Revised December 2017

Performance Report
2017-2018 Health Plan
Q1 (April 1, 2017-June 30, 2017)

A healthier future. Together.

Alberta Health Services

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Executive Summary

The Alberta Health Services (AHS) 2017-2020 Health Plan and Business Plan provides a roadmap of how AHS will meet its priorities and direction on how to measure performance through the fiscal year. This quarterly update is the first report for fiscal year 2017-2018.

The 2017-18 quarterly update has been modified to reflect a more streamlined approach to reporting AHS' priorities. The report has been designed according to the 12 objectives stated in the 2017-2020 Health Plan and Business Plan and includes an update on actions and measures from the Action Plan, priorities as stated in AH Accountability Letters as well as the 13 AHS Performance Measures. This report will be posted on the AHS public website.

The 13 new performance measures are reported as follows:

- Two measures have different reporting cycles (1) Perinatal Mortality among First Nations (annually) and (2) Employee Engagement Rates (reported every two years).
- 11 measures are reported quarterly:
    - Seven measures include the most current data available (Q1) with comparable historical data
    - One measure is new and only has current data.
    - Three of the eight measures rely on patient follow-up and Q1 data will be reported in Q2.

Q1 results (April 1 2017 to June 30 2017) for the eight performance measures is as follows:

- 75% (6 out of 8) of the performance measures are better or stable from the same period last year with two measures achieving target (Disabling Injury Rate and Percentage of Nursing Units Achieving Best Practice Targets).
- 25% (2 out of 8) of the performance measures (percentage placed in continuing care within 30 days and percentage of alternate level of care patient days) did not improve from the same period as last year due to slower than expected growth in home, continuing and community care.

AHS has identified actions aligned to our new 2017-2020 Health Plan and Business Plan which will help us achieve our targets by year end. It is important to note that it takes time to build capacity and meet targets by March 31st.

Q1 Dashboard

Q1 describes the progress undertaken by AHS from April 1, 2017 to June 30, 2017. Zones and provincial programs have provided updates to objectives and priorities in the subsequent pages as outlined in the 2017-18 Action Plan.

Goal	AHS Objective and Performance Measure	Fiscal Year 2016-17	Q1 2016-17	Q1 2017-18	Quarterly Comparison	2017-18 Target
	★Target Achieved ■ Improvement ▲ Stable over prior period ≤3% ● Area requires additional focus					
Improve patients' and families' experiences	**Make the transition from hospital to community-based care options more seamless**					
	Percentage Placed in Continuing Care within 30 Days	56.1%	62.1%	52.3%	●	56%
	Percentage of Alternate Level of Care (ALC) Patient Days	15.4%	14.2%	17.8%	●	14%
	Make it easier for patients to move between primary, specialty and hospital care					
	Number of Specialties Using eReferral Advice Request	4	4	4	▲	10
	Respect, inform, and involve patients and families in their care while in hospital					
	Adult Patient Experience with Hospital Care	82.4%	Q1 available in Q2; Q4 in appendix			85%
	Improve access to community and hospital addiction and mental health services for adults, children and families					
	Access to Adult Addiction Outpatient Services (in days)	15	Q1 available in Q2; Q4 in appendix			12
Improve patient and population health outcomes	**Improve health outcomes through clinical best practices**					
	Unplanned Medical Readmissions	13.6%	Q1 available in Q2; Q4 in appendix			13.4%
	Improve health outcomes of Indigenous peoples in areas where AHS has influence					
	Perinatal Mortality Among First Nations *(this measure does not include all indigenous populations)*	First Nations = 9.7 Non First Nations = 4.7 (2016)	Reported annually. AHS' focus is to reduce the gap between First Nations and Non First Nations.			
	Reduce and prevent incidents of preventable harm to patients in our facilities					
	Hand Hygiene Compliance	82%	82%	83%	■	90%
	Focus on health promotion and disease and injury prevention with an emphasis on childhood immunization					
	Childhood Immunization: DTPP-Hib	78.3%	78.7%	78.3%	▲	80%
	Childhood Immunization: MMR	87.4%	87.3%	86.5%	▲	88%
Improve the experience and safety of our people	**Improve our workforce engagement**					
	Employee Engagement Rate	3.46	Reported annually. Survey done every 2 years. Next Survey in 2018-19.			
	Reduce disabling injuries in our workforce					
	Disabling Injury Rate	3.9	3.2	3.2	★	3.5
Improve financial health and value for money	**Improve efficiencies through implementation of operational and clinical best practices while maintaining or improving quality and safety**					
	Percentage of Nursing Units Achieving Best Practice Targets	n/a	n/a	35.2%	★	35%
	Integrate clinical information systems to create a single comprehensive patient record					
	There is no AHS measure identified for clinical information systems. We will monitor our progress over the next three years through the accomplishment of our actions.					

Note: "Quarterly Comparison" compares data from the current quarter to the same time period as last year for easy reference, and may or may not indicate statistical significance of the results.

Objective 1: Make the transition from hospital to community-based care options more seamless.

WHY THIS IS IMPORTANT

Increasing the number of home care services and community-based options reduces demand for hospital beds, improves the flow in hospitals and emergency departments and enhances quality of life.

UNDERSTANDING THE MEASURES

AHS has two performance measures (Percentage Placed in Continuing Care within 30 Days and Percentage of Alternate Level of Care Inpatient Days) to monitor how quickly patients are moved from hospitals into community-based care. These measures help us ensure our patients are receiving the most appropriate care for their needs.

AHS PERFORMANCE MEASURE: Percentage placed in continuing care within 30 Days

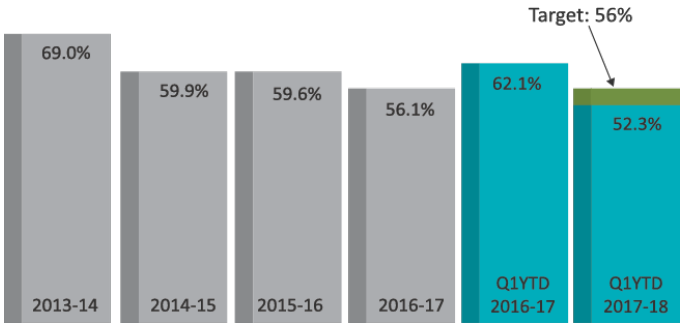
Percentage Placed in Continuing Care within 30 Days is defined as the percentage of clients admitted to a continuing care space (designated supportive living or long-term care) within 30 days of the date they are assessed and approved for placement. This includes patients/ clients assessed, approved and waiting in both hospital and community.

HOW WE ARE DOING

The higher the percentage the better, as it demonstrates capacity meeting need for long-term care or designated supportive living (levels 3, 4, and 4-dementia).

Percentage Placed in Continuing Care within 30 Days:

Quarterly Comparison ● Area requires additional focus



AHS PERFORMANCE MEASURE: Percentage of Alternate Level of Care (ALC) inpatient days

Percentage of Alternate Level of Care (ALC) inpatient days is defined as the percentage of hospital inpatient days when a patient no longer requires the intensity of care of the hospital setting and care could be provided in an alternative setting referred to as ALC.

This indicator looks at "inpatient days" – a count of the days hospital beds are occupied by patients – to measure the percentage of days hospital beds occupied by patients identified as requiring an alternate level of care.

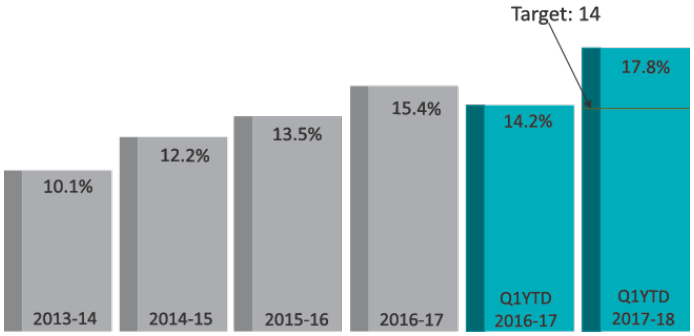
ALC patients are those who no longer need acute care services but continue to occupy an acute care bed while waiting to be discharged to a more appropriate care setting, such as a long-term care or home care.

HOW WE ARE DOING

The lower the percentage the better, as it demonstrates capacity meeting need for long-term care or designated supportive living (supportive living levels 3, 4, and 4-dementia).

Percentage of Alternate Level of Care (ALC) inpatient days:

Quarterly Comparison ● Area requires additional focus



Both performance measures have deteriorated in Q1 compared to the same period as last year due to slower than expected growth in home, continuing and community care.

In 2016-17, the growth in continuing care and addiction and mental health community care beds and the growth of home care program services were not enough to keep pace with the demand for these services. These caused longer wait times and waitlists for placement into Continuing Care Living Options. In Q1 2017-18, AHS opened 388 new continuing care beds – more than the entire 2016-17 year (376 new beds).

Objective 1: Make the transition from hospital to community-based care options more seamless (Continued)

The average wait time for continuing care placement in acute/ sub-acute care is 51 days compared to 40 days for the same period last year. The number of people waiting in acute/ sub-acute care is 765 as of June 30, 2017 compared with 718 people waiting at the same time as last year. For Q1 2017-18, there were 2,115 people placed into continuing care compared to 2,171 for the same period as last year.

AHS continues to work on minimizing the number of patients waiting for a continuing care bed. It is important to note that not all of these patients are waiting in an acute care hospital bed. Many are staying in transition beds, sub-acute beds, restorative/ rehabilitation care beds, and rural hospitals where system flow pressures and patient acuity are not as intense.

WHAT WE ARE DOING

In Q1, AHS opened 388 net new continuing care beds including 86 beds for seniors with dementia. Since 2010, AHS has opened 6,011 new beds to support individuals who need community-based care and supports (including palliative).

New continuing care facilities were opened in Calgary Zone (St. Teresa Place), Central Zone (Timberstone Mews) and North Zone (J.B. Wood Continuing Care).

In Q1, 77,198 clients with unique needs received home care, an increase of 2% from Q1 2016-17 (75,653 clients).

Respite care gives caregivers a short period of rest/relief by acute or home care staff close to home. Planning activities to increase respite services have begun.

Work continues to develop an Enhancing Care in the Community (ECC) strategy and action plan. Key initiatives of ECC phase 1 programming have been identified for implementation. As part of this strategy, policy development to support the assessment of clients for continuing care placement in their home environment and not in an acute care hospital has begun.

Q1 highlights to improve quality of care to continuing care residents and those living from dementia include:

- Appropriate Use of Antipsychotics (AUA) reduces antipsychotic medication use for continuing care residents. In Q1, 47 out of 176 supportive living sites rolled out AUA.
- A new Provincial Advisory Council for Seniors and Continuing Care is being established to provide input on strategy, policy, planning and service delivery; identify issues; and provide suggestions on ways to improve quality, access and sustainability of continuing care services in Alberta.
- Work to identify a provincial strategy and action plan for improving quality of housing and health services will begin pending the establishment of the provincial Housing and Health Services Steering Committee. This will help to prioritize and address gaps and opportunities in quality of residential continuing care services.
- Frequent Asked Question (FAQ) sheets on GPS locator technology were developed and distributed to support client/ family and AHS health professionals. Educational videos detailing the availability of the program were also distributed. Two webinar sessions were held for case managers.
- Continuing care sites in the zones are implementing processes to support person-centered care including examination of restraint policies and management, ongoing resident reviews, and interdisciplinary case conference six weeks after admission.

Objective 2: Make it easier for patients to move between primary, specialty and hospital care.

WHY THIS IS IMPORTANT

Work continues to strengthen and improve primary health care across the province. Together with Albertans, Alberta Health (AH), primary care and other health care providers, AHS is making changes to improve how patients and their information move throughout the health care system.

AHS PERFORMANCE MEASURE: Number of specialties using eReferral Advice Request

Number of specialties using eReferral Advice Request is defined as the number of physician specialty services with eReferral Advice Request implemented.

UNDERSTANDING THE MEASURE

Alberta Netcare eReferral is Alberta's first paperless referral solution and offers health care providers the ability to create, submit, track and manage referrals throughout the referral process.

Alberta Netcare eReferral Advice Request provides a secure platform for specialists to offer advice to other physicians for non-urgent questions. The more physician specialty services that are receiving eReferral Advice Requests, the more support can be provided for patients and providers seeking care.

This allows primary care physicians to better support their patients in getting access to the most appropriate specialist in a timely manner.

The number of specialties using eReferral Advice Request is a cumulative measure. The more specialties implementing eReferral, the closer we move to target.

HOW WE ARE DOING

For 2017-18, AHS is working on engaging zones to encourage ten more specialty services to implement eReferral Advice Request.

To date, there are four specialties using eReferral Advice Request (Orthopedic Surgery – Hip and Knee Joint Replacement, Oncology – Breast, Oncology-Lung and Nephrology).

