Measure	Definition	Understanding this Measure
PRIMARY CARE		
Family Practice Sensitive Conditions	Percent of Emergency Department (ED) or urgent care centre visits for health conditions that may be more appropriately managed at a family physician's office. Examples of these conditions include conjunctivitis and migraines. Values presented are crude rates.	Treatment at family physician offices when appropriate allows for proper follow-up and better patient outcomes. The expectation is that more effective provision of primary care services would result in improvement in this measure. Use of ED and urgent care services for these conditions may also result in higher costs and potentially longer patient waits in ED, than when patients visit more appropriate health care providers in the community for their needs.
Health Link Median Wait Time before Calls Answered (Minutes) - Clinical	The median wait time before clinical calls to Health Link 811 are answered (in minutes). Clinical calls are answered by health professionals, such as: RN's, Occupational & Physical Therapists, Psychologist, Social Workers and Mental Health. Clinical calls include: Nurse, Addiction & Mental Health, COVID Clinical, and Rehabilitation Advice Line. This measures is reported at the Province level only.	The lower the median wait time before answered the better. Compared to non-clinical calls, clinical calls typically take longer to address and they tend to have longer wait times.
Health Link Median Wait Time before Calls Answered (Minutes) - Non-Clinical	The median wait time before Non-Clinical calls to Health Link 811 are answered (in minutes). Non-clinical calls include those answered by non-registered health professionals such as: COVID Assistance Clerks, Immunization Booking, Information & Referral, Catch a Break, Tobacco - AlbertaQuits, and Central Access. Non-Clinical calls include: Information &Referral, Influenza, COVID Non-Clinical, Catch a Break, Tobacco, Central Access, and Immunization Booking. This measure is reported at the Province level only.	The lower the median wait time before answered the better. Compared to clinical calls, non-clinical calls are typically shorter discussions and they tend to have shorter wait times.
CONTINUING CARE		
Number of Clients Placed in Continuing Care	The number of clients placed into continuing care living options from both acute/sub-acute care (hospitals) and from community (including home) during the reporting period. Continuing care living options include long-term care or designated supportive living (supportive living level 3, 4, and 4-dementia) facilities.	The higher the number, the better, to be interpreted in conjunction with other measures such as ALC (alternate level of care days) within acute care settings. As demand remains high, a higher number placed can demonstrate better meeting need for long-term care or designated supportive living space.
Persons Waiting in Acute/Subacute Hospital Bed for Continuing Care Placement	People waiting in acute/sub-acute (hospital) beds for continuing care placement is a count of the number of persons who have been assessed and approved for placement in continuing care, who are waiting in a hospital acute care or sub-acute bed. The numbers presented are a snapshot on the last day of the reporting period.	Access to continuing care services is in significant demand in Alberta. Alberta Health Services is using multiple strategies to provide both seniors and persons with disabilities more options for quality accommodations specific to their service needs and lifestyles. Moving patients out of hospitals to more appropriate care settings produces better quality of care, reduces acute care pressures and may reduce costs.
Persons Waiting in Community (home) for Continuing Care Placement	People waiting in community for continuing care placement is a count of the number of persons who have been assessed and approved for placement in continuing care, who are waiting in the community. The numbers presented represent a snapshot on the last day of the reporting period.	Access to continuing care services is in significant demand in Alberta. Alberta Health Services is using multiple strategies to provide both seniors and persons with disabilities more options for quality accommodations specific to their service needs and lifestyles.
Client Average Wait in Acute/Subacute Hospital before Placement (days)	The average number of days a client waited from the time they were assessed and approved (ready to treat) for a living option, to time of admission.	These are wait times for individuals whose last location prior to placement was an acute or sub-acute care (hospital) setting. Wait time can also include time spent in community.

