



Provincial Performance Measure Update Q2 2014-15

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Analytics (DIMR)

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Introduction

Beginning in Quarter 1 of 2014-15, a new Quarterly report was introduced internally within AHS. This report focuses on the 16 Public Performance Measures first publicly reported annually in January 2014 for 2012-13 data and in September 2014 for 2013-14 data. The Quarterly report update is a performance management tool to track progress and assist in planning to achieve targets established within the publicly published reports.

It is expected that the quarterly report will evolve as use, intent and production adjustment combine to best meet the needs of the users.

How to read the included charts

This report is designed for an audience which is familiar with the measures and has a basic understanding of their implications. For each measure the report includes a Provincial chart page followed by a chart page for each Zone where needed. In addition, there is a corresponding page which contains a more detailed data table form along with actions and other items.

Chart content

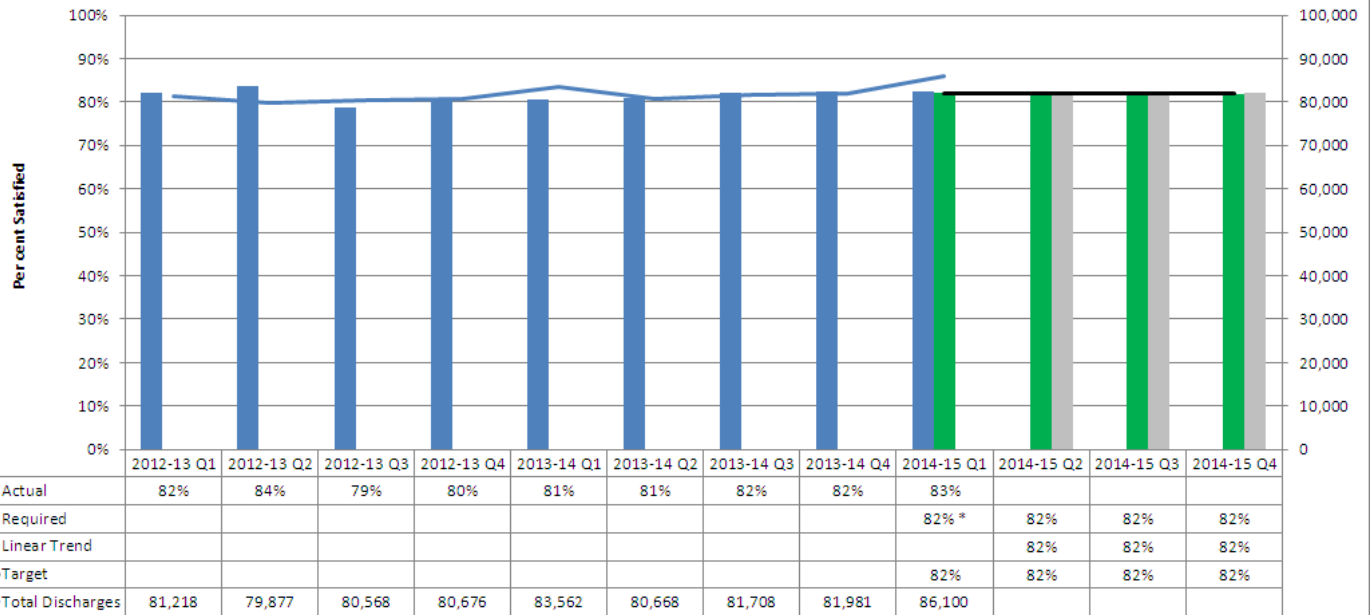
There are 3 charts for each Quarterly Measure.

- 1) Overall Results and Forecast
 - a. This graph includes “Actual” quarterly results over the past 8 quarters plus the current quarter.
 - b. Calculated “Required” values are shown. These are based on incorporating any seasonality (where detected) into a quarterly results distribution that would achieve Target for the year. Adjustments are made accordingly where less or no seasonality is evident.
 - i. For reports including no Q2 update due to a reporting lag, all four quarters present a full distribution of quarterly “Required” values to achieve target over the year.
 - ii. For reports including a Q2 update, the “Required” value is shown from Q2 along with the actual so that these can be compared. The remaining quarters are adjusted based on the result achieved in Q2, such that a result that is worse than a previously calculated “Required” will result in more aggressive expectations in the remaining quarters. Similarly, results in Q2 that exceed expectations result in a relaxed “Required” calculated value. Where this occurs future values should be interpreted with caution given ongoing improvement objectives and variation.
 - iii. “*” indicates historical “required” values that can be compared to actual to show how close the actual results were compared to what was required to meet target.
 - c. The “Linear Trend” presents a straight line projection of values based upon the presented Actual results.
 - d. A “Target” reference line indicates the 2014/15 target for the measure.
- 2) YTD Comparison.
 - a. This trend includes just the Year-to-date values (Provincially and by Zone) for this measure over the last 3 years to enable direct comparison with a corresponding historical time period.
 - b. For the Q2 report YTD will include the full six month period (April to September).
- 3) Zone Trending Graph
 - a. A multi-line trend graph shows the Actual results for each zone over a 2 year period.
 - b. This allows comparison across Zones/Sites over time.

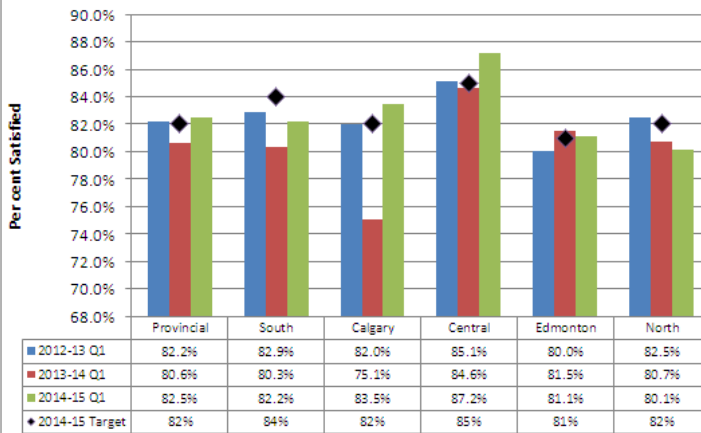
Satisfaction with Hospital Care

This measure is the percentage of adults aged 18 years and older discharged from hospitals who rate their overall stay as 8, 9 or 10 out of 10, where zero is the lowest level of satisfaction possible and 10 is the best.

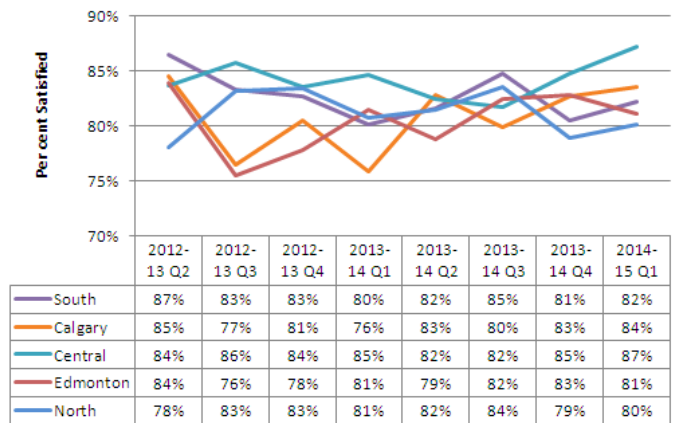
Provincial Satisfaction with Hospital Care



Satisfaction with Hospital Care YTD



Satisfaction with Hospital Care Zone Trending



Satisfaction with Hospital Care

This measure is the percentage of adults aged 18 years and older discharged from hospitals who rate their overall stay as 8, 9 or 10 out of 10, where zero is the lowest level of satisfaction possible and 10 is the best.

Provincial Overview

Zones	Key Actions
South:	<ul style="list-style-type: none"> Work with provincial team to ensure appropriate identification and selection of patient representatives for Zone committee work. All teams currently exploring how patients can be integrated into work. Work with the Provincial Patient Engagement Department to prepare a draft outline for a focused learning session for leadership groups on patient engagement and specifically on collaborating with patient/family advisors in systems level planning. Co-Sponsor an Action Learning Project for the Executive Education Program to look at the best approaches to evaluate the outcomes, experience, effectiveness and impact of a patient and family-centered care strategy beyond satisfaction surveys.
Calgary:	<ul style="list-style-type: none"> Work on new hire orientation, site-wide name tags for all staff, WiFi access, and increase patient/family involvement on committees. Participation in way finding and signage upgrades. Visiting and Family Presence guidelines revised to be more inclusive and flexible and overhead notification to end visiting hours has been stopped.
Central:	<ul style="list-style-type: none"> Engage patients and families further in inpatient care by initiating whiteboard usage in patient rooms as well as Safer Together pamphlet to admission packages. Improved signage in ICU family area to improve access to the unit, established goal to have a family conference within 24 hours of admission to the ICU, open visiting hours to 24/7, if required. Family members who are with patient during a cardiac arrest are encouraged to stay with patient in ICU and in ED. Continue implementation of CoACT.
Edmonton:	<ul style="list-style-type: none"> Participate in the roll- out and achievement of the Patient First Strategy for 2014/15 as the specific action items are known focused on improving the patient experience. The Family Advisory Council has completed its Peer to Peer training to facilitate families supporting families.
North:	<ul style="list-style-type: none"> Develop unit specific action plans of CoACT practice, process and performance elements for the sites. Develop and implement education plans for staff, physicians, volunteers and HACs to understand the initiative and potential benefits. Develop a rural discharge planning model that is flexible and responsive to specific site pressures.

Analysis

- The Q2 year-to-date results have been improving. Provincially and three zones are at or above 2014-15 target; the other two zones are demonstrating improvement from Q1.
- We will continue to innovate and look for ways to improve care. We will continue to be efficient and effective in our service delivery. And we will continue to try to see the health system through the eyes of our patients by listening to their concerns, putting them first and making patients a part of the health care team. The zones continue to educate/ develop enhanced awareness of patient relations department with staff, physicians, clients and families using brochures, posters and in-servicing. Other actions in development include multidisciplinary discussions to increase communications and planning with discharge activities.

Satisfaction with Long Term Care

This measures the percentage of families of long-term care residents who rate their overall care as 8, 9 or 10 out of 10, where zero is the lowest level of satisfaction possible and 10 is the best. Information for this measure is collected through a survey of family members whose relative is a resident in long-term care. This measure is updated every two years.

Percentage Satisfied with Long Term Care

Zone	2007	2010	2013	2014-15 Target	2015-16 Target
Provincial	71%	73%		Not	78%
South	80%	80%	2013 Values not available at time of publication	Applicable Target not	81%
Calgary	65%	70%		set since	76%
Central	78%	80%		survey results not	81%
Edmonton	67%	70%		available.	76%
North	80%	82%			83%

No Update for Q2 2014-15 as this is an annual measure.

Satisfaction with Long Term Care

This measures the percentage of families of long-term care residents who rate their overall care as 8, 9 or 10 out of 10, where zero is the lowest level of satisfaction possible and 10 is the best. Information for this measure is collected through a survey of family members whose relative is a resident in long-term care. This measure is updated every two years.

Provincial Overview

Zones	Key Actions
South:	<ul style="list-style-type: none"> Assess the need for specialty beds with supporting portfolios to address gaps in care for seniors with complex dementia and/or behavioral issues. Work with the Provincial Patient Engagement Department to prepare a draft outline for a focused learning session for leadership groups on patient engagement and specifically on collaborating with patient/family advisors in systems level planning.
Calgary:	<ul style="list-style-type: none"> Assess the need for specialty beds with supporting portfolios to address gaps in care for seniors with complex dementia and/or behavioral issues. Respond to public complaints and inquiries through the 24/7 line in a timely manner.
Central:	<ul style="list-style-type: none"> Implement resident focused satisfaction initiatives at below target Continuing Care sites with a focus on involving patients and their families in their own care planning and decisions. Identify all sites that are below the previous reported rate 81%. Results shared with lower performing sites to enable local improvement.
Edmonton:	<ul style="list-style-type: none"> Assess the need for specialty beds with supporting portfolios, to address gaps in care for seniors with complex dementia and/or behavioural issues.
North:	<ul style="list-style-type: none"> Began implementation of a coordinated placement model.

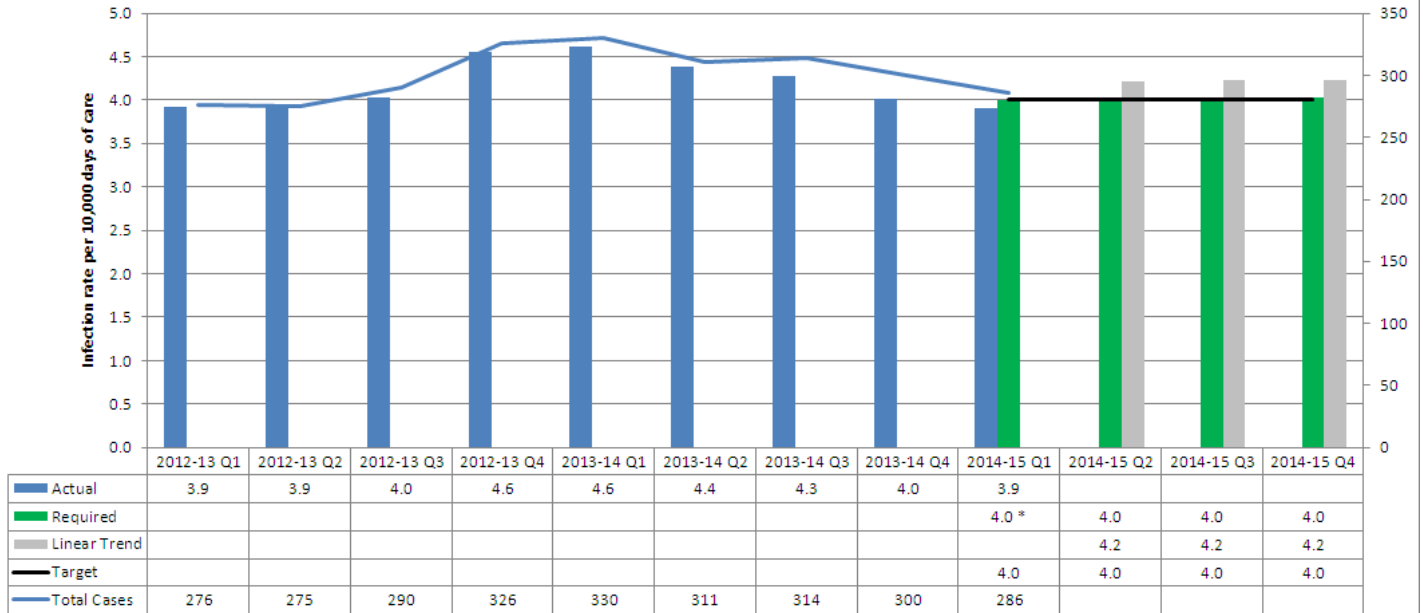
Analysis

- The most recent data is from 2010. The survey is performed by HQCA every three years.
- In 2010, the average overall family rating of care at Alberta nursing homes was 73%, a very modest but statistically significant improvement from 71% in 2007.
- Smaller facilities and facilities in rural communities may be 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.

