,548	8,164	10,295	9,450	36,457
Number of MRI Exams[9]	165,948	45,008	43,369	40,389	48,656	177,422	41,016	40,642	40,787	44,200	166,645
Number of CT Exams[10]	350,781	88,727	87,485	77,670	79,281	333,163	82,878	84,653	82,543	84,540	334,614
Number of Lab Tests	67,831,892	16,722,715	16,200,487	16,565,953	16,936,697	66,425,852	17,814,769	17,028,978	17,394,382	18,274,792	70,512,921
Number of EMS Events[11]	377,000	92,812	95,842	94,175	94,451	377,280	96,500	99,696	98,760	99,008	393,964

Access notes for interpretation here.

Performance Measure Update

Life Expectancy

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

PERFORMANCE STATUS

Performance improvement observed since last reported period.

TARGET: Improvement

2011 ACTUAL: 81.9 years

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

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

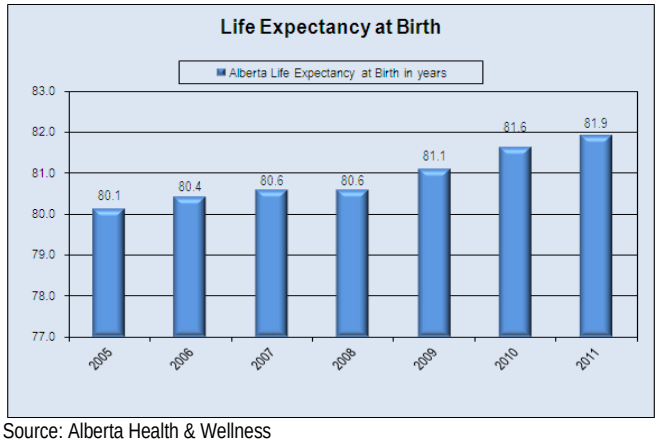
WHAT IS THE TARGET?

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

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

HOW ARE WE DOING?

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



Source: Alberta Health & Wellness

WHAT ACTIONS ARE WE TAKING?

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

WHAT ELSE DO WE KNOW?

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

Information is available by zone and First Nations status.

HOW DO WE COMPARE?

Using a similar definition, Alberta ranked fourth among the 10 provinces for life expectancy. Alberta = 80.6, Best Performing Province = 81.4 (British Columbia), Canada = 80.9 (Statistics Canada 2006/2008).

Alberta Health Services

Performance Measure Update

Potential Years of Life Lost

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

PERFORMANCE STATUS

Performance improvement observed since last reported period.

TARGET: Improvement

2011 ACTUAL: 43.3 years

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

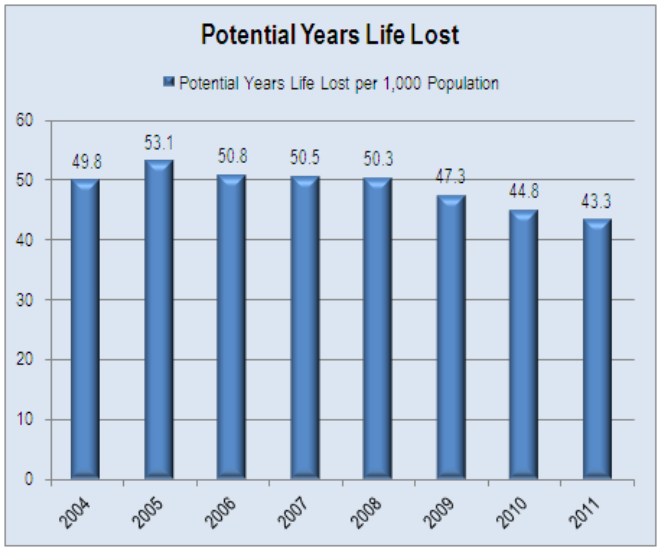
PYLL is an indicator of premature mortality that gives greater weight to causes of death that occur at a younger age than to those at older ages. It emphasizes the loss of life at an early age and the causes of early deaths such as cancer, injury and cardiovascular disease. For example, the death of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

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

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



Source: Alberta Health & Wellness

WHAT ACTIONS ARE WE TAKING?

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

WHAT ELSE DO WE KNOW?

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

Information is available by zone and sex.

HOW DO WE COMPARE?

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

Performance Measure Update

Colorectal Cancer Screening Participation Rate

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

PERFORMANCE STATUS

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

2015 TARGET: 55%

2011 ACTUAL: 57.0%

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

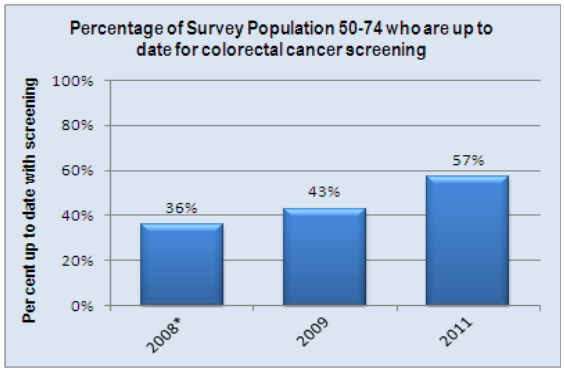
Death from colorectal cancer is 90 per cent preventable if the disease is caught at early stages. There is substantial evidence that organized colorectal cancer screening can reduce the mortality and incidence of colorectal cancer, and will significantly reduce the suffering and substantial costs of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

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

The 2011 Colon Cancer Screening in Canada Survey by Canadian Partnership Against Cancer (CPAC) showed 57 per cent of Albertans between the ages of 50 and 74 years are up to date for colorectal cancer screening. This is a substantial improvement over the 2009 rate of 43%.



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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Cervical and colorectal cancer screening program database development project has been rolled into a comprehensive screening application project. Additional Zone-specific actions completed are available here.

Subsequent actions planned: Program brochures for cervical, breast and colorectal cancer screening currently being translated into French. Additional Zone-specific actions planned are available here.

WHAT ELSE DO WE KNOW?

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

HOW DO WE COMPARE?

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

Performance Measure Update

Breast Cancer Screening Participation Rate

Data updated annually.
Most current data is 2010-2011.
Next data update expected for 2012/13.

PERFORMANCE STATUS

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

2010 - 2015 TARGET: 55% - 62%

2010-2011 ACTUAL: 54.8%

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

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

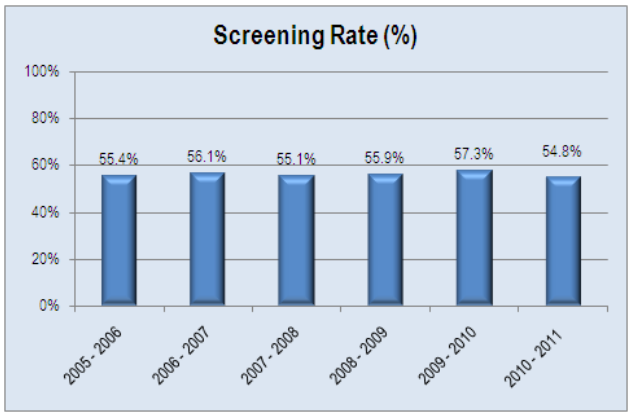
WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

The Alberta target is for 62 per cent of eligible women, 50 to 69 years of age, to have a screening mammogram at least biennially by 2015.

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



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

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Development requirements for breast cancer screening application completed. Program brochures for cervical, breast and colorectal cancer screening translated into six more languages.

Subsequent actions planned: Program brochures for cervical, breast and colorectal cancer screening currently being translated into French.

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

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

Performance Measure Update

Cervical Cancer Screening Participation Rate

Data updated annually.
Most current data is 2009 - 2011.
Next data update expected for 2012/13.

PERFORMANCE STATUS

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

2010- 2015 TARGET: 70% - 75%

2009-2011 ACTUAL: 65.0%

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

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

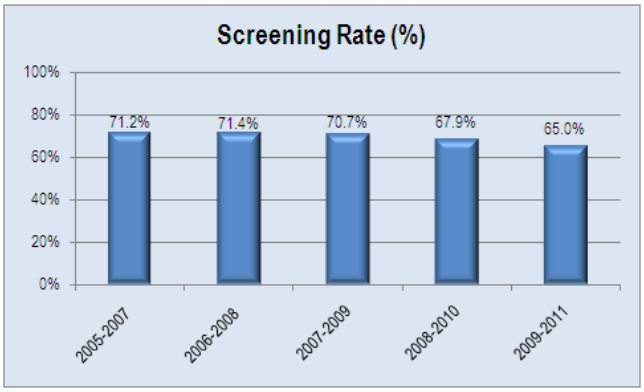
WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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

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



Source: Extracted from AHW FFS data.

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

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

HOW ARE WE DOING?

During the three-year period between January 2009 and December 2011, 65.0 per cent of eligible women aged 21 to 69 years received a screening Pap test. While this is below target, the screening percentage has been affected by new Screening guidelines introduced in 2009 (see note below graph).

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Cervical and colorectal cancer screening program database development project has been rolled into a comprehensive screening application project. Program brochures for cervical, breast and colorectal cancer screening translated into six more languages.

Subsequent actions planned: Program brochures for cervical, breast and colorectal cancer screening currently being translated into French.

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

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

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

Seniors (65+) Influenza Immunization Rate

PERFORMANCE STATUS

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

2011/12 TARGET: 75%

2011/12 ACTUAL: 61%

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

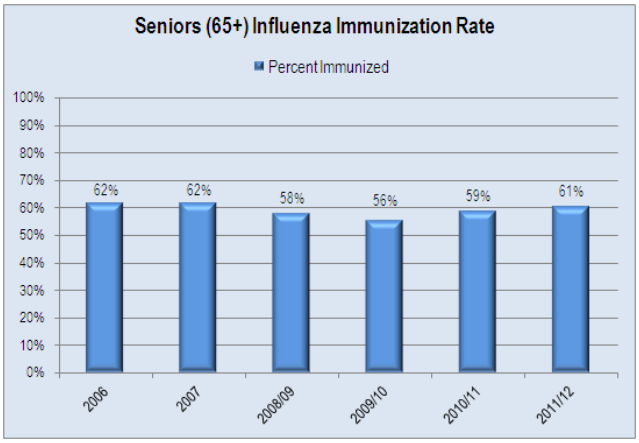
A high rate of seasonal influenza immunization among seniors will reduce the incidence of complications and death associated with influenza disease in this population. A high rate of coverage will reduce the impact of disease on the healthcare system.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

The seasonal influenza immunization rate for seniors aged 65 and older for 2011/12 is 60.6 per cent. While slightly better than the 2010/11 rate of 58.9 per cent, it is below the overall target of 75 per cent. There has been steady improvement 2009/10.



Source: Alberta Health & Wellness; 2011/12 figures are preliminary calculations from AHS.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Various strategies being implemented to increase immunization levels including items such as increased outreach clinics for seniors, e.g. recreation centres, lodges, seniors' residences, seniors' community centres, assisted living sites and snowbird clinics in all zones. Overall, number of doses delivered to Albertans increased by approximately 5% - this increase includes number of doses delivered by partners (physicians, pharmacists etc). Evaluation of the outreach is in progress

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

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

As detailed in the indicator definition, this indicator is based upon the influenza season and therefore considers doses delivered from October through to May 15th. The rate up to March 31st as reported by Alberta Health and Wellness (AHW) was 55.5%.

HOW DO WE COMPARE?

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

Performance Measure Update

Children (6 to 23 Months) Influenza Immunization Rate

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

PERFORMANCE STATUS

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

2011/12 TARGET: 75%

2011/12 ACTUAL: 30%

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

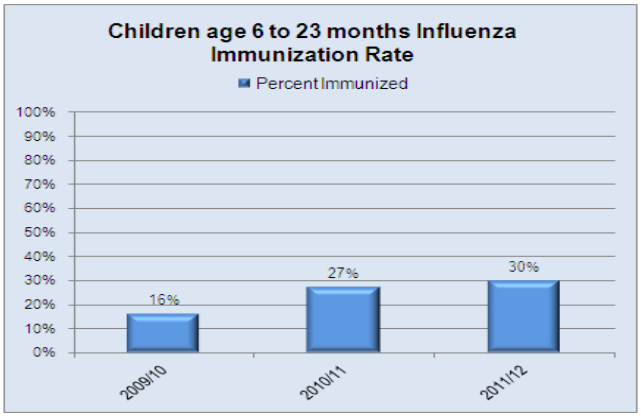
A high rate of seasonal influenza immunization among children reduces the incidence of complications and death associated with influenza disease and reduces the spread of disease to older age groups during the influenza season. A high rate of coverage will reduce the impact of disease on the healthcare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

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

The influenza immunization rate for children between the ages of 6 to 23 months was 29.9 per cent for 2011/12 which while better than the 2010/11 rate of 27.2 per cent, remains below target of 75 per cent. Over the past 2 years, since 2009/10, the immunization rate has nearly doubled.



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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: New processes include immunization pilots at day care centres and school sites at end of business day as parents present to pick-up children. Promotion of influenza immunization by use of targeted post card mail out to parents of all children 6 to 23 months of age advising re importance of annual influenza immunization. Internal processes changed to facilitate centralized data entry of doses given by AHS to children over 9 years of age to better track and report on immunizations.

Subsequent actions planned: Results from new processes and programs will be included in the comprehensive 2011-2012 influenza immunization program evaluation.

WHAT ELSE DO WE KNOW?

Children receiving influenza vaccine for the first time require two doses. Poor uptake for the needed second dose is common. Methods of data collection have been inconsistent in previous years and rates are not directly comparable. AHS is working with AHW to standardize data collection and reporting of this indicator.

Information is available by zone.

As detailed in the indicator definition, this indicator is based upon the influenza season and therefore considers doses delivered from October through to May 15th. The annual rate which is the rate up to March 31st as reported by Alberta Health and Wellness is 29%.

HOW DO WE COMPARE?

Limited comparable data is available.

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

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

PERFORMANCE STATUS

Status to be determined.

2011/12 TARGET: 97%

2008 ACTUAL: 83.8%

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

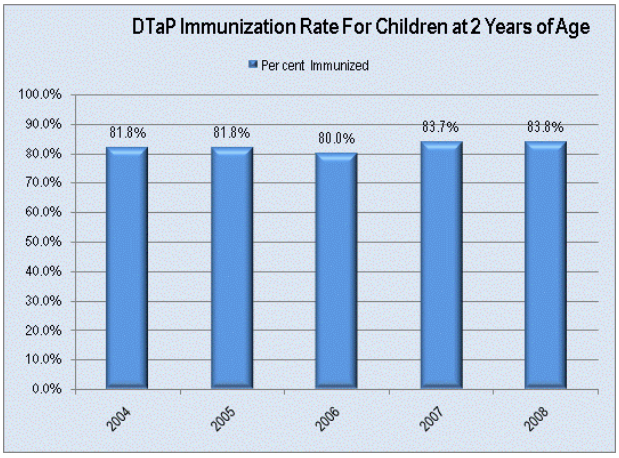
A data quality assessment is not available for this data at this time.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



Source: Alberta Health & Wellness and Alberta Health Services

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

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

Subsequent actions planned: Identify common barriers and individual zone barriers along with common strategies and individual zone strategies. Identify common evidence based strategies that can be implemented across the province and others that can be implemented in each zone.