In Q1, 24 specialties were engaged in using eReferral Advice Request. Of which, six charters were signed to start receiving eReferral Advice Requests.

Recruitment and planning for implementation of the following six specialties will begin in fall 2017:

1. Opiate Therapy Program (provincial)
2. Urology (Edmonton Zone)
3. Adult Gastroenterology (South, Calgary, Edmonton and North Zones)
4. Obstetrics and Gynecology (Calgary Zone)
5. Spinal Neurosurgery (Calgary Zone)
6. Pulmonary (Calgary Zone)

WHAT WE ARE DOING

Primary Health Care

AH is working with the Alberta Medical Association (AMA) and AHS to implement the new Primary Care Network (PCN) Governance Framework that includes a Provincial PCN Committee to provide leadership and strategic direction and priorities for PCNS and five Zone PCN Committees designed to plan, coordinate and better align primary health services between AHS and PCNs.

AHS is building a Strategic Clinical Network (SCN) ™ focused on primary health care, which will be the 15th SCN™ in Alberta – called the Primary Health Care Integration Network (PHC IN). The PHC IN will be focused on improving transitions of care between primary health care providers and acute care, emergency departments, specialized services and other community services. The Coalition for Integration was launched in June 2017 to stimulate innovative thinking and solutions to integration challenges faced in Alberta.

The Primary Healthcare Integrated Geriatric Services Initiative, supported by the Senior's Health SCN and Primary Health Care Integration Network, has partnered with five PCNs and the Alzheimer's Society of Alberta and Northwest Territories in the Central Zone to enhance capacity of primary health care clinicians and community agencies to provide care and support for those living in the community with dementia. The June 2017 early adopter initiative learning workshop included over a hundred participants, most of whom were primary healthcare clinicians (including 20 physicians).

CancerControl

End of Treatment and Transfer of Care processes improves transferring patient care, once cancer treatment is completed, from cancer centres back to the family physician. The processes for patients and primary care providers have been implemented in five early stage, curative populations (breast, prostate, testicular, cervical, endometrial). Work is underway on the next three populations (Hodgkin's, B Cell, colorectal).

Objective 2: Make it easier for patients to move between primary, specialty and hospital care. (Continued)

Recruitment has been delayed to support the expansion of hematology services in the South and Central Zones. Where possible, clinical teams collaborate to ensure patients are seen at the nearest site following consultation at a tertiary site in Calgary or Edmonton.

Increasing integrated cancer screening clinics for rural and remote communities and vulnerable populations is being accomplished through the Screening for Life Program as well as mobile breast cancer screening and connecting Albertans to useful resources and strategies at AlbertaPreventsCancer.ca.

Capital project update in cancer care:

- Open houses for the Calgary Cancer Project were held in June to introduce the selected design to key stakeholders and nearby communities. The project is entering the next phase of detailed design.
- Grande Prairie Cancer Centre construction continues as part of the new hospital project with no current issues.
- Phase 2 Jack Ady Cancer Centre in Lethbridge is ahead of schedule with occupancy of the newly renovated space scheduled for August 2017.
- Two linear accelerators (Linac) were installed and operationalized to support the treatment of cancer (Tom Baker Cancer Centre in Calgary in June and the Cross Cancer Institute in Edmonton in May).

Emergency Medical Services (EMS)

Targets for EMS response times for life threatening events in metro/ urban, rural and remote were met in Q1 for the 90th percentile. Q1 results for towns/ communities with a population greater than 3,000 (19 minutes and 3 seconds), did not meet the target of 15 minutes. EMS is developing a priority resource investment strategy that would assist in balancing resources versus demand.

Target of 1 minute and 30 seconds for time to dispatch the first ambulance which includes verifying the location of the emergency, identifying the closest ambulance and alerting the ambulance crew was met in Q1 with a response of 1 minute and 18 seconds. Performance continues to improve and is better than accredited benchmarks.

Implementation of the electronic patient care (ePCR) program for direct delivery and contract operators is on schedule. As of Q1, 93% contract and 65% direct delivery operators are using ePCR. The ePCR links patient ambulance data with their previous patient medical information to help EMS be more informed about the patient's medical history.

Work continues on completing helipad upgrades in Jasper, Fort McMurray, Medicine Hat Regional Hospital and Rocky Mountain House.

Objective 3: Respect, inform, and involve patients and families in their care while in hospital.

WHY THIS IS IMPORTANT

AHS strives to make every patient's experience positive and inclusive. Through the Patient First Strategy, we will strengthen AHS' culture and practices to fully embrace patient- and family-centred care (PFCC), where patients and their families are encouraged to participate in all aspects of the care journey.

Patient experience is important to measure because it relates directly to the work we do. Gathering perceptions and feedback from individuals using hospital/ acute care services is a critical aspect of measuring progress and improving the health system.

AHS PERFORMANCE MEASURE: Patient experience with hospital care for adults

Patient experience with hospital care for adults is defined as the percentage of adults aged 18 years and older discharged from hospitals who rate their overall stay as 8, 9 or 10, where zero is the lowest level of satisfaction possible and 10 is the best.

UNDERSTANDING THE MEASURE

This measure reflects patients' overall perceptions associated with the hospital where they received care. This measure requires patient follow-up after the patient's original discharge date and therefore reflects an earlier time period of 2016-17.

By acting on this survey, we can improve care and services, better understand health care needs of Albertans and develop future programs and policies in response to what Albertans say.

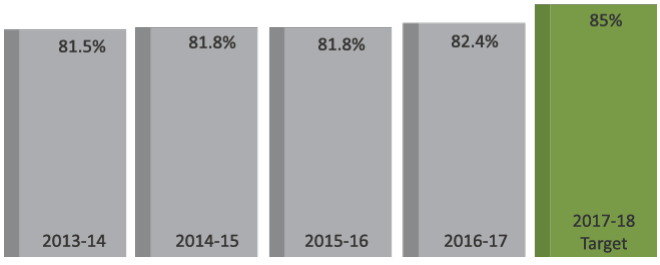
HOW WE ARE DOING

The higher the number the better, as it demonstrates more patients are satisfied with their care in hospital.

Provincially, AHS has shown improvement from the same period as last year. The percentage of adults rating their overall hospital stay as 8, 9 or 10 is 82.4% for 2016-17 compared to 81.8% in 2015-16.

Patient experience with hospital care

Q1 data will be reported in Q2.



WHAT WE ARE DOING

AHS continues to apply the Patient First Strategy by empowering and supporting Albertans to be the centre of their health care teams.

What Matters to You Day is an international event aimed at encouraging patients, families and clinicians to have conversations about what matters most to them when it comes to their health care. In June 2017, AHS hosted a live and interactive *What Matters to You* blog, featuring nine guest bloggers from across AHS, including patients and families. The blog has had over 2,800 views to date. In addition, there has been increased social media activity and over 800 page visits and nearly 1,000 views to the AHS Insite webpage.

The updated Visitation Policy was approved and is being implemented throughout the organization. Zones continue to implement family presence guidelines in inpatient units. Families are essential members of the care team as they provide pertinent information essential to the patient's care plan.

To support patient- and family- centred care for Albertans who don't speak English as their first language, AHS provides interpretation and translation services province-wide. AHS has is seeing year-over-year increases in the utilization of interpretation services. In June 2017, AHS used over 100,000 minutes of professional over-the-phone interpretation compared to approximately 50,000 during the same time frame in 2015-16, a 100% increase.

Zones continue to implement patient- and family-centred care initiatives to increase the patient voice and participation in care delivery. Examples of zone activities include use of whiteboards in acute care units, implementation of bedside shift reports, development of orientation placemats, case management with patient/ client and Leadership rounds (management attends rounds to understand how staff are serving patients).

North Zone circulated *Small Things Matter* newsletter highlighting how the small things we do can improve the patient experience.

The CoACT program helps patients, families and care providers communicate and work together. Currently, half of all patients admitted to AHS hospitals experience a more collaborative form of care through CoACT. While zones continue to rollout CoACT activities, Q1 focused primarily on the transition of funding and staffing from provincial program to zone operations.

Presentations on the Patient Reported Outcomes (PRO) dashboard to enhance cancer patient experience were made with leadership and patient advisory groups.

Six *Putting Patients First* training modules were created and uploaded to AHS' YouTube and MyLearning link.

Objective 4: Improve access to community and hospital addiction and mental health services for adults, children and families.

WHY THIS IS IMPORTANT

Timely access to addiction and mental health services is important for preventing health care, social and economic costs associated with mental illness and substance abuse, as well as the personal harms associated with these illnesses.

AHS continues to work towards strengthening and transforming our addiction and mental health services. Getting clients the care they need when they need it is critical to improving our services. This involves improving access across the continuum of addiction and mental health services and recognizing there are multiple entry points into addiction and mental health services and that these service serve a variety of different populations with different needs and paths to care.

AHS PERFORMANCE MEASURE: Access to adult addiction outpatient services

Access to adult addiction outpatient services is defined as the waiting time for adult (18 years or older) addiction outpatient treatment services delivered directly by AHS, expressed as the number of days within which 90% of clients have attended their first appointment from the time of referral to first contact.

UNDERSTANDING THE MEASURE

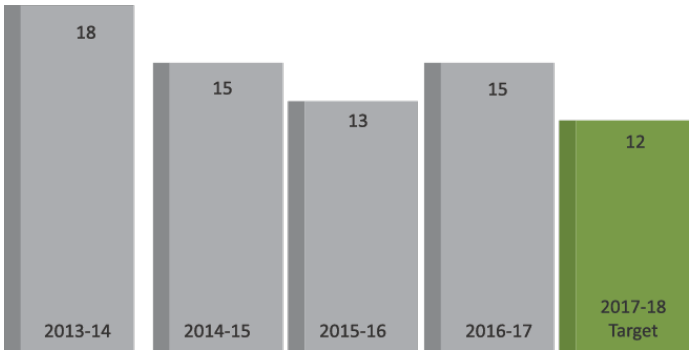
Monitoring how long clients wait to receive addiction outpatient services is an important component of describing and ultimately improving access.

HOW WE ARE DOING

The lower the number the better, as it demonstrates people are waiting for a shorter time to receive adult addiction outpatient services.

Access to adult addiction outpatient services

Q1 data will be reported in Q2.



The most recent data for this measure (access to addiction services) will always be one quarter behind the reporting period due to various reporting systems. Provincial results indicate that compared to 2015-16 (13 days), access to adult addiction outpatient services deteriorated in 2016-17 (15 days).

Although access to adult addiction outpatient treatment has decreased in the past year, it is important to note that clients continue to be served quickly in this service setting. Nine out of 10 clients wait 15 days or less to receive this service and some of the largest clinics offer walk-in services.

While addressing mental health wait times has been an AHS priority, data for the measure has not been consistently captured. Variance explanation will be provided in Q2 when Q1 data is available.

WHAT WE ARE DOING

The following are examples of key initiatives underway to improve addiction and mental health services across the province. Some of these are designed to improve access to adult outpatient services, access to scheduled children's mental health services and bed-based addiction and mental health services, and support activities related to the opioid crisis.

Work is underway to evaluate the capacity needs for addiction and mental health beds across the province.

Work continues to develop the Provincial Mental Health Diversion Standards with two standards developed to date. The Provincial Diversion Working Committee supports prevention and intervention programs within communities so that whenever possible, communities and individuals can have access to mental health, social and support services before law enforcement needs to be involved.

Individuals who have been sexually assaulted in parts of the South Zone have additional options for care and access to a specialized team of physicians with the Medicine Hat Sexual Assault Response Team (SART). This team provides medical care and sexual assault examinations to individuals 14 years of age and older, within 96 hours of the assault.

In the Calgary Zone, an Addiction and Mental Health Rural Coordinating Committee was created to address global priorities and standardize clinical processes and services in rural communities. Rural clinics are participating in the Rural Centralized Intake Line which provides patients and providers with timely available information and access regarding addiction and mental health resources in their communities.

The Calgary Zone Community Paramedic City Centre Team is improving access to mobile health care services. There were 339 patient events relating to addictions and mental health in Q1. The team also partnered with the AHS Opioid Dependency Clinic.

Objective 4: Improve access to community and hospital addiction and mental health services for adults, children and families (Continued)

North Zone is focusing efforts on implementing the Fort McMurray Wellness & Recovery Plan. A key messaging campaign, *Recovery Takes Time,* was launched in the Regional Municipality of Wood Buffalo. The Wellness Team provided supports in the community, local schools, outlying areas, and at the one year anniversary Fort McMurray wildfire event. The Indigenous Health Travel Team went to five outlying communities to increase access to health services, assist in health care navigation, and provide psychosocial support to individuals and families.

The percentage of children offered scheduled community mental health treatment within 30 days remained stable from the same period as last year (75%). Enrollment increased approximately 15% from Q1 2016-17.