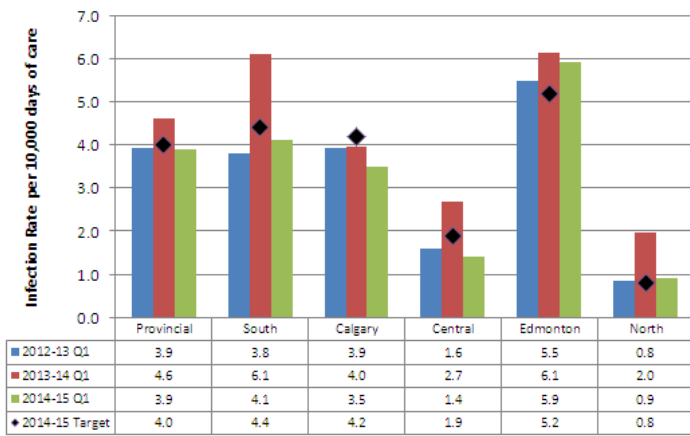
Hospital-acquired Infections

The number of Clostridium difficile infections (C-diff) acquired in hospital every 10,000 patient days. A rate of 4.0 means approximately 100 patients per month acquire C-diff infections in Alberta. C-diff infection cases include patients with a new infection or re-infection while in hospital. Patients are considered to have a C-diff if they exhibit symptoms and confirmation by a laboratory test or colonoscopy.

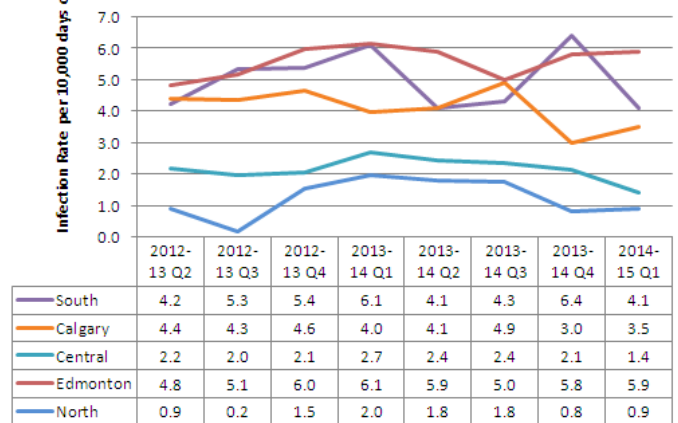
Provincial Zone Hospital Acquired Infections



Hospital Acquired Infections YTD



Hospital Acquired Infections Zone Trending



Hospital-acquired Infections

The number of Clostridium difficile infections (C-diff) acquired in hospital every 10,000 patient days. A rate of 4.0 means approximately 100 patients per month acquire C-diff infections in Alberta. C-diff infection cases include patients with a new infection or re-infection while in hospital. Patients are considered to have a C-diff if they exhibit symptoms and confirmation by a laboratory test or colonoscopy.

Provincial Overview

Zones	Key Actions
South:	<ul style="list-style-type: none"> Establish the South Zone antimicrobial stewardship framework in line with provincial strategy. Continue to monitor incidence of hospital acquired C-diff infections. Implement steps to ensure proper laundering of cleaning cloths.
Calgary:	<ul style="list-style-type: none"> Continue work with AHS Medical Affairs to implement physician-specific IPC content into an orientation program for physicians. Established innovative treatment options for patients with recurrent C-diff.
Central:	<ul style="list-style-type: none"> Implement use of Accelerated Hydrogen Peroxide in Environmental Services cleaning procedures for isolation cleans for inpatient rooms and on discharge/transfer of patients with C-diff Infection.
Edmonton:	<ul style="list-style-type: none"> Complete equipment cleaning initiative at sites. Implement Stop Hospital Acquired Infection (HAI) program to engage frontline ownership. Staff, physicians, and students make clean hands a major commitment. Achieve 20 weeks without a unit on outbreak measures by mid 2014-15 fiscal year.
North:	<ul style="list-style-type: none"> Continue implementation of the North Zone Antimicrobial Stewardship Committee, with an initial focus on the roll-out of Clostridium Difficile Infection (CDI) pre-print orders.

Analysis

- The Q1 year-to-date results have been improving significantly. Provincially and three zones are at or above 2014-15 target.
- 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.
- 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.

Hand Hygiene

The percentage of opportunities for which health care workers clean their hands during the course of patient care. For this measure, health care workers are directly observed by trained personnel to see if they are compliant with routine hand hygiene practices according to the Canadian Patient Safety Institute “4 Moments of Hand Hygiene”

Hand Hygiene Compliance

Zone (% Compliant)	2011-12	2012-13	2013-14	2014-15	2014-15 Target	2015-16 Target
Provincial	50%	59%	66%	73%	71%	80%
South	61%	69%	78%	82%	80%	84%
Calgary	38%	51%	60%	67%	66%	78%
Central	75%	59%	64%	70%	69%	79%
Edmonton	43%	60%	57%	74%	64%	76%
North	64%	56%	66%	73%	71%	81%

Note: Year-end data for Hand Hygiene was reported in August 2014 for the 2014-15 fiscal year.
No Update for Q2 2014-15 as this is an annual measure.

Hand Hygiene

The percentage of opportunities for which health care workers clean their hands during the course of patient care. For this measure, health care workers are directly observed by trained personnel to see if they are compliant with routine hand hygiene practices according to the Canadian Patient Safety Institute “4 Moments of Hand Hygiene”

Provincial Overview

Zones	Key Actions
South:	<ul style="list-style-type: none"> Continue implementation of Hand Hygiene (HH) strategy such as staff training, audits in continuing care facilities, education presentations and audits in home ambulatory clinics and in the operating rooms.
Calgary:	<ul style="list-style-type: none"> Roll out of the new Hand Hygiene data platform to sites and standardizing the process for students, return to work employees and volunteers. Implement reporting at the site/unit and zone level at determined intervals. Continue optimization of Hand Hygiene Plan in accordance with the IPC Strategy and required monitoring of compliance.
Central:	<ul style="list-style-type: none"> Enhance HH protocol adherence, monitoring and reporting across all sites. Implement Hand Hygiene committees to address sites with compliance rates below target. Focus on HH surveillance /audits, target staff and physician education and ensure the physical environment supports hand hygiene practices. HH results are posted on individual units and departments monthly, with a move to posting in areas accessible to the public.
Edmonton:	<ul style="list-style-type: none"> Enhance Hand Hygiene protocol adherence, monitoring and reporting across all sites. Develop and implement the Edmonton Zone plan to address overall compliance rates below target. Focus on HH surveillance/audits, target staff, physician and patient education, e.g. provide patient / family brochure available upon admission.
North:	<ul style="list-style-type: none"> Implement HH Action Plan through improvement of hand hygiene stations, annual education for health professionals, implementation of the provincial measurement tool to monitor, measure, report and analyze data and conducting Train the Trainer sessions for HH reporting.

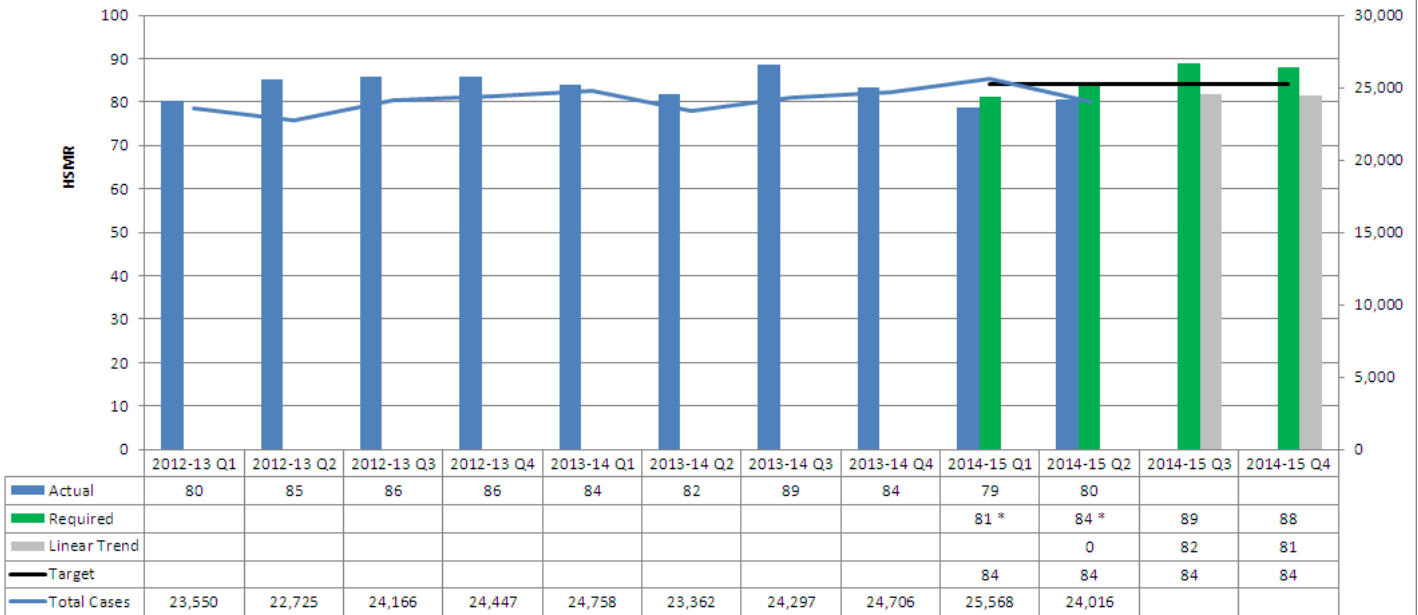
Analysis

- Hand Hygiene rates have improved significantly due to activities put into place at sites.
- This measure is reported annually.
- Q2 year-to-date provincially and all zones are all exceeding target.
- New Hand Hygiene data platform implemented which will enable real-time reporting of HH rates by unit, site, zone, and province. Recruitment for zone-embedded HH project teams initiated. These teams, consisting of a zone HH project manager and HH reviewers will support year-round HH observations and zone and site HH improvement initiatives.

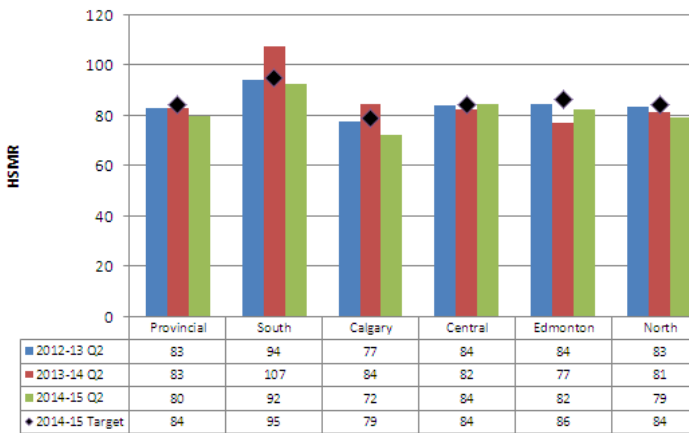
Hospital Mortality

The ratio of actual number of deaths compared to the expected number of deaths based upon the type of patients admitted to hospitals. This ratio is multiplied by 100 for reporting purposes. The ratio compares actual deaths to expected deaths after adjusting for factors that affect in-hospital mortality, such as patient age, sex, diagnosis and other conditions. The expected deaths are based on comparison to similar patients in national databases.

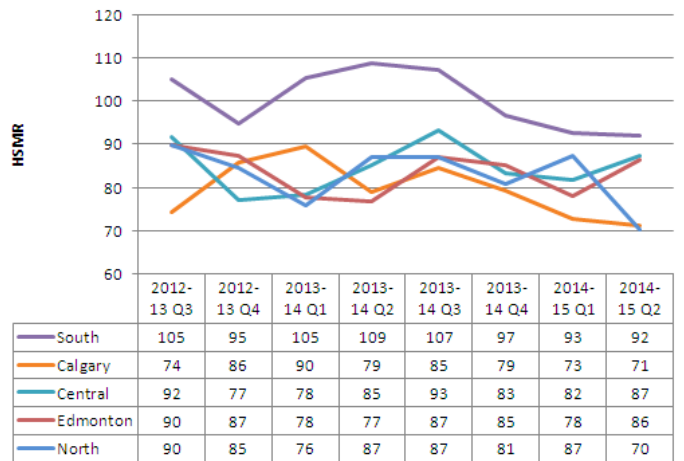
Provincial Hospital Mortality



Hospital Mortality YTD Comparison



Hospital Mortality Zone Trending



Hospital Mortality

The ratio of actual number of deaths compared to the expected number of deaths based upon the type of patients admitted to hospitals. This ratio is multiplied by 100 for reporting purposes. AHS is performing better than the national average of 89. The ratio compares actual deaths to expected deaths after adjusting for factors that affect in-hospital mortality, such as patient age, sex, diagnosis and other conditions. The expected deaths are based on comparison to similar patients in national databases.