WHAT ELSE DO WE KNOW?

There are pockets of low immunization across the province.

Information is available by zone.

HOW DO WE COMPARE?

Limited comparable data is available. In 2007, Manitoba reported 73.3 per cent of children were complete for DTaP, 88.0 per cent for Polio and 79.3 per cent for Hib by the age of two years. British Columbia reported that 75 per cent of children born in 2009 were up-to-date by two years of age for D/T/aP/IPV/HIB (BC Centre for Disease Control 2012).

Performance Measure Update

Childhood Immunization Rate for Measles, Mumps, Rubella

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

PERFORMANCE STATUS

Status to be determined

2011/12 TARGET: 98%

2008 ACTUAL: 89.3%

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

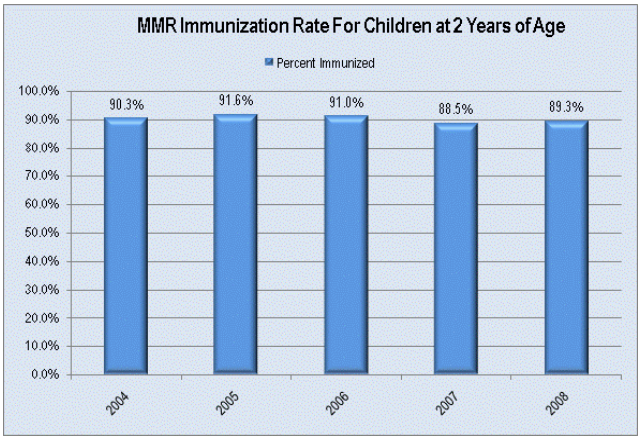
A data quality assessment is not available for this data at this time.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



Source: Alberta Health & Wellness and Alberta Health Services

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

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

Subsequent actions planned: Identify common barriers and individual zone barriers along with common strategies and individual zone strategies. Identify common evidence based strategies that can be implemented across the province and others that can be implemented in each zone.

WHAT ELSE DO WE KNOW?

There are pockets of low immunization across the province.

Information is available by zone.

HOW DO WE COMPARE?

Limited comparable data is available. In 2007, Manitoba reported 86.5 per cent of children were complete for Measles, 86.4 per cent for Mumps and 86.4 per cent for Rubella by two years. British Columbia reported that 75 per cent of children born in 2009 were up-to-date by two years of age for MMR (BC Centre for Disease Control 2012).

Albertans Enrolled in a Primary Care Network (%)

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

PERFORMANCE STATUS

Status to be determined.

2011/12 TARGET: TBD

ACTUAL: 75% **(April 2012)**

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

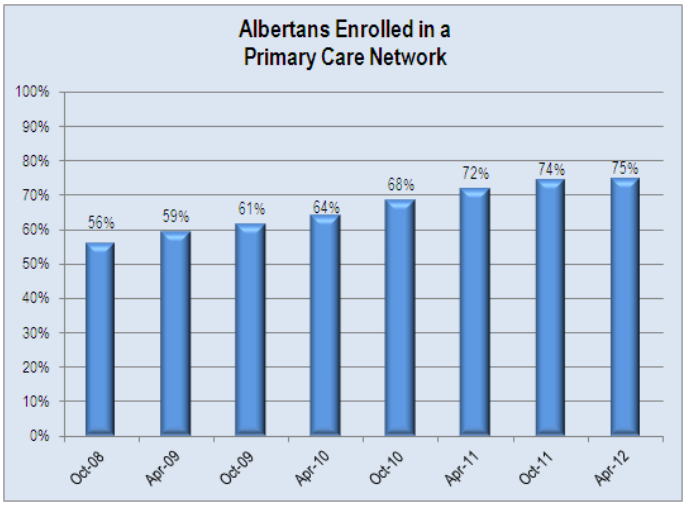
A PCN is an arrangement between a group of family physicians and Alberta Health Services (AHS) to provide and coordinate a comprehensive set of primary health care services to patients. Primary Care is the care individuals receive at the first point of contact with the healthcare system. Patients receive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

WHAT IS THE TARGET?

Targets are currently being developed for this indicator.

HOW ARE WE DOING?

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



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

WHAT ACTIONS ARE WE TAKING?

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

Subsequent actions planned: Nurse practitioners are being recruited into the FCC's, with a target of 14 FTE's.

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

Reference: Primary Care Initiative Program Management Office

HOW DO WE COMPARE?

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

Performance Measure Update

Admissions for Ambulatory Care Sensitive Conditions

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

PERFORMANCE STATUS

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

2011/12 TARGET: 297 admissions per 100,000

2011/12 ACTUAL: 278 admissions per 100,000

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

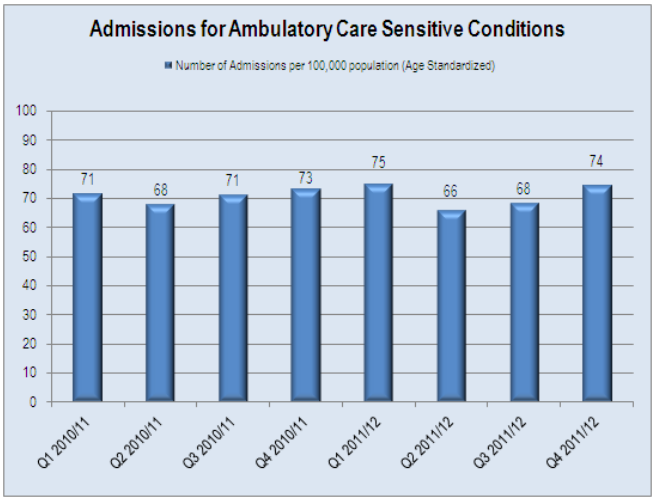
An internal review of the data quality indicates a high level of confidence with limited issues.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



Source: AHS Discharge Abstract Database

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

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

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

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

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

Performance Measure Update

Family Practice Sensitive Conditions

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

PERFORMANCE STATUS

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

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

2011/12 ACTUAL: 26.4% of ED/UCC visits

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

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

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

WHY IS THIS IMPORTANT?

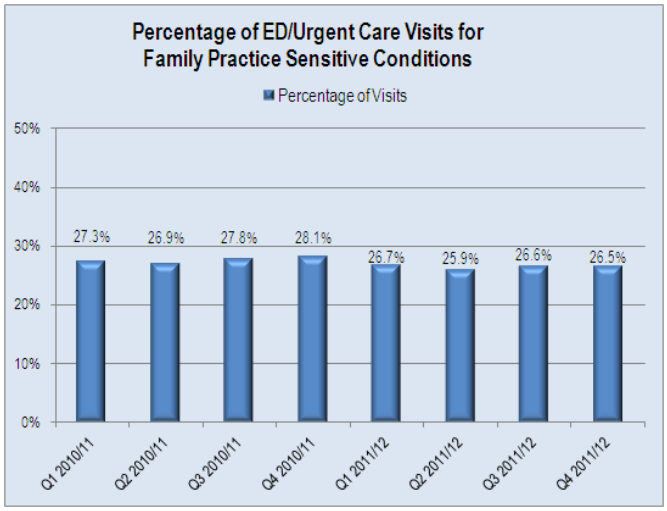
Treatment when appropriate at family physician offices allows for proper follow up and better patient outcomes. The expectation is that more effective provision of primary care services would result in improvement in this measure.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established the target for family practice sensitive conditions at 25 per cent of ED or urgent care visits.

HOW ARE WE DOING?

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



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

WHAT ACTIONS ARE WE TAKING?

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

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

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available

Performance Measure Update

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

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

PERFORMANCE STATUS

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

2011/12 TARGET: 85%

2011/12 ACTUAL: 81.0%

WHAT IS BEING MEASURED?

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

WHY IS THIS IMPORTANT?

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

Detailed indicator definition is available.

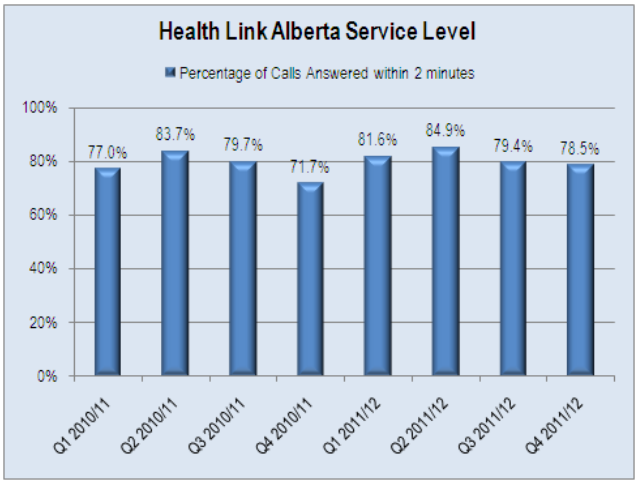
An internal review of the data quality indicates a very high level of confidence with no known issues.

WHAT IS THE TARGET?

Alberta Health Services has established a 2011/12 annual target of 85 per cent of calls to be answered within two minutes.

HOW ARE WE DOING?

The percentage of Health Link Alberta calls answered within two minutes was 78.5 per cent for Q4 2011/12, and the Year to Date (YTD) performance was 81.0 per cent.



Source: Health Link Alberta, Nortel Contact Centre Management 6.0

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: HealthLink Alberta played an expanded, dual role in a public education campaign launched by AHS. This campaign promoted the province wide telephone health information and advice service as one of a wide range of available health services, which also include family doctors, walk-in clinics and urgent care centres. During the campaign and on an ongoing basis, HealthLink Alberta also educates callers about these options. This campaign involved radio spots and signage at hospitals and other health-care facilities as part of the overall strategy to reduce pressures in emergency departments by ensuring Albertans receive the right care in the right place.

Subsequent actions planned: Implementation of stage one of strategy for the Health Link Alberta 5-year Plan. Development of Business Case and Charters for the 5-year plan. Continue to monitor progress.

WHAT ELSE DO WE KNOW?

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

HOW DO WE COMPARE?

National benchmark comparisons are not available.

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

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

PERFORMANCE STATUS

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

2011/12 TARGET: 90%

2011/12 ACTUAL: 76%

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

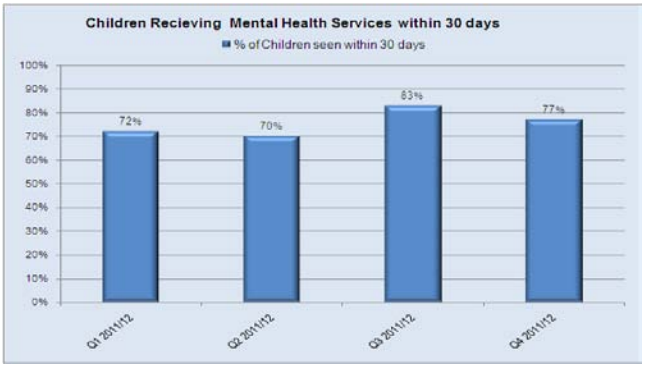
An internal review of the data quality indicates a high level of confidence with limited issues.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



Source: AHS Mental Health Services

Notes:

1. These results are limited to children enrolled in programs at community mental health clinics across Alberta.
2. Results from Edmonton Northgate clinic are an under-representation as some data quality issues exist. Improvements in data collection processes are being explored.
3. This indicator includes all children under 18 years of age.
4. These results exclude some enrolments that have not been completed within the selected time period.
5. Waiting times from other areas of the service continuum are not included (such as cases from select outpatient areas, inpatient facilities, general practitioners, private psychiatrists/ psychologists, and contracted service agencies.) These results are the most readily available information, and when results from other areas of the mental health continuum become consistently available, they will be included.
6. Results reported in this analysis may differ slightly from previous documents due to updates in datasets.
7. Age is calculated at time of service (enrolment date).
8. Commencing fiscal year 2011-2012, results include information from Regional Access and Intake System for children enrolled in clinics in the Calgary Zone. The number of new enrolment for scheduled cases in the Calgary Zone is slightly under-represented as some data quality issues exist. Improvements in data collection processes are being explored.

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The Children's Mental Health Plan for Alberta, a three Year Action Plan supports a coordinated and collaborative approach to optimizing the mental health and well-being of infants, children and youth up to 24 years of age, and their families. The Mental Health Capacity Building component of the Children's Mental Health Plan has been fully implemented and staffed. For the Plan overall, 75+ staff have been hired. Full implementation of initiatives is ongoing in some of the Zones. Recruitment to positions continues. Additional Zone-specific actions completed are available here.

Subsequent actions planned: Financial / budget status report for all 23 actions underway. Consolidation / variance reports to guide service planning. Additional Zone-specific actions planned are available here.

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

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

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

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

PERFORMANCE STATUS

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

2011/12 TARGET: 1 week

2011/12 ACTUAL: 1.9 weeks

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

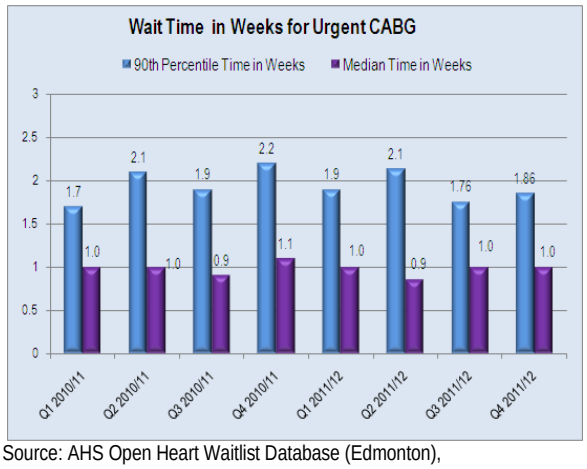
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources. Access in combination with a high quality of service delivery will help ensure optimal patient outcomes.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

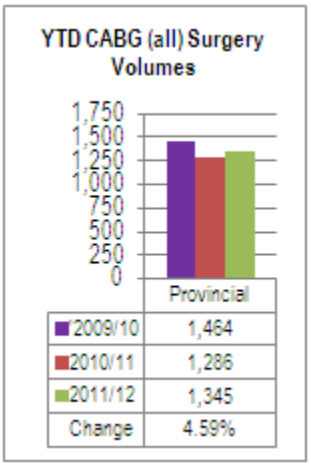
The wait time for urgent CABG surgery has increased between Q3 and Q4 and the year to date wait time remains longer than the annual target



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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Work is being done in relation to definitions for the Adult Access Targets for Surgery (aCATs) Scoring system. Cardiac surgery will follow the pilot surgical specialties in implementing aCats. Additional capacity added in February. Strategies are being developed to redistribute elective CABG waitlisted patients among surgeons. There has been an increase of over 4.6% in the total number of CABG surgeries performed annually compared to last year.



Subsequent actions planned: Undertake further collaboration with Cardiology to increase the awareness of wait times for each surgeon. Continue to update and maintain the surgical wait time database, identifying strategies for continuous improvement.

WHAT ELSE DO WE KNOW?

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

Information is available for sites performing this surgery.

HOW DO WE COMPARE?