AHS continues to address challenges in access to scheduled children mental health services by:

- Augmenting staff numbers to address wait-times.
- Providing services for families waiting for an appointment, such as community-based parenting programs and supports (e.g. Strongest Families Institute).
- Providing professional development in schools to increase capacity to support children with milder concerns.
- Developing centralized access and intake to services.
- Opening a new clinic in Edmonton (Access Open Minds) which offers a centralized option for youth ages 11 to 25.
- Continuing planning on the new Centralized Intake that will be accessible 24/7 in the Edmonton Zone. A location and floor plan has been developed.

AHS is working with AH and community partners to address the opioid crisis. Highlights for this quarter include the following:

- In Q1, over 6,700 Take Home Naloxone kits were dispensed to Albertans. Since July 2015, over 24,000 kits were dispensed, which includes kits dispensed by the Alberta Community Council on HIV (ACCH) agencies.

- In Q1, 585 overdose reversals were voluntarily reported in Alberta. Based on AHS data collected since January 2016, as of June 30, 2017, 1,707 overdose reversals were voluntarily reported in Alberta.

- A new Opioid Dependency Program (ODP) operated by AHS opened a clinic in Grande Prairie in May 2017 providing outpatient medication assisted treatment and addiction counselling to individuals with opioid use disorder. These services are provided throughout the province including Edmonton, Calgary, Fort McMurray, and Cardston and through telehealth currently available in Ponoka, Wetaskiwin, Rocky Mountain House, Stettler, Camrose, Wainwright, Sylvan Lake, Olds & Drayton Valley. The Grande Prairie ODP is co-located in the Northern Addiction Centre that also provides detoxification and residential addiction services.

- Opioid Dependency Treatment e-Preceptorship training program is under development in collaboration with the Office of Continuing Medical Education and the College of Physicians & Surgeons of Alberta.

- Primary care physicians will be able to consult by phone with expert opioid dependency physician specialists beginning in August.

- In the South Zone, AHS is a key member of the Lethbridge Coalition on Opioid Use and was involved in community consultations to establish a supervised consumption service in the community in Q1.

Additional initiatives related to addiction prevention can be found under Objective 8.

Objective 5: Improve health outcomes through clinical best practices.

WHY THIS IS IMPORTANT

AHS continues to strive to improve health outcomes through clinical best practices by increasing capacity for evidence-informed practice, supporting the work of our Strategic Clinical Networks™ (SCNs) and gaining better access to health information.

AHS PERFORMANCE MEASURE: Unplanned medical readmissions

Unplanned medical readmissions is defined as the percentage of medical patients with unplanned readmission to hospital within 30 days of leaving the hospital. Transfers, sign-outs, and deaths are excluded as well as medical reasons (delivery, chemotherapy for neoplasm, admission for mental illness, admissions for palliative care).

UNDERSTANDING THE MEASURE

Readmissions to acute care (hospital) is an important indicator of quality of care and care coordination. High rates of unplanned readmission acts 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.

HOW WE ARE DOING

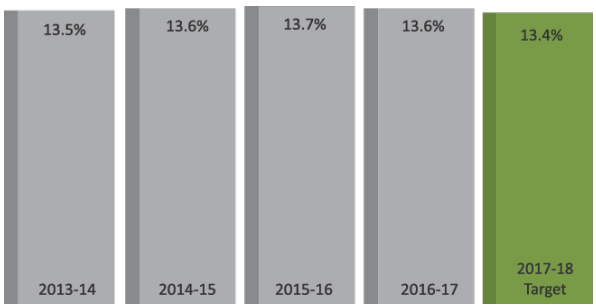
This measure requires patient follow-up after the patient's original discharge date and therefore reflects an earlier time period.

The rate of readmission has remained relatively stable over the past few years. Unplanned medical readmission to hospital results marginally improved to 13.6% in 2016-17 when compared to 13.7% in 2015-16. The lower the percentage, the better.

Variance explanation will be provided in Q2 when Q1 data is available as this measure was not consistently captured in the past nor was it a focus for improvement.

Unplanned medical readmissions

Q1 data will be reported in Q2.



WHAT WE ARE DOING

There are a number of provincewide initiatives that address readmissions. Examples include:

- Working with Primary Care Networks to ensure services are in place for complex patients.
- Multidisciplinary collaboration by the zones for discharge planning.
- Implementation in the zones of clinical pathways through the Strategic Clinical Networks (SCN)™ – Chronic Obstructive Pulmonary Disease (COPD) and heart failure, Enhanced Recovery After Surgery (ERAS), and Delirium in intensive care units.

Examples of other SCN™ initiatives underway to improve health outcomes through clinical best practices include:

- Starting Dialysis on Time at Home on the Right Therapy Project (START)
- Endovascular Therapy
- National Surgery Quality Improvement Project (NSQIP) Trauma Quality Improvement Project (TQIP)
- Basal Bolus Insulin Therapy
- Glycemic Management Policy
- Insulin Pump Therapy
- Emergency Department Document Standardization
- Early Hearing Detection and Intervention (EHDI) Program
- Elder Friendly Care in Acute Care

Planning has started in the Central Zone to engage physicians to determine solutions for discharge and transition of patients with complex health needs to community family practices.

The Provincial Breast Health Initiative will improve breast cancer care through design of provincial pathways (diagnostic assessment, same-day surgery, breast reconstruction) and execution of a provincial measurement and reporting system.

AHS continues to increase capacity for evidence-informed practice and policy through enhanced data sharing, research, innovation, health technology assessment and knowledge translation. Some of the work done in Q1 include:

- The Partnership for Research and Innovation in the Health System (PRIHS) Steering Committee endorsed AHS to proceed with funding focused on Enhanced Care in the Community.

- The Health Analytic Portal Release 1 is being prepared to go live in August to allow stakeholders (i.e. Alberta Health, Alberta Bone and Joint, Health Quality Council of Alberta) the ability to interact with selected published reports. Data reports support health outcomes studies to help determine what works and what doesn't work in health care to improve care.

Objective 6: Improve the health outcomes of indigenous people in areas where AHS has influence.

WHY THIS IS IMPORTANT

Alberta's Indigenous peoples, many of whom live in rural and remote areas of our province, have poorer health than most Albertans. AHS is building a better understanding of how historical effects and cultural care differences impact these outcomes. AHS working together with the AHS Wisdom Council, Indigenous communities, provincial and federal government, we will adapt services to better meet the health needs of Indigenous peoples.

AHS PERFORMANCE MEASURE: Perinatal mortality among First Nations

Perinatal mortality among First Nations is defined as the number of stillbirths (at 28 or more weeks gestation) plus the number of infants dying under seven days of age divided by the sum of the number of live births plus the number of stillbirths of 28 or more weeks gestation for a given calendar year; multiplied by 1,000. (This measure does not include all indigenous populations).

UNDERSTANDING THE MEASURE

The focus for 2017-18 is on women's health, going forward working with our Indigenous communities to identify health trends will help AHS better understand and more accurately respond to the complexity of Indigenous peoples health needs.

This indicator provides important information on the health status of First Nations pregnant women, new mothers and newborns.

Higher rates indicate that a greater percentage of total births are resulting in a stillbirth or a death in the first days of life. Monitoring this rate helps AHS develop and adapt population health initiatives and services to better meet the health needs of Indigenous people and reduce the health gap between Indigenous peoples and other Albertans.

HOW WE ARE DOING

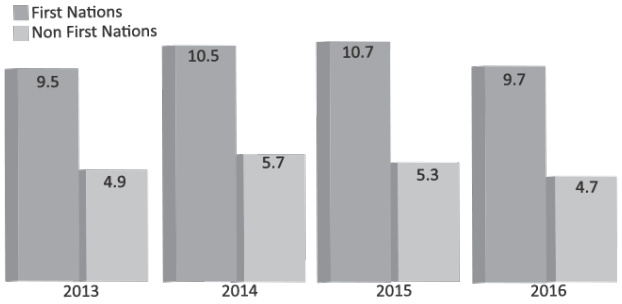
Perinatal mortality is reported on an annual basis.

Perinatal mortality is a performance indicator and there is no target identified. However, this indicator allows us to see Alberta's performance on reducing disparity between First Nations and non-First Nations populations.

AHS' long term focus is to reduce the gap between First Nations and Non First Nations populations. This will take significant collaboration with the AHS Wisdom Council, Indigenous communities, provincial and federal government, to better meet the health needs of Indigenous peoples.

The lower the number the better.

Perinatal mortality among First Nations
This is a performance indicator. No target.



Source: Alberta Vital Statistics and Alberta First Nations Registry

WHAT WE ARE DOING

Community engagement sessions were held with Treaty 8 First Nations, Health Co-Management, Yellowhead Tribal Council, Kee Tas Kee Now Tribal Council, Blood Tribe, Stoney Nation, Siksika, Western Cree Tribal Council, and Métis Nation of Alberta to support the enhancement of the Indigenous Health Program, Indigenous Wellness Clinic (IWC) in Edmonton and Elbow River Healing Lodge (ERHL) in Calgary, Primary Care Centres.

Indigenous Peoples Day/Week Celebrations were held across the province (ERHL, IWC, Chinook, Wetaskiwin, Red Deer, Rocky Mountain House and Royal Alexandra Hospital).

Work continues to promote the Alternate Relationship Plan to provide physician services and increase access to primary care in First Nations and Métis communities.

Early engagement continues on the High Prairie Hospital project to improve cultural safety for First Nation, Métis and Inuit patients, families and communities.

Eight Métis Tri-Settlement partners participated in a workshop to support the adapted 'Readiness Resource' for Indigenous prevention and screening action planning.

Ten First Nation Elders participated in a 'Best Messaging' event to determine resources, audience, format, and messages required to promote screening and behavior change in First Nation communities.

Six Indigenous communities received prevention/ screening services as a result of North Zone's strategic action plan.

AHS leadership are encouraged to complete cultural competency training sessions to gain better awareness on how to appropriately provide care to patients and families.

Objective 6: Improve the health outcomes of indigenous people in areas where AHS has influence (Continued)

Q1 actions related to Truth & Reconciliation Commission and United Nations Declaration on the Rights of Indigenous Peoples include:

- Two Listening Day sessions were held. An Indigenous reconciliation session planned for fall 2017.
- Inclusion of questions on the Tuberculosis Services Interview Guide created by Indigenous members as well as a question on equity/ equality.
- Development of a Sexually Transmitted Infection Blood & Body Fluid Infection Operational Strategy in collaboration with Indigenous stakeholders.
- Working with Alberta Health and First Nations Inuit Health Branch (FNIHB) to harmonize childhood immunization processes between Indigenous and non-Indigenous communities.

Engagement activities are underway to support the development of midwifery care service models for Indigenous and vulnerable populations. Midwifery privileges are in place at the Elbow River Healing Lodge.

The Merck for Mothers initiative improves maternal health of Indigenous women in Maskwacis, Inner City Edmonton (Pregnancy Pathways initiative) and Little Red River Cree.

AHS supports improvement of women's health; maternal, infant, child and youth health; and, the health of the vulnerable and those in need or expressing need. Examples of initiatives include:

- Early Hearing Detection and Intervention Project (EHDI) has been implemented in four neonatal intensive care units. EHDI offers screening to newborns for hearing prior to discharge.
- Work is underway to develop the antenatal care pathway to support the maternity services corridors of care initiative.
- Recruitment is underway to support MyCHILD Alberta to increase data capacity to improve outcomes and optimize public sector policies for women and children.
- The Police and Crisis Team (PACT) program in the Calgary Zone provides clinical assessment/ interventions for vulnerable individuals presenting to police with addiction and mental health concerns. In Q1, there were 62 referrals to the program, 15 new enrollments, 57 existing registrants and 18 discharges.
- In addition, the newly implemented PACT program in Medicine Hat in the South Zone began providing interventions and support for vulnerable individuals with addiction and mental health concerns in contact with police.

Objective 7: Reduce and prevent incidents of preventable harm to patients in our facilities.

WHY THIS IS IMPORTANT

Preventing harm during the delivery of care is foundational to all activities at AHS. Reducing preventable harms ensures a safe and positive experience for patents and families interacting with the health care system.

We continue to reduce preventable harm through various initiatives including the safe surgery checklist, antimicrobial stewardship program, medication reconciliation, and hand hygiene compliance.

AHS PERFORMANCE MEASURE: Hand hygiene compliance

Hand hygiene compliance is defined as the percentage of opportunities for which health care workers clean their hands during the course of patient care. 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".