Provincial Overview

Zones	Key Actions
South:	<ul style="list-style-type: none"> Implement American College of Surgeons National Surgical Quality Improvement Program (NSQIP)/ Trauma Quality Improvement Program (TQIP) to improve surgical and trauma care. Follow best practice guideline for Non ST Segment Elevation Myocardial Infarction (NSTEMI) is expected to reduce or maintain post myocardial infarction (MI) mortality. Focus on Early Supportive Discharge, Stroke Unit Equivalent Care and Community support for stroke patients. Complete Best Possible Medication History on admission in acute care, long term care, home care and ambulatory settings.
Calgary:	<ul style="list-style-type: none"> Complete Best Possible Medication History on admission – 80% compliance target met.
Central:	<ul style="list-style-type: none"> Rural roll out of Cardiac Care protocols, Stroke Protocols, asthma protocols, community acquired pneumonia protocols, and standard order sets. Rural areas continue implementation of Alberta Provincial Stroke Strategy (APSS) at Primary Stroke centers.
Edmonton:	<ul style="list-style-type: none"> Continue implementation of the Rural Stroke Action Plan. Follow best practice guideline for Non ST Segment Elevation Myocardial Infarction (NSTEMI) is expected to reduce or maintain post myocardial infarction. Pilot a medication reconciliation process on patients to inform ongoing strategies for patients in emergency departments.
North:	<ul style="list-style-type: none"> Conduct Quality Reviews of adverse and sentinel events at site and zone levels as appropriate. Reactivate the Morbidity and Mortality Committee to address performance measure to ensure sharing of best practices.

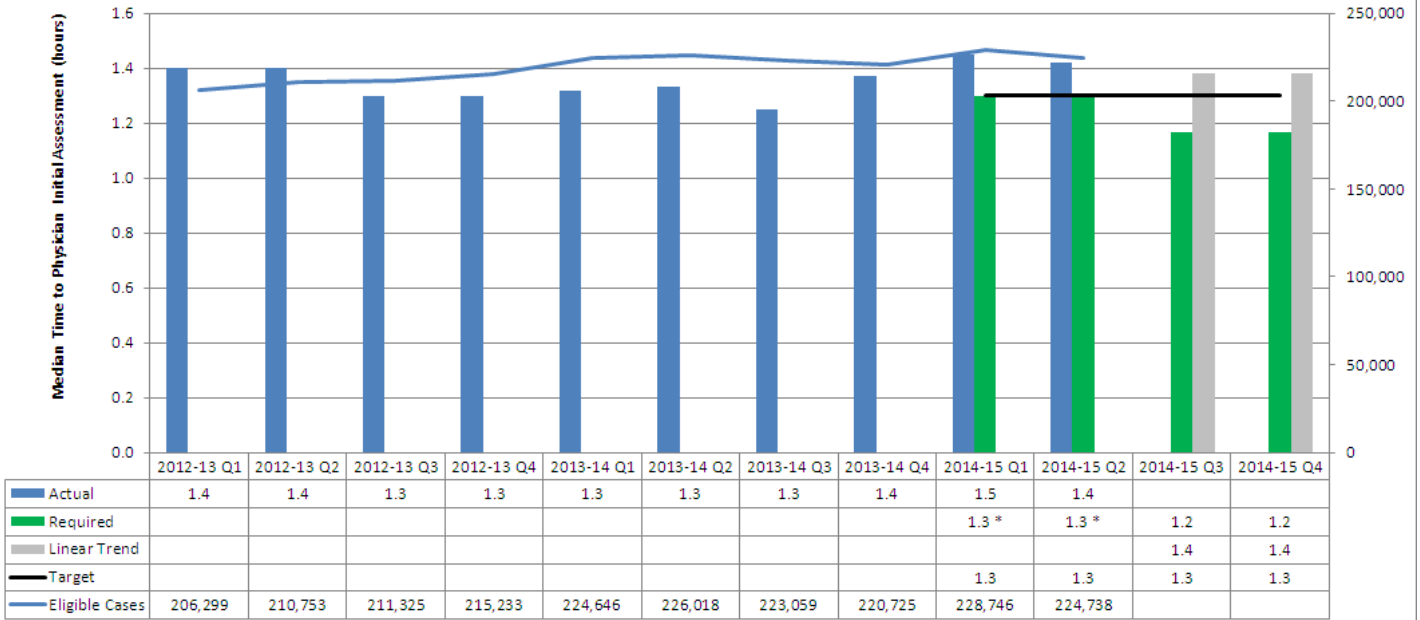
Analysis

- Q2 year-to-date provincially and all five zones are at or above target for 2014-15.
- Patient who died in the hospital and had longer hospital stays than all patients.
- Research found that most patients prefer to die in their homes.

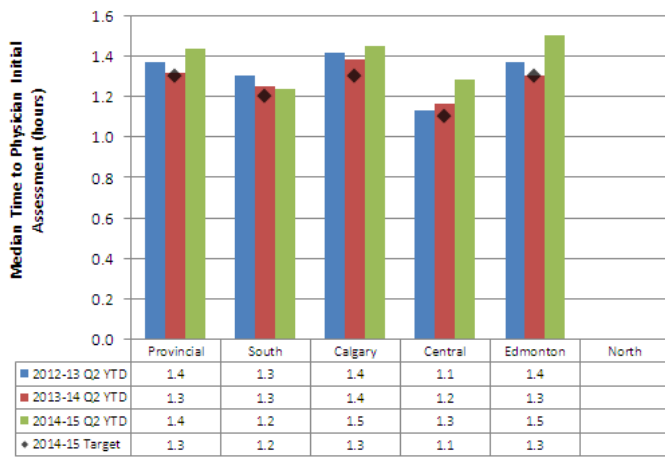
Emergency Department Wait to see a Physician

The average patient's length of time to be seen by a physician at the busiest emergency departments. This is calculated as the median wait which means that 50 per cent of patients wait to be seen by a physician in the emergency department this length of time or less. This measure is the time between when a patient is assessed by a nurse in the emergency department and when they are first seen by a physician.

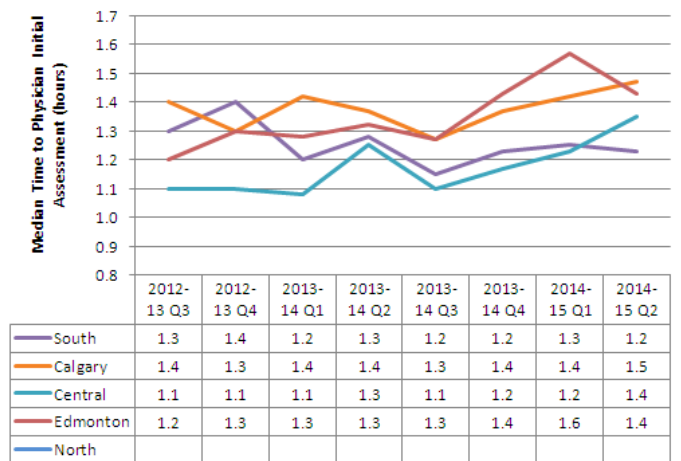
Provincial ED Time to Physician Initial Assessment



ED TPIA YTD Comparison



ED TPIA Zone Trending



Emergency Department Wait to see a Physician

The average patient’s length of time to be seen by a physician at the busiest emergency departments. This is calculated as the median wait which means that 50 per cent of patients wait to be seen by a physician in the emergency department this length of time or less. This measure is the time between when a patient is assessed by a nurse in the emergency department and when they are first seen by a physician.

Provincial Overview

Zones	Key Actions
South:	<p>A number of patient flow initiatives are in progress, by the various teams with the assistance of zone quality consultants primarily in Lethbridge and Medicine Hat; These initiatives address:</p> <ul style="list-style-type: none"> • Admission and Discharge Processes • ED visits, readmissions for individuals with Addiction and Mental Health issues and with 8 or more visits • ED visits for patients aged 65+ from Supportive Living facilities • Patient journey mapping to understand the wait times and delays of patients in the ED • Wait times for clients referred to Home Care • Working with Lab & DI to reduce output delay caused by results not being available for discharge decision making
Calgary:	<p>Calgary Zone (CZ) Emergency Department QI initiatives that are planned or in progress at each site reflect the following CZ Regional Department of Emergency Medicine (RDEM) zone priorities for the fiscal year 2014-2015:</p> <ul style="list-style-type: none"> • Engaging with community partners to support patients: the goal is to work with EMS, PCNs and other services to develop processes to support specific population, including seniors, and patients who use the EDs frequently in order to provide coordinated care across the zone.
Central:	<ul style="list-style-type: none"> • Continue implementing Emergency Department quality initiatives to improve ED Flow such as Rapid Assessment Zone (RAZ), use of Holter Monitors and diversion of patients directly to Cardiology Increased capacity of Minor treatment area • Continue to encourage after-hours service coverage with local Primary Care Network. • Increase hours for minor treatment area in the Emergency Department to assist with patient flow.
Edmonton:	<ul style="list-style-type: none"> • Collaborate with Primary Care Networks to negotiate expanded after hours support at key times (Influenza season). • Create community options for complex high needs populations (i.e. Persons with Developmental Disabilities) through collaboration with ministries. • Develop EMS community programs to decrease transports of patients identified as frequently needing service patients. • Develop Inter-facility transport model to meet needs through an integrated service for air and ground patient transport. • Expand utilization of non-ambulance transport modalities and the initiation of critical care paramedics through implementation of a critical care transport team.
North:	<ul style="list-style-type: none"> • Continue implementing Emergency Department quality initiatives and flow/LEAN improvement projects including process improvement initiative focusing on mental health patients presenting to ED. • Implement quality initiatives outlined in the Health Quality Council of Alberta EMS recommendations. • Continue implementation of the Triple Aim project in Grande Prairie – focused on improving access and flow.

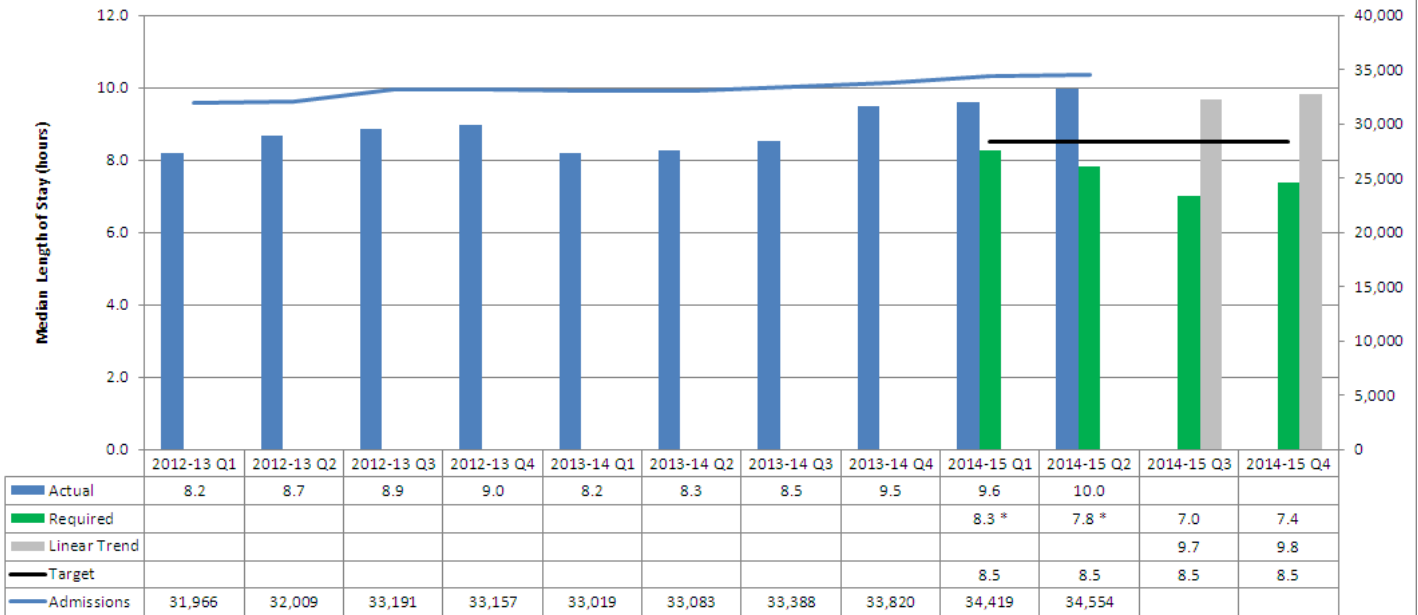
Analysis

- Majority of sites have shown a slight increase in wait times due to system capacity issues.
- Rescinding of First Available and Appropriate Living Option (FAALO) policy increased number of inpatient waiting for continuing care placement in acute care units causing the number of Emergency Inpatients to increase reducing flow.

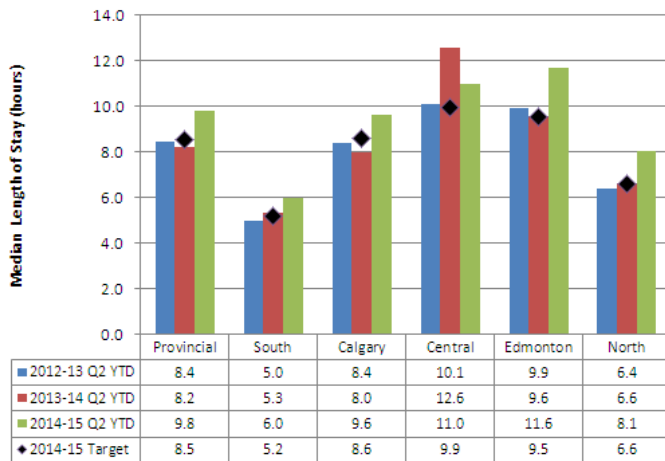
Emergency Department Length of Stay for Admitted Patients

The average patient's length of time in the emergency department before being admitted to a hospital bed at the busiest emergency departments. This is calculated as the median length of stay which means that 50 per cent of patients stay in the emergency department this length of time or less, before being admitted. This measure is the time between when a patient is assessed by a nurse in the emergency department until the time they leave the emergency department.