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

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

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

PERFORMANCE STATUS

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

2011/12 TARGET: 2 week

2011/12 ACTUAL: 6.2 weeks

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

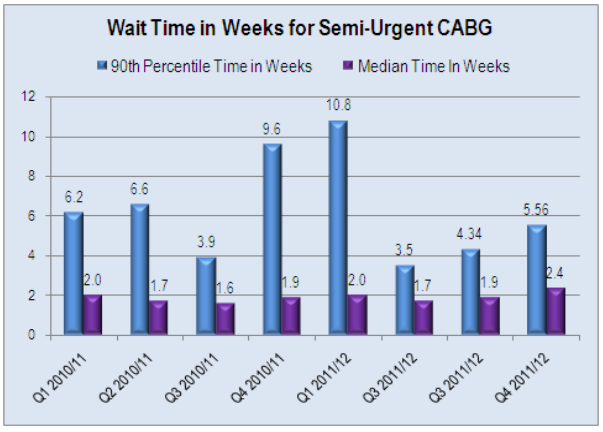
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources. Access in combination with a high quality of service delivery will help ensure optimal patient outcomes.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

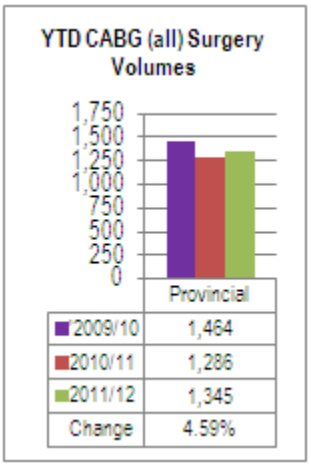
There was an increase in wait time for semi-urgent CABG surgery in the fourth quarter with the year to date value remaining higher than the annual target.



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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Work is being done in relation to definitions for the Adult Access Targets for Surgery (aCATs) Scoring system. Cardiac surgery will follow the pilot surgical specialties in implementing aCats. Additional capacity added in February. Strategies are being developed to redistribute elective CABG waitlisted patients among surgeons. There has been an increase of over 4.6% in the total number of CABG surgeries performed annually compared to last year.



	Provincial
2009/10	1,464
2010/11	1,286
2011/12	1,345
Change	4.59%

Subsequent actions planned: Undertake further collaboration with Cardiology to increase the awareness of wait times for each surgeon. Continue to update and maintain the surgical wait time database, identifying strategies for continuous improvement.

WHAT ELSE DO WE KNOW?

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

Information is available for sites performing this surgery.

HOW DO WE COMPARE?

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

Performance Measure Update

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

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

PERFORMANCE STATUS

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

2011/12 TARGET: 6 weeks

2011/12 ACTUAL: 28.8 weeks.

WHAT IS BEING MEASURED?

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

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

Patients whose urgency level changed are excluded.

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

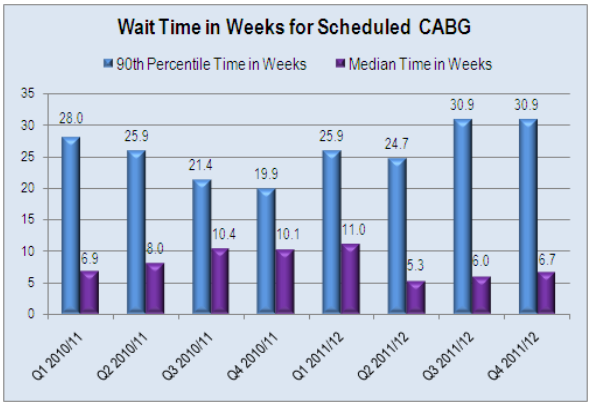
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources. Access in combination with a high quality of service delivery will help ensure optimal patient outcomes.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

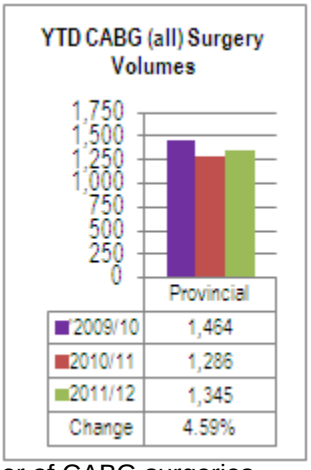
While the wait time for scheduled CABG surgery has remained consistent at 30.9 weeks over the past two quarters, the year to date wait time remains worse than target.



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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Work is being done in relation to definitions for the Adult Access Targets for Surgery (aCATs) Scoring system. Cardiac surgery will follow the pilot surgical specialties in implementing aCats. Additional capacity added in February. Strategies are being developed to redistribute elective CABG waitlisted patients among surgeons. There has been an increase of over 4.6% in the total number of CABG surgeries performed annually compared to last year.



	Provincial
2009/10	1,464
2010/11	1,286
2011/12	1,345
Change	4.59%

Subsequent actions planned: Undertake further collaboration with Cardiology to increase the awareness of wait times for each surgeon. Continue to update and maintain the surgical wait time database, identifying strategies for continuous improvement.

WHAT ELSE DO WE KNOW?

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

Information is available for sites performing this surgery.

HOW DO WE COMPARE?

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

Performance Measure Update

Hip Replacement Wait Time

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

PERFORMANCE STATUS

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

2011/12 TARGET: 27 weeks

2011/12 ACTUAL: 39.8 weeks

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available. Definition will be revised for future reporting.

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

WHY IS THIS IMPORTANT?

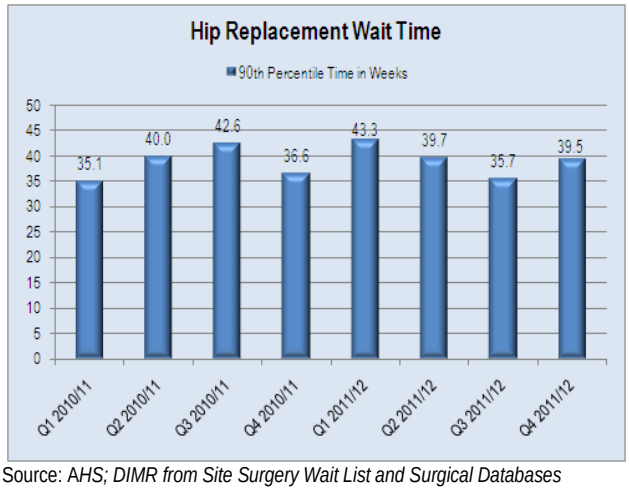
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

The provincial/territorial benchmark for hip replacement surgeries is within 26 weeks. The Alberta target for 2010/11 is 27 weeks.

HOW ARE WE DOING?

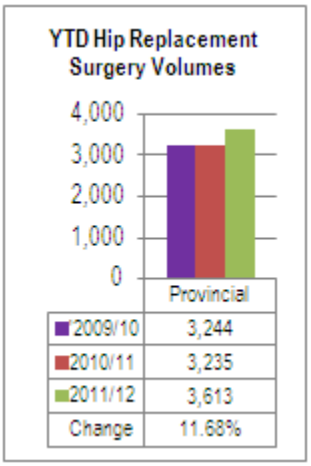
The wait time for hip replacement surgery in Q4 2011/12 was 39.5 weeks which has risen since Q3. The Year to Date (YTD) wait time was 39.8 weeks, which is longer than the target.



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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: All zones increased the number of hip surgeries to meet additional surgeries approved for this fiscal year. More hip replacement surgeries have been done this fiscal year than for either of the past two fiscal years with an 11.7% increase from last year to this year in surgical volume. There is a focused approach to clearing up existing wait lists in an effort to ensure that the existing waitlists are accurate and patients are receiving the appropriate care.



	Provincial
2009/10	3,244
2010/11	3,235
2011/12	3,613
Change	11.68%

Additional details area available at the zone level.

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

WHAT ELSE DO WE KNOW?

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

HOW DO WE COMPARE?

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

Performance Measure Update

Knee Replacement Wait Time

Data updated quarterly
Most current data is Q4 2011/12
Data update expected for Q1 Report

PERFORMANCE STATUS

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

2011/12 TARGET: 35 weeks

2011/12 ACTUAL: 48.0 weeks

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator definition is available. Definition will be revised for future reporting.

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

WHY IS THIS IMPORTANT?

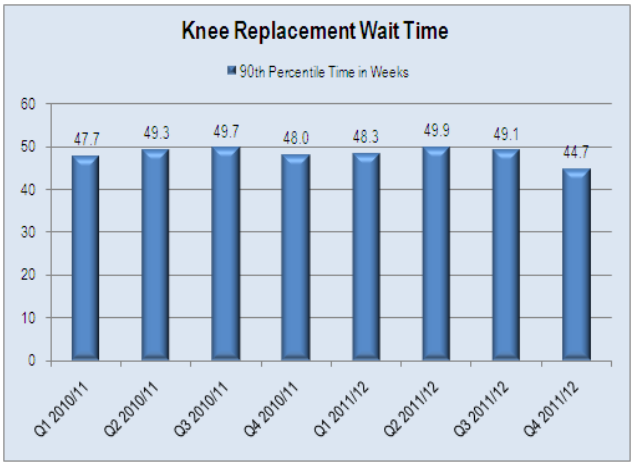
Wait times for surgical procedures are used as an indicator of access to the health care system and reflect the efficient use of resources.

WHAT IS THE TARGET?

The provincial/territorial benchmark for knee replacement surgeries is within 26 weeks. The Alberta target for 2011/12 is 35 weeks.

HOW ARE WE DOING?

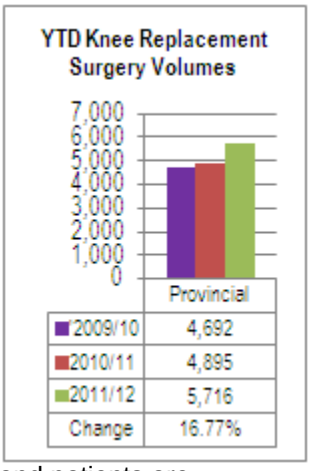
The wait time for knee replacement surgery in Q4 2011/12 was 44.7 weeks which has improved since the prior quarter. The Year to Date (YTD) wait time was 48.0 weeks which is longer than the target.



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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: All zones increased the number of knee surgeries to meet additional surgeries approved for this fiscal year. More knee replacement surgeries have been done this fiscal year than for either of the past two fiscal years with a 16.8% increase from last year to this year in surgical volume.. There is a focused approach to clearing up existing wait lists in an effort to ensure that the existing waitlists are accurate and patients are receiving the appropriate care.



	Provincial
2009/10	4,692
2010/11	4,895
2011/12	5,716
Change	16.77%

Additional details are available at the zone level

Subsequent actions planned: Process changes are being looked at on a zone by zone basis to increase efficiencies. Post operative care standards are being implemented as per Provincial hip and knee care pathway. Additional details are available at the zone level.

WHAT ELSE DO WE KNOW?

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

Information is available by site.

HOW DO WE COMPARE?

Using a similar measure in 2011, Alberta ranked fifth among the 10 provinces for knee replacement surgery wait times. Alberta = 49.1 weeks, Best Performing Province = 31.3 weeks (Ontario), Canada = 39.7 weeks (CIHI, 2011).

Performance Measure Update

Cataract Surgery Wait Time

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

PERFORMANCE STATUS

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

2011/12 TARGET: 30 weeks

2011/12 ACTUAL: 35.1 weeks

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator definition is available.

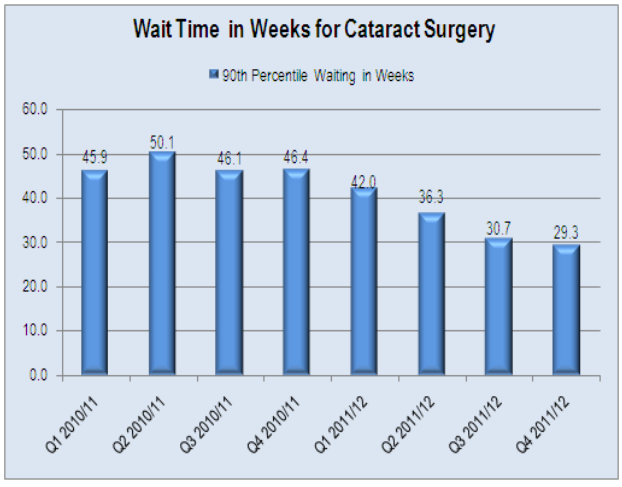
An internal review of the data quality indicates a questionable level of confidence with known issues.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

The provincial/territorial benchmark for high risk cataract surgeries is within 16 weeks. The target for 2011/12 is 30 weeks.



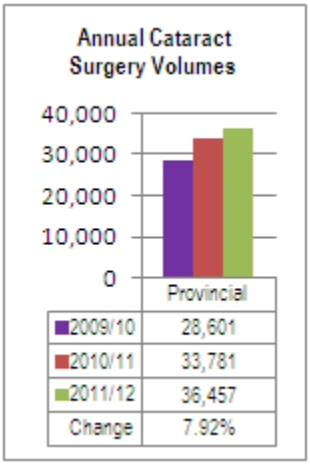
Source: Alberta Health & Wellness
Q4 2011/12 numbers are preliminary pending verification.

HOW ARE WE DOING?

The 90th percentile wait time for Cataract Surgery for Q4 2011/12 was 29.3 weeks which is better than the prior quarter. There has been a steady decline in the Cataract wait times over the past two years. The Year to Date (YTD) wait time was 35.1 weeks which is longer than the target.
Alberta Waitlist Registry volume of cataract surgeries completed for 2011/12 was 36,457.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Increases to the number of cataract surgeries have continued to bring wait times down. There have been more than 36,000 cataract surgeries this fiscal year which represents an increase of 8% in cataract surgery volume over last year. Further Zone-specific actions completed are available here.



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

WHAT ELSE DO WE KNOW?

Information is available by zone.

HOW DO WE COMPARE?

Using a similar measure in 2011, Alberta ranked tenth among the 10 provinces for cataract surgery wait times. Alberta = 39.3 weeks, Best Performing Province = 17.3 weeks (Ontario), Canada = 21.1 weeks (CIHI, 2011).

Performance Measure Update

Other Scheduled Surgery Wait Time

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

PERFORMANCE STATUS

Performance target for 2011/12 is not yet established.

2011/12 TARGET: TBD

2011/12 ACTUAL: 25.9 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.

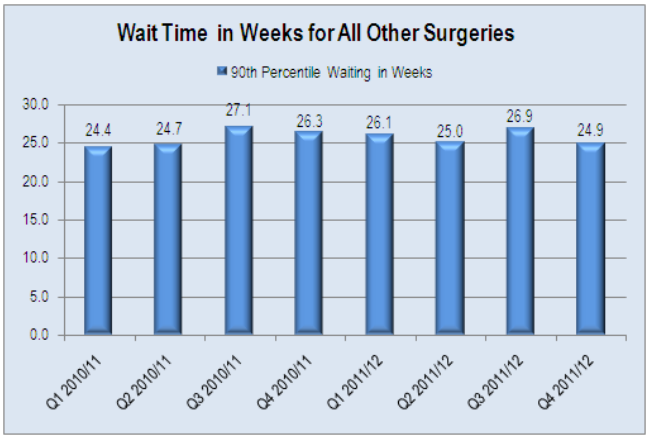
An internal review of the data quality indicates a questionable level of confidence with known issues.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

No wait time target for other scheduled surgeries has been defined.