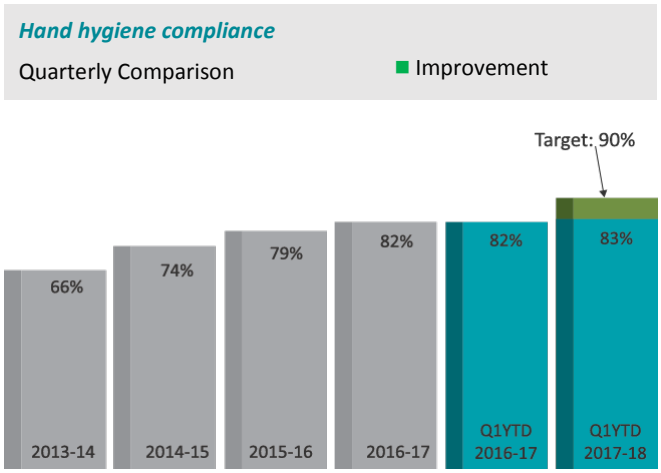
UNDERSTANDING THE MEASURE

Hand hygiene is the single most effective strategy to reduce the transmission of infection in the health-care setting. Direct observation is recommended to assess hand hygiene compliance rates for health care workers.

HOW WE ARE DOING

Hand hygiene compliance increased provincially to 83%, an improvement from last year (82%). The higher the percentage the better, as it demonstrates more health care workers are complying with appropriate hand hygiene practices.

Quarterly hand hygiene reports are available at the provincial and zone levels to address areas requiring further attention.



WHAT WE ARE DOING

Hand hygiene improvement initiatives included refresh of the AHS Hand Hygiene Policy and Procedure and learning modules, launch of a patient and family pamphlet, and participation in the Canadian Patient Safety Institute's annual *Stop! Clean Your Hands Day*.

Zones continue to recruit site-based hand hygiene reviewers to foster ownership and accountability for hand hygiene improvement in health care workers.

Each zone continues to have at least one initiative targeted at reducing utilization of the 14 select antimicrobials associated with a high risk of *Clostridium difficile* Infections (CDI). Hospital-acquired CDI rates have remained stable and low for the past few quarters.

AHS continues to monitor *Clostridium difficile* Infections (CDI) which is influenced by hand hygiene. We have many initiatives that address hospital acquired infections including:

- Antimicrobial Stewardship program includes the use of standardized physician patient care orders implemented at the time of CDI diagnosis to ensure appropriate treatment.
- Infection prevention and control supports patient management by connecting with frontline health care workers to promote the use of physician patient care order sets, follow-up on case severity, and provide feedback on case management.
- Aligned protocols for cleaning of shared patient equipment in the Edmonton Zone with those established in the Calgary Zone. Plans to implement in the regional hospitals in North, Central and South Zones by March 31, 2018.

Rate of hospital-acquired Methicillin-resistant Staphylococus *aureus* Blood Stream Infections (MRSA BSI) cases improved from the same period as last year.

Work is underway to complete the Patient Safety Strategy and Policy Suite. The strategy will focus on improving processes, human factors and using evidence to support a patient safety culture. The Policy Suite provides guidance to mitigate preventable harm and effectively manage harm when it occurs.

AHS has implemented 75% of the Parenteral Nutrition Health Quality Council of Alberta (HQCA) project plan. Parenteral nutrition is provided to some of our most vulnerable patients and is classified as a high-alert medication because significant patient harm may occur when it is used incorrectly or without regard to accepted leading practice standards.

Objective 8: Focus on health promotion and disease and injury prevention.

WHY THIS IS IMPORTANT

Working collaboratively with Alberta Health (AH) and other community agencies, AHS will continue to improve and protect the health of Albertans through a variety of strategies in areas of public health including reducing risk factors for cancer, substance use and communicable diseases, and increasing immunization rates.

AHS PERFORMANCE MEASURE: Childhood immunization

Childhood immunization is defined as the percentage of children by two years of age who have received the required immunization for Diphtheria/ Tetanus/ acellular Pertussis, Polio, Hib (DTPP-Hib) and Measles/ Mumps/ Rubella (MMR).

UNDERSTANDING THE MEASURES

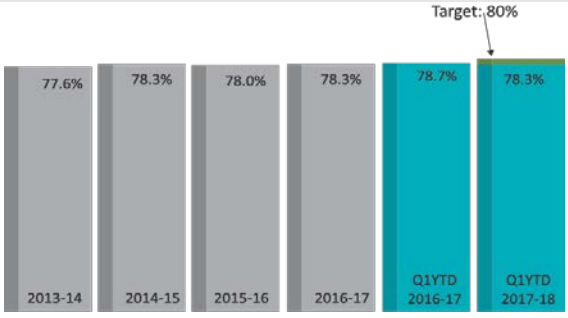
A high rate of immunization for a population reduces the incidence of vaccine preventable childhood diseases, and controls outbreaks. Immunizations protect children and adults from a number of preventable diseases, some of which can result in fatal or produce permanent disabilities.

HOW WE ARE DOING

Provincial rates for childhood immunization (both DTPP-Hib and MMR) have remained stable from the same period as last year, but remain below 2017-18 targets. The higher the percentage the better.

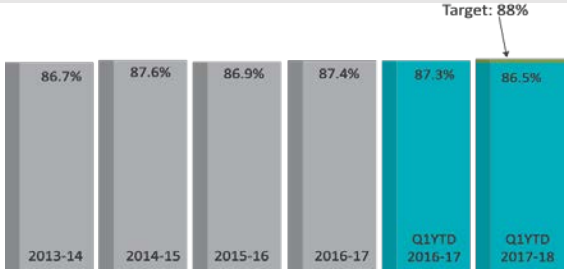
Childhood immunization: DTPP-Hib

Quarterly Comparison ▲ Stable than prior period ≤3%



Childhood immunization: MMR

Quarterly Comparison ▲ Stable than prior period ≤3%



WHAT WE ARE DOING

AHS continues to raise awareness in geographical areas where immunization rates are low, including working with Alberta Health and First Nations Inuit Health Branch (FNIHB) to harmonize childhood immunization between Indigenous communities and non-indigenous communities.

In addition to childhood immunization, AHS supports work in other areas of health promotion and disease/ injury prevention.

Disease outbreaks are coordinated and managed in accordance with standards and guidelines. AHS and AH are working with the zones to ensure a consistent approach to outbreak reporting, notification and management.

Debriefings with sites that experience outbreaks and staff feedback help inform annual revisions to AHS Department Standard Operating Procedures and Outbreak Guidelines. In Q1, some of the communicable disease outbreaks managed were for infectious gastroenteritis, influenza-like illness, mumps and pertussis.

The 2016-2020 Alberta Sexually Transmitted Blood-Borne Infections (STBBI) Operational Strategy and Action Plan began development in spring 2016, engaging over 350 stakeholders including First Nations' communities and Metis settlements. Five work streams have been established to develop recommendations.

AHS helps to protect the public by mitigating risks and hazards in the natural and built environment including food, air, and water through the development and implementation of health promotion strategies and interventions. Work continues to finalize a plan to align Alberta Agriculture and Forestry's and AHS' inspection programs overseeing meat facilities continues.

AHS' Provincial Addiction Prevention program provides consultation, facilitation, planning support, and resource development to reduce risk factors and increase protective factors important to prevent addiction. Updates for Q1 include:

- Supported 33 funded community coalitions across the province to implement promotion and prevention activities.
- Four engagement sessions with youth, and service providers who work with youth in Alberta have been conducted to provide input for future development of the Help4me website.
- Work continues on the development of the AHS Harm Reduction Policy.

The Drug Treatment Funding Program in partnership with AHS develops capacity to increase access to sustainable, evidence-informed early intervention treatment services for children and youth in Alberta with addiction and/or mental health concerns. The InRoads curriculum refresh revision and enhancement project is underway, including the development of training modules.

Objective 9: Improve our workforce engagement.

WHY THIS IS IMPORTANT

Our People Strategy guides how we put our people first, thereby improving patient and family experiences. Enhancing workforce engagement will contribute to achieving a culture where people feel supported, valued and able to reach their full potential.

An engaged workforce will promote a strong patient safety culture and advance safe work environments. We also know patient outcomes improve when our workforce is highly engaged, and when they enjoy what they are doing.

AHS PERFORMANCE MEASURE: Workforce Engagement Rate

Workforce Engagement Rate is defined as the commitment level the workforce has to AHS, their work, their manager and co-workers. High engagement correlates with higher productivity, safe patient care and willingness to give discretionary effort at work.

The AHS Workforce Engagement Rate is calculated as the average score of our workforce's responses to the AHS' Our People Survey which utilized a five-point scale, with one being 'strongly disagree' and five being 'strongly agree'.

UNDERSTANDING THE MEASURE

Hearing and understanding what AHS staff need to feel safe, healthy and valued in our workplace helps leadership to improve work environments and build a strong patient safety culture.

AHS has the opportunity to both create a satisfying workplace and to deliver services in a manner that is sustainable for the future. In order to do this, it is important that AHS fully engage its people and their skills.

HOW WE ARE DOING

Workforce engagement rate is reported every two years. The next survey will be in 2018-19.

In 2016, AHS completed a comprehensive workforce engagement and patient safety culture survey. More than 46,000 individuals – including nurses, emergency medical services, support staff, midwives, physicians and volunteers – participated and expressed what they need to feel safe, healthy and valued to improve patient care.

Participation is a key indication of engagement and the participation rate illustrates how important both patient safety and quality patient- and family-centered care are.

The higher the rate, the more employees are positive about their work. The survey results indicated that our engagement rates are above average when we compare them to other Canadian workplaces. 57% of employees were positive about the work they do at AHS, and chose a 4 or 5 for overall satisfaction, based on a five-point scale, with one being 'strongly disagree' and five being 'strongly agree'.

Although the engagement survey will be performed every two years, AHS will conduct a Pulse Survey as a "temperature check" of workforce engagement activities. The Pulse Survey is short and is designed to take snapshots of the current state. This means staff can provide valuable feedback on a regular basis. Our first Pulse Survey is scheduled for fall 2017.

Workforce engagement rates

Annually Results: **3.46** (2016-17)

2016-17 was a baseline year – no target established for 2017-18.

Engagement Survey is performed every 2 years. Next survey in 2018-19. The target in 2018-19 is 3.67.

WHAT WE ARE DOING

Our People Survey results were shared with leaders and an ongoing support framework was launched to support leaders in improving engagement within their teams.

Zones, provincial and corporate areas are participating in activities to improve engagement including succession planning, leadership development, and cultural awareness training sessions.

Roll-out of the online learning portal commenced providing leaders with online resources and learning to improve their leadership practice.

Your Voice Matters Insite webpage was launched to hear directly from employees and physicians on Our People Strategy topics.

As part of the Our People Strategy, a Diversity and Inclusion Council was formed to support, guide and inspire change by developing a strategy and creating resources to help us provide safe, healthy and inclusive environments for our people.

Objective 10: Reduce disabling injuries in our workforce.

WHY THIS IS IMPORTANT

Safe, healthy workers contribute to improving patient care and safety. AHS is committed to providing a healthy and safe work environment for all. The AHS health and safety strategy includes four areas of focus: physical safety, psychological safety, healthy and resilient employees and safety culture. Through knowledgeable and actively engaged staff, physicians and volunteers, we will reduce injuries across our organization.

AHS PERFORMANCE MEASURE: Disabling injury rate

Disabling injury rate is a representation of how many AHS workers are injured seriously enough to require modified work or time loss from work per 200,000 paid hours.

UNDERSTANDING THE MEASURE

Monitoring disabling injury rate enables us to determine the effectiveness of programs that provide AHS employees, volunteers and physicians with a safe and healthy work environment, and keep them free from injury.

HOW WE ARE DOING

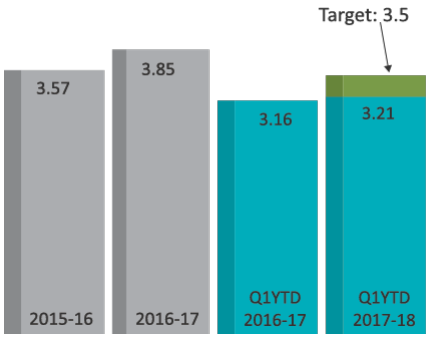
The lower the rate, the less disabling injuries are occurring at work. In Q1, disabling injury rate for the province remained stable from the same period as last year, and is meeting target. Patient handling, manual material handling and other ergonomic factors are the leading causes of injury for AHS employees.

Effective injury prevention plans will be established for areas showing deterioration. This will be closely monitored on an ongoing basis.

Disabling injury rate

Quarterly Comparison

Target achieved



WHAT WE ARE DOING

Workplace Health and Safety (WHS) continues to work with operational leaders to reduce musculoskeletal injury associated with patient handling and manual material handling. This is the main type of injury in health care. Over the next three years, efforts will be focused on those areas which experience the highest rates of injury over an extended period of time. WHS supports operational areas to ensure staff are appropriately trained on *It's Your Move* and *Move Safe* ergonomic programs, which aim to prevent lifting and handling injuries.

The AHS is committed to provide psychological safety with an increased focus on aggression and violence in the workplace. The number of workplace violence incidents reported on MySafetyNet in Q1 was 680, of which 96% were patient to worker incidents; 7% resulted in lost time injury. Increases in reporting is expected and considered a positive outcome of improved reporting culture. A baseline is currently being established for violent incidents.