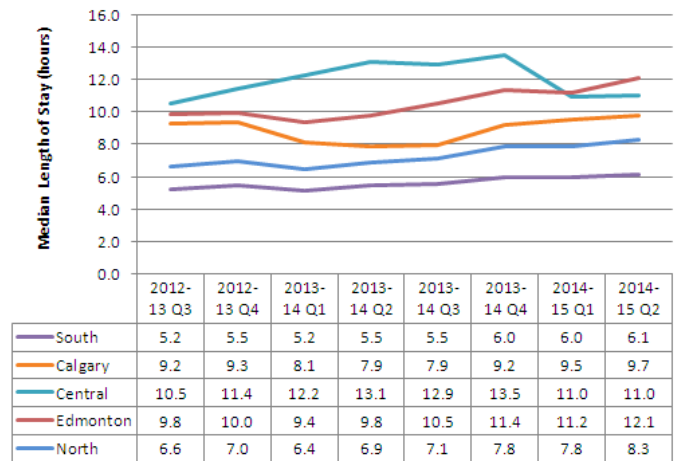
Provincial ED Length of Stay for Admitted Patients



ED LOS Admissions YTD Comparison



ED LOS Admissions Zone Trending



Emergency Department Length of Stay for Admitted Patients

The average patient's length of time in the emergency department before being admitted to a hospital bed at the busiest emergency departments. This is calculated as the median length of stay which means that 50 per cent of patients stay in the emergency department this length of time or less, before being admitted. This measure is the time between when a patient is assessed by a nurse in the emergency department until the time they leave the emergency department.

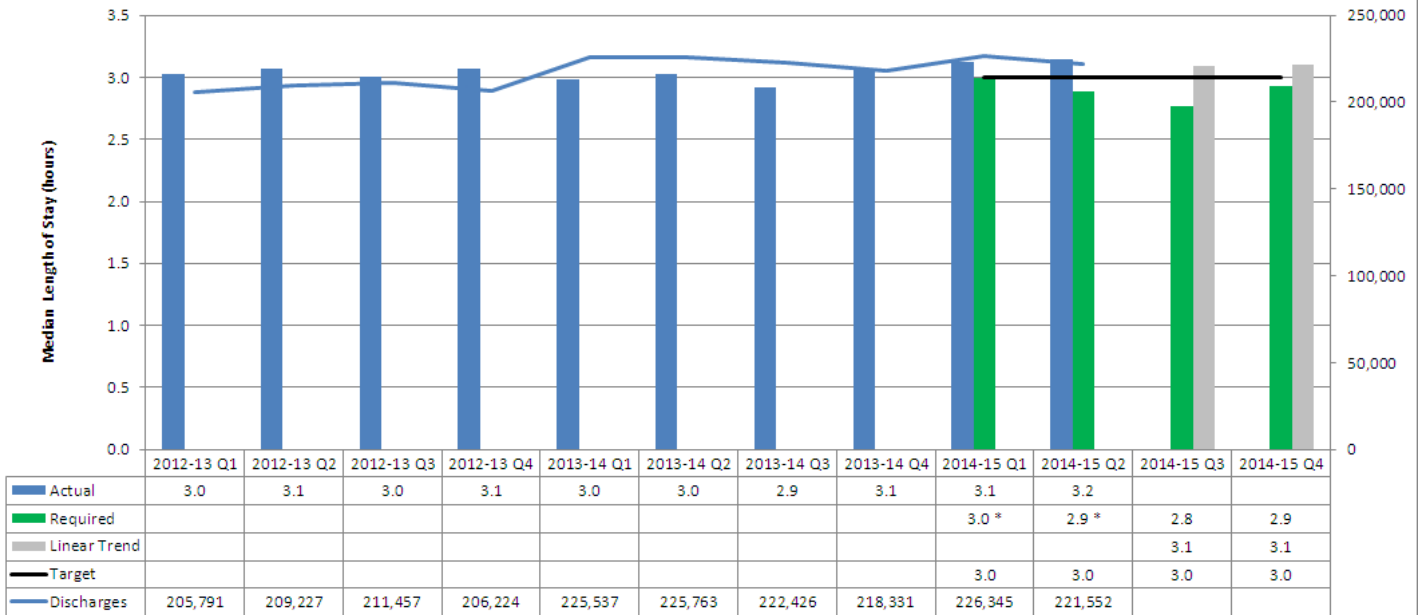
Provincial Overview

Zones	Key Actions
South:	<ul style="list-style-type: none"> • Development of Admission and Discharge Processes • Analysis of ED visits for readmissions of patients aged 65+ from Supportive Living facilities and individuals with Addiction and Mental Health issues, including potential causes of delay/variance in inflow of pediatric AMH. • Conducting Patient journey mapping to understand the wait times and delays of patients in the ED • Collaborating with housekeeping to flow map the process from the time a bed is empty until it is cleaned and ready for the next admission; new housekeeping work assignment implemented across MHRH which has shown to reduce bed turn time. • Trialing a whiteboard with standardized information and a clearly defined process for daily communication to enhance the patient journey and improve discharge outcomes. • Implementation of daily rounds and development of a transition rounds process. • Matching peak activity levels with staffing & physicians levels in the ED; Nursing shifts realigned, monitoring effectiveness. • Analysis of trends for admissions, to better match capacity within inpatients and community. • Implementation of a process change in ED admissions where the hospitalist would attend the patient in the ED to right any admission orders. • Reviewing process when Allied Health and other clinical areas (e.g. DI, Lab) to reduce cycle time from referral to seen. • Med/Surg and ED flow team meeting to identify reasons for delay getting a patient from ED to an inpatient bed. • Working to ensure that patients who visit ED from continuing care facilities are those who need emergency care and come with proper referral information. • Collaborating with hospitalists to improve response to ED and efficiency patient admission. • Ongoing work with specialists to improve ED response times and ultimately reduce ED LOS for both admitted and discharged patients
Calgary:	<p>Calgary Zone (CZ) Emergency Department QI initiatives that are planned or in progress at each site reflect the following CZ Regional Department of Emergency Medicine (RDEM) zone priorities for the fiscal year 2014-2015:</p> <ul style="list-style-type: none"> • Spread of Anticipated Date of Discharge (ADOD), Unit Councils and white boards • Complete roll-out of all 11 CoACT milestones • Convert addressographs to label printers on inpatient units
Central:	<ul style="list-style-type: none"> • Continue implementing Emergency Department quality initiatives to improve ED Flow such as Rapid Assessment Zone (RAZ), use of Holter Monitors and diversion of patients directly to Cardiology Increased capacity of Minor treatment area. • Continue to encourage after-hours service coverage with local Primary Care Network. • Implement access and flow initiatives such as implement a modified Rapid Assessment Zone, expanded patient flow coordinators, opening 24/7 on the Short Stay unit, improve utilization of Medworxx to identify delays in service or care and standardize reports on barriers to patient's progress. • Cardiology takes calls from rural sites (cardiac navigation) to divert patients directly to the Cardiology department. • Collaborate with rural sites to repatriate patients and receive diverted ED admissions.
Edmonton:	<ul style="list-style-type: none"> • Develop a plan for trauma model as part of Major Trauma Program Planning. • Increase trauma team activations at RAH and UAH to 40%. • Implement Trauma Quality Improvement Program (TQIP) at UAH, RAH and Stollery Children's Hospital. • Develop a surge influenza plan.
North:	<ul style="list-style-type: none"> • Continue implementing Emergency Department quality initiatives and flow/LEAN improvement projects including process improvement initiative focusing on mental health patients presenting to ED. • Implement quality initiatives outlined in the Health Quality Council of Alberta EMS recommendations. • Continue implementation of the Triple Aim project in Grande Prairie – focused on improving access and flow.
Analysis	
<ul style="list-style-type: none"> • Q3 data showed a significant increase in this measure. • Rescinding of First Available and Appropriate Living Option (FAALO) policy increased number of inpatient waiting for continuing care placement in acute care units causing the number of Emergency Inpatients to increase reducing flow. 	

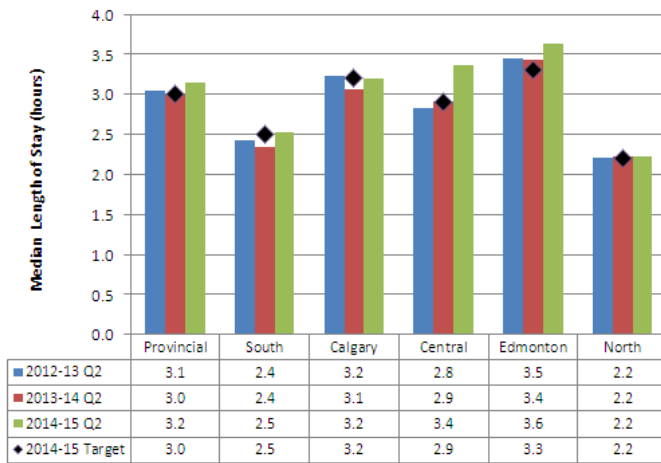
Emergency Department Length of Stay for Discharged Patients

The average patient's length of time in the ED from the time a patient is assessed by a nurse until the time they are discharged at the busiest 17 EDs. This is calculated as the median length of stay which means that 50 per cent of patients stay in the ED this length of time or less. This measure is the time between when a patient is assessed by a nurse in the emergency department until the time they leave the emergency department.

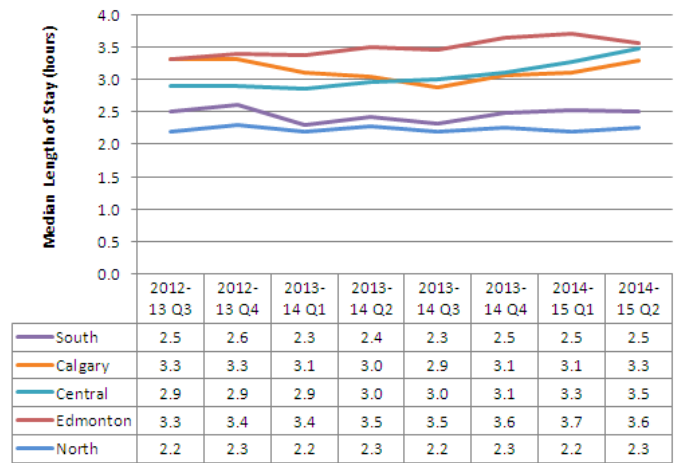
Provincial ED Length of Stay for Discharged Patients



ED LOS Discharges YTD Comparison



ED LOS Discharges Zone Trending



Emergency Department Length of Stay for Discharged Patients

The average patient's length of time in the ED from the time a patient is assessed by a nurse until the time they are discharged at the busiest 17 EDs. This is calculated as the median length of stay which means that 50 per cent of patients stay in the ED this length of time or less. This measure is the time between when a patient is assessed by a nurse in the emergency department until the time they leave the emergency department.

Provincial Overview

Zones	Key Actions
South:	<p>A number of patient flow initiatives are in progress, by the various teams with the assistance of zone quality consultants primarily in Lethbridge and Medicine Hat; These initiatives address:</p> <ul style="list-style-type: none"> • Admission and Discharge Processes • ED visits, readmissions for individuals with Addiction and Mental Health issues and with 8 or more visits • ED visits for patients aged 65+ from Supportive Living facilities • Patient journey mapping to understand the wait times and delays of patients in the ED • Wait times for clients referred to Home Care • Working with Lab & DI to reduce output delay caused by results not being available for discharge decision making
Calgary:	<p>Calgary Zone (CZ) Emergency Department QI initiatives that are planned or in progress at each site reflect the following CZ Regional Department of Emergency Medicine (RDEM) zone priorities for the fiscal year 2014-2015:</p> <ul style="list-style-type: none"> • Re-referral work from Emergency Department to Primary Care began as a partnership between the Calgary Foothills Primary Care Network and the Foothills Medical Centre as a result of the flood in Calgary in June 2013. This work continues and is offered beyond an after-hours timeframe solely, and continues to also address peak times such as influenza season and Stampede. • The results and outcomes of this work are being shared with other PCNs in the CZ in terms of ensuring other potential areas of opportunity are connected.
Central:	<ul style="list-style-type: none"> • Continue implementing Emergency Department quality initiatives to improve ED Flow such as Rapid Assessment Zone (RAZ), use of Holter Monitors and diversion of patients directly to Cardiology Increased capacity of Minor treatment area. • Establish an ongoing Rapid Assessment Zone. • Cardiology takes calls from rural sites (cardiac navigation) to divert patients directly to the Cardiology department.
Edmonton:	<ul style="list-style-type: none"> • Determine the scope and impact of the delivery of Emergency Pediatric services (including Mental Health) and develop a human resource and financial plan. • Evaluate or implement pilot of EMS/Continuing Care and Palliative Care to reduce transports of palliative care patients to ED. • Opened Emergency Department and Ambulatory Clinics at Strathcona Community Hospital and begin capital project for the development of Addiction and Mental Health Outpatient Clinics.
North:	<ul style="list-style-type: none"> • Continue implementing Emergency Department quality initiatives and flow/LEAN improvement projects including process improvement initiative focusing on mental health patients presenting to ED. • Implement quality initiatives outlined in the Health Quality Council of Alberta EMS recommendations. • Continue implementation of the Triple Aim project in Grande Prairie – focused on improving access and flow.