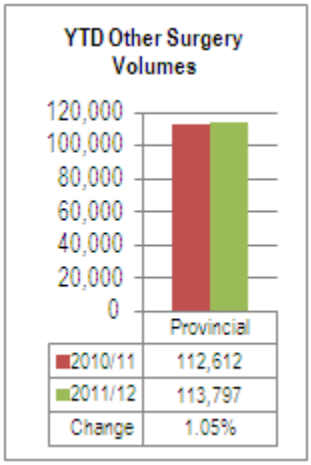


Source: Alberta Health & Wellness

HOW ARE WE DOING?

Using latest developed measurement methodology (under review) 90th percentile wait times for other surgeries was 24.9 weeks for Q4 2011/12. This is slightly better than the prior quarter. Taking all quarters into account, the year to date wait time is 25.9 weeks.

WHAT ACTIONS ARE WE TAKING?



Actions completed to date: Over 1,100 additional scheduled surgeries for other procedures have been performed this year compared to last year. This is an increase of just over 1%. Additional Bariatric surgeries have been done in a number of zones as part of the overall AHS Obesity Strategy. A number of actions are underway to reduce the wait time for surgical procedures including developing common surgical pathways; developing patient condition/diagnosis descriptions and recommended wait time targets for each surgical specialty group; creating new and innovative contracting methodologies for non-hospital surgical facilities (NHSF) and others.

Subsequent actions planned: Diagnosis and urgency access targets and related wait time management system being developed through the ACATS pilot. As of March 31, 2012, pilot is ready to launch at 9 sites for 7 surgical sub-specialties

WHAT ELSE DO WE KNOW?

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)

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

PERFORMANCE STATUS

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

2011/12 TARGET: 4 weeks

2011/12 ACTUAL: 5.3 weeks

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

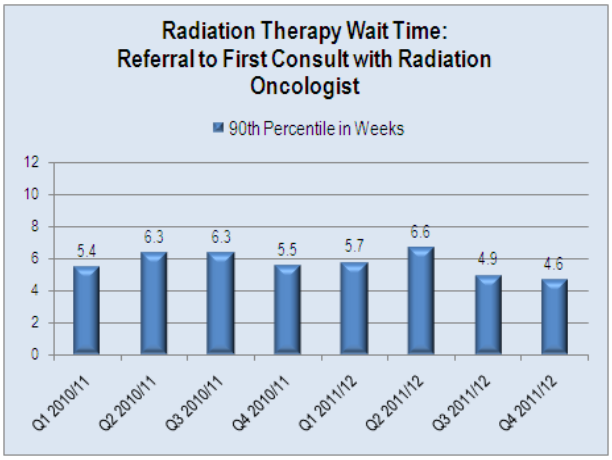
Wait times are an important measure of how quickly people are getting access to cancer care. They reflect the ability of Alberta Health Services (AHS) to meet the needs of cancer patients.

WHAT IS THE TARGET?

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

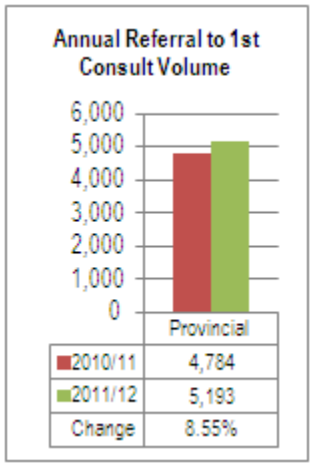
HOW ARE WE DOING?

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



Source: EBI-2009-009 – Timeliness of care – referral to first consult by consult type and facility
Note: Jack Ady Cancer Centre (Lethbridge) data is included as of Q3 2010/11.

WHAT ACTIONS ARE WE TAKING?



Actions completed to date: AHS Improvement Way (AIW) training has been initiated and is ongoing. There has been the development of Steering Committees at all three centers to ensure that appropriate communication and decision making can occur. Each Steering Committee has representation from all groups involved in the process. Review of the current scheduling of patients within the Outpatient Department (OPD) is in progress. Currently collecting and then reviewing data collected with regards to scheduling and utilization of space and manpower at all centers. There are just under 9% more patients receiving a first consult visit this year as compared to last.
Subsequent actions planned: Continue working on the Quality Improvement project during phase one and two. Phase three will be the evaluation of the changes and the potential increase in resources that are needed to maintain the changes and to decrease the wait times further.

WHAT ELSE DO WE KNOW?

Sometimes referrals are missing important medical information cancer specialists require before they meet with the patient. We are working with referring physicians to improve this situation. Information is available by site.

HOW DO WE COMPARE?

National benchmark comparisons are not currently available but are under development. Ontario targets 14 days from the time between a referral to a specialist to the time of consult with the patient. Current trends indicate that about 72 per cent of patients are seen within this target (Cancer Care Ontario, December 2011).

Performance Measure Update

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

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

PERFORMANCE STATUS

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

2011/12 TARGET: 4 weeks

2011/12 ACTUAL: 3.1 weeks

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator definition is available.

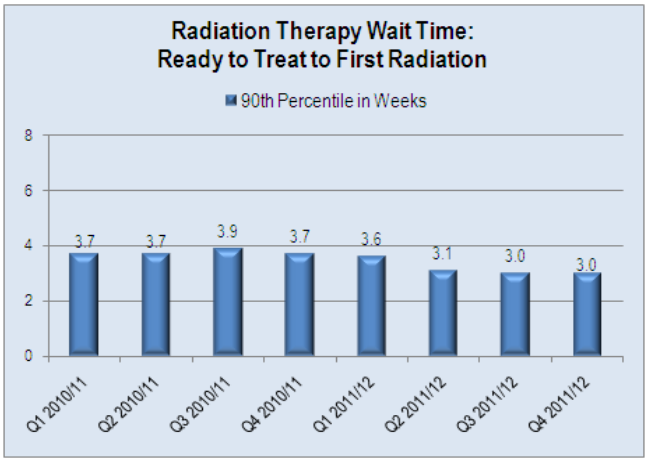
An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



Source: EBI -2009-010 Radiation Therapy Time From Ready to Treat to First Radiation Treatment by Institution
Note: Jack Ady Cancer Centre (Lethbridge) data is included as of Q3 2010/11.

HOW ARE WE DOING?

The proportion of patients receiving radiation therapy within the expected time period is better than the target. The Q4 2011/12 90th percentile time was 3.0 weeks, however the year to date 90th percentile time is 3.1 weeks.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Benchmark for this measure is 4 weeks; the provincial Q4 average is 3.0 weeks and the annual average is 3.1 weeks. Cancer care wait time is better than the target and will continue to work to maintain this wait time.

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

WHAT ELSE DO WE KNOW?

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

Information is available by site.

HOW DO WE COMPARE?

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

Performance Measure Update

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

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

PERFORMANCE STATUS

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

2011/12 TARGET: 75%

2011/12 ACTUAL: 65%

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

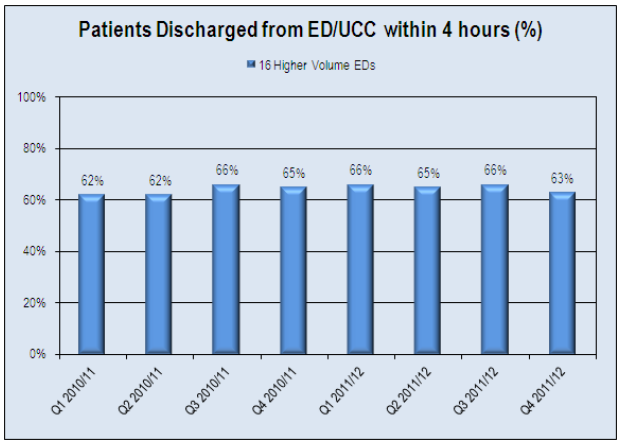
The amount of time spent waiting for treatment is a measure of access to the health care system. Patients treated in the ED/UCC should receive care in a timely fashion. Excessive wait times for care can result in treatment delays for individual patients and reduced efficiency in the flow of patients.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a 2011/12 target of 75 per cent of patients discharged within four hours for the 16 higher volume EDs.

HOW ARE WE DOING?

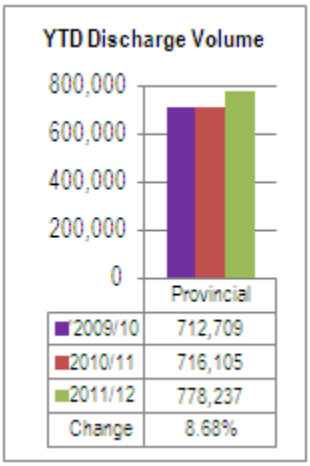
In Q4 2011/12, 63 per cent of patients at the 16 higher volume EDs were discharged within four hours.



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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: ED flow capacity for patients treated and subsequently discharged at the 16 higher volume EDs has been increased by almost 9% over last year. Detailed Zone-specific actions completed are available here.



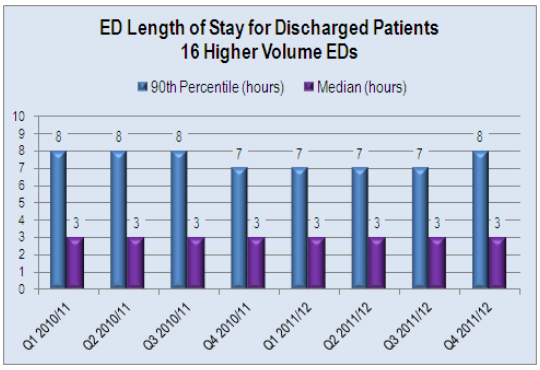
Subsequent actions planned: Process improvement efforts will continue across all Zones to continue to provide capacity and have overcapacity protocols in place. Detailed Zone-specific actions planned are available here.

WHAT ELSE DO WE KNOW?

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

Information is available by site.

Weekly ED Length of Stay (LOS) is available for a subset of sites where more timely data is available.



Median and 90th Percentile data are available by site.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

Performance Measure Update

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

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

PERFORMANCE STATUS

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

2011/12 TARGET: 84%

2011/12 ACTUAL: 80%

WHAT IS BEING MEASURED?

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

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

This ED/UCC measure is presented for all sites.

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

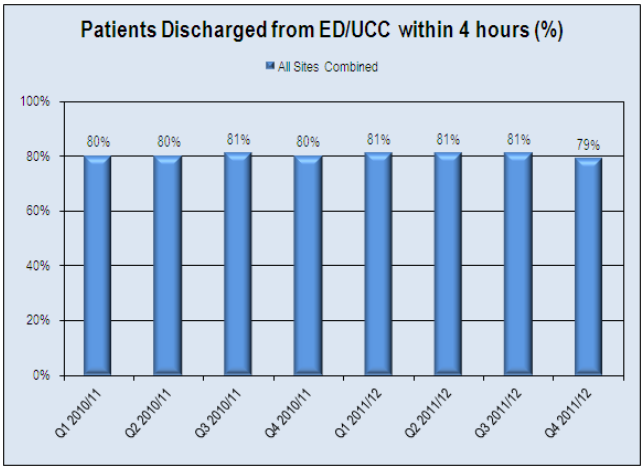
The amount of time spent waiting for treatment is a measure of access to the health care system. Patients treated in the ED/UCC should receive care in a timely fashion. Excessive wait times for care can result in treatment delays for individual patients and reduced efficiency in the flow of patients.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target for 2011/12 of 84 per cent of patients discharged within four hours for all sites.

HOW ARE WE DOING?

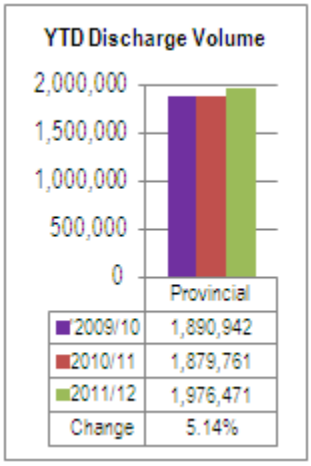
In Q4 2011/12, 79 per cent of patients at all EDs were discharged within four hours.



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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: ED flow capacity for patients treated and subsequently discharged at all ED sites has been increased by over 5% over last year. Detailed Zone-specific actions completed are available here.



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

WHAT ELSE DO WE KNOW?

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

Information is available by zone and site.

Weekly ED Length of Stay (LOS) is available for a subset of sites where more timely data is available.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

Performance Measure Update

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

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

PERFORMANCE STATUS

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

2011/12 TARGET: 60%

2011/12 ACTUAL: 45%

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

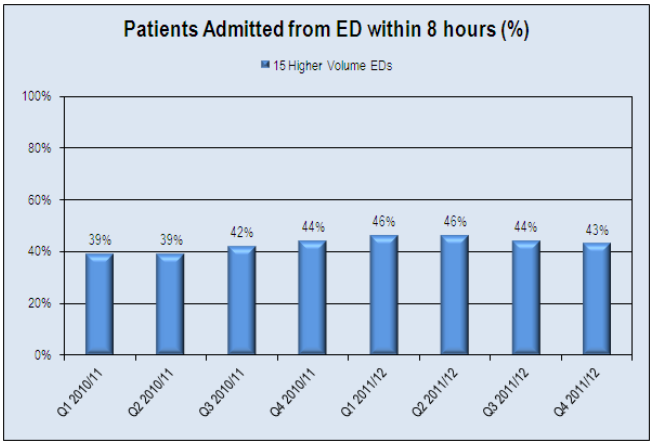
ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent can be a measure of access to the health care system and a reflection of efficient use of resources.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

In Q4 2011/12, 43 per cent of admitted patients at the 15 higher volume EDs left the ED within eight hours.

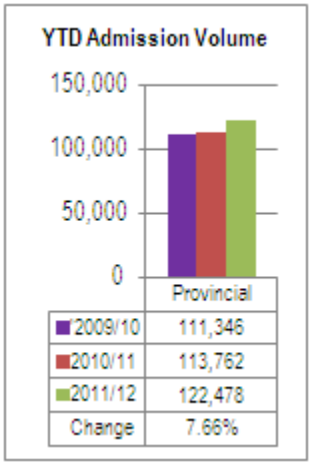


Source: Calgary and Edmonton Emergency Department Information System Data (REDIS,EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: ED flow capacity for patients treated and subsequently admitted at the 15 higher volume EDs has been increased by 7.7% over last year. Additional Zone-specific actions completed to date are available here.

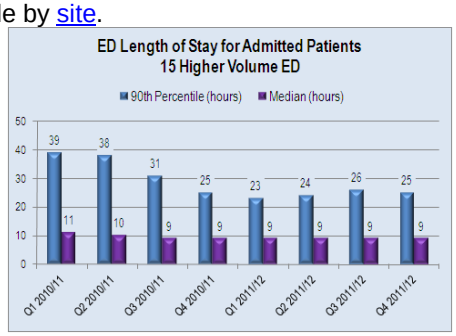
Subsequent actions planned: Process improvement efforts will continue across all Zones to continue to provide capacity and have overcapacity protocols in place. Additional Zone-specific actions planned are available here.



WHAT ELSE DO WE KNOW?