Technology can be an important adjunct to injury reduction. Installation of new power cot and power lift program across direct delivery system in emergency medical services (EMS) will commence in the fall.

Education and training are a key resource in a strong safety culture including:

- The new *Workplace Inspection Training for Workers* is available on MyLearningLink. This one-hour training provides learners with the working knowledge to conduct inspections in their workplace to ensure hazards are identified and corrective actions are used.
- EMS participated in Non-Violent Crisis Intervention training for all its staff.
- All new leaders must complete *Leading Health and Safety in the Workplace: Fundamentals* education. This course supports leaders with the fundamental knowledge to create a safe, healthy, and inclusive workplace.
- Across AHS there is continued focus on raising awareness of available training programs, injury prevention tools, and health and wellness resources, e.g. *Not Myself Today* campaign, and other AHS internal website resources.

The 2017-2021 Health and Wellness Action Plan outlines how AHS will provide resources and supports to guide priority health and wellness needs expressed by the respondents to the 2016 Employee Wellness Survey and directly supports Our People Strategy. The Action Plan will help to create a psychologically healthy and safe work environment and engage our people in the creation of a safe, healthy and resilient workforce.

Objective 11: Improve efficiencies through implementation of operational and clinical best practices while maintaining or improving quality and safety.

WHY THIS IS IMPORTANT

AHS is supporting strategies to improve efficiencies related to clinical effectiveness and appropriateness of care, operational best practice and working with partners to support service delivery. AHS is making the most effective use of finite resources while continuing to focus on quality of care.

Operational Best Practice is one of the ways to reduce costs, while maintaining and/or improving care to ensure a sustainable future. This initiative began more than a year ago, and initially focuses on the 16 largest hospitals in Alberta, clinical support services and corporate services.

AHS PERFORMANCE MEASURE: Percentage of nursing units achieving best practice targets

Percentage of nursing units achieving best practice targets is defined as the percentage of nursing units at the 16 largest sites meeting operational best practice targets.

UNDERSTANDING THE MEASURE

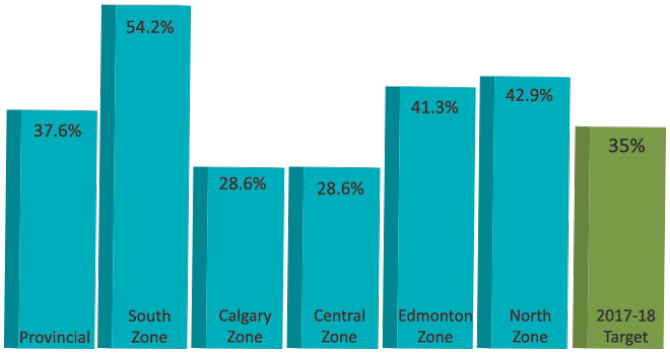
Through operational best practice, we have identified large variations in the cost of delivering services at different sites. Using comparative data from across the country, AHS developed targets for all inpatient units designed to achieve equitable service delivery across the province. The measure will be used to monitor nursing units' ability to meet targets and reduce variations in the cost of delivering high quality services at the 16 largest sites.

HOW WE ARE DOING

A higher percentage means more efficiencies have been achieved across AHS. Provincially, Q1 results met the 2017-18 target of 35%. .

Percentage of nursing units achieving best practice targets

Q1 2017-18 - this is a new measure and comparable historically data is not available.



WHAT WE ARE DOING

In addition to initiatives related to operational best practice, AHS is also engaged in many other strategies to help improve efficiencies across the organization. The following are examples of some of this work.

The creation of a Clinical Appropriateness Steering/ Advisory Committee was approved to manage clinically appropriate initiatives that will enhance patient care and contribute cost savings to AHS.

Additional initiatives to reduce inappropriate variation and apply consistent clinical standards are found in Objective #5.

Q1 results of Appropriateness of Care (based on Choosing Wisely) initiatives include:

- Q1 target was met as AHS saw a 19% decrease in CT lumber spine exams performed in Q1 compared to the same period as last year.
- Work continues on implementing a streamlined Low Molecular Weight Heparin formulary based on clinician engagement and contracting process.
- The Fetal Fibronectin (FfN) was discontinued. A clinical practice guideline to support assessment of risk for pre-term labor without use of FfN is in place.

The following Q1 updates are provided on planning activities underway with Alberta Health:

- The goal of Zone Health Care Planning is to develop a population health driven strategic plan. Initiatives identified will support quality, accessible care in the community and a sustainable health system, reduce the reliance on acute care and enhance care in the community. Engagement initiatives were held in both Calgary and Central Zones for both community initiatives and acute care streams.
- Service and Access Guidelines develop consistent principles for health care planning that supports equitable access to services across the province. This work describes the core services Albertans can reasonably expect to have access to closer to home. Subject matter experts were invited to participate in developing guidelines for medical/ surgical basic (rural), emergency health and primary care services.
- Provincial Interventional Cardiac Service Plan work proceeds which will identify the need for cardiac services in a coordinated and evidence-based approach.

Objective 12: Integrate clinical information systems to create a single comprehensive patient record.

WHY THIS IS IMPORTANT

A transformational and system-wide undertaking, the provincial Clinical Information System (CIS) will improve access to and flow of clinical information across the province.

CIS will be introduced in stages over the next several years. When complete, health providers will be able to access comprehensive and consolidated patient information that travels with patients throughout the health system.

AHS provincial CIS will ensure that health care providers have access to current and accurate patient information. With a single comprehensive record and care plan for every patient, the quality and safety of the care we deliver is improved, and our patients and their families across the health care system will have a better experience.

AHS PERFORMANCE MEASURE

There is no AHS measure for this specific AHS objective.

HOW WE ARE DOING

We will monitor our progress over the next three years through the accomplishment of our key milestones and deliverables.

WHAT WE ARE DOING

The AHS provincial Clinical Information System (CIS) is part of the Connect Care initiative.

Connect Care is a collaborative effort between Alberta Health and AHS staff, clinicians and patients to improve patient experience and the quality and safety of patient care, by creating common clinical standards and processes to manage and share information across the continuum of health care. Connect Care will also support Albertans to take ownership of their health and care by giving them access to their own health information.

With Connect Care, efficiencies will be achieved and Alberta will have a common system where health providers can access comprehensive and consolidated patient information — information that will travel with patients wherever they access the health system.

Connect Care will be implemented provincially over time in order to allow our facilities time to prepare for this transformation.

After consultation with hundreds of physicians, staff and patients, a successful vendor was selected in a Request for Proposal (RFP) to help build the AHS Provincial CIS. AHS moved from RFP to contract negotiation in July, with a view to completing the contract in late September.

Over the next few months, work will continue with physicians and staff to get a clear understanding of use and access to technology and other information needed to prepare for designing and building the AHS Provincial CIS that will support Connect Care across AHS.

Alberta Netcare is a secure and confidential electronic system of patient health information collected through a point of service (e.g. hospital, pharmacy). The number of active Alberta Netcare users increased by 5.2% (44,319 users) compared to the same period as last year (42,125 users).

Appendix

AHS Performance Measures – Zone and Site Detail

AHS has 13 performance measures that enable us to evaluate our progress and allow us to link our objectives to specific results. Provincial results and variance explanations for measures are found under each objective in the front section of this report. This appendix provides drill-down information for the zone and site levels for the performance measures. In the future, zone and site variance explanations will be provided.

Two measures will be reported annually (Perinatal Mortality among First Nations and Workforce Engagement Rates). The remaining 11 measures will be reported quarterly. Of these, eight measures include the most current data available (Q1 2017-18) and three measures rely on patient follow-up and therefore reflect an earlier time period (Q4 year-to-date 2016-17).

The following pages provides zone and site level data for the performance measures.

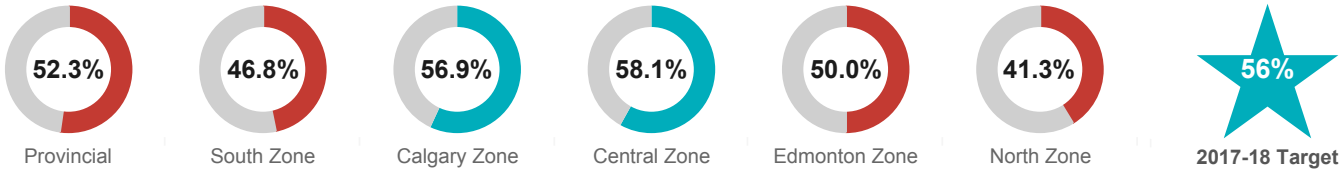
AHS Report on Performance
Quarter 1, 2017/18

PERCENTAGE PLACED IN CONTINUING CARE WITHIN 30 DAYS

This measure monitors how quickly patients are moved from hospitals into community-based care. The higher the percentage the better, as it demonstrates capacity meeting need for long-term care or designated supportive living (supportive living levels 3, 4, and 4-dementia).

Legend
- *Target achieved* ★
- *Improvement* ■
- *Stable than prior period ≤3%* ▲
- *Area requires additional focus* ●

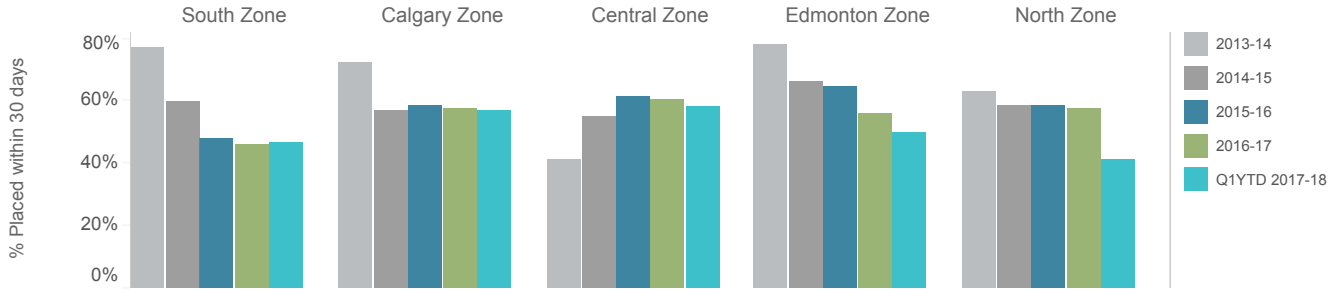
Percent Placed in Continuing Care within 30 days, Q1YTD 2017-18



Percent Placed in Continuing Care within 30 Days Trend

Zone Name	2013-14	2014-15	2015-16	2016-17	Q1YTD 2016-17	Q1YTD 2017-18	Trend	2017-18 Target
Provincial	**69.0%**	**59.9%**	**59.6%**	**56.1%**	**62.1%**	**52.3%**	●	**56%**
South Zone	77.0%	59.5%	47.6%	45.9%	49.0%	46.8%	●	56%
Calgary Zone	72.0%	57.1%	58.4%	57.4%	65.1%	56.9%	★	56%
Central Zone	41.0%	54.6%	61.5%	60.3%	62.3%	58.1%	★	56%
Edmonton Zone	78.0%	66.2%	64.5%	55.8%	63.3%	50.0%	●	56%
North Zone	63.0%	58.8%	58.7%	57.5%	64.3%	41.3%	●	56%

Percent Placed in Continuing Care within 30 days by Zone and Fiscal Year



Total Clients Placed

Zone Name	2013-14	2014-15	2015-16	2016-17	Q1YTD 2016-17	Q1YTD 2017-18
Provincial	**7,693**	**7,810**	**7,879**	**7,963**	**2,171**	**2,115**
South Zone	868	866	887	925	257	218
Calgary Zone	2,164	2,548	2,722	2,438	684	759
Central Zone	1,189	1,259	1,060	1,352	345	303
Edmonton Zone	2,742	2,443	2,506	2,575	678	600
North Zone	730	694	704	673	207	235

Source: AHS Seniors Health Continuing Care Living Options Report, as of July 20, 2017

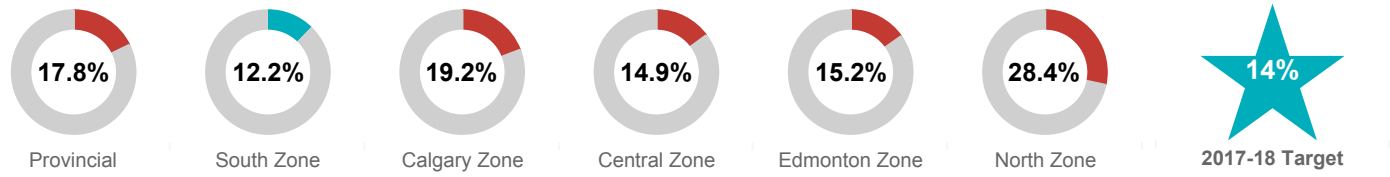
AHS Report on Performance
Quarter 1, 2017/18

PERCENTAGE OF ALTERNATE LEVEL OF CARE (ALC) PATIENT DAYS

This measure monitor how quickly patients are moved from hospitals into community-based care. The lower the percentage the better, as it demonstrates capacity meeting need for long-term care or designated supportive living (supportive living levels 3, 4, and 4-dementia).