Measure	Definition	Understanding this Measure
CANCER WAIT TIMES		
Medical Oncology Access (Referral to First Consult, 90th Percentile in Weeks)	The number of days (aggregated to weeks) from the date that a referral was received from a physician outside a Cancer Care Alberta facility (e.g., family physician or surgeon) to the date that the first physician consultation occurred. The first consult must be with the medical oncology service. The 90th percentile time indicates that 90 per cent of patients receive their first consultation in this time or less.	Medical oncology referrals include those for medical, surgical, and gynecological oncologists where care planning may be for surgery, chemotherapy, and other interventions not including radiation. Alberta Health Services is striving to meet the needs of cancer patients by monitoring timeliness of access to oncology services. Improved access can be attained through capacity and process improvements. We are standardizing and automating triage and referral processes in order to improve how quickly patients are able to access specialized cancer care. Significant increases in capacity have also been made with additional facilities now available across the province.
Radiation Oncology Access (Referral to First Consult, 90th Percentile in Weeks)	The number of days (aggregated to weeks) from the date that a referral was received from a physician outside a Cancer Care Alberta facility (e.g., family physician or surgeon) to the date that the first physician consultation occurred. The first consult must be with the radiation oncology service. The 90th percentile time indicates that 90 per cent of patients receive their first consultation in this time or less.	This indicator helps to measure performance in the consultation process and access to radiation services for patients. Alberta Health Services is striving to meet the needs of cancer patients by monitoring timeliness of access to oncology services. Improvements to the triage and referral process, standardization and automation all work towards improving capacity and outcomes for patients. The addition of new facilities has also increased capacity.
Radiation Therapy Access (RTT to First Therapy 90th Percentile in Weeks)	The number of days (aggregated to weeks) from the date the patient is ready to begin the treatment process based on clinical decision and patient choice (ready to treat date) to the date that the patient received their first radiation therapy. The 90th percentile time indicates that 90 per cent of patients receive their first radiation therapy within this length of time or less.	The purpose of this indicator is to provide a high-level perspective of how quickly patients who received radiation therapy over a given time period of interest received it from the point in time when they could have received it. This measure can be used to help understand access to care and to know how Alberta is performing in providing access to services.
ACUTE CARE		
Acute Care Occupancy (Busiest Sites*)	This measure of occupancy is the ratio of inpatients currently in hospital compared to the total hospital beds available, averaged over the reporting period. It includes all patients in hospital once registered as an inpatient regardless of location (includes operating room and while waiting in Emergency Department for instance). Over capacity and closed beds are not included. The measure includes only the top 16 busiest* hospitals in the province.	Hospital occupancy may be used as a proxy measure of hospital access. A hospital with high occupancy may experience longer times to place patients in a unit location. Large urban and suburban hospitals will typically have higher occupancy than rural facilities.
Hospital Acquired *Clostridium difficile* Infection Rate (per 10,000 Patient Days)	The number of *Clostridium difficile* infections (*C-diff*) acquired in hospital per 10,000 patients days. A rate of 4.0 means approximately 100 patients per month acquire *C-diff* infections in Alberta. *C-diff* infection cases include patients with a new infection or re-infection while in hospital. Patients are considered to have *C-diff* if they exhibit symptoms and there is confirmation by a laboratory test or colonoscopy.	Some individuals carry *C-diff* in their intestines while others may acquire it while in hospital. *C-diff* is the most frequently identified cause of hospital-acquired diarrhea. This infection complicates and prolongs hospital stays and creates risk for patients. Infections impact resources and costs in the health care system. Monitoring *C-diff* trends provide important information about effectiveness of infection prevention and control strategies.