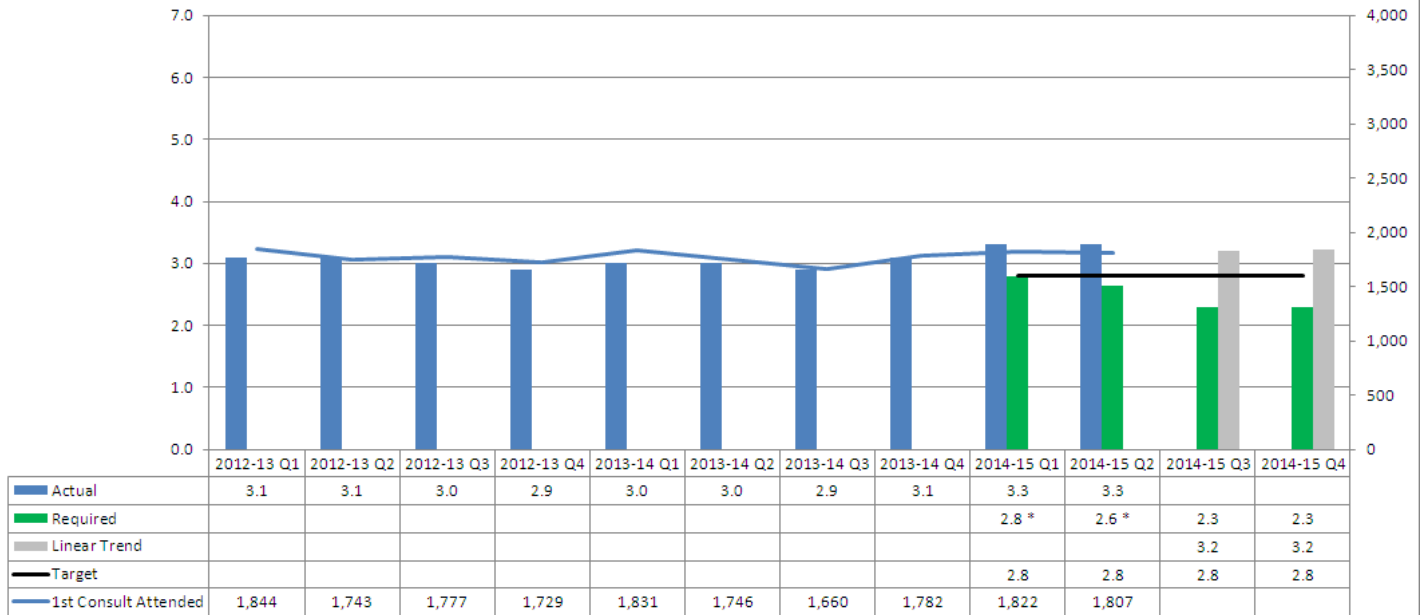
Analysis

- Majority of sites have shown a slight increase in wait times due to system capacity issues.
- Rescinding of First Available and Appropriate Living Option (FAALO) policy increased number of inpatient waiting for continuing care placement in acute care units causing the number of Emergency Inpatients to increase reducing flow.

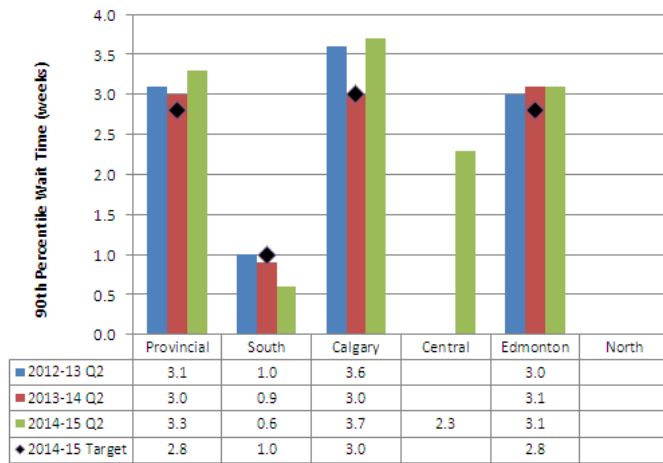
Access to Radiation Therapy

90 per cent of patients wait for radiation therapy this length of time or less (measured from when they are ready to treat). This measure 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.

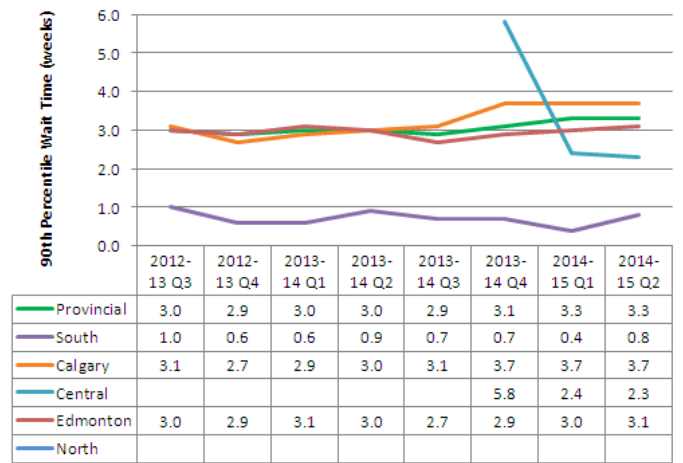
Provincial Radiation Therapy Access



Radiation Therapy YTD Comparison



Radiation Therapy Access Zone Trending



Access to Radiation Therapy

90 per cent of patients wait for radiation therapy this length of time or less (measured from when they are ready to treat). This measure 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.

Provincial Overview

Key Actions	
Cancer Care	<ul style="list-style-type: none"> Implement operational improvement initiatives at each of the tertiary and regional cancer centres to optimize the use of health professionals and resources with the goal of improving patients' access to treatment. Create a ten-year Radiation Therapy Capital Equipment Replacement Plan. Lead an interprovincial collaborative for the purchase of radiation treatment units (Linacs) to optimize buying power and strengthen related services and support from equipment vendors. Expand the Radiation Therapy Corridor through completion of the third and final component of the Radiation Therapy Corridor project in Grande Prairie by 2017.

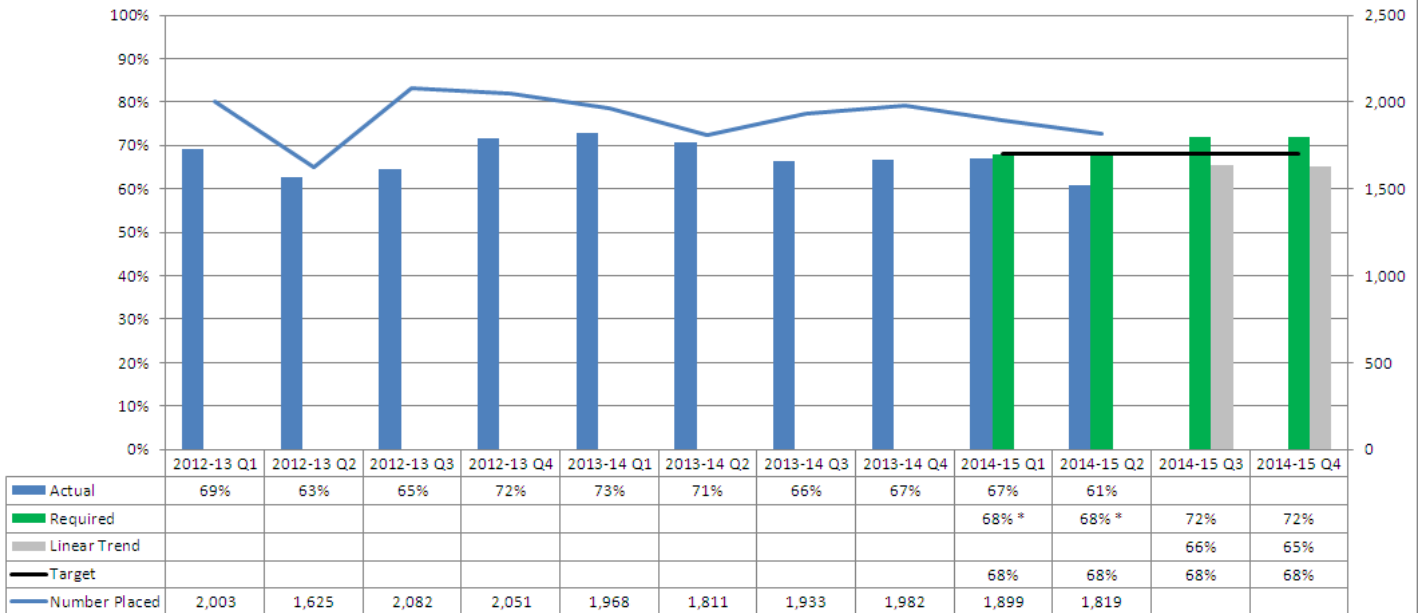
Analysis

- Long lead time for replacement of linac equipment results in a reduction in radiation therapy capacity (10%) for greater than 12 months at a time.
- Limited functionality of older equipment also reduces capacity resulting in longer wait times for some radiation therapy services.
- Operational improvement initiatives are underway but will not be ready for implementation until later in the year.
- Grande Prairie Cancer Centre is scheduled to open in 2017.

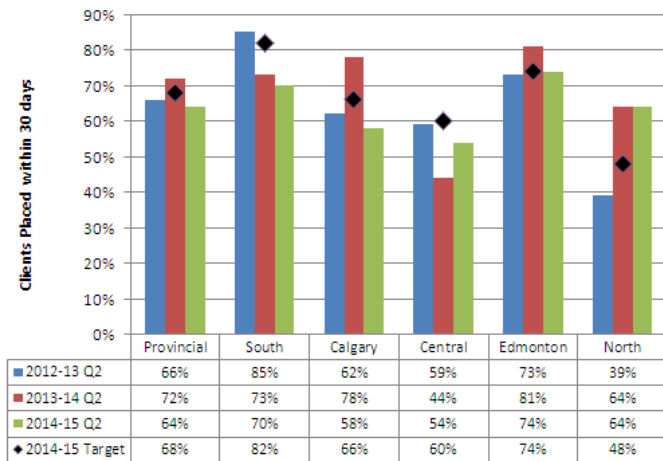
Continuing Care Placement

The percentage of clients admitted to a continuing care space (designated supportive living or long-term care) within 30 days of the date they are assessed and approved for placement. This includes patients assessed and approved and waiting in hospital or community.

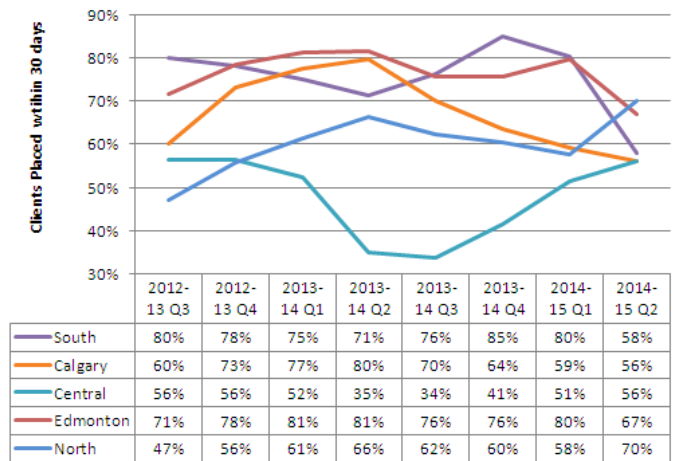
Provincial Continuing Care Placement



Continuing Care YTD Comparison



Continuing Care Zone Trending



Continuing Care Placement

The percentage of clients admitted to a continuing care space (supportive living or long-term care) within 30 days of the date they are assessed and approved for placement. This includes patients assessed and approved and waiting in hospital or community.

Provincial Overview

Zones	Key Actions
South:	<ul style="list-style-type: none"> Continue implementation of the Seniors Continuing Care Capacity Plan. In 2014-15, as of Oct. 31st South Zone opened 29 new Supportive Living 4 spaces with 24 designated for dementia.
Calgary:	<ul style="list-style-type: none"> Continue implementation of the Seniors Continuing Care Capacity Plan. In 2014-15, as of Oct. 31st Calgary Zone opened 437 new Supportive Living 4 spaces with 148 designated for dementia. Hospice contracts signed (extensions of existing capacity) Work with continuing care partners to identify hard to place patients and identify ways to repurpose or create different capacity for complex populations, determine alternate care streams for new supportive living build, and identify potential space for Persons with Developmental Disability (PDD) population and monitor use of C3 spaces for special seniors population. Complete implementation of Advanced Care Planning/ Goals of Care Designation and move into “business as usual”. Increase Home Care Capacity.
Central:	<ul style="list-style-type: none"> Continue implementation of the Seniors Continuing Care Capacity Plan. In 2014-15, as of Oct. 31st Central Zone opened 3 new Supportive Living 4 spaces. Continue to develop continuing care capacity plan for Lloydminster in partnership with Prairie North Regional Health Authority. Identify communities, spaces and/or partners that can provide new continuing care spaces. Establish an automated continuing care data collection processes which align with provincial standards for data collection management and reporting criteria. Strategy expected to increase approximately 20% of patients who are placed in 30 days.
Edmonton:	<ul style="list-style-type: none"> Continue implementation of the Seniors Continuing Care Capacity Plan. In 2014-15, as of Oct. 31st Edmonton Zone opened 18 new Supportive Living 4 spaces with 4 designated for dementia and 3 community hospice. Implement and evaluate Restorative Care Demonstration Unit at CapitalCare Norwood. Implement StrataHealth PathWays and eDischarge. Implement and evaluate Care Management Optimization in Home Living and Transition Services. Implement moveEZ to acute care with integration of Functional Mobility Guidelines. Establish 6 hospice beds at Westview Health Centre to ensure right care in the right place and reduce acute care utilization for end of life care. Increase home care capacity.
North:	<ul style="list-style-type: none"> Continue implementation of the Seniors Continuing Care Capacity Plan. In 2014-15, as of Oct. 31st North Zone opened 24 new Supportive Living 4 spaces. Develop and begin implement coordinated placement model. Awaiting approval of First Available and Appropriate Living Option (FAALO) policy.