Legend
- Target achieved ★
- Improvement ■
- Stable than prior period ≤3% ▲
- Area requires additional focus ●

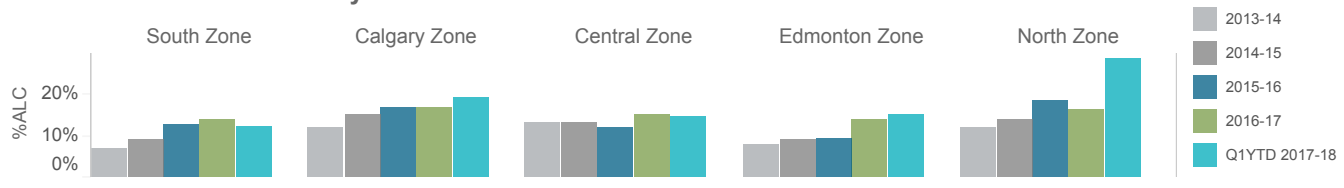
Percent ALC in Acute Care, Q1YTD 2017-18



Percent ALC in Acute Care Trend - Busiest Sites

Zone Name	Site Name	2013-14	2014-15	2015-16	2016-17	2016-17 Q1YTD	Q1YTD 2017-18	Trend	2017-18 Target
Provincial	**Provincial**	**10.1%**	**12.2%**	**13.5%**	**15.4%**	**14.2%**	**17.8%**	●	**14%**
South Zone	South Zone	6.9%	9.0%	12.6%	13.9%	14.0%	12.2%	★	14%
	Chinook Regional Hospital	5.0%	4.4%	7.8%	8.6%	8.5%	10.1%	★	14%
	Medicine Hat Regional Hospital	9.2%	14.6%	18.9%	18.9%	18.7%	16.1%	■	14%
	Other South Hospitals	7.1%	9.4%	11.5%	17.3%	18.8%	10.4%	★	14%
Calgary Zone	Calgary Zone	11.7%	15.2%	16.7%	16.9%	15.0%	19.2%	●	14%
	Alberta Children's Hospital	0.0%	0.2%	1.3%	1.2%	0.8%	1.2%	★	14%
	Foothills Medical Centre	11.5%	15.7%	14.7%	15.2%	13.8%	20.7%	●	14%
	Peter Lougheed Centre	11.0%	14.6%	13.6%	16.8%	13.5%	13.4%	★	14%
	Rockyview General Hospital	13.7%	16.2%	21.9%	22.2%	19.9%	26.5%	●	14%
	South Health Campus	12.1%	14.4%	20.4%	17.6%	15.7%	17.3%	●	14%
	Other Calgary Hospitals	17.5%	26.4%	27.2%	21.0%	21.8%	19.7%	■	14%
Central Zone	Central Zone	13.0%	13.1%	12.0%	15.3%	13.9%	14.9%	●	14%
	Red Deer Regional Hospital Centre	10.3%	11.4%	8.8%	12.4%	6.5%	11.2%	★	14%
	Other Central Hospitals	14.9%	14.4%	14.3%	17.2%	18.5%	17.4%	■	14%
Edmonton Zone	Edmonton Zone	7.8%	9.1%	9.5%	14.0%	11.9%	15.2%	●	14%
	Grey Nuns Community Hospital	8.7%	10.2%	9.2%	11.1%	7.2%	8.9%	★	14%
	Misericordia Community Hospital	8.0%	10.8%	12.8%	14.7%	15.1%	15.7%	●	14%
	Royal Alexandra Hospital	8.4%	10.6%	11.0%	18.5%	15.6%	19.1%	●	14%
	Stollery Children's Hospital	0.1%	0.0%	1.8%	0.6%	0.0%	0.0%	★	14%
	Sturgeon Community Hospital	10.7%	12.3%	12.3%	18.9%	14.6%	19.4%	●	14%
	University of Alberta Hospital	6.8%	6.0%	6.2%	11.7%	10.5%	15.5%	●	14%
	Other Edmonton Hospitals	9.2%	11.8%	12.1%	12.1%	9.9%	15.8%	●	14%
North Zone	North Zone	11.7%	13.8%	18.5%	16.4%	20.0%	28.4%	●	14%
	Northern Lights Regional Health Centre	9.4%	7.4%	18.5%	12.0%	32.1%	9.5%	★	14%
	Queen Elizabeth II Hospital	8.5%	14.0%	20.4%	15.2%	13.4%	43.5%	●	14%
	Other North Hospitals	13.2%	14.9%	17.9%	17.5%	20.2%	23.6%	●	14%

Percent ALC in Acute Care by Zone and Fiscal Year



Total ALC Discharges

Zone Name	2013-14	2014-15	2015-16	2016-17	2016-17 Q1YTD	Q1YTD 2017-18
Provincial	**9,601**	**9,776**	**10,254**	**13,513**	**2,998**	**4,309**
South Zone	544	528	624	674	190	156
Calgary Zone	3,564	4,038	4,684	5,027	1,164	1,460
Central Zone	1,215	1,196	1,085	1,327	298	337
Edmonton Zone	3,591	3,209	3,046	5,518	1,039	2,059
North Zone	687	805	815	967	307	297

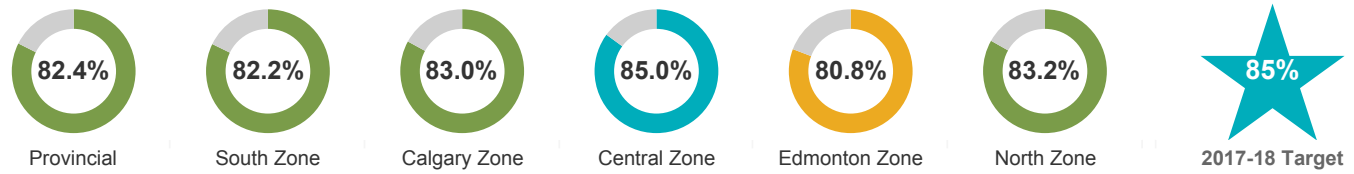
Source(s): AHS Provincial Discharge Abstract Database (DAD), as of Aug 16, 2017
Notes: Previous ALC results for Central Zone were under reported. Reporting has improved in accuracy which has resulted in higher ALC activity.
Queen Elizabeth II Hospital Q1 results were impacted due to closures of the temporary subacute transition unit with many patients discharged to continuing care facilities in May 2017. This results in higher than normal number of ALC days.

ADULT PATIENT EXPERIENCE WITH HOSPITAL CARE (8,9 & 10)

This measure reflects patients' overall perceptions associated with the hospital where they received care. The higher the number, the better, as it demonstrates more patients are satisfied with their care in hospital.

Legend
- Target achieved
- Improvement
- Stable than prior period ≤3%
- Area requires additional focus

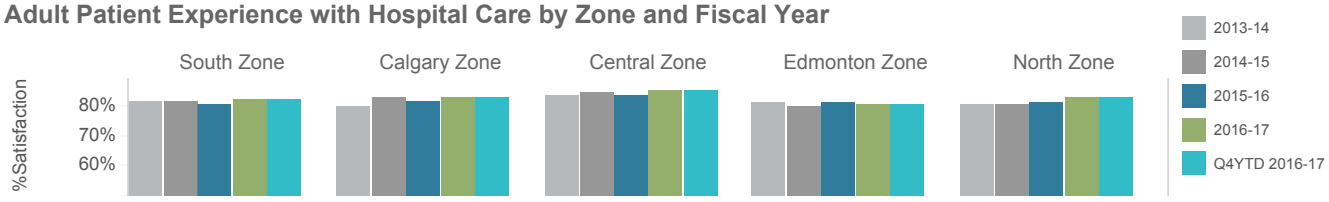
Adult Patient Experience with Hospital Care (8,9 & 10), Q4YTD 2016-17



Adult Patient Experience with Hospital Care Trend - Busiest Sites

Zone Name	Site Name	2013-14	2014-15	2015-16	Q4YTD 2015-16	Q4YTD 2016-17	Trend	2017-18 Target
Provincial	**Provincial**	**81.5%**	**81.8%**	**81.8%**	**81.8%**	**82.4%**	■	**85%**
South Zone	South Zone	81.7%	81.8%	80.9%	80.9%	82.2%	■	85%
	Chinook Regional Hospital	80.5%	76.6%	78.2%	78.2%	82.3%	■	85%
	Medicine Hat Regional Hospital	80.7%	85.7%	81.3%	81.3%	81.3%	▲	85%
	Other South Hospitals	83.5%	88.3%	87.2%	87.2%	85.5%	★	85%
Calgary Zone	Calgary Zone	80.1%	83.2%	82.0%	82.0%	83.0%	■	85%
	Foothills Medical Centre	76.6%	80.8%	80.8%	80.8%	80.3%	▲	85%
	Peter Lougheed Centre	80.9%	79.9%	77.2%	77.2%	78.7%	■	85%
	Rockyview General Hospital	82.9%	85.4%	81.7%	81.7%	85.1%	★	85%
	South Health Campus	91.9%	89.7%	90.1%	90.1%	90.9%	★	85%
	Other Calgary Hospitals	79.3%	90.3%	92.9%	92.9%	92.2%	★	85%
Central Zone	Central Zone	83.5%	84.8%	83.4%	83.4%	85.0%	★	85%
	Red Deer Regional Hospital Centre	81.1%	83.0%	82.2%	82.2%	82.7%	■	85%
	Other Central Hospitals	84.5%	86.7%	84.8%	84.8%	87.0%	★	85%
Edmonton Zone	Edmonton Zone	81.5%	80.3%	81.6%	81.6%	80.8%	▲	85%
	Grey Nun's Community Hospital	86.4%	87.2%	86.1%	86.1%	86.4%	★	85%
	Misericordia Community Hospital	78.5%	75.3%	77.2%	77.2%	79.8%	■	85%
	Royal Alexandra Hospital	79.9%	76.5%	77.3%	77.3%	76.6%	▲	85%
	Sturgeon Community Hospital	89.8%	87.6%	89.8%	89.8%	88.0%	★	85%
	University of Alberta Hospital	77.1%	80.2%	83.5%	83.5%	80.4%	●	85%
	Other Edmonton Hospitals	70.9%	85.3%	86.3%	86.3%	85.7%	★	85%
North Zone	North Zone	81.0%	80.6%	81.3%	81.3%	83.2%	■	85%
	Northern Lights Regional Health Centre	75.4%	74.7%	78.6%	78.6%	82.2%	■	85%
	Queen Elizabeth II Hospital	76.0%	77.2%	78.6%	78.6%	80.3%	■	85%
	Other North Hospitals	83.4%	83.7%	83.5%	83.5%	84.8%	★	85%

Adult Patient Experience with Hospital Care by Zone and Fiscal Year



Total Eligible Discharges Zone Name	2013-14	2014-15	2015-16	Q4YTD 2015-16	Q4YTD 2016-17	Number of Valid Responses	Margin of Error (95% Confidence Interval)
Provincial	**183,462**	**200,428**	**218,546**	**218,546**	**246,917**	**25,745**	**±0.47%**
South Zone	18,271	19,341	19,737	19,737	19,840	2,116	±1.63%
Calgary Zone	45,800	51,199	61,044	61,044	83,208	8,474	±0.80%
Central Zone	26,134	28,254	29,272	29,272	29,531	3,257	±1.22%
Edmonton Zone	68,913	76,197	82,559	82,559	89,005	8,983	±0.81%
North Zone	24,344	25,437	25,934	25,934	25,333	2,915	±1.36%

Source: AHS Canadian Hospital Consumer Assessment of Healthcare Providers and Systems(CH-CAHPS) Survey, as of July 21, 2017
Notes: This quarter is a quarter later due to requirements to followup with patients after end of reporting quarter;
Weighted percentage; Margin of error: estimated to be accurate within this margin of error, 19 times out of 20.

ACCESS TO ADULT ADDICTION OUTPATIENT SERVICES (IN DAYS)

Monitoring how long clients wait to receive addiction outpatient services is an important component of describing and ultimately improving access. The lower the number, the better, as it demonstrates people are waiting for a shorter time to receive addiction outpatient services.