Measure	Definition	Understanding this Measure
Hospital Standardized Mortality Ratio (HSMR)	The ratio of actual number of deaths compared to the expected number of deaths based upon the type of patients admitted to hospitals. This ratio is multiplied by 100 for reporting purposes. The ratio compares actual deaths to statistically expected death rates after adjusting for factors that affect in-hospital mortality, such as patient age, sex, diagnosis, and other risk factors. The expected deaths are based on rates amongst similar patients in national databases, using 2012-13 data as a baseline (as per CIHI estimate), thus allowing comparison of this measure over time.	This measure of quality care shows how successful hospitals have been in delivering and managing care to reduce patient deaths. A mortality ratio equal to 100 suggests that there is no difference between the hospital's mortality rate and the national average rate. A mortality ratio greater than 100 suggests that the local mortality rate is higher than the national average. A mortality ratio less than 100 suggests that the local mortality rate is lower than the national average. This measure is based on the CIHI methodology. Care should be taken in interpreting results where smaller group sizes are reported (due to small sites or time periods). The baseline is held constant at 2012-13 in order to mitigate confounding variables in trends over time and allow comparisons of this measures over time.
Heart Attack (AMI) In-Hospital Mortality within 30 Days (Risk-adjusted)	The risk adjusted rate of all-cause in-hospital death within 30 days of first admission for a heart attack (diagnosis of acute myocardial infarction, AMI). This measure is adjusted for age, sex, and other risk factors, and then standardized to the 2012-13 national average heart attack in-hospital 30 day mortality rate (as per CIHI estimate), thus allowing comparison of this measure over time.	Heart attacks are one of the leading causes of death in Canada. Breakthroughs in treatments, particularly the timing of re-opening coronary arteries for blood flow, are greatly increasing survival rates. This measure is based on the CIHI methodology. Care should be taken in interpreting results where smaller group sizes are reported (due to small sites or time periods). Annual reporting is recommended. The baseline is held constant at 2012-13 in order to mitigate confounding variables in trends over time and allow comparisons of this measures over time.
Stroke In-Hospital Mortality within 30 Days (Risk-adjusted)	The risk adjusted rate of all-cause in-hospital death within 30 days of first admission for a stroke. This measure is adjusted for age, sex and other conditions, and standardized to the 2012-13 national average stroke in-hospital 30 day mortality rate (as per CIHI estimate), thus allowing comparison of this measure over time.	Stroke is a significant cause of death and disability in the Canadian population. This rate may be influenced by a number of factors, including effectiveness of emergency treatments and quality of care in hospitals. Stroke outcomes are greatly influenced by early intervention after stroke symptoms appear. Specialty care and intervention are actively used in Alberta. This measure is based on the CIHI methodology. Care should be taken in interpreting results where smaller group sizes are reported (due to small sites or time periods). Annual reporting is recommended. This measure is standardized to the 2012-13 national average stroke in-hospital 30 day mortality rate, thus allowing comparison of this measure over time.
Medical Readmissions within 30 days (Risk adjusted)	The ratio of the number of observed, non-elective readmissions to hospital within 30 days compared to the number of expected, non-elective readmissions to hospital within 30 days (derived from Alberta patient risk profile coefficients), multiplied by the Alberta average medical readmission rate (calculated by Alberta Health). This measure is further controlled by the patient's Episode of Care.	This measure is an Alberta adapted implementation of the CIHI measure “Medical Patients Readmitted to Hospital” using risk adjustment factors based on the analysis of provincial data from Alberta Health. Therefore, this measure aligns with Alberta Health published reports. Using risk adjusted rates allow valid comparison across jurisdictions, zones and sites. Lower rates are desirable, however not all urgent readmissions are avoidable. Reporting date is based on the discharge of the index episode of care. Readmission rates can be influenced by a range of factors including quality of inpatient acute care, discharge readiness and appropriateness, continuity of care transition, and access to follow up services and support.

Measure	Definition	Understanding this Measure
EMERGENCY DEPARTMENT		
Emergency Department Length of Stay (LOS) for Admitted Patients (Median Time in Hours at the Busiest Sites*)	The length of time in the Emergency Department (ED) from the start of visit in the ED until the time they are admitted as an inpatient and leave the ED at the busiest EDs. This is calculated as the median time which means that 50 percent of patients stay in the ED this length of time or less. The measure includes only the top 17 busiest* hospitals in the province.	ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent can be a measure of access to the health care system and a reflection of efficient use of resources. As such, this measure can reflect performance of the entire system. It is influenced by our ability to manage complex patients in primary care, efficiencies in the ED, efficiencies and capacity in the acute care (when staying in hospital), better quality of care and integration with community services in reducing unplanned readmissions, timely placement of patients into continuing care (e.g., long-term care) and linking patients to the appropriate services in the community after a stay in hospital. Long wait times in ED for admitted patients suggest pressures in acute care bed capacity which is impacted by many factors.
Emergency Department Patients Treated and Admitted to Hospital within 8 hours (LOS ≤ 8 Hours, %) (All Sites and Busiest Sites*)	This measures the percentage of patients admitted from Emergency Department (ED) with a total stay in ED of eight hours or less. The total time is from start of patient visit in the ED until they are admitted and leave the ED. The measure is reported for all hospitals in the province as well as the top 17 busiest* hospitals in the province.	**See note above**. The measure is reported for all hospitals in the province as well as the top 17 busiest* hospitals in the province.
Emergency Department Length of Stay (LOS) for Discharged Patients (Median Time in Hours at the Busiest Sites*)	The length of time in the Emergency Department (ED) from the start of visit in the ED until the time they are discharged at the busiest EDs. This is calculated as the median time which means that 50 percent of patients stay in the ED this length of time or less. The measure includes only the top 17 busiest* hospitals in the province.	Patients treated in an ED should be assessed and treated in a timely fashion. This measure focuses on the total time these patients are in the ED before being discharged. Many patients seen in the ED may not require admission to hospital but may require other treatment during their ED stay. Excessive wait times for care can result in treatment delays. Reasons for variation of length of stay across sites include complexity of patients, capacity limitations, operational efficiency and access to other primary care options (family physicians, walk-in clinics).
Emergency Department and Urgent Care Centre Patients Treated and Discharged within 4 Hours (LOS ≤ 4 Hours, %) (All Sites and Busiest Sites*)	This measures the percentage of patients discharged from an Emergency Department (ED) or Urgent Care Centre (UCC) with a total stay in ED or UCC of four hours or less. The total time is from the start of visit in the ED or UCC until they are discharged and leave the ED or UCC. The measure is reported for all sites in the province (which include UCC) as well as the top 17 busiest* hospitals in the province.	**See note above.** The measure is reported for all sites in the province (which include UCC) as well as the top 17 busiest* hospitals in the province.
Emergency Department Time to Physician Initial Assessment (TPIA) (Median Time in Hours at the Busiest Sites*)	The length of time in the Emergency Department (ED) before being seen by a physician at the busiest EDs. This is calculated as the median time which means that 50 per cent of patients wait this length of time or less to be seen by a physician. This time is measured from the start of visit in the ED and when they are first seen by a physician. The measure includes only the top 16 busiest* hospitals in the province.	Patients coming to the ED need to be seen by a physician in a timely manner for diagnosis or treatment. It is important to keep this number low to also ensure people do not leave without being seen. In Emergency Departments, every effort is made to ensure that the sickest patients are seen in priority.