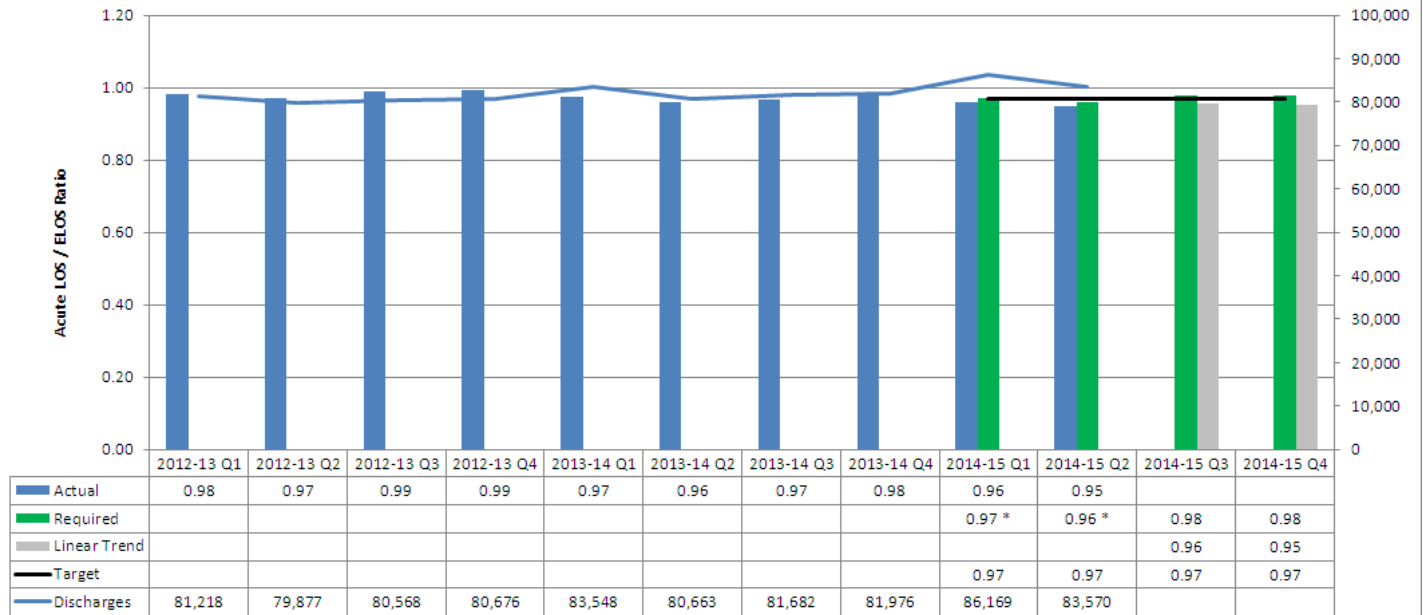
Analysis

- Provincially less people are being placed within 30 days due to system capacity issues.
- Rescinding of First Available and Appropriate Living Option (FAALO) policy increased number of inpatient waiting for continuing care placement in acute care units causing the number of Emergency Inpatients to increase reducing flow.
- The number of people waiting in acute care for continuing care placement has increased from 512 in Q4 of 2013/14 to 765 in Q2 of 2014/15.
- From April 2014 to October 2014, 511 net new continuing care beds have been opened across the province.
- Since 2010, AHS has opened 3,545 continuing care beds including long term care, supportive living and palliative beds.

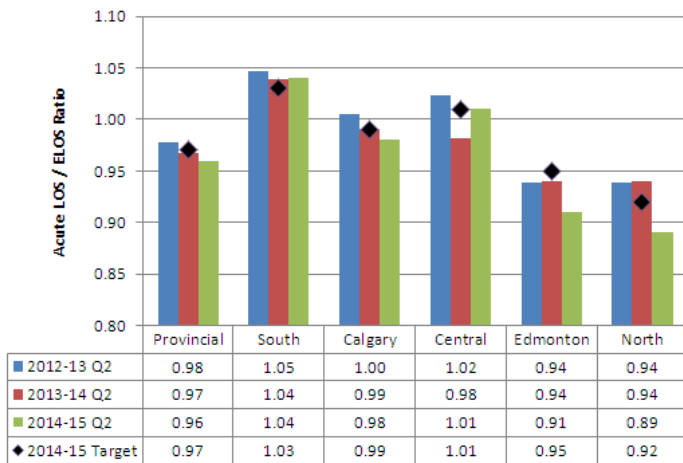
Acute (Actual) Length of Hospital Stay Compared to Expected Stay

The average number of days patients stay in acute care hospitals compared to the expected length of stay for a typical patient. This measure compares acute length of stay in hospital to expected length of stay after adjusting for factors that affect in-hospital mortality, such as patient age, sex, diagnosis and other conditions. The expected length of stay is based on comparison to similar patients in national databases.

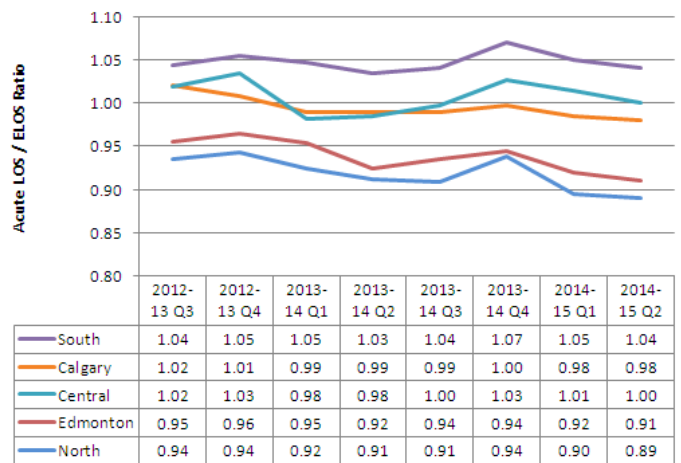
Provincial Acute (Actual) LOS to Expected LOS Ratio



Acute LOS/ELOS YTD Comparison



Acute LOS / ELOS Zone Trending



Acute (Actual) Length of Hospital Stay Compared to Expected Stay

The average number of days patients stay in acute care hospitals compared to the expected length of stay for a typical patient. This measure compares acute length of stay in hospital to expected length of stay after adjusting for factors that affect in-hospital mortality, such as patient age, sex, diagnosis and other conditions. The expected length of stay is based on comparison to similar patients in national databases.

Provincial Overview

Zones	Key Actions
South:	<ul style="list-style-type: none"> • Continue implementation of CoAct and patient flow initiatives. • Develop plan and implementation for scheduling and optimization. • Implement tools to support the Collaborative Practice Model. • Spread Path2Home/Medworxx to larger rural sites.
Calgary:	<ul style="list-style-type: none"> • Continue implementation of CoAct and patient flow initiatives. • Increase acute care capacity – Medicine Beds.
Central:	<ul style="list-style-type: none"> • Continue implementation of CoAct and patient flow initiatives such as Rapid Rounds 7 days a week. • Develop a proposal for restorative care services. • Optimize Medworxx to support flow and safe discharge.
Edmonton:	<ul style="list-style-type: none"> • Continue implementation of CoAct and patient flow initiatives. • Increase acute care capacity – Medicine Beds.
North:	<ul style="list-style-type: none"> • Continue implementation of CoAct and patient flow initiatives. • Continue implementation of discharge planning tools such as the rural discharge planning model.
Strategic Clinical Networks:	<ul style="list-style-type: none"> • Implement new and consistent ways of managing care before, during, and after specific colorectal surgeries by focusing on mobility, nutrition, hydration and pain management (Enhanced Recovery After Surgery - ERAS). • Implement Elder Friendly care units at specific sites.

Analysis

- Overall, the provincial results have improved and are better than target.

Early Detection of Cancer

The percentage of patients with breast, cervical and colorectal cancers who were diagnosed at early stages 1 or 2. This measure covers the three most common cancers; breast, cervical and colorectal. It represents the percentage of invasive cancer cases diagnosed in the stages (Stage I, and II (and stage 0 for breast cancer)) in relation to all patients diagnosed with these diseases in all stages.

Per Cent diagnosed at early Stages

Zone	2008	2009	2010	2011	2012	2014-15 Target	2015-16 Target
Provincial	64%	65%	67%	66%	67%	67%	70%
South	60%	66%	68%	64%	63%	66%	70%
Calgary	66%	69%	66%	70%	70%	70%	71%
Central	62%	61%	63%	62%	63%	64%	69%
Edmonton	65%	65%	69%	66%	66%	67%	70%
North	65%	61%	65%	61%	64%	64%	69%

No Update for Q2 2014-15 as this is an annual measure.

Early Detection of Cancer

The percentage of patients with breast, cervical and colorectal cancers who were diagnosed at early stages 1 or 2. This measure covers the three most common cancers; breast, cervical and colorectal. It represents the percentage of invasive cancer cases diagnosed in the stages (Stage I, and II (and stage 0 for breast cancer)) in relation to all patients diagnosed with these diseases in all stages.

Provincial Overview

Zones	Key Actions
South:	<ul style="list-style-type: none"> • Work with Primary Care Networks and Lab regarding options to increase uptake of FIT, targeting clinics with low FIT test return rates. • Provide education for primary care physicians on the use of FIT testing. • Monitor and evaluate FIT testing implementation. • Develop and implement clear follow-up processes for patients with positive FIT results.
Calgary:	<ul style="list-style-type: none"> • Work with Primary Care Networks and Lab regarding options to increase uptake of FIT, targeting clinics with low FIT test return rates. • Provide education for primary care physicians on the use of FIT testing. • Monitor and evaluate FIT testing implementation. • Develop and implement clear follow-up processes for patients with positive FIT results.
Central:	<ul style="list-style-type: none"> • Implement FIT Testing across the zone as the average risk colon cancer screening tool. • Develop a coordinated approach to colonoscopies that addresses provincial standards for colon cancer screening. • Participate in Provincial Alberta Colorectal Cancer Screening Program (ACRCSP) quality monitoring workshop. • Work with Family Care Clinics, physicians and Primary Care Networks to enhance case management of early discharge and early detection of cancer for colorectal (FIT).
Edmonton:	<ul style="list-style-type: none"> • Work with Primary Care physicians and Lab on options to increase uptake of Fecal Immunochemical Testing. • Continue ongoing Target clinics with low FIT test return rates and provide more education to primary care. • Continue ongoing cancer prevention enhancements through provincial cancer screening initiatives: Fecal Immunochemical Testing (FIT), Mobile mammography and Cervical cancer screening • Continue to enhance ability to utilize ambulatory EMR (eClinician) to trigger early detection.
North:	<ul style="list-style-type: none"> • Continue delivering community cancer screening programs (e.g. mobile screening services, cervical screening, fecal immunochemical test, colonoscopy). • Work with partners to develop a Community Cancer Prevention Profile tool for rural and remote communities to assess environments for cancer prevention support. • Work with communities to prioritize actions, monitor progress and evaluate interventions. • Implement the Enhanced Access to Cancer Screening Pilot Project and spread the evaluation findings across communities. • Expand cancer screening to First Nation communities to improve access to services. • Continue to promote Toward Optimized Practice’s panel management/screening program for PCNs during business planning.

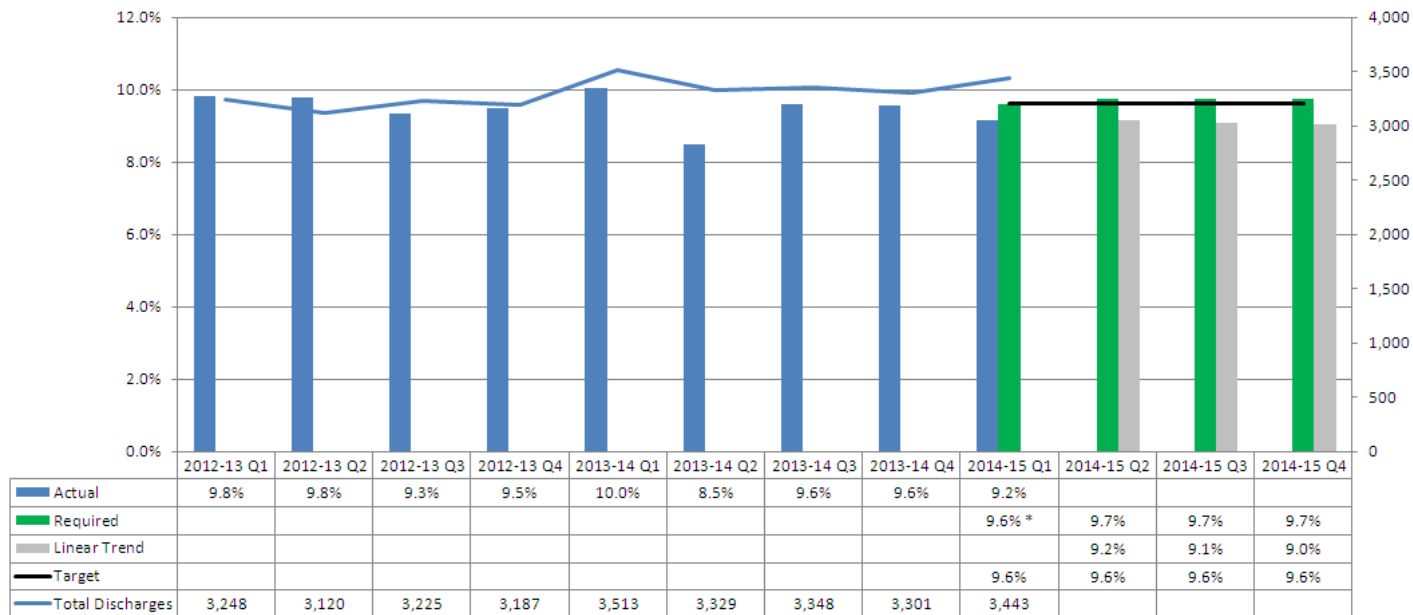
Analysis

- Data is published annually.
- The changes to colorectal cancer screening participation are gradual and may be affected by many factors, including an individual’s knowledge and attitude toward colorectal cancer screening, access to services, as well as seasonal variation and service interruptions.
- Continue to work to incorporate a full spectrum of screening program activities within the Alberta Breast Cancer Screening Program.
- Work is underway within the zones to offer cervical cancer screening to clients during clinic visits as per provincial screening guidelines.