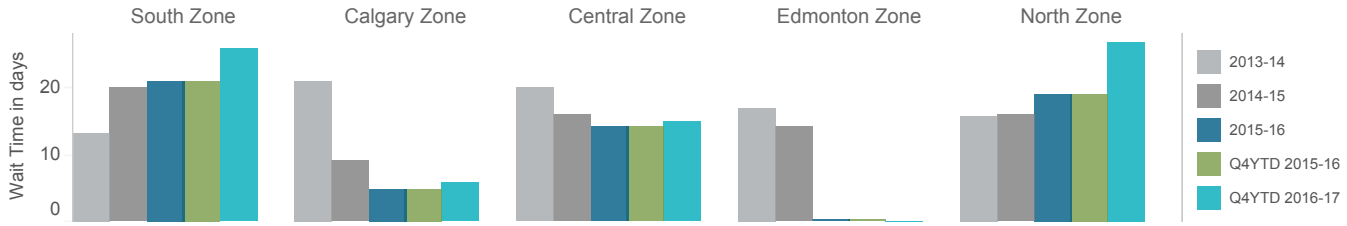
Legend
- Target achieved
- Improvement
- Stable than prior period ≤3%
- Area requires additional focus

Addiction Outpatient Treatment Wait Time, Q4YTD 2016-17

Addiction Outpatient Treatment Wait Time Trend by Zone

Zone Name	2013-14	2014-15	2015-16	Q4YTD 2015-16	Q4YTD 2016-17	Trend	2017-18 Target
Provincial	**18**	**15**	**13**	**13**	**15**	●	**12**
South Zone	13	20	21	21	26	●	12
Calgary Zone	21	9	5	5	6	★	12
Central Zone	20	16	14	14	15	●	12
Edmonton Zone	17	14	0	0	0	★	12
North Zone	16	16	19	19	27	●	12

Addiction Outpatient Treatment Wait Time by Zone and Fiscal Year



Total Enrollments

Zone Name	2013-14	2014-15	2015-16	Q4YTD 2015-16	Q4YTD 2016-17
Provincial	**19,818**	**19,533**	**18,424**	**18,424**	**17,881**
South Zone	1,682	1,556	1,759	1,759	1,817
Calgary Zone	5,086	4,764	4,617	4,617	4,453
Central Zone	3,201	3,517	3,468	3,468	3,547
Edmonton Zone	6,379	6,097	5,051	5,051	4,538
North Zone	3,470	3,599	3,529	3,529	3,526

Source: Addiction System for Information and Service Tracking (ASIST) Data Research View for Treatment Service, Standard Data Product, Clinical Activity Reporting Application (CARA), Geriatric Mental Health Information System (GMHIS), as of July 26, 2017
Notes:
1.This quarter is a quarter later due to requirements to followup with patients after end of reporting quarter.
2. The vast majority of clients (in both urban settings – Edmonton and Calgary) are walk-ins. The large downtown clinic offers walk-in services but the satellite services (suburban clinics) generally do not offer walk-in services and are scheduled. These larger clinics have higher volumes and may impact the overall zone percentile rank.

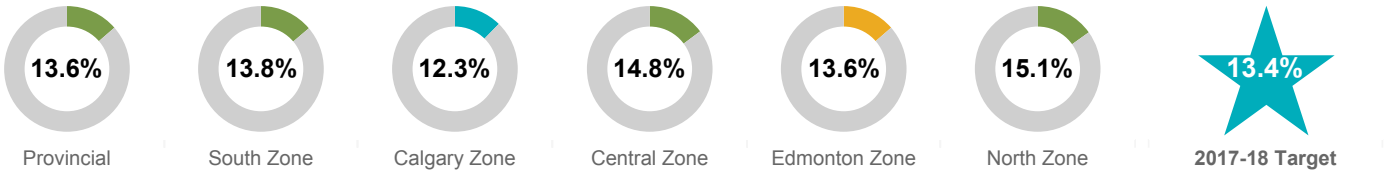
AHS Report on Performance Quarter 1, 2017/18

UNPLANNED MEDICAL READMISSIONS WITHIN 30 DAYS

The lower the number, the better. High rates of unplanned readmission acts 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.

Legend
- Target achieved
- Improvement
- Stable than prior period ≤3%
- Area requires additional focus

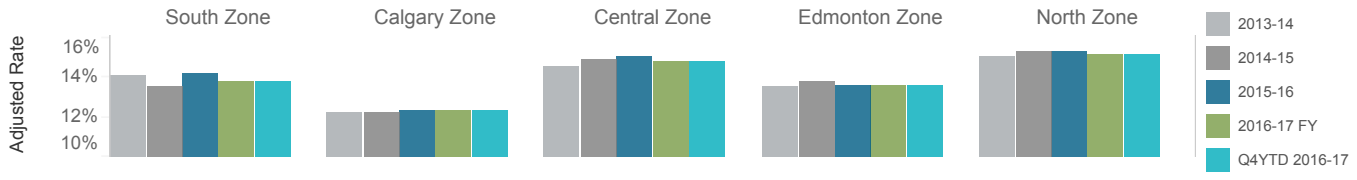
Unplanned Medical Readmissions within 30 days, Q4YTD 2016-17



Unplanned Medical Readmissions within 30 days Trend - Busiest Sites

Zone Name	Site Name	2013-14	2014-15	2015-16	Q4YTD 2015-16	Q4YTD 2016-17	Trend	2017-18 Target
Provincial	Provincial	**13.5%**	**13.6%**	**13.7%**	**13.7%**	**13.6%**	■	**13.4%**
South Zone	South Zone	14.1%	13.5%	14.2%	14.2%	13.8%	■	13.4%
	Chinook Regional Hospital	13.2%	13.5%	14.1%	14.1%	13.2%	★	13.4%
	Medicine Hat Regional Hospital	14.4%	12.5%	14.0%	14.0%	13.7%	★	13.4%
	Other South Hospitals	15.0%	14.7%	14.4%	14.4%	14.9%	●	13.4%
Calgary Zone	Calgary Zone	12.2%	12.2%	12.3%	12.3%	12.3%	★	13.4%
	Foothills Medical Centre	12.2%	12.1%	12.3%	12.3%	12.3%	★	13.4%
	Peter Lougheed Centre	12.1%	12.2%	12.8%	12.8%	13.1%	★	13.4%
	Rockyview General Hospital	12.0%	11.9%	11.9%	11.9%	12.0%	★	13.4%
	South Health Campus	12.3%	12.3%	12.0%	12.0%	11.3%	★	13.4%
	Other Calgary Hospitals	12.8%	13.6%	12.5%	12.5%	13.0%	★	13.4%
Central Zone	Central Zone	14.5%	14.9%	15.0%	15.0%	14.8%	■	13.4%
	Red Deer Regional Hospital Centre	14.0%	13.8%	13.9%	13.9%	13.0%	★	13.4%
	Other Central Hospitals	14.6%	15.3%	15.4%	15.4%	15.6%	●	13.4%
Edmonton Zone	Edmonton Zone	13.5%	13.8%	13.6%	13.6%	13.6%	▲	13.4%
	Grey Nuns Community Hospital	12.6%	12.3%	13.2%	13.2%	12.7%	★	13.4%
	Misericordia Community Hospital	13.0%	13.7%	13.5%	13.5%	14.9%	●	13.4%
	Royal Alexandra Hospital	13.2%	14.0%	13.7%	13.7%	13.0%	★	13.4%
	Sturgeon Community Hospital	12.3%	13.6%	13.4%	13.4%	13.1%	★	13.4%
	University Of Alberta Hospital	14.6%	14.6%	14.2%	14.2%	14.4%	●	13.4%
	Other Edmonton Hospitals	13.4%	12.8%	11.9%	11.9%	12.8%	●	13.4%
North Zone	North Zone	15.0%	15.3%	15.3%	15.3%	15.1%	■	13.4%
	Northern Lights Regional Health Centre	13.4%	12.8%	13.4%	13.4%	14.3%	★	13.4%
	Queen Elizabeth II Hospital	12.6%	11.9%	13.3%	13.3%	13.2%	★	13.4%
	Other North Hospitals	15.5%	16.1%	15.9%	15.9%	15.5%	■	13.4%

Unplanned Medical Readmissions within 30 days by Zone and Fiscal Year



Total Discharges

Zone Name	2013-14	2014-15	2015-16	Q4YTD 2015-16	Q4YTD 2016-17
Provincial	**110,164**	**112,049**	**113,804**	**113,804**	**113,914**
South Zone	10,058	9,887	9,632	9,632	9,824
Calgary Zone	33,903	34,931	35,449	35,449	35,553
Central Zone	16,168	16,747	16,826	16,826	16,743
Edmonton Zone	34,911	35,801	37,646	37,646	37,688
North Zone	15,124	14,683	14,251	14,251	14,106

Source(s): AHS Provincial Discharge Abstract Database (DAD), as of August 2, 2017
Notes: This quarter is a quarter later due to requirements to followup with patients after end of reporting quarter.
This indicator measures the risk-adjusted rate of urgent readmission to hospital for the Medical patient group, which is adapted from the CIHI methodology.

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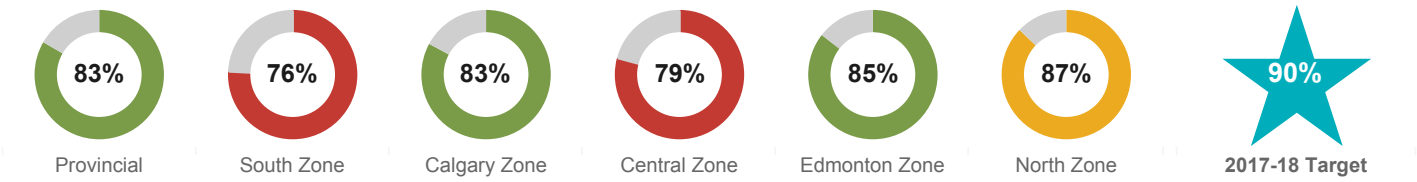
HAND HYGIENE COMPLIANCE RATE

Direct observation is recommended to assess hand hygiene compliance rates for health care workers. The higher the percentage, the better as it demonstrates more health care workers are complying with appropriate hand hygiene practices.

Legend
- Target achieved ★
- Improvement ■
- Stable than prior period ≤3% ▲
- Area requires additional focus ●

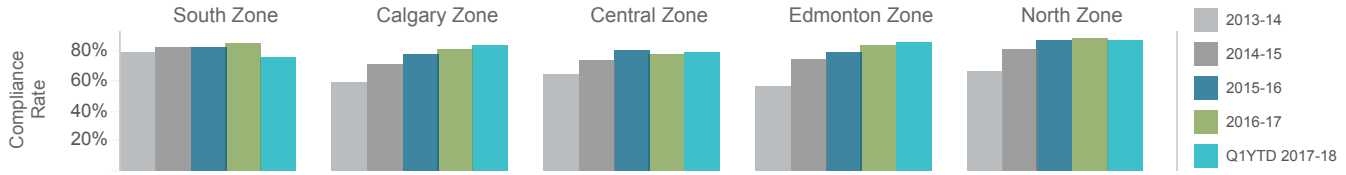
Hand Hygiene Compliance Rate, Q1YTD 2017-18



Hand Hygiene Compliance Rate Trend - Busiest Sites

Zone Name	Site Name	2013-14	2014-15	2015-16	2016-17	Q1YTD 2016-17	Q1YTD 2017-18	Trend	2017-18 Target
Provincial	**Provincial**	**66%**	**75%**	**80%**	**82%**	**83%**	**83%**	■	**90%**
South Zone	South Zone	78%	82%	82%	84%	86%	76%	●	90%
	Chinook Regional Hospital	81%	85%	82%	83%	87%	70%	●	90%
	Medicine Hat Regional Hospital	76%	77%	82%	87%	86%	82%	●	90%
	Other South Sites	79%	85%	83%	83%	84%	75%	●	90%
Calgary Zone	Calgary Zone	59%	71%	78%	81%	81%	83%	■	90%
	Alberta Children's Hospital	57%	74%	77%	80%	79%	81%	■	90%
	Foothills Medical Centre	52%	66%	76%	83%	81%	83%	■	90%
	Peter Lougheed Centre	62%	77%	85%	79%	81%	79%	▲	90%
	Rockyview General Hospital	62%	68%	74%	84%	80%	91%	★	90%
	South Health Campus	59%	59%	69%	76%	78%	80%	■	90%
	Other Calgary Sites	63%	77%	80%	79%	80%	81%	■	90%
Central Zone	Central Zone	64%	74%	81%	78%	83%	79%	●	90%
	Red Deer Regional Hospital Centre	75%	69%	78%	78%	78%	84%	■	90%
	Other Central Sites	57%	77%	82%	78%	84%	78%	●	90%
Edmonton Zone	Edmonton Zone	57%	74%	79%	83%	82%	85%	■	90%
	Grey Nuns Community Hospital **	64%	75%	73%	83%	80%	87%	■	90%
	Misericordia Community Hospital **	71%	77%	75%	80%	75%	85%	■	90%
	Royal Alexandra Hospital	62%	75%	81%	84%	84%	86%	■	90%
	Stollery Children's Hospital	58%	75%	79%	80%	80%	80%	▲	90%
	Sturgeon Community Hospital	59%	81%	84%	86%	84%	88%	■	90%
	University of Alberta Hospital	43%	70%	74%	85%	83%	88%	■	90%
	Other Edmonton Sites	64%	74%	78%	82%	80%	85%	■	90%
North Zone	North Zone	66%	81%	87%	88%	89%	87%	▲	90%
	Northern Lights Regional Health Centre	56%	64%	88%	87%	79%	84%	■	90%
	Queen Elizabeth II Hospital	68%	91%	96%	91%	92%	88%	●	90%
	Other North Sites	66%	74%	85%	88%	89%	87%	▲	90%

