Alberta Health Services

AHS Q4 2015-16 Performance Measures Update

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Executive Summary

AHS' 17 performance measures were established in collaboration with Alberta Health. The measures reflect a balance across the spectrum of health care and accurately reflect health system performance. They were developed to enable us to compare AHS performance nationally. The measures play a key role in advising staff and physicians about our progress and where we may need to adjust actions to achieve the identified targets; they also help in communicating with Albertans about the value provided by health funding expenditures.

The performance measures are organized according to the Alberta Quality Matrix for Health, developed by the Health Quality Council of Alberta (HQCA), which describes six dimensions of quality: acceptability, accessibility, appropriateness, effectiveness, efficiency and safety.

The 2015-16 targets were established in the AHS 2014-17 Health and Business Plan. These performance targets help us measure our progress and improve the health system.

AHS remains committed to building on its performance through quality improvement and innovation, and to strive toward the goal of delivering the type of health care system expected by Albertans. When we look at 2015-16, we can see improvements in a number of areas when comparing performance last year.

AHS continues to see volume increases. The demand for services continues to increase within the province as shown within the volume tables below each measure. Initiatives within AHS are being put in place in an effort to not only move measures toward their targets, but also to compensate for these increases in demand.

Summary Results

When we compare nationally with 2014-15 data, Alberta is ranked high for several measures:

- ✓ *Clostridium difficile* Infections – better than national results
- ✓ Hospital Mortality – same as national rate; 3rd best out of 10 provinces
- ✓ Access to Radiation Therapy – 3rd best out of 9 provinces
- ✓ ALOS / ELOS – 3rd best out of 9 provinces
- ✓ Mental Health Readmission – better than national rate; 2nd best out of 10 provinces
- ✓ Surgical Readmission – same as national rate; 5th best out of 10 provinces (compared to 7th in 2013-14)
- ✓ Heart Attack (AMI) Mortality – same as national rate; 4th best out of 10 provinces
- ✓ Stroke Mortality – same as national rate; 4th best out of 10 provinces
- ✓ Early Detection of Cancer – 2nd best out of 9 provinces for breast cancer

The Q4 performance report represents final year data (April 1, 2015 to March 31, 2016) and has been updated as of May 13 (where available) for the period ending March 31, 2016; 15 of the measures are reported quarterly. Nine measures include the most current data available. There are six quarterly measures which rely on patient follow up after a patient's original discharge date for a period up to 90 days. Therefore reporting results reflect patients discharged in an earlier time period (i.e., Q3). Two measures: Early Detection of Cancer (Alberta Cancer Registry Data), and Satisfaction with Long-Term Care (external source - HQCA) reporting cycles do not align with AHS', which are not reported every year.

Six performance measures *achieved 2015-16 target* *(refer to the following pages for more actions)***:**

1. Hospital Acquired *Clostridium difficile* Infection (CDI) (Q3 YTD):
   - ✓ CDI targets were achieved by focused work across the province to reduce the risk of CDI acquisition and transmission. This includes antimicrobial stewardship, use of standardized physician care orders, isolation, enhanced environmental cleaning, human waste management system change with installation of macerators on medical units, a strong focus on hand hygiene and appropriate donning and doffing of personal protective equipment. AHS has initiated a pilot project examining the use of a room disinfection technology (Nocospray) following discharge. This technology will be used in five units across the Edmonton/Calgary Zones with one outcome measure being reduction in CDI.

2. Hand Hygiene Compliance Rate:
   - ✓ Hand hygiene target was achieved and is the number one way to prevent the spread of communicable disease and infection. AHS will continue to build on these successes through education and awareness, increased monitoring and timely feedback, more health care workers cleaning their hands consistently and properly, and protecting patients by reducing the risk of infection.

3. Hospital Mortality:
   - ✓ HSMR achieved target with several initiatives underway to address this work, such as: implementation of clinical pathways for venous thromboembolism, falls risk management, safe surgery checklist and ongoing audits on use of pathways and tools. Also, AHS is working in several ways to continue to reduce in-hospital deaths, including Medication Reconciliation to ensure each patient has a complete and accurate medication list throughout their care journey.

4. ALOS/ELOS:
   - ✓ Provincially and in all zones, the average number of actual days patients stay in acute care hospitals compared to the expected length of stay for a typical patient improved in 2015-16. AHS met the 2015-16 target provincially as well as in three zones. Zones continue to implement organization-wide initiatives such as CoACT, Medworxx, and are also engaged in SCN-specific projects such as Enhanced Recovery after Surgery (ERAS) and the development of clinical care pathways to help reduce the length of stay in hospital.

5. Early Detection of Cancer (2014):
   - ✓ We know the importance of detecting cancer at early stage. Overall, provincial and zone results are showing consistent improvement since 2011. AHS continues to work with the zones to ensure cancer screening is made available to all Albertans. The target for 2014-15 was 67% and was achieved in 2014 (69%). Of particular note, vulnerable populations in the northern parts of our province are getting more access to cervical and colorectal screening through the Screen Test mobile unit and increasing education and awareness. In addition, the Screen Test Mobile Mammography van reached more than 100 rural and remote communities, providing access to breast cancer screening for women who live in those communities.

6. Mental Health Readmissions (Q3 YTD):
   - ✓ Mental Health Readmissions improved from 9.3% in 2014-15 to 9.1% in Q3 YTD 2015-16. AHS also met the 2015-16 target provincially and in four zones. Often, individuals with serious and persistent mental disorders are admitted to hospital, discharged after stabilization, but deteriorate in the community, only to be readmitted. A Community Treatment Order is a tool intended to assist patients in maintaining compliance with treatment while in the community, thereby breaking this cycle.

Eleven performance measures *are at or better than the same time period as last year*:

1. Satisfaction with Hospital Care (Q3 YTD)
2. Hand Hygiene Compliance Rate
3. Hospital Mortality
4. ED Wait to see a Physician
5. ED Length of Stay for Discharged Patients
6. ED Length of Stay for Admitted Patients
7. Access to Radiation Therapy
8. Continuing Care Placement
9. ALOS/ELOS
10. Mental Health Readmission (Q3 YTD)
11. Heart Attack (AMI) Mortality

The following outlines measures that did not meet 2015-16 targets as well as examples of what AHS is doing to improve these areas. Please refer to the subsequent pages for more actions on each measure.

Patient Satisfaction

- While targets for **Satisfaction with Hospital Care** were not achieved, results remained stable and some zones demonstrated improvement from last year. High occupancy at sites has had an impact on patient and staff satisfaction. With the launch of the Patient First Strategy in 2015, AHS remains committed to ensuring patient- and family- experiences are the centre of everything we do and every decision we make.
- **Satisfaction with Long-Term Care** - this measure is reported by external sources and the survey is conducted every two to three years. AHS and continuing care operators continuously analyze available resident outcome data to find opportunities for quality improvement.

Emergency Department (ED) Flow

- Provincially, and in individual zones, ED wait times have improved compared to the same period last year.
  - ED Wait Times to See a Physician: Two zones achieved 2015-16 targets.
  - ED LOS Admitted: Targets not achieved but three zones demonstrated improvement from last year.
  - ED LOS Discharged: North Zone achieved target, three zones demonstrated improvement from last year.
- Targets were not achieved due to an increased average length of stay, decreased discharges, increased occupancy and an increased percentage of alternate level of care. These negatively impact the ability to transfer admitted patients from ED to inpatient units within the targeted timeframe. Also, the increase in emergency inpatients within the ED reduces available care spaces to assess and treat the patients to be discharged within the four hour timeframe. Despite efforts to provide other options, the volume of ED visits continues to increase slightly.

Access to Radiation Therapy

- Provincially, access to radiation therapy improved from 3.1 weeks in 2014-15 to 2.9 weeks in 2015-16. AHS still has work to do to achieve target.
- Alberta ranks 3rd best nationally among nine provinces. However, 95% of patients in Alberta receive treatment within the 4-week benchmark.
- Some sites have experienced a slight deterioration due to patient volumes continuing to grow even though we are continuing to optimize the regional sites.

Children's Mental Health Access

- In 2015-16, AHS saw a decline in the percent of children offered scheduled mental health treatment within 30 days from 89% in 2014-15 to 85% in 2015-16. The most significant decline can be seen in the Calgary Zone and South Zone. Zone targets were not established for 2015-16 as this was a new measure.
- Overall, children's mental health access wait times showed deterioration from 2014-15 due to increases in the number of scheduled patients and no increase in staff resources, transitioning to a new electronic scheduling system and electronic health record and errors in time-stamping. These issues are being addressed by recruitment of staff, completing transition to the new system and resolving errors, and monitoring wait times to clearly identify children who may be offered appointments longer than 25 days away.
- AHS continues to work with other government ministries to streamline access to children's addiction mental health services.

Continuing Care Placement

- Provincial results have remained stable and two zones have demonstrated improvement.
- In 2015-16, AHS opened 997 continuing care spaces for a total of 25,135 community-based services. Since 2010, AHS has opened 5,247 new beds to support individuals who need community based housing, care and supports. This performance has not kept pace with the level of growth required.
- In the next two years, AHS expects about 2,000 more continuing care beds to be made available across Alberta.
- It is important to note that not all of these patients are waiting in an acute care hospital bed in a busy urban hospital. Many are staying in transition beds, sub-acute beds, and rural hospitals where system flow pressures are not as intense.
- AHS is working to ensure beds in acute care are used in the most efficient manner, improving communication between all health care team members, patients and families to facilitate discharges and ensure that patients are getting the best care for their personal situations.

Surgical Readmissions

- This measure has slightly deteriorated from 6.5% in 2014-15 to 6.6% in Q3 YTD 2015-16. Calgary Zone has met target in 2015-16. CIHI national comparison demonstrates AHS has improved to 5th best in 2014-15 (compared to 7th best in 2013-14) and AHS is performing at the same as the national rate.
- Strategic Clinical Networks (SCNs) are working on initiatives to improve patient outcomes after surgery, such as National Surgical Quality Improvement Program/Trauma Quality Improvement Program (NSQIP/TQIP), Adult Coding Access Targets for Surgery (aCATS) and Enhanced Recovery After Surgery (ERAS).

Heart Attack and Stroke Mortality

- Two zones have achieved targets for **Heart Attack Mortality** and two zones demonstrated improvement. Alberta is ranked 4th best nationally and is performing the same as the national rate. We expect there to be fluctuations in this measure due to smaller sites having low numbers and therefore more susceptible to variations. AHS is monitoring this measure to see if a trend emerges.
- Two zones have demonstrated improvement for **Stroke Mortality**. Alberta is ranked 4th best nationally and is performing the same as the national rate.
- Endovascular treatment, stroke unit care and anticoagulation are clearly shown to reduce mortality.

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Performance Measures Dashboard	2014-15	2015-16	Quarterly Comparison	Target 2015-16	2015-16 Target Achieved	National Comparison Alberta ranked****
Acceptability						
Satisfaction with Hospital Care**	82%	82% Q3 YTD	→	84%		not available
Satisfaction with Long-term Care	72%	Reported every 3 years by HQCA		78%		not available
Safety						
Hospital-Acquired *Clostridium difficile* Infections** (rate per 10,000 patient days)	3.5	3.6 Q3 YTD	↓	4.0	✓	better than national results
Hand Hygiene	73%	80%	↑	80%	✓	not available
Hospital Mortality (HSMR standardized rate)	82	82	→	84	✓	3rd best (out of 10 provinces)
Accessibility						
Emergency Department Wait to see a Physician (median) in hours *	1.4	1.3	↑	1.2		4th best (out of 5 provinces)
Emergency Department Length of Stay for Admitted Patients (median) in hours *	9.9	9.4	↑	8.2		3rd best (out of 5 provinces)
Emergency Department Length of Stay for Discharged Patients (median) in hours *	3.2	3.2	→	2.8		4th best (out of 5 provinces)
Access to Radiation Therapy (90th percentile) in weeks	3.1	2.9	↑	2.6		3rd best (out of 9 provinces)
Children's Mental Health Access (% placed within 30 days)	89%	85%	↓	90%		not available
Appropriateness						
Continuing Care Placement (% placed within 30 days)	60%	60%	→	70%		not available
Efficiency						
Acute (Actual) Length of Hospital Stay Compared to Expected Stay***	0.96	0.93	↑	0.96	✓	3rd best (out of 9 provinces)
Effectiveness						
Early Detection of Cancer	69% (2014)	Data not available	↑	67% (2014) 70% (2015)	✓	2nd best for breast cancer & 8th for colorectal (out of 9 provinces)
Mental Health Readmissions**	9.3%	9.1% Q3 YTD	↑	9.5%	✓	2nd best (out of 10 provinces)
Surgical Readmissions**	6.5%	6.6% Q3 YTD	↓	6.3%		5th best (out of 10 provinces)
Heart Attack Mortality**	6.2%	6.2% Q3 YTD	→	5.9%		4th best (out of 10 provinces)
Stroke Mortality**	13.9%	14.8% Q3 YTD	↓	13.2%		4th best (out of 10 provinces)

Quarterly Comparative Performance compares data from the current quarter to the same time period as last year: Comparison to an equivalent period in a prior year is provided for easy reference, and may or may not indicate statistical significance of the results. Additional performance insights can be obtained by reviewing the trending over time provided in the graphical displays and site detail tables where available. These are provided in detail for each measure in this report.

* AHS reports on the busiest 17 Emergency Departments across Alberta. One of these sites, Northeast Community Health Centre, is a non-admitting site. Therefore, it is not included in the Emergency Department Length of Stay for Admitted Patients measure.

** This measure is reported a quarter later due to the requirement to follow-up with patients after the end of the reporting quarter.

*** The ALOS/ELOS ratio is calculated using the Expected Length of Stay (ELOS) from the 2014 Case Mix Group Plus (CMG+) for each inpatient case. The CMG+ methodology is updated on a yearly basis by the Canadian Institute for Health Information (CIHI). There were significant methodology differences between the 2014 and 2015 CMG+ methodologies producing results which are not comparable from 2014-15 to 2015-16. To address this limitation, the 2015-16 results in this report are calculated using the 2014 CMG+ methodology.

**** National Comparisons are based on the most recent data available, typically 2014-15. Parts of this material are based on data and information provided by the Canadian Institute for Health Information (CIHI). However, the analyses, conclusions, opinions and statements expressed herein are those of the author, and not necessarily those of the CIHI.