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

Weekly ED Length of Stay (LOS) is available for a subset of sites where more timely data is readily available. Median and 90th Percentile data are available by site.



HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

Performance Measure Update

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

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

PERFORMANCE STATUS

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

2011/12 TARGET: 65%

2011/12 ACTUAL: 55%

WHAT IS BEING MEASURED?

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

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

Detailed definition is available.

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

WHY IS THIS IMPORTANT?

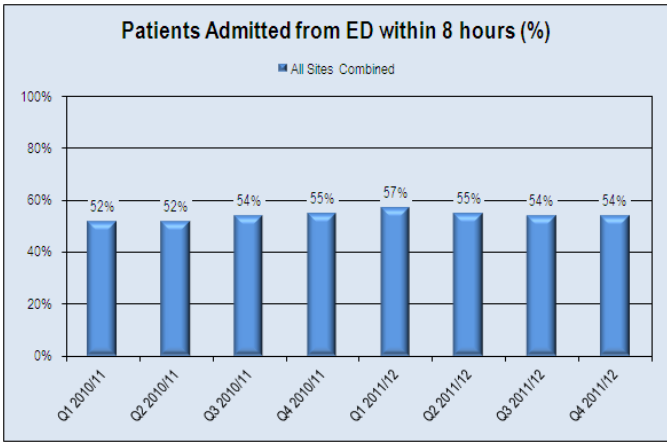
ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent by a patient in an ED can be a measure of access to the health care system and a reflection of efficient use of resources.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target for all ED sites combined of 65 per cent of patients admitted leaving the ED within eight hours for 2011/12.

HOW ARE WE DOING?

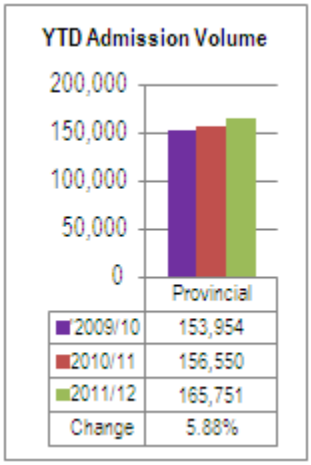
In Q4 2011/12, 54 per cent of admitted patients left the ED within eight hours which is below the target of 65 per cent.



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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: ED flow capacity for patients treated and subsequently admitted at all EDs has been increased just under 6% over last year. Additional Zone-specific actions completed to date are available here.



	Provincial
2009/10	153,954
2010/11	156,550
2011/12	165,751
Change	5.88%

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

Additional Zone-specific actions planned are available here.

WHAT ELSE DO WE KNOW?

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

Information is available by site and zone.

Weekly ED Length of Stay (LOS) is available for a subset of sites where more timely data is available.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

Performance Measure Update

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

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

PERFORMANCE STATUS

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

2011/12 TARGET: 375

2011/12 ACTUAL: 467 (Mar 2012)

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

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

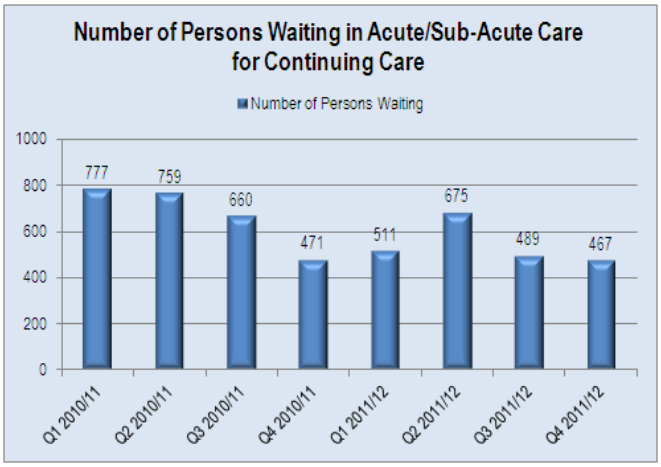
WHY IS THIS IMPORTANT?

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

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

WHAT IS THE TARGET?

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

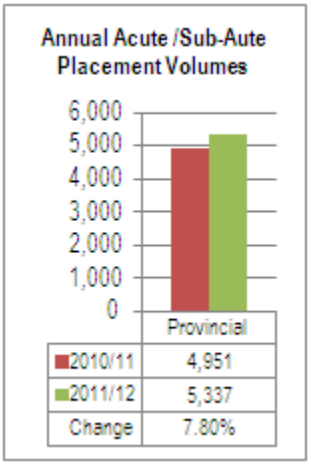


Source: AHS "Snapshots" of the Wait List at the end of the report period.

HOW ARE WE DOING?

At the end of 2011/12, 467 people were waiting in acute/sub-acute (hospital) beds for continuing care placement. While not achieving target, an improving trend has been seen over the past two years.

WHAT ACTIONS ARE WE TAKING?



Actions completed to date: Additional beds are now available including new Long Term Care and Supportive Living (SL) options. AHS continues to add continuing care beds. In 2010/11, 1,155 beds were added to the system and 1,002 beds were opened as of 2011/2012, which reflects 100% of the target, bringing the total number of continuing care beds in the province to nearly 21,700 AHS will continue to open more continuing care capacity in 2012/2013, with 1,133 new beds. AHS is on track to add more than 5,300 beds between 2010 and 2015. Home Care services continue to be expanded across the province. Zone-specific actions completed to date are available here.

Subsequent actions planned: Continue to add new beds in zones. Zone-specific actions planned are available here.

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

Relevant national comparisons will be included as available.

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

People Waiting in Community for Continuing Care Placement

PERFORMANCE STATUS

Performance is outside acceptable range, take action and monitor progress

2011/12 TARGET: 900

2011/12 ACTUAL: 1,002 (Mar 2012)

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

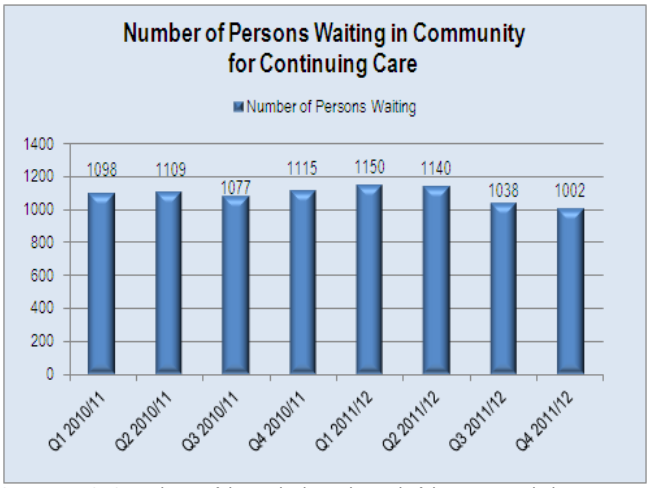
Access to continuing care services is a significant issue in Alberta. As such, a focused, multiple-strategy approach is needed to provide both seniors and persons with disabilities more options for quality accommodations specific to their service needs and lifestyles.

WHAT IS THE TARGET?

The target for 2011/12 is for 900 or fewer people to be waiting in the community (at home) for continuing care placement. This is a decrease from the baseline of 1,065 in 2008/09.

HOW ARE WE DOING?

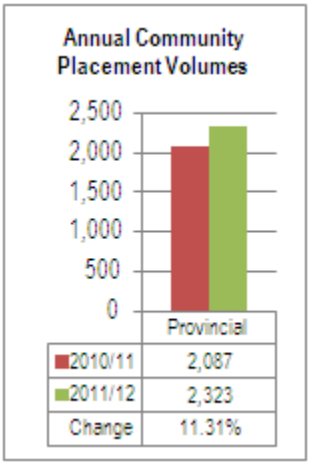
At the end of 2011/12, 1,002 people were waiting in the community (at home) for continuing care placement, which is not achieving the target.
On a Year to Date basis, 11.31% more people have been placed this year than last.



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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Additional beds are now available including new Long Term Care and Supportive Living (SL) options. AHS continues to add continuing care beds. In 2010/11, 1,155 beds were added to the system and 1,002 beds were opened as of 2011/2012, which reflects 100% of the target, bringing the total number of continuing care beds in the province to nearly 21,700. AHS will continue to open more continuing care capacity in 2012/2013, with 1,133 new beds. AHS is on track to add more than 5,300 beds between 2010 and 2015. Home Care services continue to be expanded across the province. Detailed Zone-specific actions completed to date are available here.



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

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

No national benchmark comparisons were found.

Performance Measure Update

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

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

PERFORMANCE STATUS	2011/12 TARGET: TBD
Performance Target for 2011/12 has not been established for comparison.	2011/12 ACTUAL: 41 days

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is currently in development.

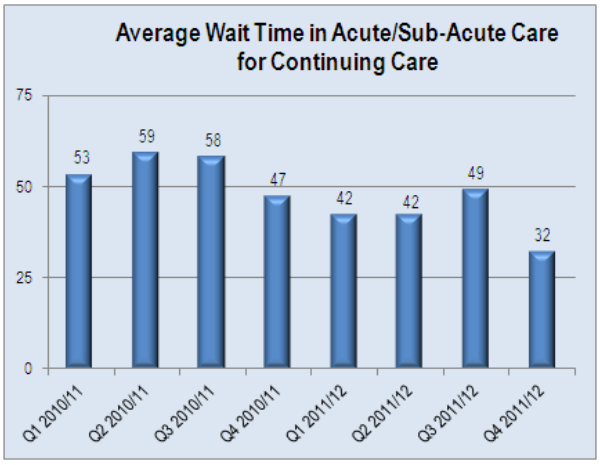
An internal review of the data quality indicates an acceptable level of confidence with known issues.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

Targets are currently being developed for this indicator.



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

HOW ARE WE DOING?

The average wait time in acute/sub-acute care for continuing care was 32 days in Q4 of 2011/12. The 2011/12 annual average wait time was 41 days.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Additional beds are now available including new Long Term Care and Supportive Living (SL) options. AHS continues to add continuing care beds. In 2010/11, 1,155 beds were added to the system and 1,002 beds were opened as of 2011/2012, which reflects 100% of the target, bringing the total number of continuing care beds in the province to nearly 21,700 AHS will continue to open more continuing care capacity in 2012/2013, with 1,133 new beds. AHS is on track to add more than 5,300 beds between 2010 and 2015. Home Care services continue to be expanded across the province.

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

WHAT ELSE DO WE KNOW?

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Performance Measure Update

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

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

PERFORMANCE STATUS	2011/12 TARGET: TBD
Performance target has not been established for comparison.	2011/12 ACTUAL: 64%

WHAT IS BEING MEASURED?

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

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

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

Detailed indicator definition is available.

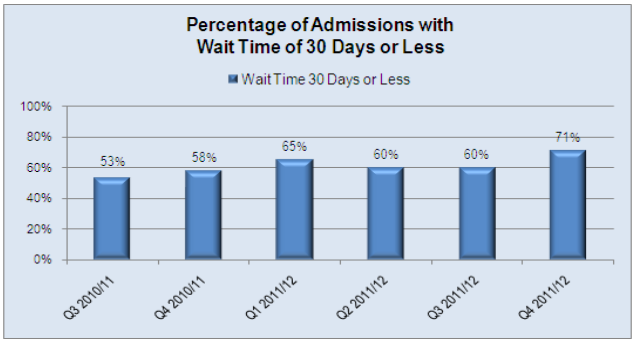
An internal review of the data quality indicates an acceptable level of confidence with known issues.

WHY IS THIS IMPORTANT?

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

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

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



Source: Continuing Care Wait Time Data

WHAT IS THE TARGET?

AHS has not established a target for this measure.

HOW ARE WE DOING?

The percentage of patients placed in Supportive Living or Long Term Care within 30 days of being assessed was 71 per cent in Q4 of 2011/12. The year to date (YTD) percentage was 64 per cent for April 2011 to March 2012.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Additional beds are now available including new Long Term Care and Supportive Living (SL) options. AHS continues to add continuing care beds. In 2010/11, 1,155 beds were added to the system and 1,002 beds were opened as of 2011/2012, which reflects 100% of the target, bringing the total number of continuing care beds in the province to nearly 21,700 AHS will continue to open more continuing care capacity in 2012/2013, with 1,133 new beds. AHS is on track to add more than 5,300 beds between 2010 and 2015. Home Care services continue to be expanded across the province.

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

WHAT ELSE DO WE KNOW?

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

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

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Performance Measure Update

Number of Home Care Clients

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

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.

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

Targets are currently being developed for this indicator.

HOW ARE WE DOING?

The number of unique / individual Home Living Clients was 67,709 in Q4 of 2011/12.

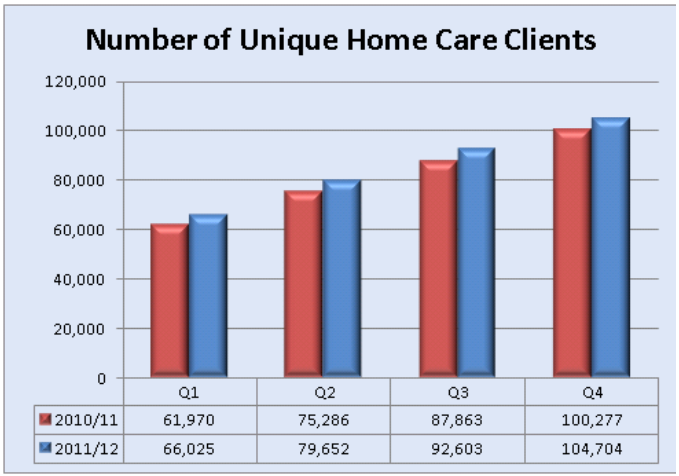


Chart represents the cumulative number of unique home care clients. For clients who come and go off the case load multiple times, they will only be counted once.

PERFORMANCE STATUS	2011/12 TARGET: TBD
Performance Target for 2011/12 has not been established for comparison.	2011/12 ACTUAL: 104,704

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: More seniors and adults with disabilities are able to remain safe and independent in their own homes as AHS continues to add home care clients. The target of adding 3,000 additional clients by March 2012 was exceeded by Q3 this year with an overall total of over 4,400 additional clients being added. A number of initiatives are underway to provide additional services to Home Care Clients. These initiatives range from hiring additional resources to increasing responsibilities such as allow Nurse Practitioners to have direct admitting privileges as well as establishing new focused teams. Detailed Actions completed are available by Zone.

Subsequent actions planned: With plans defined, hire into new positions where required, monitor other initiatives to determine their effectiveness and continue to implement new plans. Detailed Actions planned are available by Zone.

WHAT ELSE DO WE KNOW?

This measure now reports the cumulative number of unique home care clients over the year. This is a change from the prior methodology when the number of unique home care clients per quarter were reported. The new methodology ensures that a person who moves in and out of home care multiple times in a year is only counted once per year. Prior quarters (and years) have been restated to reflect the new methodology.

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Performance Measure Update

Rating of Care
Nursing Home – Family

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

PERFORMANCE STATUS	2011/12 TARGET: TBD
Performance target for 2011/12 has not been established for comparison.	2010/11 ACTUAL: 73.4%

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asked family members of Alberta nursing home residents about their rating of the care in the Alberta Long Term Care Family Experience Survey. The most recent report was released in 2012 and is based on a survey from November 2010 to February 2011.