Measure	Definition	Understanding this Measure
Emergency Department Patients Left Without Being Seen and Left Against Medical Advice	This measures the percentage of patients who attend an Emergency Department (ED) or Urgent Care Centre (UCC) with the visit ending as "Left Without Being Seen (LWBS)" or "Left Against Medical Advice (LAMA)", identified via disposition codes. This quantifies the visits that terminated prematurely for any reason.	Patients who visit an ED or UCC and then leave for unknown reasons before being seen by an ED/UCC physician or leave prior to the diagnosis or completion of other aspects of care may be at risk and represent utilization of the system without closure. Lengthy wait times in Alberta EDs can result in higher rates for this measure as patients may be unsure about care or unable to wait this length of time. Where alternative care sites are available, patients may seek care in another location and hence higher rates for this measure may be found in urban centres with multiple EDs, UCCs, or other clinical options. This measure can assist in quantifying this patient population for risk and resource impact of ED/UCC services.

SURGICAL PROCEDURES		
Surgical wait times are reported as RTT (Ready to Treat to Treatment)	***Ready to Treat to Treatment (RTT)*** *represents the wait time beginning when the patient is ready for surgery and ending on the date the surgery is completed. RTT does not include delays due to patient medical, functional, or social reasons. AHS and national reporting on wait times has shifted to use of RTT as it better represents how long the patient will wait for the service and the steps along the way. DTT (Decision to Treat to Treatment) is no longer reported.*	
Cataract Surgery RTT (median and 90th Percentile Wait Time in Weeks)	This measure represents the time until the cataract surgery was completed. Only scheduled surgeries on the first eye are included. The median (50th percentile) wait time indicates that 50 per cent of patients received their first surgery in this time or less, and the 90th percentile wait time indicates that 90 per cent of patients received their first surgery in this time or less.	Providing reasonable access to health service is a major objective of Alberta Health Services. Longer wait times may affect quality of life and impact clinical outcomes. Cataract surgeries are frequently completed at contract providers. For further comparison of wait times across Canada see CIHI's report on *Wait Times for Priority Procedures in Canada*.
Scheduled Coronary Artery Bypass Graft (CABG) Wait Time (median and 90th Percentile Wait Time in Weeks)	This measure represents the wait time (in weeks) for scheduled coronary artery bypass graft (CABG) surgery from the point in time when a patient is ready for treatment (ready-to-treat date) to the treatment date. The median (50th percentile) wait time indicates that 50 per cent of patients received their surgery in this time or less, while the 90th percentile wait time indicates that 90 per cent of patients received their surgery in this time or less. Emergent/urgent cases are not included.	Providing reasonable access to health service is a major objective of Alberta Health Services. Longer wait times may affect quality of life and impact clinical outcomes. For further comparison of wait times across Canada see CIHI's report on *Wait Times for Priority Procedures in Canada*.
Hip Replacement Surgery (median and 90th Percentile Wait Time in Weeks)	This measure represents the time until hip replacement (arthroplasty) surgery was completed. The median (50th percentile) wait time indicates that 50 per cent of patients received their first surgery in this time or less, and the 90th percentile time indicates that 90 per cent of patients receive their first surgery in this time or less. Emergency cases are not included.	Providing reasonable access to health service is a major objective of Alberta Health Services. Longer wait times may affect quality of life and impact clinical outcomes. For further comparison of wait times across Canada see CIHI's report on *Wait Times for Priority Procedures in Canada*.
Knee Replacement Surgery (median and 90th Percentile Wait Time in Weeks)	This measure represents the time until knee replacement (arthroplasty) surgery was completed. The median (50th percentile) wait time indicates that 50 per cent of patients received their first surgery in this time or less, and the 90th percentile time indicates that 90 per cent of patients receive their first surgery in this time or less. Emergency cases are not included.	Providing reasonable access to health service is a major objective of Alberta Health Services. Longer wait times may affect quality of life and impact clinical outcomes. For further comparison of wait times across Canada see CIHI's report on *Wait Times for Priority Procedures in Canada*.