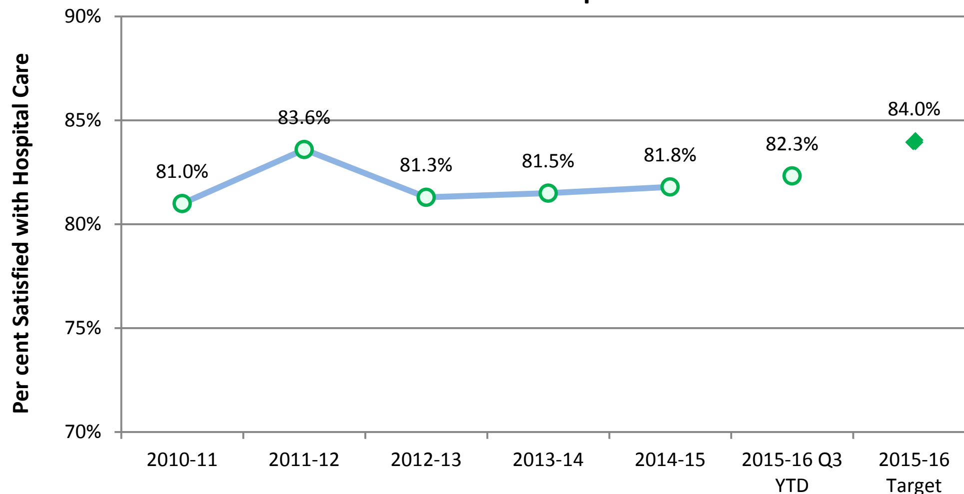
Satisfaction with Hospital Care

Measure Definition

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

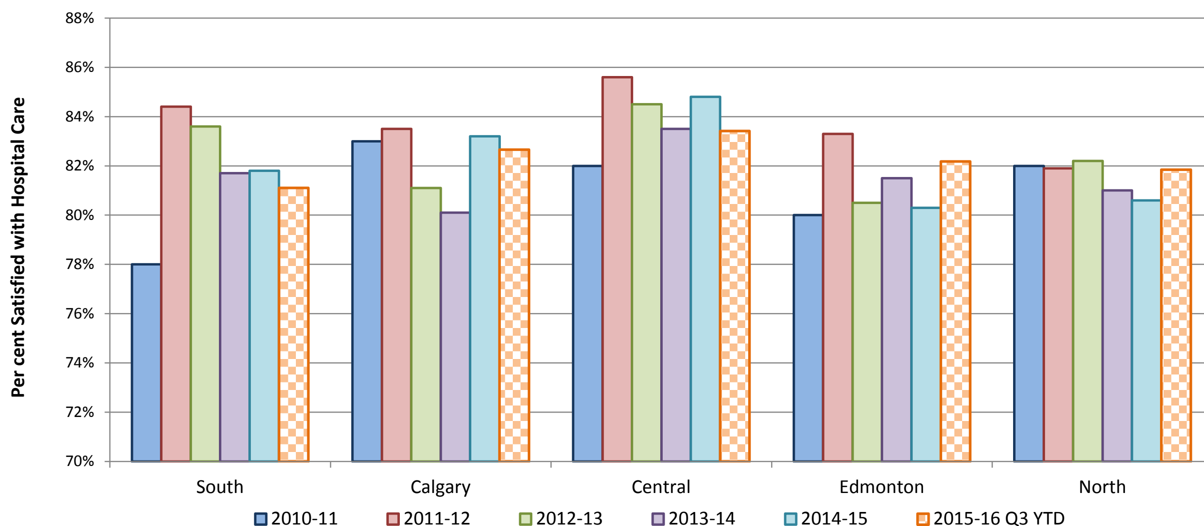
Understanding this Measure

Feedback gathered from individuals using hospital services is critical to improving the health system. This measure reflects patients' overall experience with their hospital care. Telephone interviews are conducted with a random sample of patients within six weeks of their discharge date from hospital. Source: Hospital-Consumer Assessment of Healthcare Providers and Systems (H-CAHPS) Survey. NOTE: This measure relies on patient follow up after a patient's original discharge date for a period up to 90 days. Therefore reporting results reflect patients discharged in an earlier time period (i.e., Q3 YTD).



How Do We Compare?

Comparable national data is not available for this measure.



Satisfaction with Hospital Care – Actions

Zone	Actions
Provincial/ Strategic Clinical Network	• AHS continues to roll out the Patient First Strategy across the organization. • AHS created new directives to support family presence and visitation and the purposeful design of physical space (i.e. family rooms) to support patients, families and employees. • Six Phase 1 CoACT elements were implemented across the province including collaborative care leadership, care hubs, rapid rounds, comfort rounds, patient bedside whiteboards and bedside shift report. Implementation of CoACT deliverables was 64% at 20 sites in 161 patient care units. Target was 100% at 20 sites.
South	• Co-ACT implementation underway at all units at Medicine Hat Regional Hospital (MHRH), Chinook Regional Hospital and Brooks. Key highlights include participating in collaborative care leadership, white boards, RAAPID rounds, team charters, and care hubs. iRounds piloted at two units at MHRH. • Clinical Quality Improvement developed a patient story bank to be part of a toolkit for staff to document patient stories and incorporate the voice of the patient. • Culture Awareness Training offered to staff. • Work continues to introduce patient/family advisors to quality councils.
Calgary	• All adult sites in process of CoACT implementation at various stages. • Work is underway on family presence and visiting practices. • The “No One Dies Alone” initiative was launched, which provides 24/7 on-call compassionate volunteers to patients who are dying and have no support or support requires respite. • ACH Pain Committee was established and a pain resource team was adopted. • The ACH Emergency Department Pain Research project results indicated that patients receiving analgesia increased from 32.5% to 53.9% and dissatisfaction decreased from 18.1% to 9.7%.
Central	• Red Deer Regional Hospital Centre (RDRHC) intensive care unit/coronary care unit initiated a White Rose program to provide support, dignity and respect for family and patients when withdrawal of life support decisions are made. • Enhanced Communications, and Respect and Dignity was supported through medication reconciliation, two patient identifiers, safe surgery checklist, information transfer at transitions of care, Name-Occupation-Duty (NOD), bedside whiteboards and comfort rounds. • "No One Dies Alone” was implemented in the palliative care unit at RDRHC. • Physician handover process improvements were completed at rural sites. • RDRHC, Wetaskiwin Hospital and Care Centre, and Drumheller Health Centre implemented various elements of CoACT implementation. • Initiated a process to include patient and family input on Patient First Strategy.
Edmonton	• Implemented consistent messaging to patients/families across the continuum of care relating to their care journey. • Completed implementation of standardized patient information and approach to way-finding at University of Alberta Hospital.
North	• CoACT implementation is ongoing at four sites. Operationalization of CoACT Phase1 audit tools available for the collaborative care elements.

IN SUMMARY

The Q3 provincial results have remained stable. Two zones demonstrate slight improvement from Q3 last year.

DID YOU KNOW

***Patient First Strategy** reflects a patient- and family-centred care. The strategy will enable AHS to advance health care in Alberta by empowering and enabling Albertans to be at the centre of their health care team, improving their own health and wellness.*

***CoACT** is an innovative model of care in which care provider teams collaborate more closely with patients. This provincial program designs tools and processes for Collaborative Care.*

*The new **iRound** application provides a robust platform to view, discuss and update integrated care plans for each patient. There are quality checks and balances within the application from the time a patient is admitted, for the duration of their stay, through to discharge. All members of the care team can review the care plan, patient goals, barriers to discharge and the status of those barriers. It also lists all health care professionals supporting each patient.*

Satisfaction with Hospital Care – Zone and Site Details

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

Satisfaction with Hospital Care	2012-13	2013-14	2014-15	Q3 YTD		Trend *	2015-16 Target
				2014-15 Last Year	2015-16 Current		
Provincial	**81.3%**	**81.5%**	**81.8%**	**81.7%**	**82.3%**	**→**	**84.0%**
South Zone Total	**83.6%**	**81.7%**	**81.8%**	**82.8%**	**81.1%**	**↓**	**85.0%**
Chinook Regional Hospital	82.1%	80.5%	76.6%	77.5%	78.3%	→	84.0%
Medicine Hat Regional Hospital	85.7%	80.7%	85.7%	86.8%	82.4%	↓	86.0%
All Other Hospitals	84.2%	83.5%	88.3%	89.2%	87.0%	↓	85.0%
Calgary Zone Total	**81.1%**	**80.1%**	**83.2%**	**82.7%**	**82.7%**	**→**	**84.0%**
Alberta Children's Hospital	Measure restricted to Adult Sites only						
Foothills Medical Centre	78.6%	76.6%	80.8%	80.5%	81.4%	→	82.0%
Peter Lougheed Centre	83.5%	80.9%	79.9%	80.3%	76.6%	↓	84.0%
Rockyview General Hospital	81.7%	82.9%	85.4%	84.9%	84.0%	↓	84.0%
South Health Campus	Opened February 2013		89.7%	88.3%	90.2%	↑	84.0%
All Other Hospitals	81.4%	79.3%	90.3%	88.4%	92.4%	↑	90.0%
Central Zone Total	**84.5%**	**83.5%**	**84.8%**	**85.2%**	**83.4%**	**↓**	**86.0%**
Red Deer Regional Hospital Centre	81.5%	81.1%	83.0%	83.5%	82.1%	↓	84.0%
All Other Hospitals	85.8%	84.5%	86.7%	86.9%	84.7%	↓	87.0%
Edmonton Zone Total	**80.5%**	**81.5%**	**80.3%**	**79.8%**	**82.2%**	**↑**	**83.0%**
Grey Nuns Community Hospital	86.4%	86.4%	87.2%	86.4%	87.6%	↑	87.0%
Misericordia Community Hospital	76.8%	78.5%	75.3%	73.7%	76.9%	↑	82.0%
Royal Alexandra Hospital	76.1%	79.9%	76.5%	76.0%	77.7%	↑	81.0%
Stollery Children's Hospital	Measure restricted to Adult Sites only						
Sturgeon Community Hospital	87.1%	89.8%	87.6%	86.6%	89.4%	↑	88.0%
University of Alberta Hospital	77.9%	77.1%	80.2%	80.4%	84.5%	↑	82.0%
All Other Hospitals	67.1%	70.9%	85.3%	87.5%	88.2%	→	84.0%
North Zone Total	**82.2%**	**81.0%**	**80.6%**	**80.6%**	**81.9%**	**↑**	**84.0%**
Northern Lights Regional Health Centre	78.5%	75.4%	74.7%	73.2%	80.3%	↑	82.0%
Queen Elizabeth II Hospital	80.7%	76.0%	77.2%	76.0%	79.8%	↑	83.0%
All Other Hospitals	82.8%	83.4%	83.7%	84.7%	83.4%	↓	84.0%

***Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

Total Discharges	2012-13	2013-14	2014-15	Q3 YTD	
				2014-15 Last Year	2015-16 Current
Provincial	**385,536**	**393,765**	**401,331**	**302,250**	**302,772**
South Zone	31,640	31,093	31,125	23,507	22,957
Calgary Zone	130,842	136,598	140,563	105,489	106,678
Central Zone	45,619	44,589	45,691	34,262	34,222
Edmonton Zone	132,337	135,970	139,052	104,896	105,967
North Zone	45,098	45,515	44,900	34,096	32,948

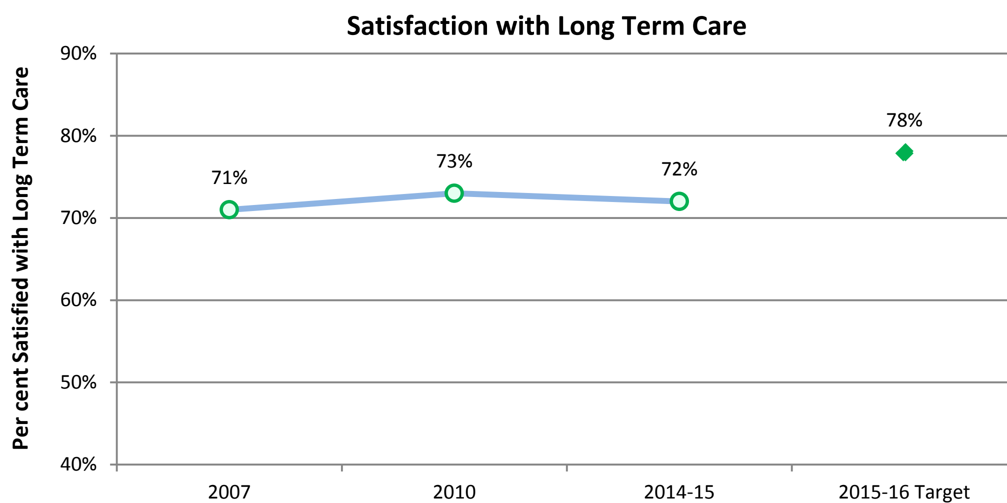
Satisfaction with Long-Term Care

Measure Definition

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

Understanding this Measure

Measuring family satisfaction with the care that is being delivered to residents is an important component of managing the quality of Alberta's long-term care services. The survey is administered by the Health Quality Council of Alberta every two to three years.



How Do We Compare?

Comparable national data is not available for this measure.

Satisfaction with Long-Term Care	2007	2010	2014-15	2015-16 Target
Provincial	**71%**	**73%**	**72%**	**78%**
South Zone	80%	80%	80%	81%
Calgary Zone	65%	70%	70%	76%
Central Zone	78%	80%	77%	81%
Edmonton Zone	67%	70%	70%	76%
North Zone	80%	82%	76%	83%

Satisfaction with Long-Term Care – Actions

Provincial/ Strategic Clinical Network (SCN)	• SCNs are working collaboratively on the Appropriate Use of Antipsychotics (AUA) project to guide care for persons with dementia. • The Resident Assessment Instrument (RAI) quality indicator for AUA improved from a baseline of 26.8% Q4 2011-12 to 18.3% in Q3 2015-16. This exceeds the AUA target of 20% expected to be obtained by 2017-18. • Approximately 800 long-term care (LTC) residents were taken off antipsychotics. Expanding AUA work to ten supportive living sites. • The new Visitation and Family Presence Directive came into effect for all LTC, designated supportive living settings and contracted partners.
South	• The Continuing Care Resolution Reporting Team continues to receive concerns via Health Link. All questions and concerns from clients and families have been addressed. • Family Care conferences occurring in all LTC sites. • Implementing AUA.
Calgary	• Working with continuing care sites to provide support for sites where families and residents have concerns, or are dissatisfied with aspects of their care and to find ways to improve their experience. • Reviewed survey with HQCA at Integrated Continuing Care Steering Committee and suggestions for further detailed survey examined.
Central	• Continued actions to sustain AUA at all LTC sites. • Worked with continuing care sites to support families and residents with concerns or are dissatisfied with care through the patient engagement team. • Reviewed survey results and developing action plans to address issues identified in the family satisfaction survey.
Edmonton	• Sites are reviewing, monitoring and responding to findings of the HQCA LTC survey. • Based on results of the HQCA satisfaction survey results for Designated Supportive Living 2013-14, operators developed quality improvement plans with a larger focus on sites that ranked in the bottom quartile.
North	• Centralized placement work completed through implementation of a virtual team and intake processes. • Implementing AUA.

IN SUMMARY

AHS and continuing care operators continuously analyze available resident outcome data to find opportunities for quality improvement.

On June 10, 2015, CIHI and AHS began publicly reporting on nine long term care quality indicators focused on safety, appropriateness and effectiveness of care. The websites feature health indicators, which are reported provincially, by zones and by sites and presented in a way that is accessible to the public.

DID YOU KNOW

Appropriate Use of Antipsychotics (AUA) *guides the appropriate use of antipsychotic drugs and the education of staff on other ways to care for persons with dementia thereby improving safety and quality of life for residents.*

The ***Resident Assessment Instrument (RAI)*** *is a standardized tool that focuses on the functioning and quality of care of residents in long-term care. A lower percentage is desirable as it indicates a lower proportion of long-term care residents who received a potentially inappropriate antipsychotic medication.*

Visitation and Family Presence Directive *reinforces that visitation and family presence are integral to clients' safety, healing process, wellbeing and quality of life. The directive provides temporary governance until a policy/ procedure is developed.*

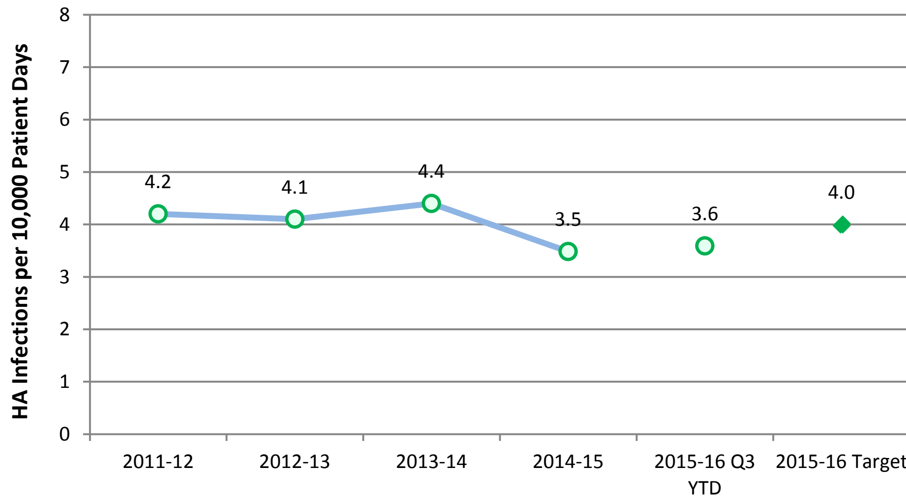
Hospital-Acquired *Clostridium difficile* Infections

Measure Definition

The number of *Clostridium difficile* infections (C-diff) acquired in hospital for every 10,000 patient days. A rate of 4.0 means approximately 100 patients per month acquire C-diff infections in Alberta. AHS is performing better than the national average of 7.0. C-diff infection cases include patients with a new infection or re-infection while in hospital. Patients are considered to have a C-diff if they exhibit symptoms and confirmation by a laboratory test or colonoscopy.