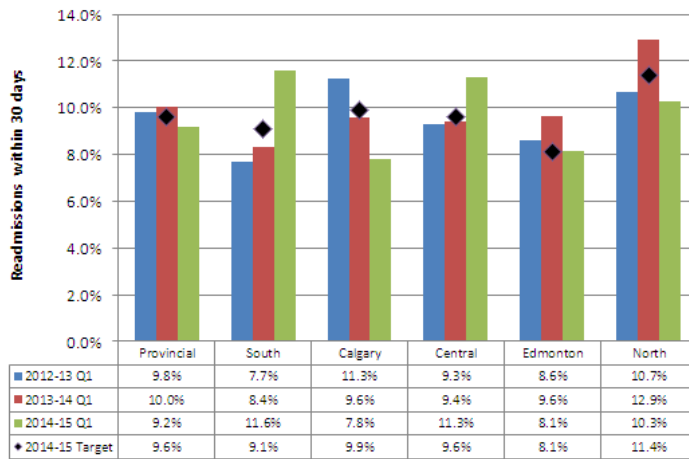
Mental Health Readmissions

The percentage of patients who have mental health disorders with unplanned readmission to hospital within 30 days of leaving hospital. Excludes scheduled readmissions such as for planned follow-up care.

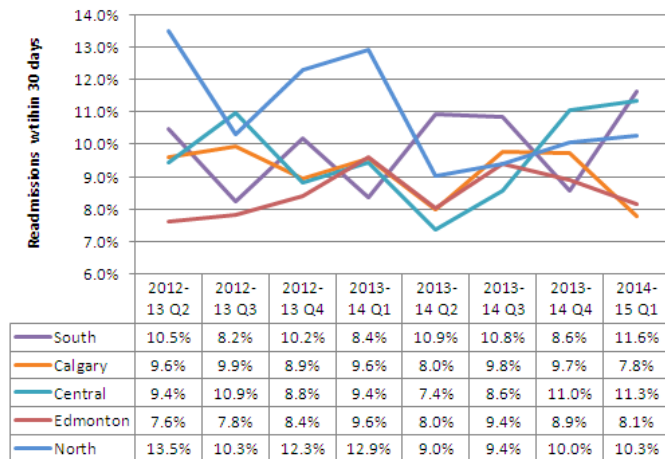
Provincial Mental Health Readmissions



Mental Health Readmits YTD Comparison



Mental Health Readmits Zone Trending



Mental Health Readmissions

The percentage of patients who have mental health disorders with unplanned readmission to hospital within 30 days of leaving hospital. Excludes scheduled readmissions such as for planned follow-up care.

Provincial Overview

Zones	Key Actions
South:	<ul style="list-style-type: none"> Complete health and service needs assessment. Develop Strategy and Operational Plan.
Calgary:	<ul style="list-style-type: none"> Open new adolescent mental health inpatient beds Repurpose 14 bed inpatient adolescent mental health unit. Contact patients within 7 days of discharge to provide post-discharge support and reinforcement of discharge recommendations. Reduce hospitalization for Community Treatment Orders (CTO) clients with a mental disorder one year post CTO issuance.
Central:	<ul style="list-style-type: none"> Work with Family Care Clinics, physicians and Primary Care Networks to enhance case management of individuals with mental health concerns. Develop Mental Health Service Planning as part of the Long Range Service Plan.
Edmonton:	<ul style="list-style-type: none"> Consolidate and expand existing community addiction and mental health services into three new clinic locations outpatient clinics (Leduc, Forensic Community Services and Strathcona Community Hospital). Commence the Community Urgent Services and Stabilization Team commenced which includes an Urgent Psychiatric Clinic, Crisis Response, Home Based and Clinic Assessment and stabilization as well as Social Work and Addiction Counsellors. Capital planning required for new bed capacity at AHE and the RAH. Implement an integrated electronic health record (eClinician) in all community, ambulatory and outpatient services. Develop a provincial model on opioid dependency programming.
North:	<ul style="list-style-type: none"> Complete Addiction and Mental Health Strategic and Operational Plan. Continue implementation of the Triple Aim project. Develop Aboriginal Mental Health Strategy and action plan (service area based action planning). Initiate recruitment of aboriginal mental health traveling team comprising of an aboriginal mental health cultural helper and therapist.

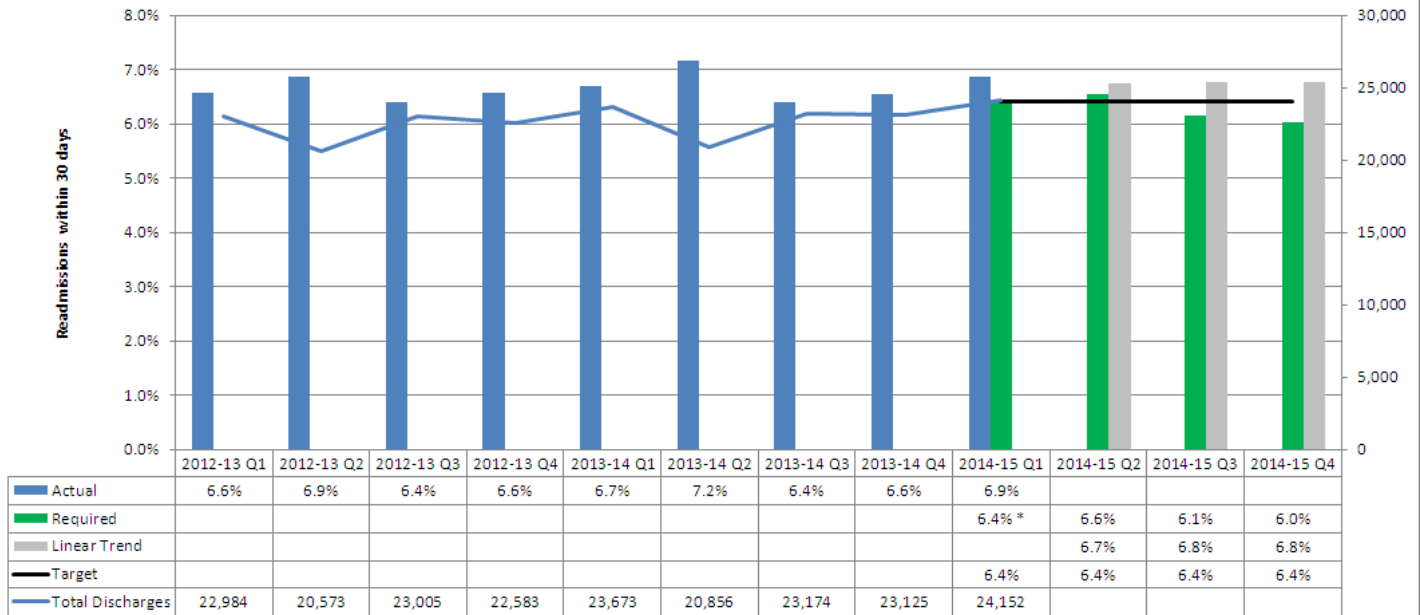
Analysis

- Provincially, rates have improved (9.2%) exceeding the target 9.6%.

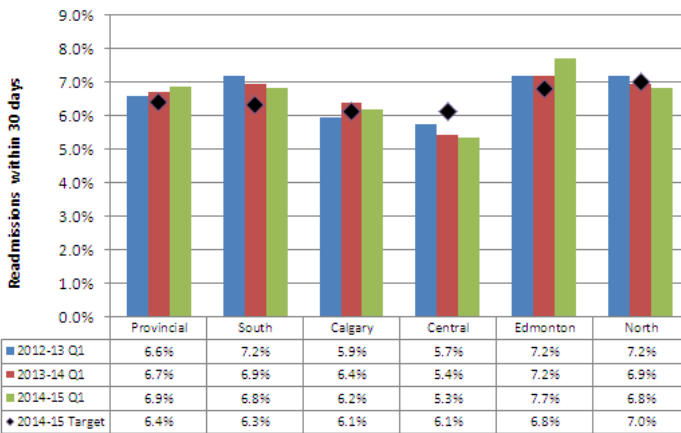
Surgical Readmissions

The percentage of surgical patients with unplanned readmission to hospital within 30 days of leaving the hospital. Excludes scheduled readmissions such as for planned follow up care.

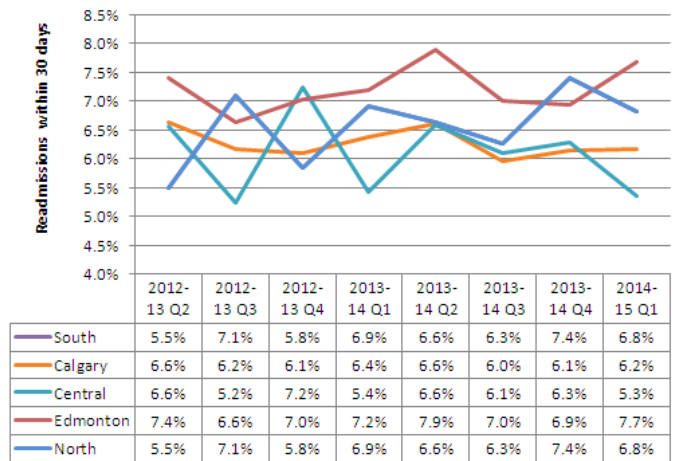
Provincial Surgical Readmissions



Surgical Readmits YTD Comparison



Surgical Readmits Zone Trending



Surgical Readmissions

The percentage of surgical patients with unplanned readmission to hospital within 30 days of leaving the hospital. Excludes scheduled readmissions such as for planned follow up care.

Provincial Overview

Zones	Key Actions
South:	<ul style="list-style-type: none"> Refine Zone Rural Surgical and Obstetrical plan.
Calgary:	<ul style="list-style-type: none"> Increase capacity for Alberta Thoracic Oncology Program (ATOP) surgeries (cancer surgery). Monitor volumes and impact on wait times and inpatient bed resources. Utilize aCATS data to prioritize wait lists and plan for additional surgical capacity.
Central:	<ul style="list-style-type: none"> Develop protocols and implement standardized falls risk management (FRM) strategies for targeted populations. Implement and sustain medication reconciliation (MedRec) in all settings. Implement NSQIP by establishing Surgical Clinical reviewer, surgical champion and anesthesia champion. Implement Safe Surgical Checklist. Conduct a gap analysis for colorectal and other surgery practices using ERAS Enhanced Recovery After Surgery protocols. Develop a Zone based obstetrical and surgical service plan.
Edmonton:	<ul style="list-style-type: none"> Complete Surgical and Operative Services Planning. Implement additional capacity for cancer surgery and associated beds. Implementation plan underway of new Enhancing Recovery After Surgery (ERAS) protocols including major gynecology and urology procedures. Implement Head and Neck Pathway and Hip Fracture pathway.
North:	<ul style="list-style-type: none"> Work to support the Surgery Strategic Clinical Network in development of a provincial surgical service planning framework to guide surgical planning and decision making. Implement recommendations for reprocessing and sterilization.
Strategic Clinical Networks:	<ul style="list-style-type: none"> Continue implementation of the Safe Surgery Checklist. Continue implementation of Adult Coding Access Target for Surgery (aCATS) which standardizes surgical wait times based on patient's condition and level of urgency. Continue implementation of Enhancing Recovery After Surgery (ERAS) for colorectal surgeries. Develop and implement standardized pathways to decrease system demands on length of stay (e.g. hip fracture pathway, head and neck surgical pathways). Implement the National Surgical Quality Improvement Program (NSQIP) and the Trauma Quality Improvement Program (TQIP).

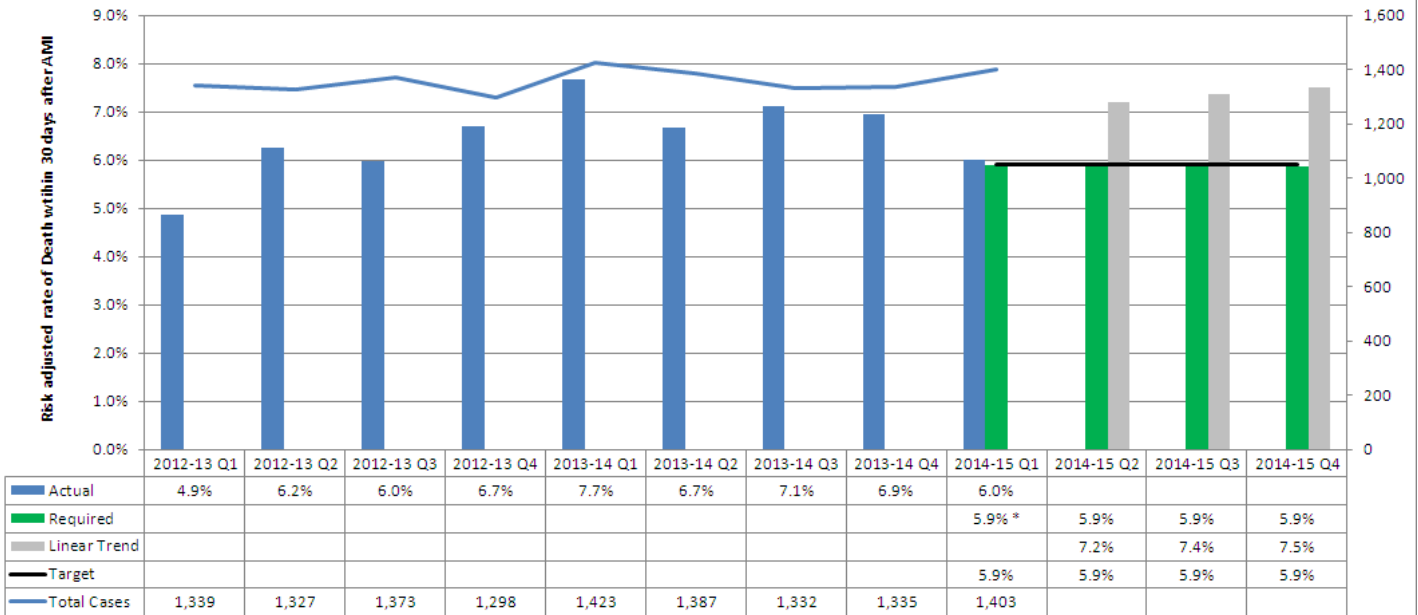
Analysis

- Provincially, the results demonstrated movement away from target.