Hand Hygiene Compliance Rate by Zone and Fiscal Year



Total Observations *(excludes Covenant Sites)*

Zone Name	2015-16	2016-17	Q1YTD 2016-17	Q1YTD 2017-18
Provincial	**396,272**	**383,975**	**101,262**	**91,997**
South Zone	39,185	38,314	14,339	4,387
Calgary Zone	183,110	162,423	38,765	39,573
Central Zone	45,103	35,952	9,049	9,754
Edmonton Zone	99,795	125,281	33,223	31,857
North Zone	29,079	22,005	5,886	6,426

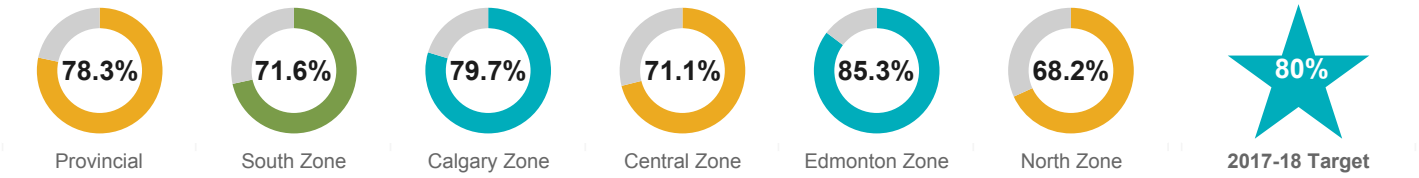
Source: AHS Infection, Prevention and Control Database, as of July 28, 2017
*- ** Covenant sites (including Misericordia Community Hospital and Grey Nuns Hospital) use different methodologies for capturing and computing Hand Hygiene compliance rates. These are available twice a year in spring and fall.*
"Other Sites" include any hand hygiene observations performed at an AHS operated program, site, or unit including acute care, continuing care, and ambulatory care settings such as CancerControl, Corrections, EMS, hemodialysis (e.g., NARP and SARP), home care, and public health.

CHILDHOOD IMMUNIZATION RATE (DTPP-Hib)

The higher the percentage, the better. 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 result in fatal or produce permanent disabilities.

Legend
- *Target achieved* ★
- *Improvement* ■
- *Stable than prior period ≤3%* ▲
- *Area requires additional focus* ●

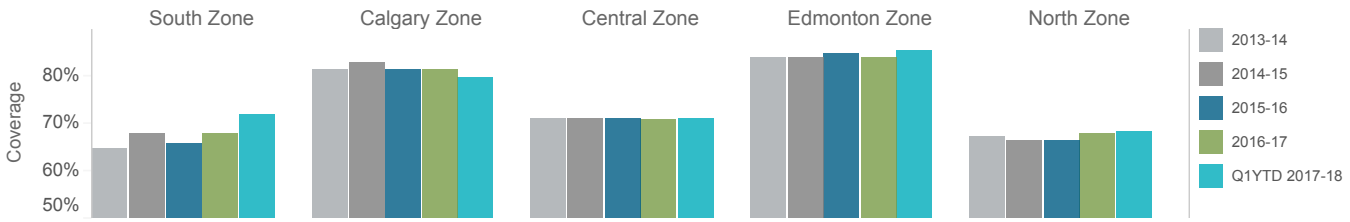
DTPP-Hib Childhood Immunization Rate, Q1YTD 2017-18



DTPP-Hib Childhood Immunization Rate

Zone Name	2013-14	2014-15	2015-16	2016-17	Q1YTD 2016-17	Q1YTD 2017-18	Trend	2017-18 Target
Provincial	**77.6%**	**78.3%**	**78.0%**	**78.3%**	**78.7%**	**78.3%**	▲	**80%**
South Zone	64.6%	67.9%	65.7%	67.8%	65.9%	71.6%	■	80%
Calgary Zone	81.4%	82.6%	81.5%	81.4%	82.3%	79.7%	★	80%
Central Zone	71.1%	71.1%	70.9%	70.6%	71.8%	71.1%	▲	80%
Edmonton Zone	84.0%	84.0%	84.6%	84.0%	84.4%	85.3%	★	80%
North Zone	67.2%	66.6%	66.5%	67.7%	68.5%	68.2%	▲	80%

DTPP-Hib Childhood Immunization Rate by Zone and Fiscal Year



Total Eligible Population

Zone Name	2013-14	2014-15	2015-16	2016-17	Q1YTD 2016-17	Q1YTD 2017-18
Provincial	**51,613**	**53,206**	**54,267**	**55,138**	**14,002**	**14,366**
South Zone	4,061	4,179	4,104	4,157	1,082	1,163
Calgary Zone	18,360	19,031	19,602	20,424	5,102	5,268
Central Zone	6,427	6,495	6,240	5,833	1,578	1,557
Edmonton Zone	15,695	16,229	16,870	17,578	4,354	4,477
North Zone	7,070	7,272	7,451	7,146	1,886	1,901

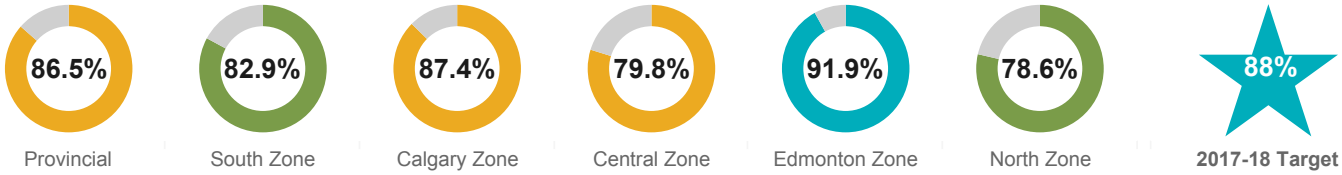
Source: AHS Public Health Surveillance Database, as of July 26, 2017

CHILDHOOD IMMUNIZATION RATE (MMR)

The higher the percentage, the better. 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 result in fatal or produce permanent disabilities.

Legend
Target achieved ★
Improvement ■
Stable than prior period ≤3% ▲
Area requires additional focus ●

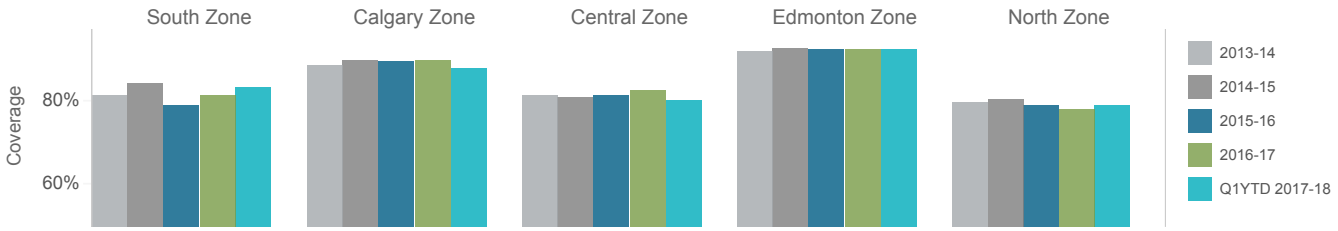
MMR Childhood Immunization Rate, Q1YTD 2017-18



MMR Childhood Immunization Rate Trend

Zone Name	2013-14	2014-15	2015-16	2016-17	Q1YTD 2016-17	Q1YTD 2017-18	Trend	2017-18 Target
Provincial	**86.7%**	**87.6%**	**86.9%**	**87.4%**	**87.3%**	**86.5%**	▲	**88%**
South Zone	81.1%	83.9%	78.8%	81.0%	80.2%	82.9%	■	88%
Calgary Zone	88.3%	89.6%	89.2%	89.6%	90.0%	87.4%	▲	88%
Central Zone	81.2%	80.8%	81.1%	82.3%	81.8%	79.8%	▲	88%
Edmonton Zone	91.7%	92.2%	91.9%	91.8%	92.3%	91.9%	★	88%
North Zone	79.6%	80.3%	78.5%	77.8%	77.2%	78.6%	■	88%

MMR Childhood Immunization Rate by Zone



Total Eligible Population

Zone Name	2013-14	2014-15	2015-16	2016-17	Q1YTD 2016-17	Q1YTD 2017-18
Provincial	**51,613**	**53,206**	**54,267**	**55,138**	**14,002**	**14,364**
South Zone	4,061	4,179	4,104	4,157	1,082	1,163
Calgary Zone	18,360	19,031	19,602	20,424	5,102	5,268
Central Zone	6,427	6,495	6,240	5,833	1,578	1,555
Edmonton Zone	15,695	16,229	16,870	17,578	4,354	4,477
North Zone	7,070	7,272	7,451	7,146	1,886	1,901

Source: AHS Public Health Surveillance Database, as of July 26, 2017

Disabling Injury Rate (DIR)

Monitoring disabling injury rate enables us to determine the effectiveness of programs that provide AHS employees, volunteers and physicians with a safe and healthy work environment, and keep them free from injury. The lower the rate, the less injuries are occurring at work...

Legend
- *Target achieved* ★
- *Improvement* ■
- *Stable than prior period ≤3%* ▲
- *Area requires additional focus* ●

Most Recent Time Period: Q1YTD 2017-18

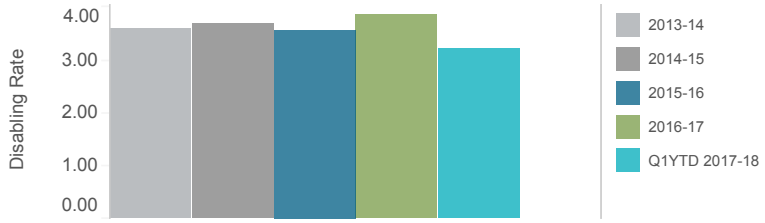
Provincial

2017-18 Target

Disabling Injury Rate by AHS Portfolio

Level of Portfolio	Portfolios or Departments	2015-16	2016-17	Q1YTD 2016-17	Q1YTD 2017-18	Trend	2017-18 Target
Provincial	**Provincial**	**3.57**	**3.85**	**3.16**	**3.21**	★	**3.5**
Zone	South Zone Clinical Operations	3.54	3.50	2.30	2.65	★	3.5
	Calgary Zone Clinical Operations	3.54	3.86	3.42	3.46	★	3.5
	Central Zone Clinical Operations	4.00	4.14	3.00	4.38	●	3.5
	Edmonton Zone Clinical Operations	3.59	3.83	3.06	3.27	★	3.5
	North Zone Clinical Operations	4.33	3.78	2.26	2.76	★	3.5
Provincial Portfolios	Cancer Control	1.71	1.43	0.68	0.66	★	3.5
	Capital Management	2.37	3.77	3.52	2.00	★	3.5
	Collaborative Practice, Nursing & Health Profession	4.93	4.23	3.56	7.31	●	3.5
	Community Engagement and Communications	0.00	0.00	0.00	0.00	★	3.5
	Contracting, Procurement & Supply Management	2.70	3.74	3.09	3.50	★	3.5
	Diagnostic Imaging	1.81	2.90	2.91	2.46	★	3.5
	Emergency Medical Services	12.92	15.09	14.21	13.51	■	3.5
	Finance	0.16	0.33	0.66	0.66	★	3.5
	Health Information Management	1.29	2.19	1.23	1.23	★	3.5
	Information Technology (IT)	0.25	0.16	0.00	0.21	★	3.5
	Internal Audit and Enterprise Risk Management	0.00	0.00	0.00	0.00	★	3.5
	Laboratory Services	1.31	1.55	1.05	1.22	★	3.5
	Linen & Environmental Services	7.62	8.00	7.21	5.43	■	3.5
	Nutrition Food Services	5.91	5.38	4.28	3.93	■	3.5
	People, Legal, and Privacy	0.74	0.50	0.00	0.39	★	3.5
	Pharmacy Services	1.09	1.69	1.37	0.00	★	3.5
	Population Public & Indigenous Health	1.29	1.13	0.41	0.41	★	3.5
	Research, Innovation and Analytics	0.27	0.26	0.00	1.48	★	3.5

Disabling Injury Rate by Fiscal Year, Provincial



Source: AHS Workplace Health & Safety and Disability Management and WCB Alberta, Electronic Payroll Analytics (ePA) , 2017.18 June YTD data as of August 10, 2017
Notes:
Community Engagement & Communications and Internal Audit & Enterprise Risk Management reporting of "0.00" is accurate and reflects these two portfolios having very safe and healthy work environments.