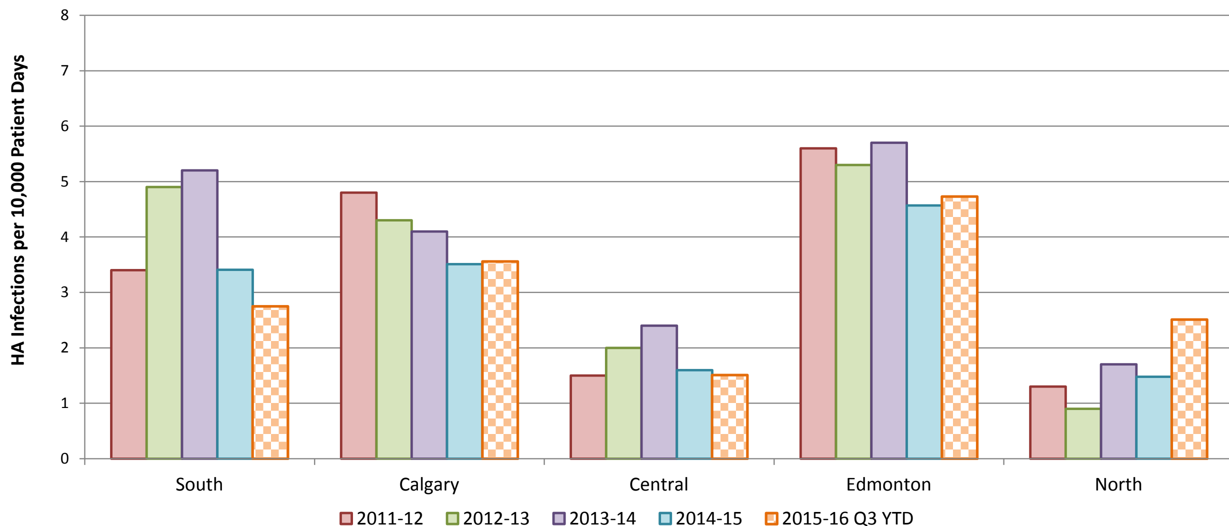
Understanding this Measure

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 impacts resources and costs in the health care system. Monitoring C-diff trends provide important information about effectiveness of infection prevention and control strategies. NOTE: This measure relies on patient follow up after a patient's original discharge date for a period up to 90 days. Therefore reporting results reflect patients discharged in an earlier time period (i.e., Q3 YTD).



How Do We Compare?

According to the Canadian Nosocomial Infection Surveillance Program based on 60 participating Canadian hospitals, the Western region which includes Alberta has a lower rate of infections than the country overall.



Hospital-Acquired Infections – Actions

Zone	Actions
Provincial/ Strategic Clinical Network (SCN)	• Zone-based *Clostridium difficile* Infection (CDI or *C. difficile*) working groups established. • Zone CDI clinical management guidelines and algorithms are being implemented in all zones. • Environmental Services standards and protocols for clean patient environment established. • Bugs & Drugs: An Antimicrobial/Infectious Diseases Reference is available on the AHS internal website for staff and physicians. This reference is also available via print, iPhone and Android apps. • AHS supported over 40 separate antimicrobial stewardship initiatives to improve antibiotic use and launched the "Reduce your Antibiotic Footprint" campaign. • Revised admission screening guidelines for patients at risk for antibiotic resistant organisms was implemented provincewide.
South	• Ongoing collaboration with public health programs, and Infection, Prevention and Control (IPC) to further integrate surveillance processes. • Developed interdisciplinary antimicrobial stewardship committee to monitor top 14 antibiotics associated with CDI.
Calgary	• Obtained and reported antibiotic utilization data for the 15 units with the highest *C. difficile* infection rates. • Electronic patient care system medical logic order sets for the management of CDI was implemented. An “app” is available to physicians. • The Microbial Health Clinic at Foothills Medical Centre provides novel treatment options for patients with recurrent *C. difficile*. • South Health Campus and IPC launched a pilot project to test an overcapacity patient checklist that screens patients who are not appropriate for an overcapacity space due to an increased infection transmission risk.
Central	• Rolled out CDI toolkit to all facilities. Audit and feedback evaluation of CDI toolkit framework completed and developed. • Monitored surveillance reports and new cases including investigations and interventions when an increase in cases was identified. • Top 15 antibiotics use monitored at Red Deer Regional Hospital Centre. • Tools provided to staff in continuing care sites to assist with identification and treatment of urinary tract infections in residents.
Edmonton	• Reported antibiotic utilization data for top 15 CDI units. • Created a response process for facilities with high CDI rates. • Implemented pre-printed patient care orders which are placed on the chart when the patient presents with, or develops, diarrhea in acute care. • Assessing the use of antibiotics and acid blocking agents in patients before and after *C. difficile* infection diagnosis. • Developed workplan for asymptomatic bacteriuria. • Human waste management system change with installation of macerators on medical units.
North	• Established CDI working group with quality consultants to identify actions to address recent increase in CDI cases. • Continued implementation of preprinted patient care order. • CDI presentations delivered to staff.

IN SUMMARY

The Q3 provincial results have shown deterioration from last year. However, provincially and four zones are at or above the 2015-16 target.

AHS Infection Prevention and Control works collaboratively with physicians, staff and public health by providing C. difficile rates and assisting with intervention and control strategies.

DID YOU KNOW

Antimicrobial stewardship *is the practice of minimizing the emergence of antimicrobial resistance by using antibiotics only when necessary and, if needed, by selecting the appropriate antibiotic at the right dose, frequency and duration to optimize outcomes while minimizing adverse effects.*

Hospital-Acquired Infections – Zone and Site Details

The number of Clostridium difficile infections (C-diff) acquired in hospital for every 10,000 patient days. A rate of 4.0 means approximately 100 patients per month acquire C-diff infections in Alberta.

Hospital Acquired Infections	2012-13	2013-14	2014-15	Q3 YTD		Trend *	2015-16 Target
				2014-15 Last Year	2015-16 Current		
Provincial	**4.1**	**4.4**	**3.5**	**3.5**	**3.6**	**↓**	**4.0**
South Zone Total	**4.9**	**5.2**	**3.4**	**3.9**	**2.8**	**↑**	**4.4**
Chinook Regional Hospital	7.9	7.5	5.4	6.2	4.7	↑	6.9
Medicine Hat Regional Hospital	1.3	2.8	1.7	1.9	1.0	↑	1.3
All Other Hospitals	4.2	4.3	2.0	2.3	1.5	↑	4.0
Calgary Zone Total	**4.3**	**4.1**	**3.5**	**3.6**	**3.6**	**→**	**4.1**
Alberta Children's Hospital	2.4	3.5	1.4	0.9	3.5	↓	**2.4**
Foothills Medical Centre	6.5	5.4	5.2	5.5	4.7	↑	6.1
Peter Lougheed Centre	2.1	3.4	2.8	3.2	3.6	↓	2.1
Rockyview General Hospital	3.5	4.0	3.2	2.9	3.4	↓	3.4
South Health Campus	N/A	2.2	2.3	2.3	2.1	↑	4.1
All Other Hospitals	2.4	1.5	0.9	1.2	1.0	↑	2.3
Central Zone Total	**2.0**	**2.4**	**1.6**	**1.4**	**1.5**	**↓**	**1.9**
Red Deer Regional Hospital Centre	3.1	3.3	3.1	3.0	2.7	↑	2.8
All Other Hospitals	1.6	2.0	1.0	0.8	1.0	↓	1.5
Edmonton Zone Total	**5.3**	**5.7**	**4.6**	**4.6**	**4.7**	**↓**	**4.9**
Grey Nuns Community Hospital	5.7	5.9	3.5	3.4	3.7	↓	5.4
Misericordia Community Hospital	6.9	6.3	3.9	4.2	3.6	↑	6.4
Royal Alexandra Hospital	6.5	7.3	6.7	6.6	6.6	→	6.1
Stollery Children's Hospital	2.1	3.1	4.0	4.2	5.7	↓	2.0
Sturgeon Community Hospital	5.6	9.3	6.0	4.9	8.1	↓	5.3
University of Alberta Hospital	8.7	8.6	7.1	7.8	6.6	↑	7.8
All Other Hospitals	1.6	1.9	1.4	1.0	2.0	↓	1.6
North Zone Total	**0.9**	**1.7**	**1.5**	**1.7**	**2.5**	**↓**	**0.8**
Northern Lights Regional Health Centre	1.0	0.7	2.0	2.6	0.9	↑	1.0
Queen Elizabeth II Hospital	1.1	3.0	1.2	1.6	3.4	↓	1.0
All Other Hospitals	0.8	1.5	1.5	1.5	2.6	↓	0.8

N/A: No results available. South Health Campus opened February 2013.
*** Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

Number of Cases	2012-13	2013-14	2014-15	Q3 YTD	
				2014-15 Last Year	2015-16 Current
Provincial	**1,166**	**1,265**	**1,065**	**809**	**796**
South Zone	91	101	69	59	39
Calgary Zone	378	374	353	272	263
Central Zone	83	100	68	45	47
Edmonton Zone	594	650	539	403	403
North Zone	20	40	36	30	44

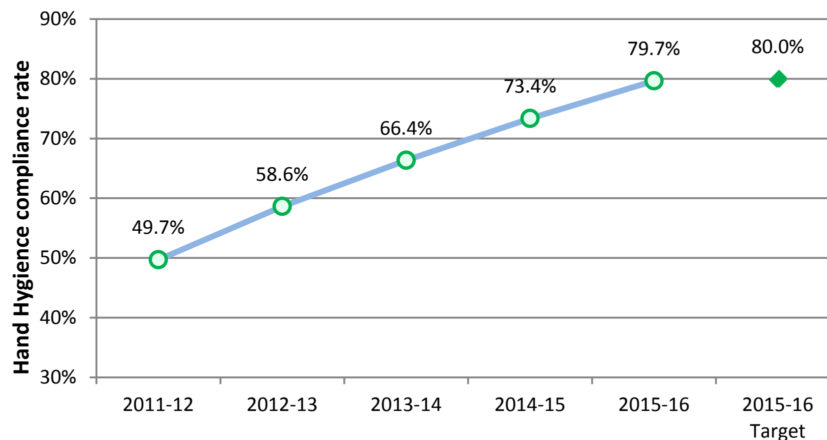
Hand Hygiene

Measure Definition

The percentage of opportunities for which health care workers clean their hands during the course of patient care. For this measure, health care workers are directly observed by trained personnel to see if they are compliant with routine hand hygiene practices according to the Canadian Patient Safety Institute "4 Moments of Hand Hygiene". Included in the AHS Quarterly HH reviews are observations from across the continuum of care including AHS operated acute care facilities, combined acute care & continuing care facilities, ambulatory, urgent care, and cancer care centers, standalone rehabilitation facilities, and addictions and mental health facilities. Excluded from this report are HH observations from EMS, Corrections Health, and non-AHS contracted continuing care facilities.

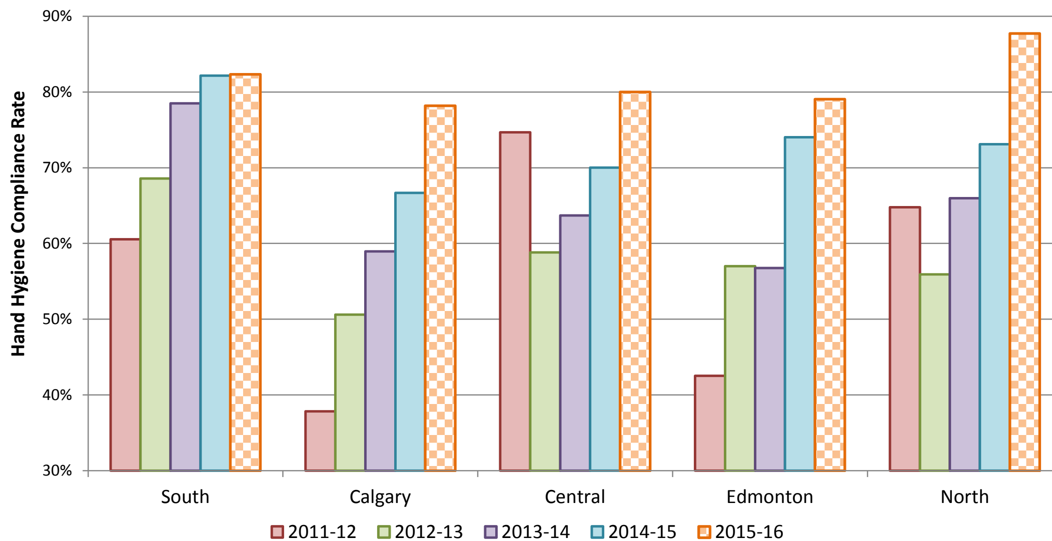
Understanding this Measure

Hand hygiene is the single most effective strategy to reduce transmission of infection in the health-care setting. The World Health Organization and Canadian Patient Safety Institute have identified four opportunities during care when hand hygiene should be performed, most commonly before and after contact with a patient or the patient's environment. Direct observation is recommended to assess hand hygiene compliance rates for health care workers. Hand hygiene performance is a challenge for all health care organizations. In AHS, compliance has improved overall for the last three years and has improved for each type of health care worker. We must continue to improve our health care worker hand hygiene compliance and are working hard to achieve our targets.



How Do We Compare?

Direct comparison to other jurisdictions is not possible given different approaches to measuring hand washing compliance.



Hand Hygiene – Actions

Zone	Actions
Provincial/ Strategic Clinical Network (SCN)	• Quarterly reporting of Hand Hygiene (HH) Compliance rates implemented April 1, 2015. • Alcohol-based hand rub guidelines were developed for staff on the prevention and mitigation of harm while supporting standards for acceptable hand hygiene practice.
South	• Continue use of display boards at nursing stations in acute and long-term care sites to help increase culture and compliance. • Collaboration with contracted partner sites to build HH champions and education. • Implementation of HH education and reviews at ambulatory home care locations in Lethbridge, Medicine Hat and Brooks, as well as public health clinics. • Complete regular audits on areas with less than 80% compliance. • Work with Working Safely to identify and provide treatment plans for staff with HH product sensitivities.
Calgary	• Action plans are initiated to increase compliance in areas requiring improvement including posting HH compliance results for public and staff in respective clinical areas. • Working towards a goal of unit ownership for HH compliance. • Alberta Children's Hospital HH committee created a draft of a Standard Operating Procedure for HH compliance. • Working with HH reviewer to audit the operating room and post-anaesthetic care unit.
Central	• Sites generated regular reports for more timely intervention and improvement on HH practice. • Promotion of awareness of HH results and just in time learning continued at all acute care and long-term care sites. • Staff and physician training sessions continued at all sites. • A monthly hand hygiene success story was showcased on Insite. • Supported hand hygiene compliance auditing in home care and community environments.
Edmonton	• The Clean Hands Pro™ software was rolled out in acute care. • Implementation of Clean Hands Pro in the ambulatory clinics, continuing care and EMS is underway. • Developed resources for hand hygiene reviewers to assist with difficult conversations and just in time education. • Completed Hand Health video and posted on website.
North	• Celebration huddles were held to celebrate successes, recognize improvement opportunities and set goals. • All sites have hand lotion consistently available in dispensers to help staff maintain skin integrity.