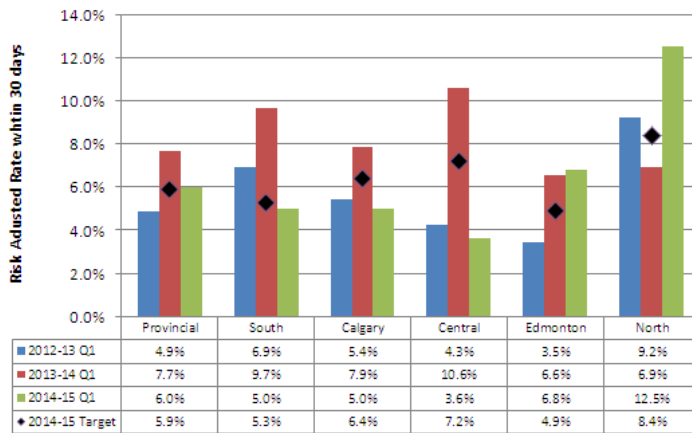
Heart Attack Mortality

The probability of dying in hospital within 30 days of being admitted for a heart attack. This measure represents hospital deaths occurring within 30 days of first admission to a hospital with a diagnosis of acute myocardial infarction (AMI), often called a heart attack. This measure is adjusted for age, sex and other conditions.

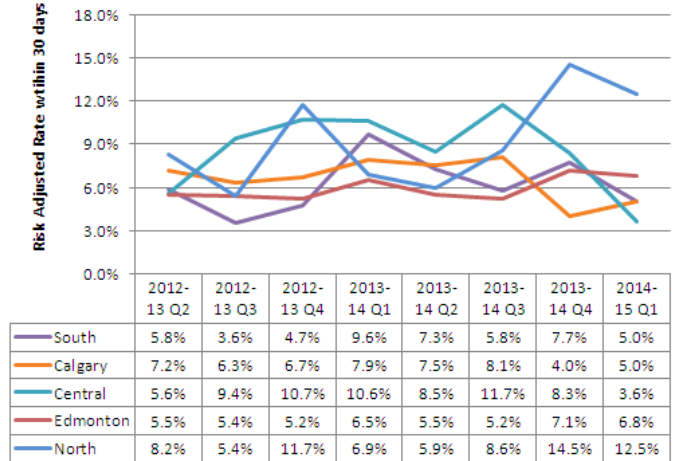
Provincial Heart Attack Mortality



Heart Attack Mortality YTD Comparison



Heart Attack Mortality Zone Trending



Heart Attack Mortality

The probability of dying in hospital within 30 days of being admitted for a heart attack. This measure represents hospital deaths occurring within 30 days of first admission to a hospital with a diagnosis of acute myocardial infarction (AMI), often called a heart attack. This measure is adjusted for age, sex and other conditions.

Provincial Overview

Zones	Key Actions
South:	<ul style="list-style-type: none"> Develop specific action plans for areas that are not currently meeting target.
Calgary:	<ul style="list-style-type: none"> Focus on strategies that address heart attack mortality such as implementation of projects including improving ED times (door-to-needle time). Developed NSTEMI (non-ST segment elevation myocardial infarction)/Acute Coronary Syndrome Guidelines provincially. Provide Quality Improvement through direct feedback with teams involved in heart attack care.
Central:	<ul style="list-style-type: none"> Continue implementation of quality initiatives on such as New Cardiac “Heart Attack Month-Unit 22”. Implement Medworxx as single point of entry. Undertake review and needs assessment for a Cardiac Catheterization Lab/ Interventional Cardiology Service. Develop provincial chest pain protocol.
Edmonton:	<ul style="list-style-type: none"> Focus on strategies that address heart attack mortality such as implementation of projects including improving ED times (door-to-needle time). Provide Quality Improvement through direct feedback with teams involved in heart attack care.
North:	<ul style="list-style-type: none"> Increase uptake of NSTEMI (non-ST segment elevation myocardial infarction) order sets to achieve provincial best practice standards. Continue to liaise with Primary Care Networks and Family Care Clinics to promote participation in C-CHANGE guideline implementation. Continue to engage community pharmacies and provide education on screening and early vascular risk management. Continue to work with Nexxon and SunLife on the worksite vascular risk screening and early management demonstration project.

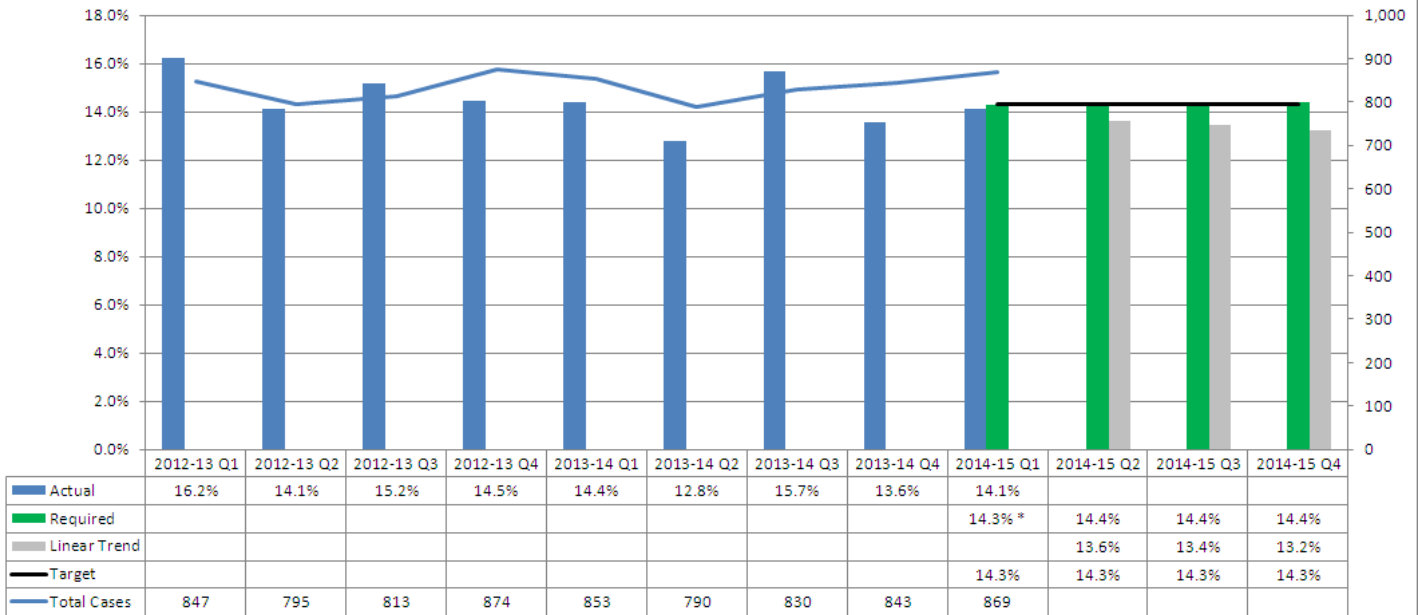
Analysis

- Provincially, the rate has improved (6.0%) and is close to target (5.9%).

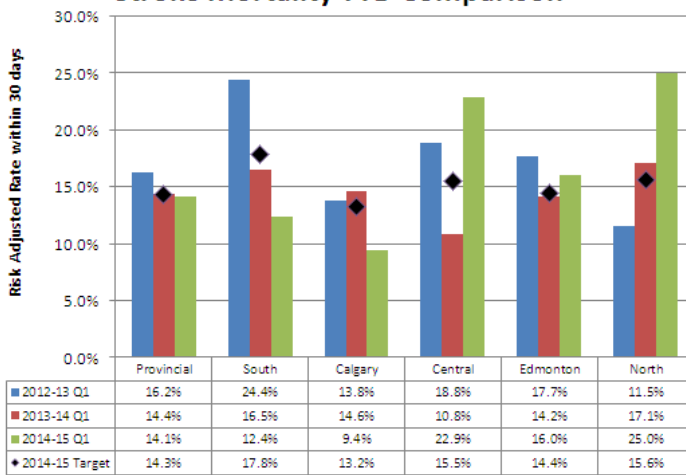
Stroke Mortality

The probability of dying in hospital within 30 days for patients admitted because of stroke. This measure represents hospital deaths occurring within 30 days of first admission to a hospital with a diagnosis of stroke. This measure is adjusted for age, sex and other conditions.

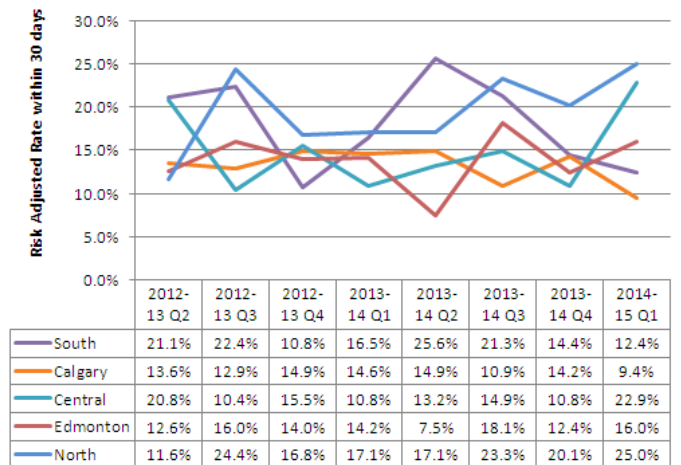
Provincial Stroke Mortality



Stroke Mortality YTD Comparison



Stroke Mortality Zone Trending



Stroke Mortality

The probability of dying in hospital within 30 days for patients admitted because of stroke. This measure represents hospital deaths occurring within 30 days of first admission to a hospital with a diagnosis of stroke. This measure is adjusted for age, sex and other conditions.

Provincial Overview

Zones	Key Actions
South:	<ul style="list-style-type: none"> Continue implementation of Rural Stroke Action plan: Early Supportive Discharge (ESD) and Stroke Unit Equivalent Care (SUEC) and Community support of stroke patients.
Calgary:	<ul style="list-style-type: none"> Continue improvement in Door-to-Needle (DTN) times for tPA for acute stroke; and a reduction in median DTN times resulting tPA access and DTN time improvements commended in Calgary Stroke Program Accreditation/Canada Stroke Distinction report. Increase access to Stroke Unit Care associated with improved flow from Early Supported Discharge (ESD) and Central Stroke Rehab Coordination <ul style="list-style-type: none"> Incorporate quality review of Alberta stroke strategy guidelines in action plan including Stroke Unit Equivalent Care at primary stroke centres Cardiovascular Health & Stroke: Implement the Rural Stroke Action Plan: Stroke Unit Equivalent Care is expected to reduce mortality by 15% (Edmonton, North, Central, South and Calgary).
Central:	<ul style="list-style-type: none"> Continue Early Supported Stroke Discharge (ESD) and program monitoring and evaluation of ESD pilot. Implement Stroke Unit Equivalent Care at primary stroke centres through adherence to standards created for small urban and rural Primary Stroke Centres that follow. Work with SCN to evaluate stroke services in comparison to Canadian Stroke Best Practice Guidelines (CSBPG).
Edmonton:	<ul style="list-style-type: none"> Continued improvement in Door-to-Needle (DTN) times for tPA for acute stroke; and a reduction in median DTN times. Increase access to Stroke Unit Care (SUEC) associated with improved flow from Early Supported Discharge (ESD) and Central Stroke Rehab Coordination. Incorporate quality review of Alberta stroke strategy guidelines in action plan including Stroke Unit Equivalent Care at primary stroke centres. Implement the Rural Stroke Action Plan: Stroke Unit Equivalent Care is expected to reduce mortality by 15%. Increase access to same day assessment for high risk TIA pts (24 hours). Maintain the Stroke Service of Distinction Award from Accreditation Canada. Work with non-stroke sites to ensure stroke neurology consultation is obtained urgently and patients are transferred.
North:	<ul style="list-style-type: none"> Develop Stroke Mortality Audit Tool. Implement Stoke Action Plan. Continue to monitor and report Door to Needle times. Engage stakeholders and develop an implementation plan for Stroke Unit Equivalent Care within six Primary Stroke Centres (PSC's) and one non-PSC site. Engage stakeholders and develop an implementation plan for Stroke Early Supported Discharge including presentation on TeleHealth by stroke neurologist. Continue to liaise with Primary Care Networks and Family Care Clinics to promote participation in C-CHANGE guideline implementation Continue to engage community pharmacies and provide education on screening and early vascular risk management Continue to work with Nexxon and SunLife on the worksite vascular risk screening and early management demonstration project Conduct an environmental scan to assess opportunities and identify pilot sites for integration of vascular risk reduction services.

Analysis

- Provincially, the rate has improved (14.1%) and is better than target (14.3%).