Rating of Care Nursing Home – Family measures the overall family rating of care at Alberta nursing homes, on a scale from 0 to 10. , The per cent of respondents who rated overall level of care as 8, 9 or 10 on a scale of 1 to 10 is reported.

Detailed indicator definition is available.

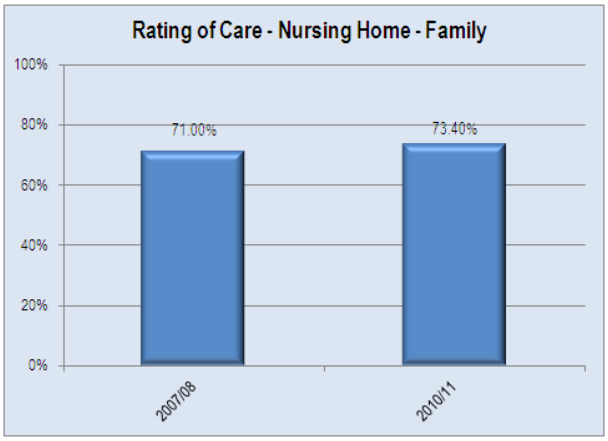
An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



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

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Facility specific reports and highlights sent to all providers. AHS received technical report. AHS Briefing Note on comparative results by facility and zones being prepared from HQCA information.

Subsequent actions planned: Each LTC facility will be required to provide an action plan based on their results as part of 2012-13 Quality Incentives Funding and Accountabilities. Zones will review results in their Quality Councils and discuss strengths and opportunities for improvement.

WHAT ELSE DO WE KNOW?

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

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

Information is available by zone.

HOW DO WE COMPARE?

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

Performance Measure Update

Head Count to FTE Ratio

Data updated quarterly
Most current data is Q4 201/12
Next data update expected for Q1 report

PERFORMANCE STATUS

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

2011/12 TARGET: 1.62

2011/12 ACTUAL: 1.55

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

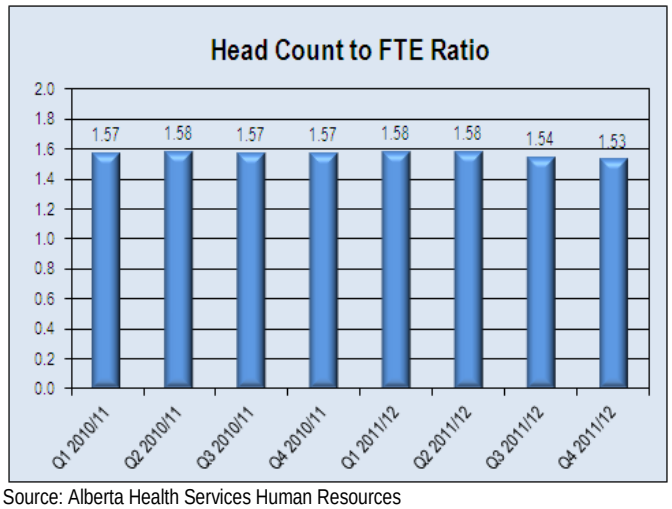
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

WHAT IS THE TARGET?

A target of 1.62 head count to FTE ratio has been established for 2011/12. This is a reduction from the 2010/11 target of 1.63.

HOW ARE WE DOING?

In 2009/10 and 2010/11, the head count to FTE ratio was 1.57. For 2011/12, the annual ratio was 1.55.



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

WHAT ACTIONS ARE WE TAKING?

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

Subsequent actions planned: Version 2 of the Tools for Operational Managers will have a section on increasing FTEs. This version was to be published February 2012 but has been rescheduled to May 2012. This will increase overall awareness of the plans to hire more FTE personnel.

The Manager Workforce Report continues to be refined to provide managers with effective information to support better workforce decision making. This includes developing roll-up reports in the 2012/13 fiscal year.

WHAT ELSE DO WE KNOW?

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

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

This measure does not include the Capital Care Group, Calgary Laboratory Services or Carewest entities even though these are wholly owned entities of AHS.

Information is available by portfolio.

HOW DO WE COMPARE?

This measure is not benchmarked externally.

Performance Measure Update

Registered Nurse Graduates Hired by AHS (%)

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

PERFORMANCE STATUS

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

2011/12 TARGET: 70%

2011/12 ACTUAL
Total: 98%+
Non-Casual: 67%

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

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

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

WHY IS THIS IMPORTANT?

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

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

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

AHS has hired a total of 1,652 (98%+) new nurse graduates (2011/12). Of these, 1,038 (67%) were hired into non-casual positions. This represents a significant improvement (20%) over AHS hiring of RN graduates in the previous fiscal year. By the end of fiscal year 2010/11 AHS hired 1,383 (87%) of nursing graduates. Of these, 653 (41%) were hired into non-casual positions.

The total estimated RN graduates for 2011/12 are 1,552. New grads hired are slightly higher than the estimated number of available (1,652 hired v. 1,552 available). The difference is likely the result of the methodology limitations described in the “What Is Being Measured” section.

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: A program has been put in place to promote AHS as an employer of choice to new graduates at a number of academic institutions in Alberta. Targeted recruitment of the April 2012 cohort is underway. Negotiations with UNA to improve and revitalize the Transitional Graduate Nurse Recruitment Program (TGNRP) as a proven mechanism for recruiting and retaining new grads have been successfully concluded. Recruitment for these positions commenced in January 2012. To date, 59 TGNRP full time positions have been filled (6 North Zone/17 South Zone/1 Edmonton Zone/16 Central Zone/19 Calgary Zone).

Subsequent actions planned: AHS is considering initiatives to cover expected growth; expected replacement; and time to bring in external candidates continues to improve. Supports for new grad nurses and managers have been developed to support the successful transition into the workplace. Rotations are being optimized through the Provincial Scheduling Transformation Project to increase full time/part time ratios, decrease overtime and deploy relief resources efficiently. 15 units are completed at the RAH in Edmonton. South Health Campus rotations are being finalized. 48 additional units will be done by end of June 2012. By July 2012, this project will also develop provincial master rotation guidelines and standardize staff scheduling rules and processes.

WHAT ELSE DO WE KNOW?

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

Information is available by portfolio.

HOW DO WE COMPARE?

This measure is not benchmarked externally.

Performance Measure Update

Disabling Injury Rate

Data updated quarterly
Most current data is Calendar Year (CY) 2012 Q1
Next data update expected for Q1 report

PERFORMANCE STATUS

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

2012 Calendar Year (CY) TARGET: 2.20

2012 CY Q1 (Jan-Mar) ACTUAL: 0.94
2012 CY ANNUALIZED: 3.87

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

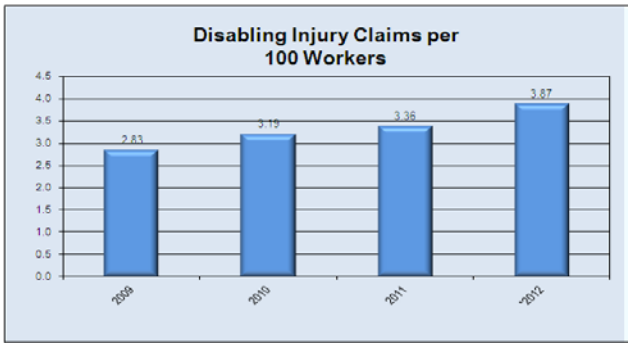
The performance of our health care system is directly related to the health and wellness of the people who provide care and services. AHS is committed to enabling staff to deliver high quality and safe care by providing the appropriate supports, such as education, a safe and supportive work environment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

WHAT IS THE TARGET?

AHS has established a target of 2.20 disabling injury claims per 100 workers.

HOW ARE WE DOING?

In 2009, AHS' disabling injury rate (DIR) was 2.83. In 2010 AHS' DIR was 3.19. This represents a 13% increase in the DIR over 2009. The target DIR for 2010 was 2.41. The AHS DIR actual in 2010 was 32% higher than target.
In 2011, AHS' DIR was 3.36. This represents a 5% increase in the DIR over 2010. The target DIR for 2011 was 2.20. The AHS DIR actual in 2011 was 53% higher than target.
For 2012 Q1, the actual DIR was 0.94 (cumulative Jan – Mar). If this rate continues through WCB's 2011 final reconciliation (a 15 month period), the DIR annual rate is projected to be 3.87.



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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: The three goals of the AHS Occupational Injury Action Plan are to prevent injuries, respond appropriately to injuries and support sustainable return to work for injured employees. Foundational components now in place include AHS commitment to a Safety "Value", the WHS Policy and Management System, the Shared Responsibility Framework, Hazard identification and Control, Incident Investigation program and a Job Demands Summary system. The "It's Your Move" safe client handling program continued across the province and has trained 4,500 staff to date. "Move Safe" manual materials handling pilot testing and training is complete. $5M of Ergonomic Equipment has been approved and delivered to operational sites. The Modified Work Standard and program has been launched in all Zones. Timely reporting to WCB is being monitored through portfolio Health and Safety Improvement Plans. A standard process for resolving long term WCB cases is being used in all Zones. Quarterly reporting of injury data at the AHS, Zone, SVP and VP levels is now in place.

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

WHAT ELSE DO WE KNOW?

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

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

HOW DO WE COMPARE?

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

Performance Measure Update

Staff Overall Engagement (%)

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

PERFORMANCE STATUS

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

2011/12 TARGET: 54%

2011/12 ACTUAL: 52%

WHAT IS BEING MEASURED?

Staff overall engagement measures the per cent of Alberta Health Services (AHS) employees (excluding physicians and volunteers) who report they are favorably engaged at work. To determine the level of staff engagement, AHS launched a workforce engagement survey in March 2012.

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

AHS has established a target of 54 per cent of employees reporting they are favorably engaged at work for 2011/12.

HOW ARE WE DOING?

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

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

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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: AHS is collaborating with HQCA in creating a framework document and toolkits designed to enhance the healthcare workplace with respect to intimidation and bullying. The 2012 AHS Workforce Engagement Survey was completed in April 2012. Communications plan is in place. Grassroots action planning process is scheduled to launch in June, with plans completed by September. Organizational Development and TalentMap are working on a Toolkit for Managers to use to help them understand their results and to develop their own department plans.
Subsequent actions planned: A communications plan, scheduling milestone communications events up to December, 2012. A grassroots action planning process identifying milestones and quarterly reporting requirements.

WHAT ELSE DO WE KNOW?

Overall, 53 per cent of staff, physicians and volunteers who participated in the survey are favorably engaged, up significantly from 37 per cent recorded in a similar survey conducted in early 2010. An increase in favorable engagement scores was seen in each of the three population groupings. Efforts will continue to further increase engagement levels across the organization.

Information is available by zone for the 2009/10 survey. Zone level information will be available for 2011/12 in the next quarterly performance report.

HOW DO WE COMPARE?

Using third party provider benchmark data (engagement data drawn from 28 Canadian healthcare organizations - 40 per cent from Western Canada), the 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 (%)

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

PERFORMANCE STATUS

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

2011/12 TARGET: 54%

2011/12 ACTUAL: 39%

WHAT IS BEING MEASURED?

Physician overall engagement measures the per cent of physicians associated with Alberta Health Services (AHS) who report they are favorably engaged in this association. To determine the level of physician engagement, AHS launched a Workforce Engagement Survey in March 2012.

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

AHS has established a target of 54 per cent of the physician community reporting they are favorably engaged at work for 2011/12.

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Implementation of Physician Advocacy Assistance Line under the auspices of the Physician Advocacy Working Group by January 31st. Working Group hosted Physician Advocacy Planning Session with external stakeholders in February with participation by UofC and UofA medical schools, PARA, HQCA and AMA to jointly identify current activities and future programs that support Physician Advocacy.

Subsequent actions planned: CMO Office is engaged in implementing responses to HQCA recommendations related to advocacy and intimidation. The Physician Advocacy Working Group will be confirming a work plan for 2012/13.

WHAT ELSE DO WE KNOW?

Overall, 53 per cent of staff, physicians and volunteers who participated in the survey are favorably engaged, up significantly from 37 per cent recorded in a similar survey conducted in early 2010. An increase in favorable engagement scores was seen in each of the three population groupings. Efforts will continue to further increase engagement levels across the organization.

Information is available by zone for the 2009/10 survey. Zone level information will be available for 2011/12 in the next quarterly performance report.

HOW DO WE COMPARE?

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

Performance Measure Update

Direct Nursing Average Full Time Equivalency

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

PERFORMANCE STATUS

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

2011/12 TARGET: 0.62

2011/12 ACTUAL: 0.60

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

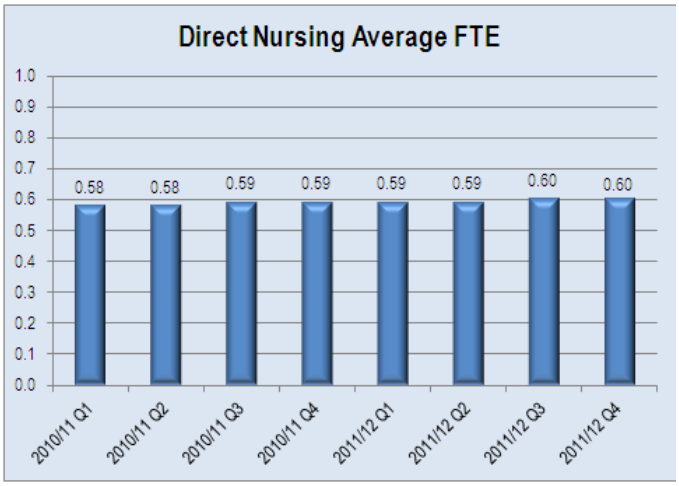
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure supports the clinical workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

In 2010/11 the Direct Nursing (DN) average FTE was 0.59. In Q4 2011/12 the ratio is at 0.60.



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

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Initiatives underway to address productivity and effective utilization of the clinical workforce. The Joint Workforce Regularization Project (JWRP): AHS and the United Nurses Association (UNA) are working jointly to identify where there may be opportunity to create more regular, higher FTE and increased full time positions. Support for managers has been provided in the Tools for Operational Managers (Supporting Effective Management of Labour Costs) document issued August 31, 2011 and updated in April 2012. The Transitional Graduate Nurse Recruitment Program (TGNPR) has been reintroduced with 59 full time positions filled to date. Rotations are being optimized through the Provincial Scheduling Transformation Project to increase full time/part time ratios, decrease overtime and deploy relief resources efficiently. 15 units are completed at the RAH in Edmonton. South Health Campus rotations are being finalized. 48 additional units will be done by end of June 2012. By July 2012, this project will also develop provincial master rotation guidelines and standardize staff scheduling rules and processes.
Subsequent actions planned: Targeted recruitment of the April 2012 cohort of new grads during the final courses of their formal programs has commenced.

WHAT ELSE DO WE KNOW?

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

Note that this measure does not include the Capital Care Group, Calgary Laboratory Services or Carewest entities even though these are wholly owned entities of AHS.

Information is available by portfolio.

HOW DO WE COMPARE?

This measure is not benchmarked externally.

Performance Measure Update

Absenteeism (#Days/FTE)

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

PERFORMANCE STATUS

Performance is within an acceptable range, continue to monitor.