IN SUMMARY

Hand Hygiene rates have improved significantly due to activities put into place at sites.

Previously reported annually, quarterly reporting of hand hygiene compliance rates was implemented. Hand hygiene compliance results went from 73% in 2014-15 to 80% in 2015-16, meeting the 80% target. Targets were achieved in four out of five zones.

Hand hygiene is the number one way to prevent the spread of communicable disease and infection and AHS will continue to build on these successes. Through education and awareness, increased monitoring and timely feedback, more health care workers are cleaning their hands consistently and properly, protecting patients by reducing the risk of infection.

Hand Hygiene – Zone and Site Details

Percentage of opportunities for which health care workers clean their hands during the course of patient care.

Hand Hygiene	2011-12	2012-13	2013-14	2014-15	2015-16 Q4 YTD	Trend *	2015-16 Target
Provincial	**49.7%**	**58.6%**	**66.4%**	**73.4%**	**79.7%**	**↑**	**80.0%**
South Zone Total	**60.6%**	**68.6%**	**78.5%**	**82.2%**	**82.4%**	**→**	**84.0%**
Chinook Regional Hospital	65.2%	66.6%	80.6%	84.0%	82.1%	↓	84.0%
Medicine Hat Regional Hospital	50.5%	69.8%	76.1%	79.8%	81.9%	↑	83.0%
All Other Sites	69.2%	69.5%	78.6%	85.5%	82.9%	↓	83.0%
Calgary Zone Total	**37.8%**	**50.6%**	**59.0%**	**66.7%**	**78.2%**	**↑**	**78.0%**
Alberta Children's Hospital	54.2%	73.7%	57.2%	73.3%	76.9%	↑	77.0%
Foothills Medical Centre	32.0%	44.9%	51.8%	65.2%	76.2%	↑	73.0%
Peter Lougheed Centre	35.4%	50.8%	62.2%	69.7%	84.8%	↑	80.0%
Rockyview General Hospital	33.5%	45.1%	61.7%	70.7%	74.3%	↑	79.0%
South Health Campus	Opened February 2013		58.7%	56.0%	68.6%	↑	78.0%
All Other Sites	39.9%	54.0%	63.2%	67.4%	79.9%	↑	81.0%
Central Zone Total	**74.7%**	**58.8%**	**63.7%**	**70.0%**	**80.0%**	**↑**	**79.0%**
Red Deer Regional Hospital Centre	57.1%	61.7%	75.4%	65.3%	78.0%	↑	83.0%
All Other Sites	78.4%	58.1%	57.2%	72.5%	81.4%	↑	77.0%
Edmonton Zone Total	**42.5%**	**57.0%**	**56.8%**	**74.0%**	**79.1%**	**↑**	**76.0%**
Grey Nuns Community Hospital **	N/A	66.5%	70.5%	75.0%	N/A	N/A	82.0%
Misericordia Community Hospital **	N/A	77.4%	77.4%	75.8%	N/A	N/A	81.0%
Royal Alexandra Hospital	43.2%	48.9%	61.6%	75.1%	80.9%	↑	79.0%
Stollery Children's Hospital	45.6%	57.3%	58.1%	73.8%	78.7%	↑	79.0%
Sturgeon Community Hospital	48.0%	59.3%	58.9%	79.3%	84.1%	↑	78.0%
University of Alberta Hospital	40.1%	57.3%	42.9%	70.2%	74.4%	↑	68.0%
All Other Sites	42.7%	58.0%	57.5%	73.8%	79.0%	↑	77.0%
North Zone Total	**64.8%**	**55.9%**	**66.0%**	**73.1%**	**87.7%**	**↑**	**81.0%**
Northern Lights Regional Health Centre	60.6%	52.4%	56.2%	63.6%	87.9%	↑	76.0%
Queen Elizabeth II Hospital	54.5%	48.6%	68.4%	85.6%	95.8%	↑	82.0%
All Other Sites	77.4%	58.0%	66.2%	71.5%	85.4%	↑	81.0%

*** Trend** compares the current Year to Date value against the 2014-15 Fiscal Year value. ↑ Improvement → Stability ↓ Area requires additional focus

****N/A** 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. Grouped results (All Other Hospitals, Zone and Provincial totals) reflect AHS sites only.

Total Observations	2011-12	2012-13	2013-14	2014-15	2015-16 Q4 YTD
Provincial	**27,375**	**59,117**	**85,687**	**115,518**	**385,297**
South Zone	3,418	16,441	23,688	26,116	36,439
Calgary Zone	10,976	15,625	17,458	27,028	180,595
Central Zone	3,634	8,409	20,500	16,617	42,430
Edmonton Zone	6,243	9,778	10,277	19,714	100,087
North Zone	3,104	8,864	13,764	26,043	25,746

Note: Total observations for 2015-16 are not comparable to previous fiscal year as previous years were only measured annually (over a 4 month period) versus quarterly.

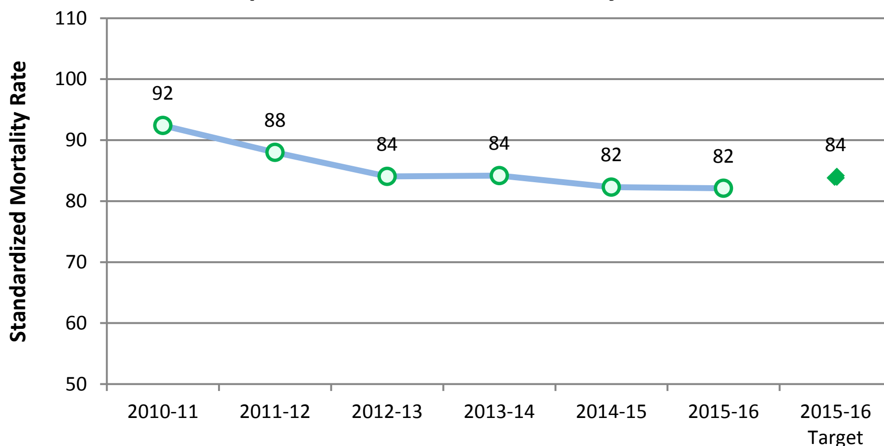
Hospital Mortality

Measure Definition

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

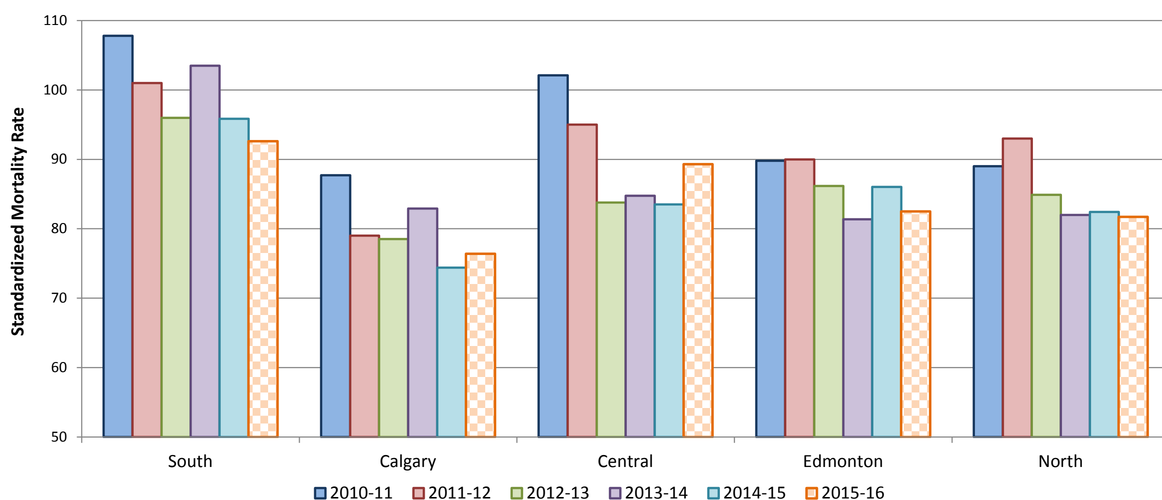
Understanding this Measure

This measure of quality care shows how successful hospitals have been in reducing patient deaths and improving patient care. A mortality ratio equal to 100 suggests that there is no difference between the hospital's mortality rate and the overall average rate. A mortality ratio greater than 100 suggests that the local mortality rate is higher than the overall average. A mortality ratio less than 100 suggests that the local mortality rate is lower than the overall average.



How Do We Compare?

Alberta ranked 3rd best nationally out of 10 provinces. Alberta is performing the same as the national rate.



Hospital Mortality – Actions

Zone	Actions
Provincial/ Strategic Clinical Network (SCN)	• Zones continue to complete and sustain Medication Reconciliation upon admission, transfer and discharge in acute care, ambulatory care and home care. • Implementation of National Surgical Quality Improvement Program / Trauma Quality Improvement Program (NSQIP/TQIP) to improve surgical and trauma care (one NSQIP site; three TQIP sites). • The Line and Tubing Verification Policy and High Alert Medications guidelines were introduced to avoid errors and improve patient safety. • Zones continue to monitor compliance of the safe surgery checklist. • Sites have several initiatives underway including implementation of clinical pathways for venous thromboembolism (VTE), falls risk management, compliance of the safe surgery checklist and ongoing audits on use of pathways and tools. • AHS is also working on Medication Reconciliation to ensure each patient has a complete and accurate medication list throughout their care journey.
South	• Ongoing rollout of auditing of MedRec to operations. • Completed rollout of MedRec education posters and discharge prescription tool. • Work initiated on establishing Falls Risk Management Strategy. • High Alert Medication annual audit strategy in development.
Calgary	• Emergency Department (ED) identifying patients on whom MedRec is required and implementing process. • Foothills Medical Centre Transition Units are participating in the Provincial Falls Collaborative; developing measurement and prevention strategies. • Work continues on increasing inpatient compliance and implementing MedRec at transfer and discharge at the Alberta Children's Hospital.
Central	• MedRec implementation of transfer / discharge occurred in the EDs for high risk patients. A pilot project to inform next providers of high risk medication changes occurred at Two Hills. Implemented MedRec processes and education for ambulatory care and home care. • Rapid Access Team from the intensive care unit were used to support inpatient units when unstable, decompensating patients were identified at Red Deer Regional Hospital Centre (RDRHC). • The Falls Risk Management program implemented in acute care and EDs. • Venous thromboembolism best practice guidelines and assessment of audit results implemented at RDRHC.
Edmonton	• Work continues to implement standardized pressure ulcer prevention protocol. Completed limited roll-out to units within medicine, emergency and surgical programs. • Completed draft tool for pressure ulcer prevalence measurement. • Developed plan to implement standardized falls prevention protocol.
North	• Implemented site-specific action plans to address hospital mortality. • Chart audits initiated for top three sites. Local action plans to be developed following outcome of chart audit.

IN SUMMARY

The Q4 provincial results remained stable from last year. Provincially and three zones are performing at or above the target for 2015-16.

Trending HSMR results for several years has proven very useful: stable reporting year after year helps show how our HSMR has changed in relation to our quality improvement efforts – where we've made progress and where we can continue to improve.

DID YOU KNOW

Medication incidents are one of the leading causes of patient injury. ***Medication Reconciliation*** *plays a key role in patient safety. This process ensures the medication history is comprehensive and accurate, and that all the discrepancies are addressed.*

Hospital Mortality – Zone and Site Details

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.

Hospital Standardized Mortality Rate	2012-13	2013-14	2014-15	Q4 YTD		Trend *	2015-16 Target
				2014-15 Last Year	2015-16 Current		
Provincial	**84**	**84**	**82**	**82**	**82**	**→**	**84**
South Zone Total	**96**	**103**	**96**	**96**	**93**	**↑**	**91**
Chinook Regional Hospital	90	110	95	95	94	↑	89
Medicine Hat Regional Hospital	115	104	98	98	99	↓	105
All Other Hospitals	84	91	96	96	84	↑	85
Calgary Zone Total	**79**	**83**	**74**	**74**	**76**	**↓**	**79**
Foothills Medical Centre	79	86	81	81	82	↓	79
Peter Lougheed Centre	77	77	73	73	75	↓	77
Rockyview General Hospital	78	81	66	66	69	↓	79
South Health Campus	N/A	78	66	66	67	↓	79
All Other Hospitals	86	92	83	83	85	↓	81
Central Zone Total	**84**	**85**	**84**	**84**	**89**	**↓**	**84**
Red Deer Regional Hospital Centre	90	90	85	85	88	↓	88
All Other Hospitals	81	82	83	83	90	↓	81
Edmonton Zone Total	**86**	**81**	**86**	**86**	**83**	**↑**	**85**
Grey Nuns Community Hospital	83	78	82	82	77	↑	83
Misericordia Community Hospital	89	77	96	96	79	↑	88
Royal Alexandra Hospital	82	82	87	87	82	↑	83
Sturgeon Community Hospital	89	84	71	71	81	↓	88
University of Alberta Hospital	90	83	88	88	90	↓	88
All Other Hospitals	84	77	83	83	70	↑	84
North Zone Total	**85**	**82**	**82**	**82**	**82**	**→**	**83**
Northern Lights Regional Health Centre	56	65	38	38	81	↓	56
Queen Elizabeth II Hospital	102	76	83	83	87	↓	96
All Other Hospitals	83	85	86	86	80	↑	83

N/A – South Health Campus opened February 2013
***Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

Eligible Cases	2012-13	2013-14	2014-15	Q4 YTD	
				2014-15 Last Year	2015-16 Current
Provincial	**94,888**	**97,087**	**99,914**	**99,914**	**101,269**
South Zone	8,000	7,981	8,167	8,167	8,021
Calgary Zone	31,310	32,188	33,298	33,298	34,013
Central Zone	12,428	12,294	12,828	12,828	12,718
Edmonton Zone	32,745	34,266	34,959	34,959	36,118
North Zone	10,405	10,358	10,662	10,662	10,399

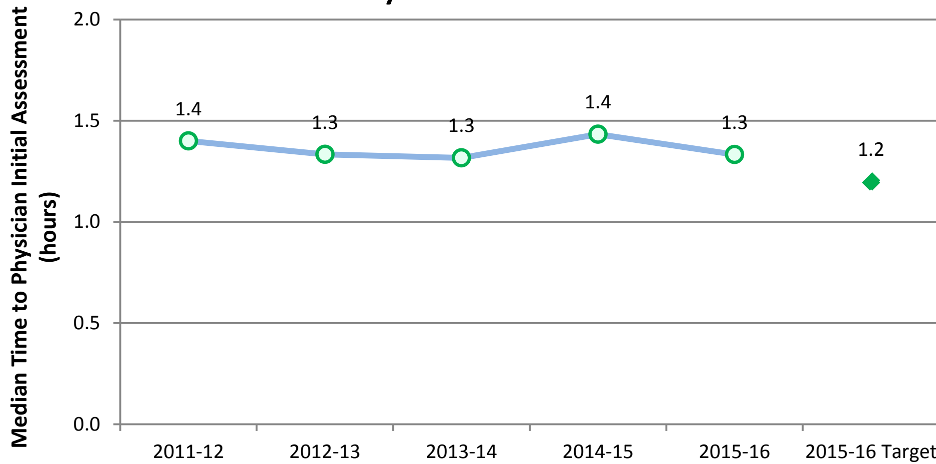
Emergency Department (ED) Wait to See a Physician