Measure	Definition	Understanding this Measure
Postponements of Scheduled Surgeries due to System Capacity	This measure is the percentage of elective surgical cases, at the 16 busiest* sites, that are postponed due to capacity issues (such as unavailable beds, shortage of equipment and products, lack of operating room space, or staffing availability). The same surgery is to be performed at a rescheduled time and date. Excludes cases where a patient's condition has changed, a patient is too sick to be operated on, or further tests are required.	AHS acknowledges and understands that postponing surgeries can be stressful to our patients and their families. We know that preparing for surgery can be difficult, and often requires making significant arrangements to work and personal lives. AHS tracks surgical postponements to help us understand where the access pressures are in the health system, so we can make appropriate improvements.
Hip Fracture Repair within 48 Hours	This measure is the percentage of hip fracture surgeries performed within 48 hours of admission. Cases included are all discharges that had a pre-admission hip fracture recorded and where hip fracture repair surgery was performed.	There is strong evidence to suggest that hip fracture surgical procedures delayed by more than 48 hours are associated with poorer outcomes, specifically with respect to length of hospital stay, self-reported pain, 30-day mortality and one-year mortality. Measuring the delay to hip fracture surgery provides an opportunity for hospitals to monitor and improve access to this health care service.

MENTAL HEALTH		
Child and Youth Mental Health Wait Times (Median and 90th percentile in days)	The time (in days) that individuals 18 years of age and younger (child and youth) wait to receive basic, core mental health outpatient treatment services delivered directly by AHS in the community. The measure is calculated as time (in days) between the date with which the referral was received to the date where the earliest therapeutic appointment was scheduled to occur. The median wait time is the number of calendar days within which half of the referred cases (median or 50th percentile) have their first therapeutic appointment scheduled. The 90th percentile is the number of calendar days within which 90% of the referred cases have their first therapeutic appointment scheduled. Standalone psychiatric facilities are not included.	The measure describes the number of days within which 50% of clients will have their first therapeutic appointments scheduled after the time of referral (first contact date is used in some legacy systems where referral date is missing/not available). Expressing the indicator as a percentile reduces the influence of extreme values on the results. The lower the number the better, as it demonstrates people are waiting for a shorter time to receive services.

*Busiest Hospitals:

This group of 16 acute care hospitals are included where indicated for measures reporting on the top 16 busiest hospitals (e.g., Emergency Department TPIA, Acute Care Occupancy).

South Zone

- Chinook Regional Hospital
- Medicine Hat Regional Hospital

Calgary Zone

- Alberta Children's Hospital
- Foothills Medical Centre
- Peter Lougheed Centre
- Rockyview General Hospital
- South Health Campus

Central Zone

- Red Deer Regional Hospital Centre

Edmonton Zone

- Grey Nuns Community Hospital
- Misericordia Community Hospital
- Royal Alexandra Hospital
- Stollery Children's Hospital
- Sturgeon Community Hospital
- University of Alberta Hospital

North Zone

- Northern Lights Regional Health Centre
- Queen Elizabeth II Hospital

This site (below) is included, along with the aforementioned sites (above)—totaling 17 sites—for Emergency Department measures indicating the use of 17 sites.

Edmonton Zone: Northeast Community Health Centre

Notes:

Emergency Department (ED) measures are reported for the "busiest EDs" in the province as well as for "all EDs" in the province, as noted in the measure title.

For measures referring to "discharges", the data includes Urgent Care Centres (UCCs) as well, as noted in the measure title.

Northeast Health Centre in Edmonton Zone is classified as an ED and therefore is included in the measures for ED where patients are discharged (median length of stay for busiest sites and % discharged within 4 hours). However, Northeast Health Centre is not included in measures where patients are admitted from an ED. Since it is a standalone ED with no hospital beds, patients are not admitted to this site. Also, it is not included in the Acute Care Occupancy measure.