2011/12 TARGET: 11.95 days/FTE

2011/12 ACTUAL: 12.04 days/FTE

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

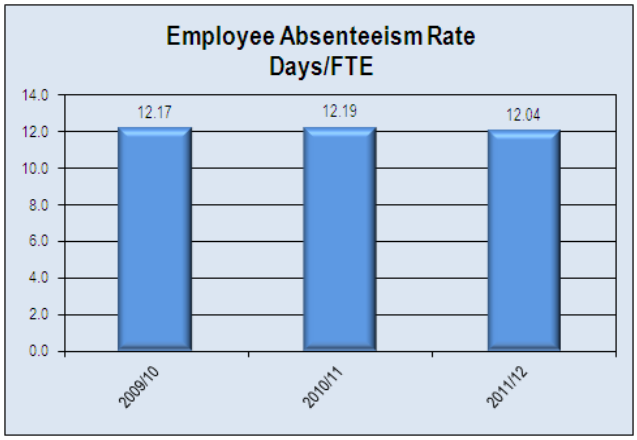
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

Days taken per FTE have remained fairly constant throughout 2009/10, 2010/11 and 2011/12 fiscal years.



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

WHAT ACTIONS ARE WE TAKING?

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

Subsequent actions planned: Tools and resources to assist front line managers in managing attendance are provided in the Tools for Operational Managers (Supporting Effective Management of Labour Costs) document that was distributed to managers August 31, 2011. A further update was distributed in February 2012.

WHAT ELSE DO WE KNOW?

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

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

Information is available by portfolio.

HOW DO WE COMPARE?

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

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

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

Performance Measure Update

Overtime Hours to Paid Hours

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

PERFORMANCE STATUS

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

2011/12 TARGET: 1.67%

2011/12 ACTUAL: 1.98%

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

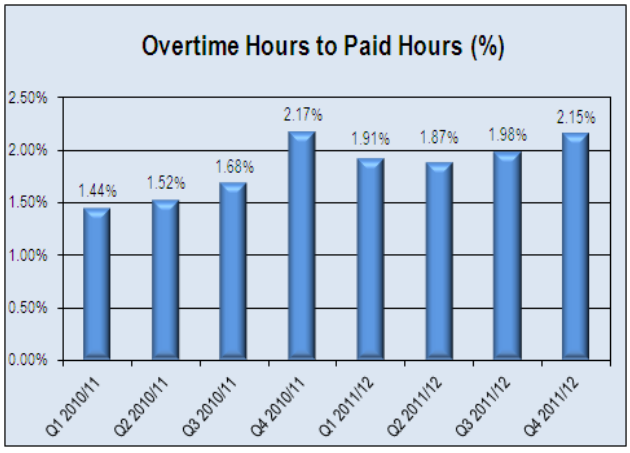
The performance of our health care system is directly related to the people who provide care and services to the citizens and communities we serve. This measure also supports workforce efficiencies and indicates better ability to effectively manage scheduling and productivity challenges.

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

Overtime hours accounted for only 1.62 per cent of total paid hours in 2009/10. This increased slightly in 2010/11 to 1.70 per cent. Overtime hours accounted for 2.15 per cent of total paid hours in Q4 2011/12 while on a Year to Date (YTD) basis, 1.98 per cent of total paid hours were overtime hours.



Source: Labour Cost Forecasting System (LCFS)

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: In the direct nursing functional bargaining unit a joint working group has been established to review the possibility of converting overtime hours (and others) into regular positions. Through performance agreements, managers, in all areas, are responsible for adherence to budgets for their sections.

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

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

WHAT ELSE DO WE KNOW?

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

Information is available by portfolio.

HOW DO WE COMPARE?

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

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

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

Performance Measure Update

Labour Cost per Worked Hour ($/hr)

New Measure, data updated quarterly.
Most current data is Q4 201//12.
Next data update expected for Q1 report.

PERFORMANCE STATUS

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

2011/12 TARGET: $48.55

2011/12 ACTUAL: $51.39

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

For 2011/12, the Labour Cost per worked hour was $51.39.

Time Period	Labour Cost (Billions)	Worked Hours	Labour Cost Per Worked Hour
2008/09	$5.02	N/A	N/A
2009/10	$5.48	113,230,155	$48.43
2010/11	$5.67	114,401,543	$49.54
2011/12 Q1	$1.48	28,970,210	$50.98
2011/12 Q2	$2.91	56,902,320	$51.07
2011/12 Q3	$4.44	87,384,992	$50.76
2011/12*	$6.15	119,686,352	$51.39

Source: AHS Financial Services.
* Preliminary

WHAT ACTIONS ARE WE TAKING?

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

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

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

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

WHAT ELSE DO WE KNOW?

Figures include the following wholly owned subsidiaries of AHS:

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

Information is available by portfolio.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Performance Measure Update

Number of Netcare Users

Data updated quarterly.
Most current data is Q4 2011/12
Next data update expected for Q1report

PERFORMANCE STATUS

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

2011/12 TARGET: 12,998

2011/12 ACTUAL: 14,605

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

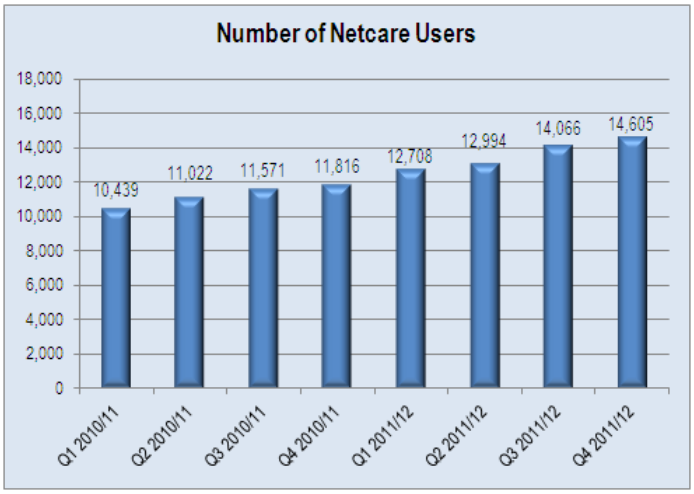
The Alberta Netcare EHR Portal improves patient care by providing up-to-date information immediately at the point of care. Making basic patient information available to health service providers supports better care decisions and improves patient safety.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a target of a 10 per cent increase in Netcare users from 2010/11 to 2011/12.

HOW ARE WE DOING?

The peak quarterly number of nurses and physicians accessing Netcare was 14,605 in Q4 of 2011/12. This represents a 4 per cent increase over the previous quarter.



Source: Alberta Netcare Portal

WHAT ACTIONS ARE WE TAKING?

Actions completed to date: Alberta is leading Canada in the successful implementation of a single, province-wide Electronic Health Record (EHR). Alberta Netcare is a program that encompasses all the projects, processes, products, and services that work together to make Alberta's EHR a reality. It has been developed by Alberta Health and Wellness (AHW) in cooperation and partnership with Alberta Health Services, and many other partners including the health professional colleges and associations. Most Home care areas in Zones are now actively using Netcare to access data sources already published

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

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available.

Performance Measure Update

On Budget: Year To Date

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

PERFORMANCE STATUS

Performance is better than annual target, continue to monitor.

2011/12 TARGET ACCUMULATED SURPLUS: $36M

Q4 ACTUAL ACCUMULATED SURPLUS: $82M

WHAT IS BEING MEASURED?

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

An accumulated surplus/deficit is the surplus or deficit that has accrued since AHS was formed.

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

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

WHAT IS THE TARGET?

By way of the five year funding agreement, AHS is committed to have an accumulated surplus greater than $0M at the end of the five years. For the year ended March 31, 2012, the targeted accumulated surplus is $36M. This targeted surplus results from the March 31, 2011 actual accumulated surplus of $116M being reduced for the budgeted operating deficit of $20M, the net change in internally funded capital assets of $75M, and the repayment of $19M of long term debt; these reductions are offset by the utilization of $34M of other internally restricted net assets for the South Health Campus and parkades.

Table: Accumulated surplus in $Millions as at:

	Actual
June 30, 2011	175
September 30, 2011	194
December 31, 2011	252
March 31, 2012	82

Source: *Unaudited Quarterly Financial Statements for the period ended March 31, 2012.*

HOW ARE WE DOING?

At March 31, 2012, the year end accumulated surplus was $82M which is $46M higher than budget.

WHAT ACTIONS ARE WE TAKING?

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

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

WHAT ELSE DO WE KNOW?

The year end accumulated surplus has decreased from March 31, 2011 by $17M primarily due to an operating surplus of $85M offset by a net decrease in internally funded capital assets of $88M, long term debt repayment of $11M, and net utilization of other internally funded capital assets of $3M. The operating surplus is higher than target primarily due to delayed implementation of new initiatives and difficulties in recruitment for staff vacancies. Utilization of other internally restricted net assets for the South Health Campus and parkades is lower mainly as a result of delays in opening. The AHS financial reporting documents can be obtained from the www.albertahealthservices.ca website.

HOW DO WE COMPARE?

National benchmark comparisons are not applicable.

Alberta Health Services

Performance Measure Update

Adherence to Five Year Budgeted Government Funding

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

PERFORMANCE STATUS

Performance is better than annual target, continue to monitor

2011/12 TARGET DEFICIT ADHERENCE RANGE: WITHIN 1.5%

2011/12 ACTUAL ADHERENCE VALUE: SURPLUS OF 0.9%

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

The Provincial Government has provided AHS with a five year Health Action Plan funding commitment from which AHS will provide future health care services to Albertans.
As part of this commitment, AHS is not to run an operating deficit greater than 1.5% of annual global funding. Over this time period AHS must monitor its adherence to the agreement closely in order to ensure that the five year funding commitments are not exceeded and to ensure budget sustainability into the future.

WHAT IS THE TARGET?

By way of the five year funding agreement, AHS is committed to have an accumulated surplus greater than $0M at the end of the five years. For the year ending March 31, 2012, the variance from global funding (if in deficit) is targeted to be less than 1.5%.

HOW ARE WE DOING?

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

Table: Adherence to Five Year Budgeted Government Funding

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

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

WHAT ACTIONS ARE WE TAKING?

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

WHAT ELSE DO WE KNOW?

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

HOW DO WE COMPARE?

National benchmark comparisons are not applicable.

Performance Measure Update

Patient Satisfaction
Adult Acute Care

Data updated quarterly with one quarter lag.
Most current data is Q3 2011/12.
Next data update expected for Q1 report.

PERFORMANCE STATUS

Performance target has not been established for comparison.

2011/12 TARGET: TBD

YTD 2011/12 ACTUAL: 84% (Apr-Dec)

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

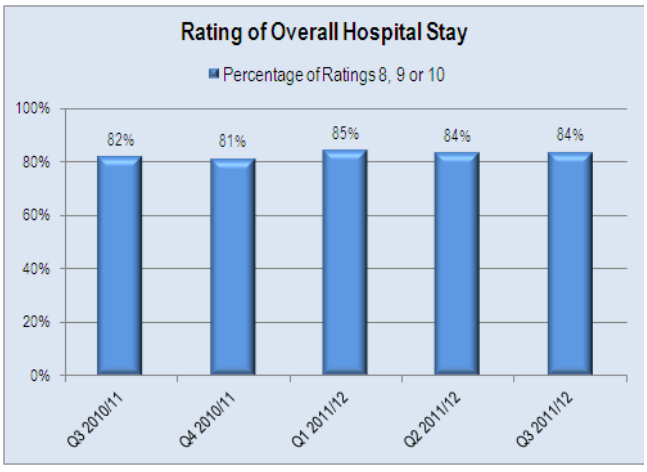
Gathering perceptions and feedback from individuals who use hospital acute care services is a critical aspect of measuring progress and improving the health system. This measure reflects overall patient perceptions associated with the hospital where they received care and is derived from a well-established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

WHAT IS THE TARGET?

Alberta Health Services has not established a target of for patients rating their overall hospital stay as eight, nine or ten.

HOW ARE WE DOING?

The percentage of adults rating their overall hospital stay as eight, nine or ten is the same in Q3 as it was in Q2.



Source: AHS H-CAHPS Survey data

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

WHAT ACTIONS ARE WE TAKING?

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

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

WHAT ELSE DO WE KNOW?

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

Information is available by zone, and semi-annually by site.

HOW DO WE COMPARE?

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

Performance Measure Update

Patient Satisfaction Addiction and Mental Health

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

PERFORMANCE STATUS

Performance target has not been established for comparison.

2011/12 TARGET: TBD

2011/12 ACTUAL: 92.3%

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

Alberta Health Services has not established a final target for the per cent of patients indicating that overall they are satisfied with addiction and mental health services they received.

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

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

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

WHAT ELSE DO WE KNOW?

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

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

Information is available by zone.

HOW DO WE COMPARE?

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

Performance Measure Update

Percentage of Patient Feedback as Commendations

Data updated quarterly.
Most current data is Q4 201/12
Next data update expected for Q1 report

PERFORMANCE STATUS	2011/12 TARGET: TBD
Performance Target for 2011/12 has not been established for comparison.	2011/12 ACTUAL: 10.28%

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

Of the 2808 pieces of feedback provided to the Patient Relations Department between January 1 – March 31, 2012, (including EMS and Covenant Health), 9.86% were commendations.

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

Fiscal Year 2011/12	Number of Commendations	Percentage of All Feedback
Q1	233	8.53 %
Q2	271	10.67 %
Q3	307	12.28 %
Q4	277	9.86 %
Total	1,088	10.28%

WHAT ACTIONS ARE WE TAKING?

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

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

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

This measure is not benchmarked externally.

[1] This Feedback is defined as follows:

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

Data updated quarterly.
Most current data is Q4 2011/12
Next data update expected for Q1 report 2012/13.

Percentage of Patient Concerns Escalated to Patient Concerns Officer

PERFORMANCE STATUS

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

2011/12 TARGET: TBD

2011/12 ACTUAL: 0.52%

WHAT IS BEING MEASURED?

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

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

WHY IS THIS IMPORTANT?

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

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

WHAT IS THE TARGET?

Provincial tracking of concerns in a consistent manner has only been possible since November 1, 2010 with the implementation of a new provincial database. The Feedback and Concerns Tracking (FACT) tool provides for consistent documentation and reporting of patient feedback.

HOW ARE WE DOING?

During the period January 1 to March 31, 2012, 9 files were reviewed by the Patient Concerns Officer that had been managed first by the Patient Relations Department. These files represent a total of 0.39% for Quarter 4.

Table 1 - Patient Concerns Officer Reviews Initiated

Fiscal Year 2011/12	Concerns		
	Total Managed by PR*	PCO Reviews Initiated	%
Q1	2,216	14	0.63%
Q2	2,114	13	0.61%
Q3	1,988	9	0.45%
Q4	2,330	9	0.39%
Total	8,648	45	0.52%

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

WHAT ACTIONS ARE WE TAKING?

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

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

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

This measure is not benchmarked externally.

Performance Measure Update

Albertans Reporting Unexpected Harm

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

PERFORMANCE STATUS

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

2011/12 TARGET: 9%

2011 ACTUAL: 12.2%

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asks Albertans about unexpected harm in the Health Services Satisfaction Survey, which is conducted every two years. As well, the Provincial Survey about Health and the Health System in Alberta is conducted on an annual basis and reported within the AHW Annual Report. The most recent annual report is for 2010 – 2011.