Measure Definition

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

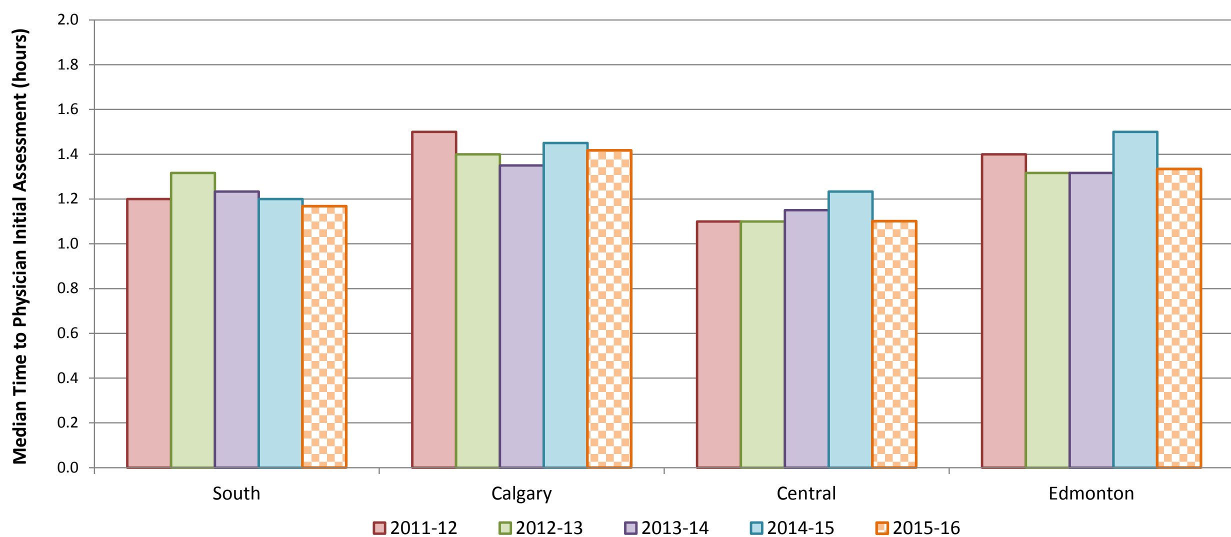
Understanding this Measure

Patients coming to the emergency department need to be seen by a physician in a timely manner for diagnosis or treatment. It is important to keep this number low to ensure people do not leave without being seen.



How Do We Compare?

Alberta ranked 4th best nationally out of 5 provinces.



Note: North Zone results not reported due to to low percentage of eligible cases with Physician Assessment Time recorded.

ED Wait to See a Physician – Actions

Zone	Actions
Provincial/ Strategic Clinical Network (SCN)	• Provincially, AHS continues to develop initiatives to assist in ensuring patients are seen and treated in a reasonable time. These include launching "Know Your Options" and Dementia Advice through Health Link and offering estimated real time ED wait times on the AHS website.
South	• “Move to chair” study in process where all patients are evaluated for appropriateness to be moved to a chair once assessment completed. • Staff assignments realigned to improve consistent movement of patients into care spaces. • Utilizing one patient care space for rapid assessments to improve triage to physician time has been effective for treatment of CTAS triage 3 and 4 patients. • Developing patient protocols to standardize and improve patient care and outcomes. • At Chinook Regional Hospital, implemented movement of ambulatory care (ED2) to space more proximal to triage which enables ED2 nurse to pull patients from waiting room resulting in more time at triage for the triage nurse. In addition, changes to assignments have enabled the “float” nurse to play a larger role in facilitating patient flow.
Calgary	• Reviewing nurse initiated protocols to reduce the number of tests/procedures automatically ordered for patients (Choosing Wisely). • Developing automated surge triggers within Real-time Emergency Department Patient Access & Coordination dashboard to bring in on-call physician. • Implemented Radar Rounds at Peter Lougheed Centre for complex patients. This initiative brings together a multi-disciplinary team to quickly identify complex patients on admission and to expedite decision-making for those individuals with no discharge or housing option. • Several initiatives underway to increase efficiencies including Model of Care work at Foothills Medical Centre, Emergency Medical Services (EMS) Hallway Process at Rockyview General Hospital, pharmacy pilot of daily lab reviews for physicians and nurses optimizing clinical intake space at Alberta Children’s Hospital.
Central	• Increased operating hours for the Minor Treatment Area in the ED. • Harmonized physician schedules with ED demand and capacity.
Edmonton	• Ongoing improvements to the surge protocol including a visual system to show real time flow in the ED. • EDs and EMS continue to refine processes to improve flow including changes to surge protocol. • EMS overcapacity protocol put in place.
North	• Regional sites initiating reporting and documentation processes and requirements. • Ongoing work with clinical teams to address wait to initial assessment through fast track options.

IN SUMMARY

Q4 year-to-date demonstrated an improvement provincially and in three reporting zones compared to the same period as last year. Two zones are at 2015-16 targets.

AHS monitors transfer processes and has identified opportunities for improvement. This includes increasing communication and collaboration as patients move through the hospital.

DID YOU KNOW

Real-time Emergency Department wait times *across urban hospitals and urgent care centres are available to the public on the AHS website.*

The ***Know Your Options*** *campaign provides information on when a visit to the ED is appropriate, and when someone should consider another treatment option when emergency care is not needed.*

Dementia Advice *through Health Link provides 24/7 telephone nurse advice for individuals and caregivers living with dementia and Alzheimer’s disease and, when needed, callers are referred to a specialized dementia nurse for additional support. It also aims to reduce the number of avoidable emergency department (ED) visits for dementia-related concerns.*

ED Wait to See a Physician – Zone and Site Details

The average patient's length of time (hours) that they wait to be seen by a physician at the busiest emergency departments

ED Time to Physician Initial Assessment - Busiest Sites	2012-13	2013-14	2014-15	Q4 YTD		Trend *	2015-16 Target
				2014-15 Last Year	2015-16 Current		
Provincial	**1.3**	**1.3**	**1.4**	**1.4**	**1.3**	**↑**	**1.2**
South Zone Total	**1.3**	**1.2**	**1.2**	**1.2**	**1.2**	**→**	**1.2**
Chinook Regional Hospital	1.4	1.3	1.2	1.2	1.2	→	1.2
Medicine Hat Regional Hospital	1.2	1.1	1.2	1.2	1.1	↑	1.1
Calgary Zone Total	**1.4**	**1.4**	**1.5**	**1.5**	**1.4**	**↑**	**1.2**
Alberta Children's Hospital	1.2	1.1	1.2	1.2	1.1	↑	1.0
Foothills Medical Centre	1.5	1.5	1.5	1.5	1.5	→	1.3
Peter Lougheed Centre	1.6	1.8	1.8	1.8	1.6	↑	1.4
Rockyview General Hospital	1.4	1.3	1.4	1.4	1.4	→	1.2
South Health Campus	N/A	1.3	1.6	1.6	1.6	→	1.2
Central Zone Total	**1.1**	**1.2**	**1.2**	**1.2**	**1.1**	**↑**	**1.1**
Red Deer Regional Hospital Centre	1.1	1.2	1.2	1.2	1.1	↑	1.1
Edmonton Zone Total	**1.3**	**1.3**	**1.5**	**1.5**	**1.3**	**↑**	**1.2**
Grey Nuns Community Hospital	1.3	1.1	1.2	1.2	1.1	↑	1.1
Misericordia Community Hospital	1.5	1.4	1.4	1.4	1.3	↑	1.3
Northeast Community Health Centre	1.5	1.4	1.4	1.4	1.3	↑	1.3
Royal Alexandra Hospital	1.5	1.9	2.2	2.2	1.9	↑	1.4
Stollery Children's Hospital	0.8	0.8	1.1	1.1	1.0	↑	0.8
Sturgeon Community Hospital	1.3	1.3	1.5	1.5	1.3	↑	1.2
University of Alberta Hospital	1.3	1.5	2.1	2.1	1.7	↑	1.3

Note: North Zone results not reported due to to low percentage of eligible cases with Physician Assessment Time recorded.
N/A: No results available. South Health Campus opened February 2013.
***Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

ED Time to Physician Initial Assessment - Eligible Cases (Busiest Sites)	2012-13	2013-14	2014-15	Q4 YTD	
				2014-15 Last Year	2015-16 Current
Provincial	**843,610**	**894,448**	**891,643**	**891,643**	**894,925**
South Zone	84,840	85,567	86,187	86,187	86,208
Calgary Zone	321,448	363,570	367,775	367,775	365,532
Central Zone	56,861	54,730	55,861	55,861	55,892
Edmonton Zone	380,461	390,581	381,820	381,820	387,293

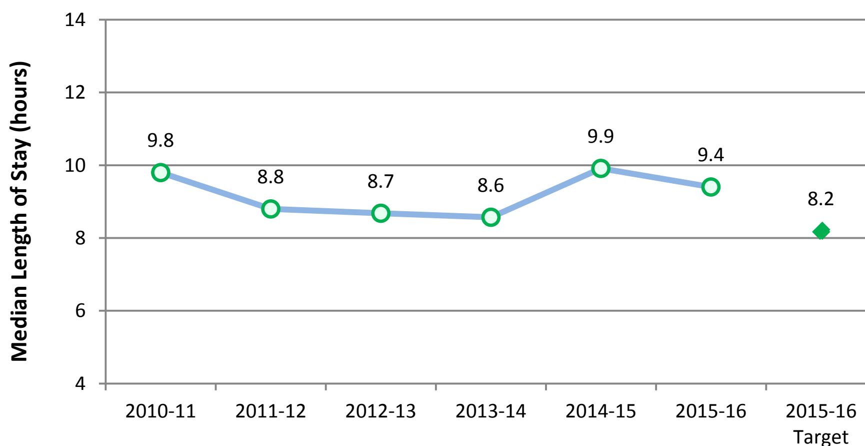
Emergency Department Length of Stay for Admitted Patients

Measure Definition

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

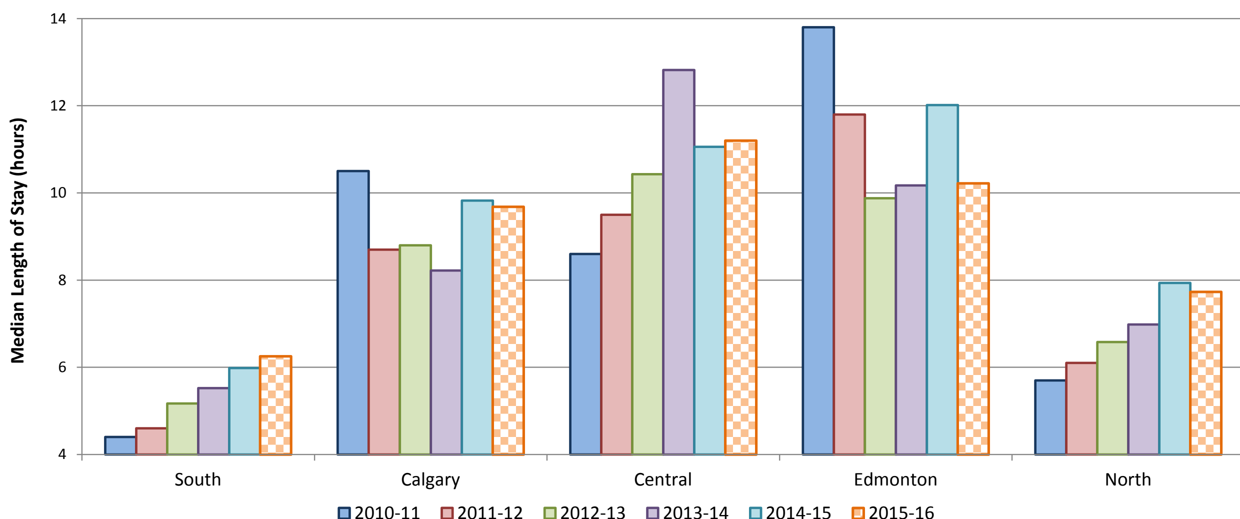
Understanding this Measure

This measure reflects the performance of the entire system. It is influenced by our ability to manage complex patients in primary care, efficiencies in the Emergency Department, 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.



How Do We Compare?

Alberta ranked 3rd best nationally out of five provinces.



ED Length of Stay for Admitted Patients – Actions

Zone	Actions
Provincial/ Strategic Clinical Network	• CoACT implementation is underway in all zones which will start to demonstrate a positive impact on efficiency and emergency department (ED) flow. • Work is underway to review diagnostic testing protocols to reduce testing where appropriate. • Continued ED quality council committee initiatives including: triage efficiencies, wayfinding improvements, optimization of treatment spaces, and proper triage of two of acute and ambulatory patients resulting in less movement throughout the department.
South	• Collaborate with ED physicians and hospitalists to improve efficiency in the decision to admit and admission orders process. • Continue to utilize daily bed huddles to ensure patient discharges are identified in timely manner. • At Chinook Regional Hospital, ongoing collaboration with specialists to ensure timely consults in an effort to reduce length of stay on admitted patients.
Calgary	• Developing improved processes to support transfer of ED admitted patients to inpatient units. • Pilot started at Foothills Medical Centre (FMC) to support both timely transfer of patients to inpatients and prompt ED discharge. • Collaborating with the Alberta Children Hospital mental health liaison to ensure optimal patient movement with FMC and South Health Campus adolescent unit. • In conjunction with the physician group, created a surge strategy to address physician coverage. • The sites also continue to liaison with their Primary Care Networks to provide options to patients with lower acuity to access care in the community.
Central	Red Deer Regional Hospital: • Repatriated patients to rural sites and received diverted ED patients from rural sites. • Medworxx data used to identify and address long hospital length of stay. • General Internal Medicine Clinic implementation planning completed to reduce inpatient length of stay.
Edmonton	• At University of Alberta Hospital (UAH), implementation of ED to ED business rule: change in practice for triage nurses responding to demands of Inter-Facility Transfers to meet 30 minute off load targets. Improved coordination of transport arrival times and consideration of Zone Triage Time to prioritize these patients at triage. • Work continues to optimize patient flow in the Rapid Transfer Unit (RTU) at the Royal Alexandra Hospital (RAH) and UAH. • Trauma Team Activation improved at UAH and RAH through focused work. • Focused quality improvement work underway with general surgery, neurology and orthopedics.
North	• Ongoing implementation of strategies to mitigate barriers to admission. • Increased education to enhance commitment to length of stay performance metrics.

IN SUMMARY

Q4 year-to-date demonstrated an improvement provincially and in three reporting zones compared to the same period as last year.

Other initiatives are underway including operationalizing in-progress bed movement process to move patients to vacant beds in a more timely fashion.

AHS has created care units in some of its urban hospitals – called the Rapid Transfer Unit in Edmonton and the Rapid Access Unit in Calgary. These units are located next to the EDs and allow care providers to observe patients receiving treatments for a longer period of time, with the goal of being able to send them home rather than admit them to hospital.

ED Length of Stay for Admitted Patients – Zone and Site Details

The average patient's length of time (hours) in the emergency department before being admitted to a hospital bed at the busiest emergency departments.

ED LOS Admitted - Busiest Sites	2012-13	2013-14	2014-15	Q4 YTD		Trend *	2015-16 Target
				2014-15 Last Year	2015-16 Current		
Provincial	**8.7**	**8.6**	**9.9**	**9.9**	**9.4**	**↑**	**8.2**
South Zone Total	**5.2**	**5.5**	**6.0**	**6.0**	**6.3**	**↓**	**5.1**
Chinook Regional Hospital	5.6	6.0	6.0	6.0	6.2	↓	5.5
Medicine Hat Regional Hospital	4.8	5.1	5.9	5.9	6.3	↓	4.7
Calgary Zone Total	**8.8**	**8.2**	**9.8**	**9.8**	**9.7**	**↑**	**8.3**
Alberta Children's Hospital	6.5	6.3	6.8	6.8	6.5	↑	6.4
Foothills Medical Centre	8.5	8.0	8.9	8.9	8.8	↑	8.3
Peter Lougheed Centre	9.8	9.1	11.5	11.5	11.5	→	8.8
Rockyview General Hospital	9.4	8.6	11.1	11.1	10.5	↑	8.7
South Health Campus	N/A	8.1	10.2	10.2	11.5	↓	8.3
Central Zone Total	**10.4**	**12.8**	**11.1**	**11.1**	**11.2**	**↓**	**9.0**
Red Deer Regional Hospital Centre	10.4	12.8	11.1	11.1	11.2	↓	9.0
Edmonton Zone Total	**9.9**	**10.2**	**12.0**	**12.0**	**10.2**	**↑**	**8.8**
Grey Nuns Community Hospital	13.3	16.8	23.5	23.5	20.7	↑	9.4
Misericordia Community Hospital	12.0	12.5	17.0	17.0	12.5	↑	9.3
Royal Alexandra Hospital	9.7	9.9	11.5	11.5	9.8	↑	8.8
Stollery Children's Hospital	7.8	7.4	8.6	8.6	7.4	↑	7.7
Sturgeon Community Hospital	13.4	20.5	28.4	28.4	18.6	↑	9.4
University of Alberta Hospital	9.2	9.1	10.4	10.4	9.0	↑	8.6
North Zone Total	**6.6**	**7.0**	**7.9**	**7.9**	**7.7**	**↑**	**6.5**
Northern Lights Regional Health Centre	5.4	5.9	6.3	6.3	6.3	→	5.3
Queen Elizabeth II Hospital	8.3	8.6	11.0	11.0	11.4	↓	8.2

N/A: No results available. South Health Campus opened February 2013.
***Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

ED Admissions from ED - Busiest Sites	2012-13	2013-14	2014-15	Q4 YTD	
				2014-15 Last Year	2015-16 Current
Provincial	**130,323**	**133,310**	**137,390**	**137,390**	**140,344**
South Zone	11,475	11,656	11,939	11,939	11,598
Calgary Zone	52,473	54,634	56,732	56,732	58,023
Central Zone	8,901	8,815	9,254	9,254	9,730
Edmonton Zone	49,988	50,644	51,858	51,858	53,521
North Zone	7,486	7,561	7,607	7,607	7,472

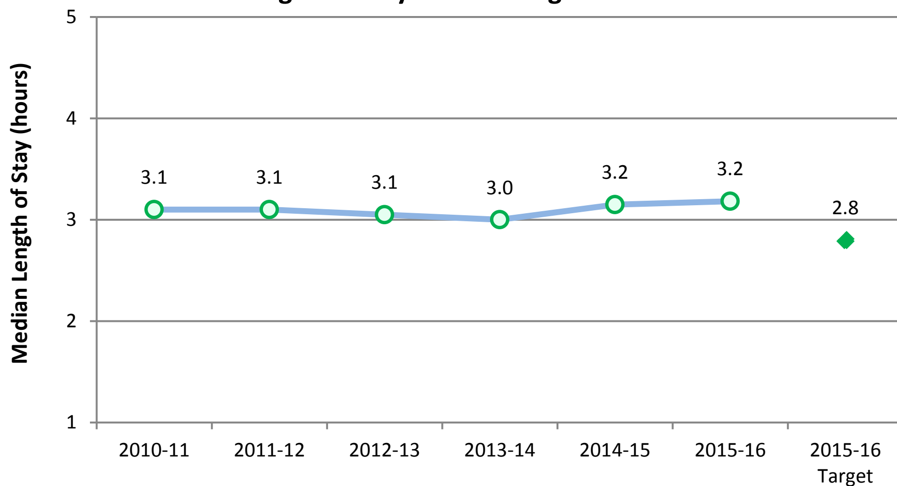
Emergency Department Length of Stay for Discharged Patients

Measure Definition

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

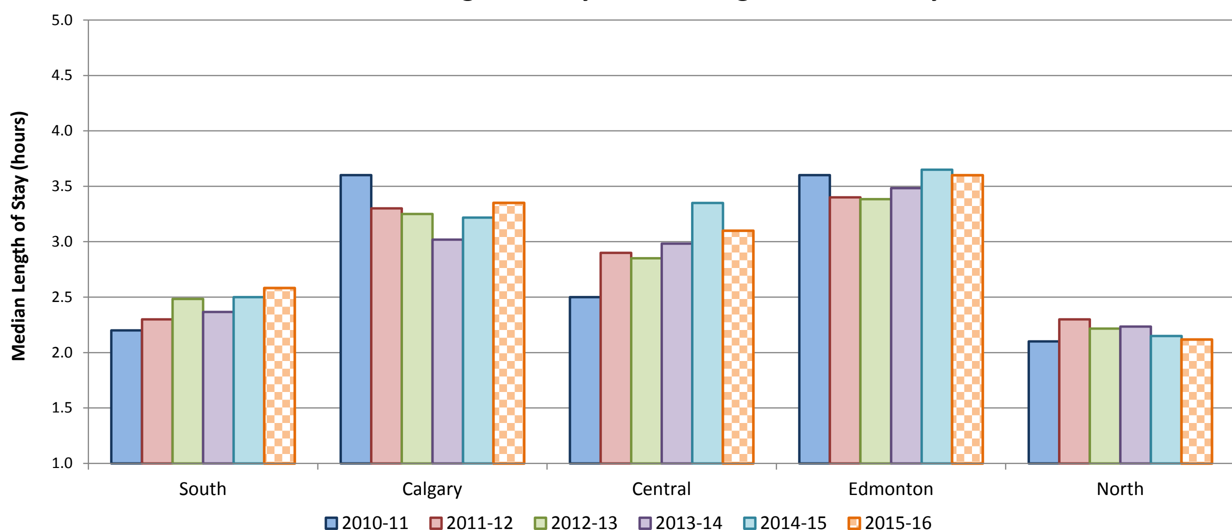
Understanding this Measure

Patients treated in an emergency department 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 home. Many patients seen in the emergency do not require admission to hospital. The length of stay in an ED is used to assess the timeliness of care delivery, overall efficiency, and accessibility of health services throughout the system.



How Do We Compare?

Alberta ranked 4th best nationally out of five provinces.



ED Length of Stay for Discharged Patients – Actions

Zone	Actions
Provincial/ Strategic Clinical Network (SCN)	• Emergency departments (ED) have incorporated the Emergency Nursing Provincial Educational Program modules into their orientation program for new staff (project led by the ED SCN and AHS Health Professions Strategy & Practice).
South	• Working with Healthy Living to develop care pathways for early access to programs for patients with congestive heart failure and chronic obstructive pulmonary disease. • Identify high-frequency users to ED with mental health and/or addiction issues. • Continue to utilize transition team to plan early effective discharge for patients or to find alternative arrangements instead of admissions. • Continue Move to Chair initiative which helps decrease initial time to physician and overall length of stay. • At Chinook Regional Hospital, moving ambulatory care spaces closer to triage to shorten time to physician thereby reducing length of stay for discharged patients.
Calgary	• Implemented a new mental health service stream in three community clinics. This new service stream provides followup care to patients when they are discharged from the emergency department or an inpatient unit. • Intake processes at all sites being reviewed and refined to ensure continued improvement of early access to physician assessment and treatment. • Working with mental health team on processes to enhance access to Psychiatric Assessment Services. • Launched a project between Rockyview General Hospital and Primary Care Network (PCN) for patients to access the PCN clinic for ultrasound and medical follow up instead of using ED resources. • Continual work with physicians and nursing to ensure patients who present with limb injuries receive timely pain medication, education and proper follow up.
Central	Red Deer Regional Hospital: • A joint initiative with emergency medical services (EMS), continuing care and palliative care, to improve end of life care and reduce transport of palliative care clients to the ED, where that care could be supported in the home. • Palliative and End of Life Care (PEOLC) and EMS physicians were engaged to develop symptom management guidelines. Education for EMS practitioners, health care clinicians and emergency communications officers developed and training delivered. • PEOLC education was provided for nursing staff in home care.
Edmonton	• Implemented urgent clinics at University of Alberta Hospital (UAH). • UAH site will pilot a rapid consultation process in the Medicine program.
North	• Expanded hours of fast track and physician coverage at Queen Elizabeth II (QEII). • Mental Health refocused efforts to address improving access and flow through the Triple Aim project at QEII. • Ongoing collaboration with PCN to facilitate appropriate use of resources and enhancement of public awareness to access after-hours primary care in Fort McMurray.

IN SUMMARY

Q4 year-to-date, provincial results have remained stable and three zones have shown an improvement in wait times compared to the same period as last year. One zone is at 2015-16 target.

DID YOU KNOW

Albertans can seek alternative ways to get treatment before going to the ED, such as visiting your family physician, going to a walk-in clinic and using other community services.

Use the AHS web site to access ED Wait Times, Dementia Advice, HealthLink and "Know Your Options" to learn when to go to the ED and what options you have for a shorter wait time.

ED Length of Stay for Discharged Patients – Zone and Site Details

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

ED LOS Discharged - Busiest Sites	2012-13	2013-14	2014-15	Q4 YTD		Trend *	2015-16 Target
				2014-15 Last Year	2015-16 Current		
Provincial	**3.1**	**3.0**	**3.2**	**3.2**	**3.2**	**→**	**2.8**
South Zone Total	**2.5**	**2.4**	**2.5**	**2.5**	**2.6**	**↓**	**2.5**
Chinook Regional Hospital	2.6	2.4	2.4	2.4	2.5	↓	2.5
Medicine Hat Regional Hospital	2.4	2.3	2.7	2.7	2.8	↓	2.4
Calgary Zone Total	**3.3**	**3.0**	**3.2**	**3.2**	**3.4**	**↓**	**3.0**
Alberta Children's Hospital	2.3	2.2	2.4	2.4	2.4	→	2.3
Foothills Medical Centre	4.0	3.7	3.8	3.8	4.1	↓	3.3
Peter Lougheed Centre	3.7	3.6	3.7	3.7	3.7	→	3.2
Rockyview General Hospital	3.5	3.1	3.4	3.4	3.6	↓	3.1
South Health Campus	N/A	2.8	3.3	3.3	3.6	↓	3.0
Central Zone Total	**2.9**	**3.0**	**3.4**	**3.4**	**3.1**	**↑**	**2.8**
Red Deer Regional Hospital Centre	2.9	3.0	3.4	3.4	3.1	↑	2.8
Edmonton Zone Total	**3.4**	**3.5**	**3.7**	**3.7**	**3.6**	**↑**	**3.0**
Grey Nuns Community Hospital	3.1	3.3	3.3	3.3	3.3	→	2.9
Misericordia Community Hospital	3.3	3.2	3.2	3.2	3.1	↑	3.0
Northeast Community Health Centre	3.2	3.2	3.2	3.2	3.0	↑	3.0
Royal Alexandra Hospital	4.4	5.1	5.5	5.5	5.1	↑	3.4
Stollery Children's Hospital	2.3	2.3	2.7	2.7	2.7	→	2.3
Sturgeon Community Hospital	3.0	2.9	3.3	3.3	3.3	→	2.9
University of Alberta Hospital	4.6	4.9	5.7	5.7	5.5	↑	3.4
North Zone Total	**2.2**	**2.2**	**2.2**	**2.2**	**2.1**	**↑**	**2.1**
Northern Lights Regional Health Centre	2.1	2.1	1.8	1.8	1.9	↓	2.1
Queen Elizabeth II Hospital	2.3	2.4	2.7	2.7	2.5	↑	2.3

N/A: No results available. South Health Campus opened February 2013.
***Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

ED Discharges from ED - Busiest Sites	2012-13	2013-14	2014-15	Q4 YTD	
				2014-15 Last Year	2015-16 Current
Provincial	**832,699**	**892,057**	**878,560**	**878,560**	**870,633**
South Zone	76,322	76,902	75,132	75,132	75,144
Calgary Zone	255,767	307,564	308,414	308,414	304,203
Central Zone	47,743	45,682	46,311	46,311	45,710
Edmonton Zone	327,842	338,229	328,131	328,131	331,564
North Zone	125,025	123,680	120,572	120,572	114,012

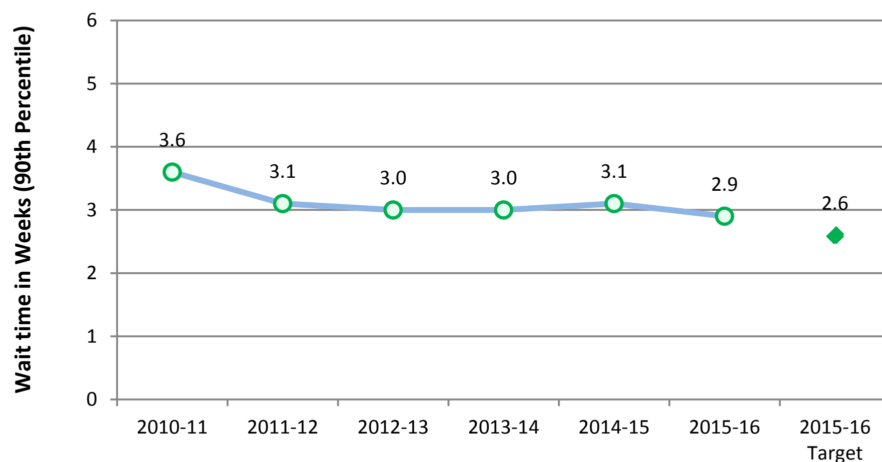
Access to Radiation Therapy

Measure Definition

Ninety per cent of patients wait for radiation therapy this length of time or less (measured from when they are ready to treat). This measure is the time from the date the patient was physically ready to commence treatment, to the date that the patient received his/her first radiation therapy.

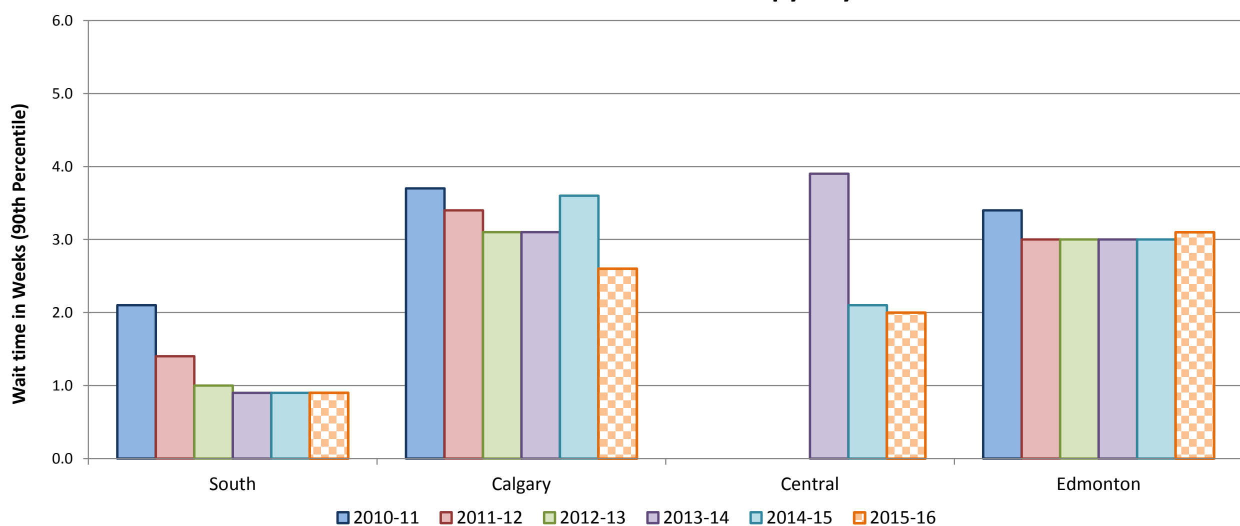
Understanding this Measure

Timely access to radiation therapy for cancer diagnosis can impact treatment effectiveness and outcomes. Currently, this data is reported on patients who receive radiation therapy at the Cross Cancer Institute in Edmonton, the Tom Baker Cancer Centre in Calgary, the Jack Ady Cancer Centre in Lethbridge and the new Central Alberta Cancer Centre in Red Deer. The data applies only to patients receiving external beam radiation therapy.