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

Detailed indicator definition is available.

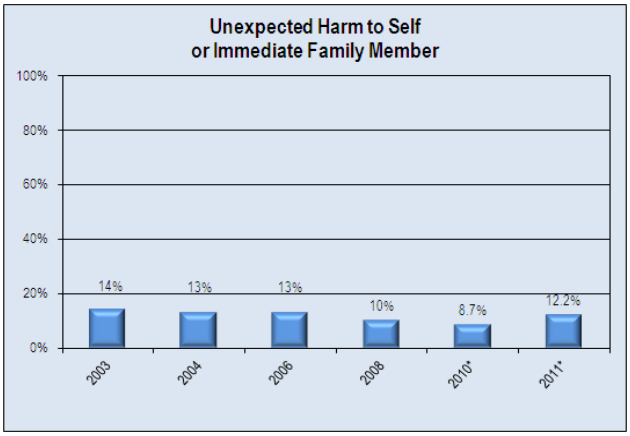
An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

Based on previous survey data, AHS has established a 2011/12 target of 9 per cent for the per cent of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year. The change from 2010 to 2011 is not statistically significant, likely due to the low sample rate and high error rate.



Source: Health Quality Council of Alberta (HQCA) Health Services Satisfaction Survey
Note: This measure applies only to adults aged 18 years and over who used health care services in Alberta in the past year.
* 2010 error rate of +/- 1.2; 2011 error rate of +/- 2.1.

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

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

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

WHAT ELSE DO WE KNOW?

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

The next survey being conducted by Alberta Health and Wellness is currently underway. Once complete, finalized results are available they will be reported within the Quarterly Performance Report.

Information is available by zone.

HOW DO WE COMPARE?

National benchmark comparisons are not available

Performance Measure Update

Patient Satisfaction
Emergency Department (15 Higher Volume)

Data updated quarterly with a one quarter lag
Most current data is Q3 2011/12
Next data update expected for Q1 report 2012/13.

PERFORMANCE STATUS	2011/12 TARGET: TBD
Performance target has not been established for comparison.	YTD ACTUAL: 68% Adult 82% Pediatric (Apr-Dec)

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

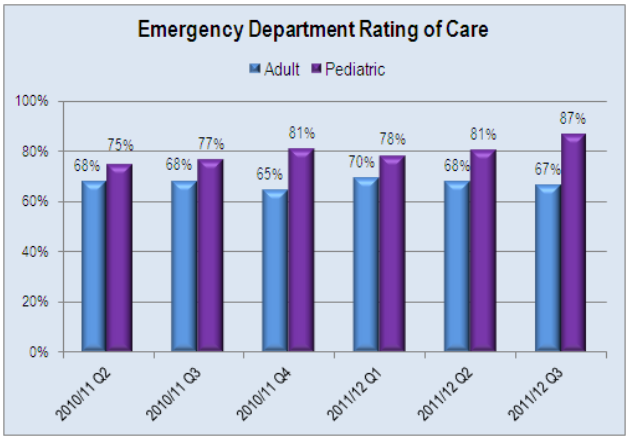
Patient satisfaction with emergency department services is a crucial and critical dimension of quality; it is a high level indicator of the structure, process and outcome of care in emergency departments. The information provides insights into the consequences of policy and strategic changes from the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

WHAT IS THE TARGET?

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

HOW ARE WE DOING?

For Q3 Year to Date (Apr – Dec) 2011/12 68 per cent of Adult and 82 per cent of Pediatric ED Satisfaction surveys resulted in High Satisfaction Ratings (score of 8, 9, or 10).



Source: AHS H-CAHPS Survey data
Notes: The results are based on sample surveys with standard error within 3%.

WHAT ACTIONS ARE WE TAKING?

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

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

WHAT ELSE DO WE KNOW?

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

Information is available by zone, and semi-annually by site.

HOW DO WE COMPARE?

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

Performance Measure Update

Patient Satisfaction
Health Care Services Personally Received

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

PERFORMANCE STATUS

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

2011/12 TARGET: 66%

2011 ACTUAL: 67%

WHAT IS BEING MEASURED?

The Health Quality Council of Alberta (HQCA) asks Albertans about satisfaction with health care services in the Health Services Satisfaction Survey, which is conducted every two years. As well, the Provincial Survey about Health and the Health System in Alberta is conducted on an annual basis and reported within the AHW Annual Report. The most recent annual report is for 2010 – 2011.

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

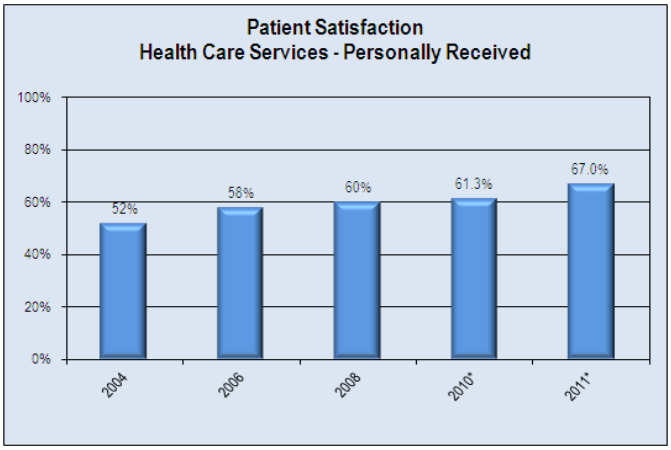
Health care services include personal family doctor, other health care professionals at family doctor's office, community walk-in clinics, specialists, MRI, other diagnostic imaging, pharmacists, emergency departments, inpatient hospital services, outpatient hospital services and mental health services.

Detailed indicator definition is available.

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

WHY IS THIS IMPORTANT?

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



Source: Health Quality Council of Alberta (HQCA) Health Services Satisfaction Survey
Note: This measure applies only to adults aged 18 years and over who used health care services in Alberta in the past year.
* 2010 error rate of +/- 2%; 2011 error rate of +/- 3%.

WHAT IS THE TARGET?

Alberta Health Services (AHS) has established a 2011/12 target of 66 per cent of Albertans who were satisfied with the health care services they personally received in Alberta within the past year.

HOW ARE WE DOING?

The per cent of Albertans who were satisfied with the health care services they personally received in Alberta within the past year was 67 per cent.

WHAT ACTIONS ARE WE TAKING?

AHS works closely with HQCA (Health Quality Council of Alberta) to monitor Patient satisfaction. AHS is undertaking focused improvement activities in access areas including Emergency Department and Primary Care Physician as well as specialty services such as Cancer Treatment and Surgery.

WHAT ELSE DO WE KNOW?

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

The next survey being conducted by Alberta Health and Wellness is currently underway. Once complete, finalized results are available they will be reported within the Quarterly Performance Report.

Information is available by zone.

HOW DO WE COMPARE?

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

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

Central Venous Catheter Bloodstream Infection Rate

PERFORMANCE STATUS	2011/12 TARGET: TBD
Performance target for 2011/12 is not yet established for comparison	YTD 2011/12 ACTUAL: 1.00 (Apr-Dec)

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

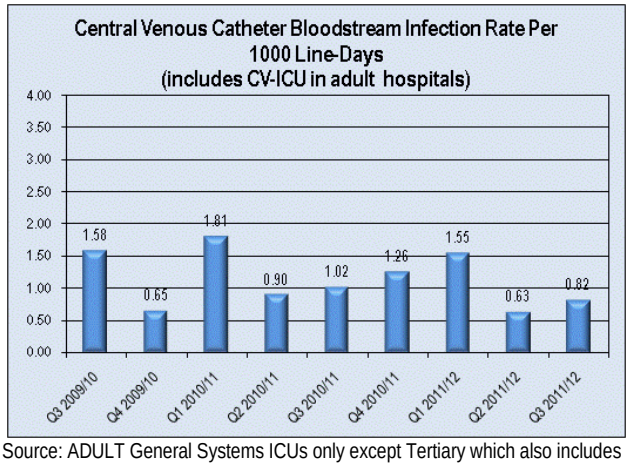
An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



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

References:

1 Centers for Disease Control and Prevention. Guidelines for the prevention of intravascular catheter-related infections [Erratum to p. 29, Appendix B published in MMWR Vol. 51, No. 32, p. 711]. MMWR 2002;51(No. RR-10):1-32.

2 Crnich CJ, Maki DG. Intravascular Device Infections. Chapter 24 In: Association for Professionals in Infection Control and Epidemiology (eds), APIC Text of Infection Control and Epidemiology. 2004 pp 24-1 – 24-26.

3 Pittet D, Tarara D, Wenzel RP. Nosocomial bloodstream infection in critically ill patients. JAMA 1994;271:1598-1601.

4 CVC-BSI Working Group and the Candian Nosocomial Infection Surveillance Program (CNISP). Surveillance for Central Venous Catheter Associated Blood Stream Infections (CVC-BSI) in Intensive Care Units. 2011/2012 CVC-BSI Surveillance Protocol. March 24. 2011

HOW ARE WE DOING?

The central venous catheter bloodstream infection rate for adult sites was 0.82 per 1,000 line-days in Q3 2011/12 and the year to date (Apr-Dec) rate was 1.00 per 1,000 line-days.

WHAT ACTIONS ARE WE TAKING?

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

WHAT ELSE DO WE KNOW?

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

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

Information is available by adult acute care sites presented as a one year rolling rate.

HOW DO WE COMPARE?

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

Performance Measure Update

Methicillin-Resistant *Staphylococcus aureus* – Bloodstream Infection

Data updated quarterly (Year to Date (YTD)).
Most current data is Q3 2011/12.
Next data update expected for Q1 report.

PERFORMANCE STATUS	2011/12 TARGET: TBD
Performance target for 2011/12 is not yet established for comparison	YTD 2011/12 ACTUAL: 0.18 (Apr-Dec)

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

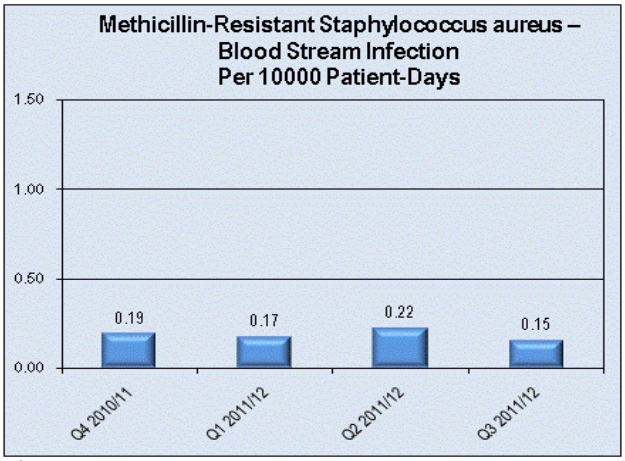
An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



References

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

HOW ARE WE DOING?

The MRSA bloodstream infection rate was 0.15 per 10,000 patient days in Q3 of 2011/12 while the year to date (Apr-Dec) rate was 0.18.

WHAT ACTIONS ARE WE TAKING?

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

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

WHAT ELSE DO WE KNOW?

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

Information is available by adult acute care sites.

HOW DO WE COMPARE?

National benchmark comparisons are not available. "The Ontario Ministry of Health and Long Term Care published an overall rate of 0.2 cases of MRSA bacteremia per 10,000 patient-days for patients admitted to a hospital for longer than 72 hours in 2009. http://www.health.gov.on.ca/english/media/news_releases/archives/nr_09/apr/bg_20090430_3.html.The Alberta definition uses longer than 48 hours after admission."
Internal benchmarks will be developed over time.

Performance Measure Update

Clostridium difficile Infection

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

PERFORMANCE STATUS

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

2011/12 TARGET: TBD

YTD TARGET TBD
HA ACTUAL: 4.0 (Apr-Dec)

WHAT IS BEING MEASURED?

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

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

Detailed indicator definition is available.

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

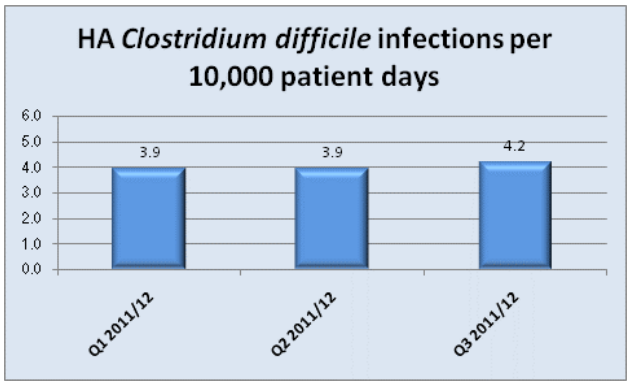
WHY IS THIS IMPORTANT?

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

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

WHAT IS THE TARGET?

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



Source: AHS Infection Prevention and Control

HOW ARE WE DOING?

The Hospital-Acquired (HA) CDI rate was 4.2 per 10,000 patient days in October – December 2011 and the April – December 2011 rate was 4.0.

Between October and December 2011, the total number of hospitalized cases of CDI was 432.

WHAT ACTIONS ARE WE TAKING?

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

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

WHAT ELSE DO WE KNOW?

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

Information is available by site.

HOW DO WE COMPARE?

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

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

Performance Measure Update

30 Day Unplanned Readmission Rate

Data updated quarterly with one quarter lag.
Most current data is Q3 2011/12.
Next data update expected for Q1 report.

PERFORMANCE STATUS

Performance target has not been established for comparison.

2011/12 TARGET: TBD

YTD TARGET TBD
ACTUAL: 8.06%
(Apr-Dec)

WHAT IS BEING MEASURED?

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

Detailed indicator definition is available.

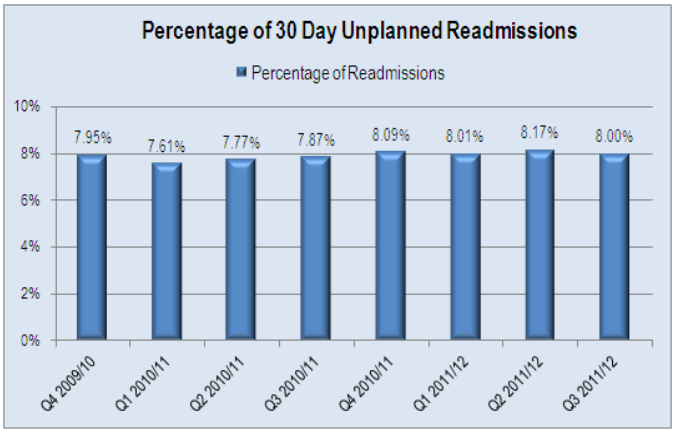
An internal review of the data quality indicates a very high level of confidence with no known issues.

WHY IS THIS IMPORTANT?

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

WHAT IS THE TARGET?

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



Source: AHS Discharge Abstract Database

HOW ARE WE DOING?

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

WHAT ACTIONS ARE WE TAKING?

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

WHAT ELSE DO WE KNOW?

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

Information is available by zone.

HOW DO WE COMPARE?

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