How Do We Compare?

Alberta ranks 3rd best nationally among nine provinces.



Note: Central Zone Cancer Center opened in November 2013. Grande Prairie Cancer Centre is planned to open in the North Zone in 2019.

Access to Radiation Therapy – Actions

Provincial/ Strategic Clinical Network (SCN)

- Work continues to establish benchmark for radiotherapy activity costing at the four Radiation Therapy centres in Alberta.
- Work continues to expedite access to lung cancer treatment through the Alberta Thoracic Oncology Program (ATOP) by expanding the radiology notification program and proactively monitoring performance in collaboration with the zones.
- The number of patients referred to the Alberta Thoracic Oncology Program (ATOP) continues to grow and surgical wait times are showing improvement. In Q4, 682 referrals were made compared to 651 referrals in 2014-15. Surgical wait times from decision to treat until surgery improved from 58 days in Q4 2014-15 compared to 50 days in Q4 2015-16.
- Improvements in staff scheduling and cancellation processes at the Tom Baker Cancer Centre (TBCC) Ambulatory Clinic have helped to decrease patient wait times.
- Provincially, radiation wait times had a slight decrease in the last month. For April 2016, the wait time for ready to treat to treatment for radiotherapy was 19 days which is one day higher than the AHS provincial target (2.6 weeks or 18.2 days).
- Jack Ady Cancer Centre and Central Alberta Cancer Centre consistently achieved well below the AHS target of 18 days for the last four quarters. TBCC has met this target for the last three quarters, whereas Cross Cancer Institute (CCI) has been over target ranging between 19 to 24 days over the last four quarters.
- The wait time target was achieved for just under half of the referral tumor groups over the last 12 months. Breast, GI-colon/rectum, Head and Neck, Central Nervous System, and Musculoskeletal did not meet the target as each group showed between 80% - 85% of patients treated within the target. Prostate, GI-other, Gynecology, Lymphoma, Cutaneous ranged between 86% and 90% of patients treated within the target.
- At TBCC, Ready-to-Treat to radiation therapy treatment wait time decreased by a day to 18 for April 2016 which meets the target set by TBCC.
- CCI has set their wait time target at 20 days which was achieved in April 2016.
- CACC has set their target at 10 days which was achieved and remained the same as the previous month.
- JACC has set their target at 5 days. The wait time for Ready-to-Treat to radiation therapy treatment for April was 8 days, therefore the target was not achieve this past month. This was an increase of 4 days wait time from March 2016.
- The national wait time target is 28 days. This has been achieved by all facilities for the past 12 months.

IN SUMMARY

Q4 year-to-date, provincial and two zone results improved since the same period as last year. Two zones are at or above 2015-16 target.

AHS CancerControl is responsible for treating patients with cancer. This provincial network of cancer professionals and facilities provide most cancer treatment except for surgery.

DID YOU KNOW

If you are diagnosed with cancer, your family physician or surgeon may refer you to a cancer facility to discuss further treatment options. If you are referred, you will meet with a doctor specially trained to treat cancer. The two most common types of treatment given in the cancer facilities are chemotherapy and radiation therapy.

Radiation therapy is available at the Cross Cancer Institute in Edmonton; Tom Baker Cancer Centre in Calgary; Jack Ady Cancer Centre in Lethbridge and Central Alberta Cancer Centre in Red Deer.

Access to Radiation Therapy – Zone and Site Details

Ninety per cent of patients wait for radiation therapy this length of time or less (measured from when they are ready to treat). This measure is the time from the date the patient was physically ready to commence treatment, to the date that the patient received his/her first radiation therapy.

Access to Radiation Therapy (weeks)	2012-13	2013-14	2014-15	Q4 YTD		Trend *	2015-16 Target
				2014-15 Last Year	2015-16 Current		
Provincial	**3.0**	**3.0**	**3.1**	**3.1**	**2.9**	↑	**2.6**
South Zone (JackAdy Cancer Centre)	1.0	0.9	0.9	0.9	0.9	→	1.0
Calgary Zone (Tom Baker Cancer Centre)	3.1	3.1	3.6	3.6	2.6	↑	2.7
Central Zone (Central Alberta Cancer Centre)	N/A	3.9	2.1	2.1	2.0	↑	n/a
Edmonton Zone (Cross Cancer Institute)	3.0	3.0	3.0	3.0	3.1	↓	2.6

N/A: No results available. Central Alberta Cancer Centre opened November 2013. Grande Prairie Cancer Centre is tentatively planned to open in the North Zone in 2019.

***Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

Number of patients who started radiation therapy	2012-13	2013-14	2014-15	Q4 YTD	
				2014-15 Last Year	2015-16 Current
Provincial	**7,093**	**7,182**	**7,438**	**7,438**	**7,854**
South Zone	414	431	415	415	421
Calgary Zone	2,916	2,803	2,910	2,910	3,269
Central Zone	N/A	145	425	425	485
Edmonton Zone	3,763	3,803	3,688	3,688	3,679

N/A: No results available. Central Alberta Cancer Centre opened November 2013. Grande Prairie Cancer Centre is planned to open in the North Zone in 2019.

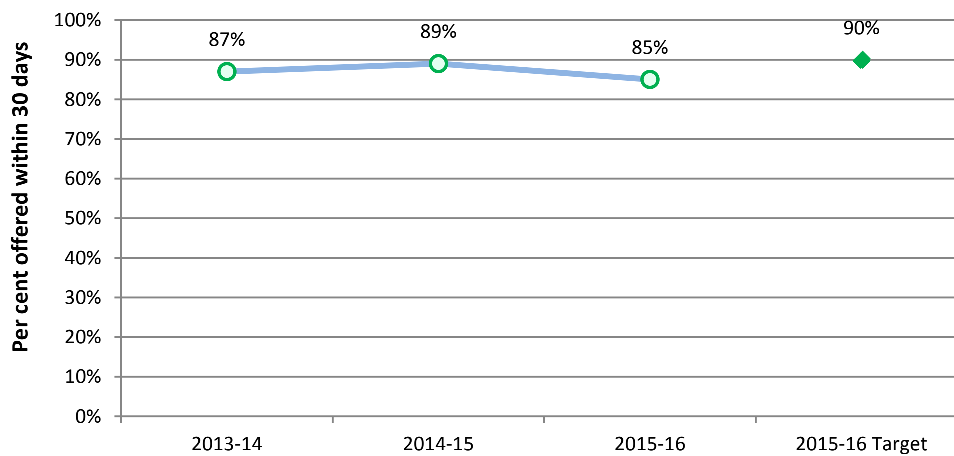
Children's Mental Health Access

Measure Definition

Percentage of children aged 0 to 17 years offered scheduled community mental health treatment within 30 days from referral.

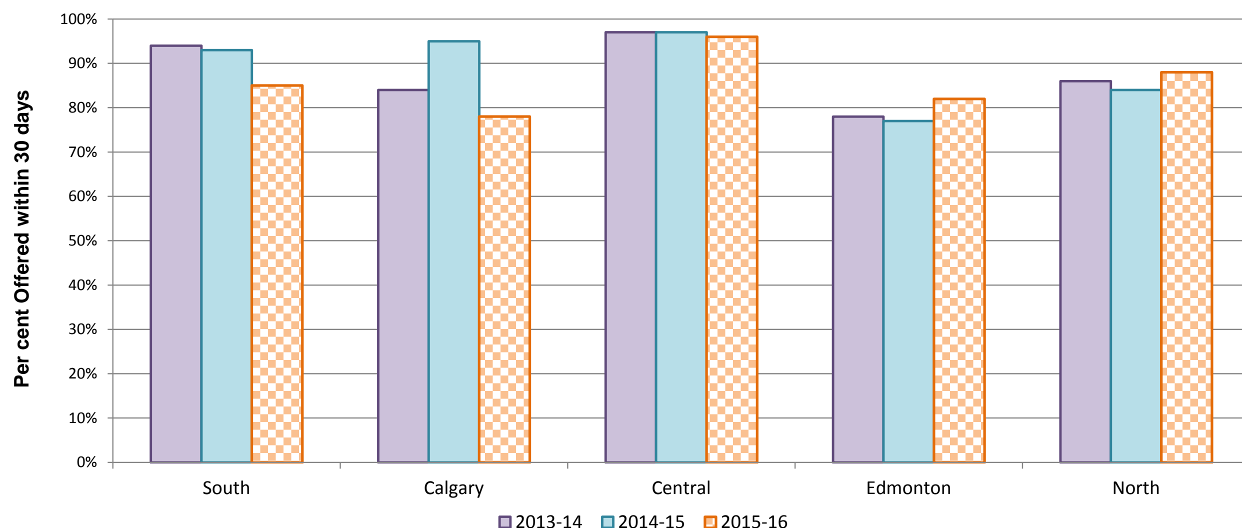
Understanding this Measure

Delays in treating mental illness can have negative consequences, including exacerbation of the client's condition. Research has shown that the longer children wait for service, the more likely they are to not attend their first appointment. One of the strategies associated with Addiction and Mental Health is to improve how children and youth access addiction and mental health services. Monitoring the percentage of children who have symptoms or problems that require attention but are not considered urgent or emergent can help in identifying system delays and assessing service capacity, while ensuring that children most in need of treatment receive it immediately.



How Do We Compare?

Comparable national data is not available for this measure.



Children's Mental Health Access – Actions

Zone	Actions
Provincial/ Strategic Clinical Network (SCN)	• The Addiction & Mental Health (AMH) SCN continues to work with government partners to develop a comprehensive model for school mental health based on learning from the EMPATHY work. • The Youth Patient Journey study was completed to examine homeless youth that transition to homeless adults. Eighty youth were surveyed across Alberta. Recommendations will include examining trends, needs related to rural and urban settings and availability and utilization of resources.
South	• Participating on two Regional Collaborative School Delivery committees to streamline access to children's addiction mental health services. • Developed an electronic intake book to monitor in real time the wait times and to clearly identify children who may be offered appointments longer than 25 days away. • Developed and implemented a wait list protocol for children waiting more than 30 days to access to services earlier. • Conducted an analysis to determine how quickly wait time data can be assessed to help identify trends sooner. •
Calgary	• Completed the Brain Health integration planning which includes future needs for children and youth requiring mental health care and treatment across the continuum of care. • A webpage is under development to share templates and tools across AHS. This work will be presented nationally at the Canadian Association of Pediatric Health Centers. • A new electronic scheduling system and electronic health record was implemented.
Central	• Participated on three Regional School Delivery collaboratives with the Regional Collaborative School Delivery Model. • Worked in collaboration with provincial AMH portfolio to support Mental Health Review and response to a rural Quality Assurance Review.
Edmonton	• The Strongest Families Institute continues to be contracted to manage approximately 45 families per month. This support reduces the number of children and families that require in-clinic services, therefore increasing the availability for other children and youth with more urgent mental health concerns to AHS community clinics. • Continue to implement strategies to manage the increasing number of emergency presentations by children and adolescents for mental health concerns. Examples of strategies include walk-in appointments every day, Crisis Team visits to any school that highlights an urgent concern for a student, and collaboration with Child and Family Services and Disability Services for youth in group homes.
North	• Participating on six Regional Collaborative School Delivery committees working to streamline access to children's addiction mental health services. • Continue spread of Alberta Access, Improvement, Measures (AIM), and AHS Improvement Way (AIW) process improvement implementation. • Suicide Risk Management protocol for children in schools developed in Fort McMurray has been spread to other sites in the zone and shared with Regional Collaborative Services Delivery teams.

IN SUMMARY

The Q4 provincial results have shown deterioration from last year. Two zones have demonstrated improvement compared to the same period as last year.

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

DID YOU KNOW

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

Children's Mental Health Access – Zone Details

Percentage of children aged 0 to 17 years offered scheduled community mental health treatment within 30 days from referral.

Children Offered Mental Health Services within 30 days	2013-14	2014-15	Q4 YTD		Trend *	2015-16 Target
			2014-15 Last Year	2015-16 Current		
Provincial	**87%**	**89%**	**89%**	**85%**	**↓**	**90%**
South Zone	94%	93%	93%	85%	↓	n/a
Calgary Zone	84%	95%	95%	78%	↓	n/a
Central Zone	97%	97%	97%	96%	↓	n/a
Edmonton Zone	78%	77%	77%	82%	↑	n/a
North Zone	86%	84%	84%	88%	↑	n/a

***Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

Number of new enrollments	2013-14	2014-15	Q4 YTD	
			2014-15 Last Year	2015-16 Current
Provincial	**7,456**	**7,947**	**7,947**	**8,870**
South Zone	1,450	1,697	1,697	1,749
Calgary Zone	1,465	1,815	1,815	2,038
Central Zone	1,170	1,257	1,257	1,458
Edmonton Zone	1,852	1,562	1,562	1,703
North Zone	1,519	1,616	1,616	1,922

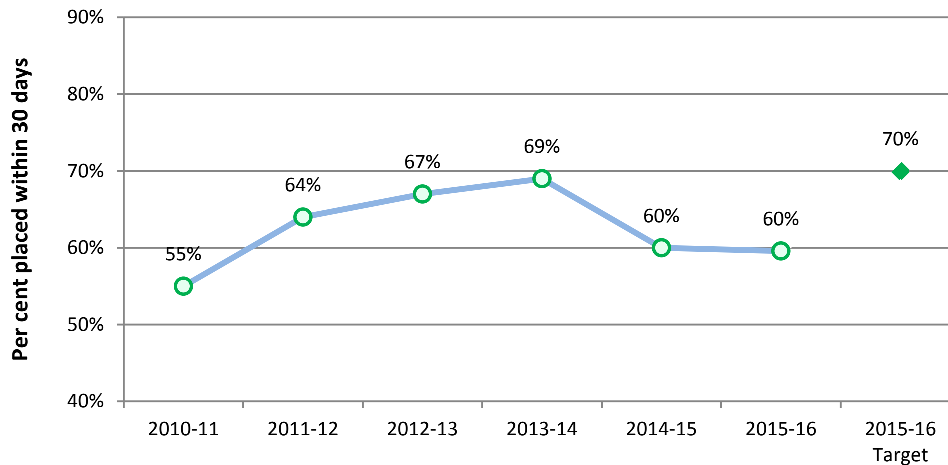
Continuing Care Placement

Measure Definition

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 and approved and waiting in hospital or community.

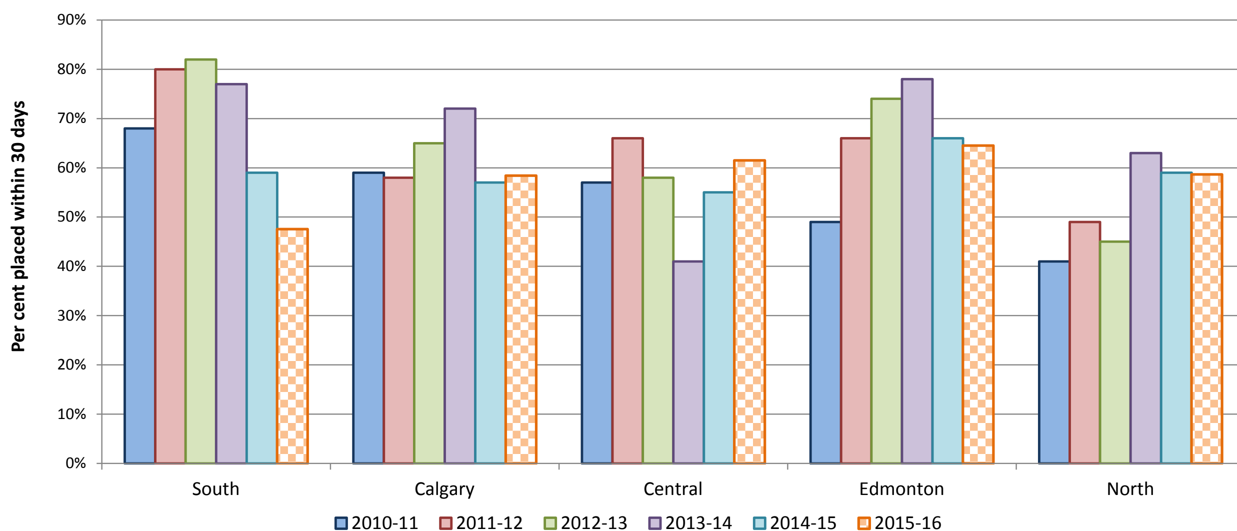
Understanding this Measure

Providing appropriate care for our aging population is extremely important to Albertans. Timely access to continuing care (designated supportive living or long-term care) ensures higher quality of life for our seniors. In addition, by improving access to continuing care, AHS is able to improve flow throughout the system, provide more appropriate care, decrease wait times and deliver care in a more cost effective manner.



How Do We Compare?

Comparable national data is not available for this measure.



Continuing Care Placement – Actions

Zone	Actions
Provincial/ Strategic Clinical Network (SCN)	• In 2015-16, AHS opened 997 continuing care spaces for a total of 25,135 community-based services. These include 717 supportive living beds, 203 long-term care beds, 42 restorative care beds, and 35 community palliative beds. • The number of people waiting in acute care/sub-acute and community for continuing care placement has decreased by 133 individuals from 2014-15 (n=1,544) to 2015-16 (n=1,411). • Work continues across the province to implement the Seniors Health Continuing Care Capacity Plan. Significant work has been done to date to achieve an increase of 2,000 long-term and dementia care beds within the next four years.
South	• In 2015-16, opened 111 net new continuing care spaces. • Implementation of Seniors Health Continuing Care Capacity Plan.
Calgary	• In 2015-16, opened 667 net new continuing care spaces. • Implementation of Seniors Health Continuing Care Capacity Plan.
Central	• In 2015-16, opened 18 net new continuing care spaces. • A process improvement implementation of Meditech statistical tracking was accomplished at the placement office. • Planning is underway to address gaps for clients with complex dementia and/or behavioral issues.
Edmonton	• In 2015-16, opened 156 net new continuing care spaces in Supportive Living 4 and Supportive Living 4-Dementia.
North	• In 2015-16, opened 45 net new continuing care spaces. • The continuing care placement team was centralized and continues to reviews processes to establish consistent practice across the zone.

IN SUMMARY

Provincial results have remained stable since last year. Two zones have improved compared to results from last year.

AHS has placed more clients in continuing care living options in 2015-16 (7,879) as compared to 2014-15 (7,810).

Since April 2010, as of March 31, 2016, AHS has added 5,247 spaces to the continuing care system, and more spaces will continue to be added in the coming years.

In addition to opening continuing care spaces, AHS is expanding home care services. This allows more seniors to remain safe and independent in their own homes, which is where they want to be.

AHS is working to ensure beds in acute care are used in the most efficient manner, improving communication between all health care team members, patients and families to facilitate discharges and ensure that patients are getting the best care for their personal situations.

DID YOU KNOW

Hundreds of adult day program spaces are also being added to monitor seniors living at home with complex and unstable health conditions, to give seniors additional opportunities for socializing, and to provide respite for caregivers.

Continuing Care Placement – Zone Details

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

Continuing Care Clients Placed within 30 days	2012-13	2013-14	2014-15	Q4 YTD		Trend *	2015-16 Target
				2014-15 Last Year	2015-16 Current		
Provincial	**67%**	**69%**	**60%**	**60%**	**60%**	→	**70%**
South Zone	82%	77%	59%	59%	48%	↓	83%
Calgary Zone	65%	72%	57%	57%	58%	↑	68%
Central Zone	58%	41%	55%	55%	62%	↑	63%
Edmonton Zone	74%	78%	66%	66%	65%	↓	75%
North Zone	45%	63%	59%	59%	59%	→	53%

***Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

Total Placed	2012-13	2013-14	2014-15	Q4 YTD	
				2014-15 Last Year	2015-16 Current
Provincial	**7,761**	**7,693**	**7,810**	**7,810**	**7,879**
South Zone	930	868	866	866	887
Calgary Zone	2,301	2,164	2,548	2,548	2,722
Central Zone	1,281	1,189	1,259	1,259	1,060
Edmonton Zone	2,620	2,742	2,443	2,443	2,506
North Zone	629	730	694	694	704

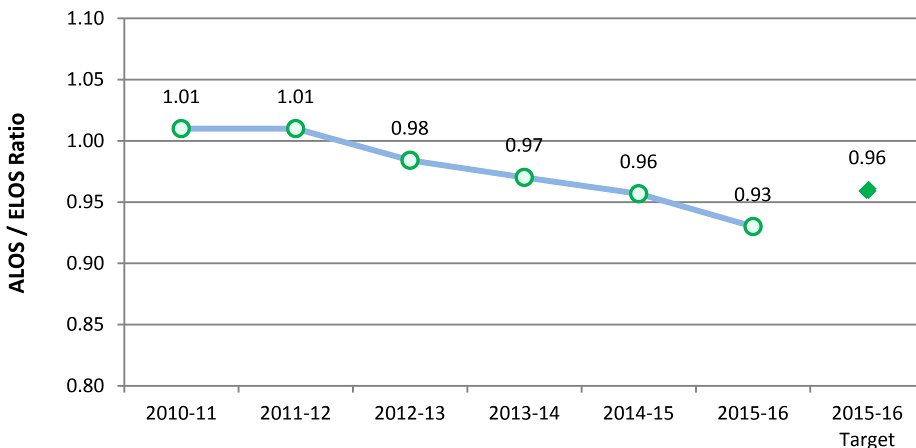
Acute (Actual) Length of Hospital Stay (ALOS) Compared to Expected Length of Stay (ELOS)

Measure Definition

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

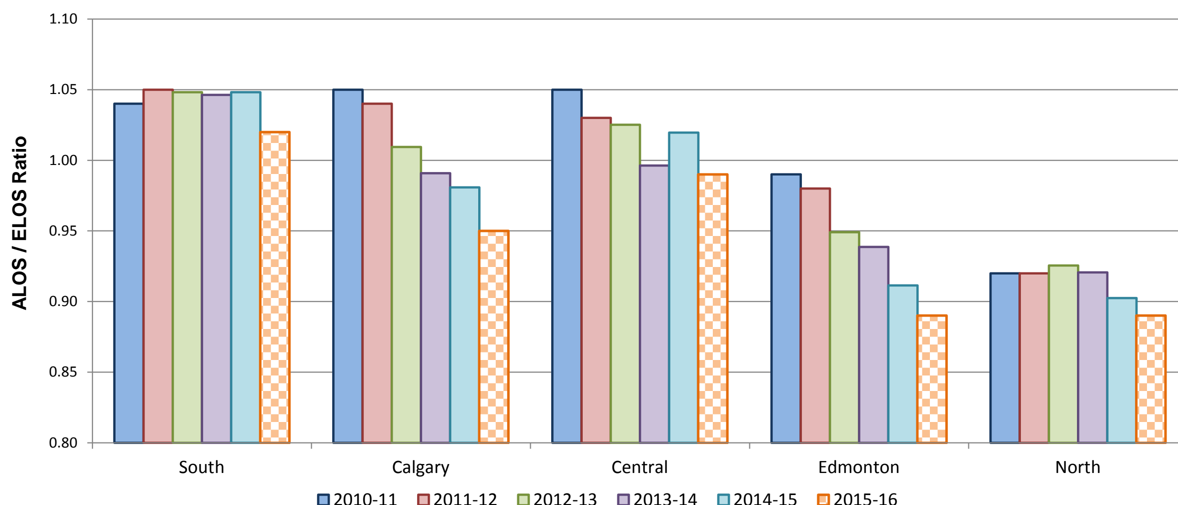
Understanding this Measure

This measure gauges how efficiently beds are utilized in the hospital. A ratio of actual to expected length of stay which is below one, represents an overall greater than expected efficiency and indicates that more patients are able to be treated for a given inpatient bed. Monitoring this ratio can help health-care teams ensure care appropriateness and efficiency. Improvement in this measure enables the ability to treat more patients with the existing beds and other resources.



How Do We Compare?

Alberta ranked 3rd best nationally out of nine provinces.



ALOS/ELOS – Actions

Zone	Actions
Provincial/ Strategic Clinical Network (SCN)	• Continue implementation of CoACT for all 16 in-scope AHS facilities, commence implementation and audit process for bedside shift report, bedside whiteboards, care hubs, comfort rounds, rapid rounds and frontline leadership development. • Continue deployment of Medworxx across acute care system. • Continued implementation of the Enhanced Recovery After Surgery (ERAS) project at six early adopter sites (Surgery SCN). Funding approved for three additional sites and 12 additional protocols. • SCNs are developing key clinical care pathways (i.e. Hip Fracture Pathway, Rectal Cancer Pathway, and Heart Failure Pathway) to reduce unwarranted practice variation. • Led by the Diabetes, Obesity and Nutrition SCN, work continues on hospital glycemic management of diabetics by implementing basal bolus insulin therapy to reduce prevalence of hyperglycemia associated with increased infections, delayed wound healing, increased length of stay, readmissions and mortality.
South	• Co-ACT implementation underway at all units at Medicine Hat Regional Hospital (MHRH), Chinook Regional Hospital and Brooks. Key highlights include participating in collaborative care leadership, white boards, RAAPID rounds, team charters, and care hubs. iRounds piloted at two units at MHRH. • Implementation of acute and sub-acute hip fracture pathway underway.
Calgary	• Implemented a new mental health service stream in three community clinics. This new service stream provides followup care to patients when they are discharged from the emergency department or an inpatient unit. • Implementation of the six core elements of CoACT including care hubs at Rockyview General Hospital and South Health Campus (SHC). • A pilot project is planned at SHC to decrease average time of discharge and increase discharges on weekends. • Referral Access Advice Placement Information Destination (RAAPID) proposal to have a repatriation nurse at Foothills Medical Centre to better assist with repatriation identification and paperwork.
Central	• Applied six priority CoACT core elements occurring at all in scope sites (Red Deer Regional Hospital, Wetaskiwin Hospital and Care Centre, and Drumheller Health Centre). • Medworxx utilization optimized to facilitate interdisciplinary team communication and discharge planning and identification of delays that extend length of stay and impact timely discharge.
Edmonton	• All inpatient units have identified Collaborative practice Quartet members and the Collaborative Leadership Development Program training is underway. • CoACT Phase 1 implementation is at various stages in all acute care settings. • Process improvement at Royal Alexandra Hospital is underway to ensure patients are on the appropriate service, thereby increasing efficiencies and throughput. Bed side shift report and comfort rounds started on all units. • Longstay rounds conducted at the site level with LTC and Homecare.
North	• CoACT Phase 1 implementation is at different stages. Many of the elements will be completed in Phase 2. • Audit tools are available for many of the collaborative care elements.

IN SUMMARY

Overall, the provincial and zone results have demonstrated an improvement in Q4 year-to-date.

AHS is developing standardized care planning tools such as care pathways for specific patient groups, to improve communication between all team members, our patients and their families. This will ensure that every patient receives the best quality of care for their medical condition as well as their personal situation.

DID YOU KNOW

Medworxx *is a tool used for proactive discharge planning, to enhance how acute care capacity is managed and improve patient experience. It is used by those involved in patient care / flow, including front-line nursing staff, physicians, clinical coordinators, discharge planners and hospital administration. These reports are used to identify barriers, delays and interruptions to patient care and to achieve an optimal length of stay.*

ALOS/ELOS– Zone and Site Details

The average number of actual days patients stay in acute care hospitals compared to the expected length of stay for a typical patient.

Acute (Actual) Length of Hospital Stay Compared to Expected Stay	2012-13	2013-14	2014-15	Q4 YTD		Trend *	2015-16 Target
				2014-15 Last Year	2015-16 Current		
Provincial	**0.98**	**0.97**	**0.96**	**0.96**	**0.93**	**↑**	**0.96**
South Zone Total	**1.05**	**1.05**	**1.05**	**1.05**	**1.02**	**↑**	**1.00**
Chinook Regional Hospital	1.08	1.06	1.06	1.06	1.02	↑	1.01
Medicine Hat Regional Hospital	1.05	1.08	1.06	1.06	1.04	↑	1.00
All Other Hospitals	0.95	0.93	0.98	0.98	0.96	↑	0.95
Calgary Zone Total	**1.01**	**0.99**	**0.98**	**0.98**	**0.95**	**↑**	**0.97**
Alberta Children's Hospital	0.98	1.00	0.91	0.91	0.89	↑	0.96
Foothills Medical Centre	1.04	1.01	1.01	1.01	0.98	↑	1.00
Peter Lougheed Centre	0.99	0.98	0.97	0.97	0.95	↑	0.97
Rockyview General Hospital	1.00	0.99	0.99	0.99	0.95	↑	0.97
South Health Campus	N/A	0.94	0.94	0.94	0.87	↑	0.97
All Other Hospitals	0.96	0.96	0.96	0.96	0.93	↑	0.96
Central Zone Total	**1.03**	**1.00**	**1.02**	**1.02**	**0.99**	**↑**	**0.98**
Red Deer Regional Hospital Centre	1.06	1.03	1.05	1.05	1.01	↑	1.00
All Other Hospitals	1.00	0.97	0.99	0.99	0.98	↑	0.97
Edmonton Zone Total	**0.95**	**0.94**	**0.91**	**0.91**	**0.89**	**↑**	**0.94**
Grey Nuns Community Hospital	0.99	0.93	0.88	0.88	0.86	↑	0.97
Misericordia Community Hospital	1.04	0.97	0.96	0.96	0.90	↑	0.99
Royal Alexandra Hospital	0.92	0.93	0.91	0.91	0.89	↑	0.91
Stollery Children's Hospital	0.98	1.00	0.92	0.92	0.92	→	0.97
Sturgeon Community Hospital	0.90	0.92	0.90	0.90	0.86	↑	0.90
University of Alberta Hospital	0.92	0.91	0.91	0.91	0.90	↑	0.92
All Other Hospitals	0.98	1.02	0.97	0.97	0.98	↓	0.97
North Zone Total	**0.93**	**0.92**	**0.90**	**0.90**	**0.89**	**↑**	**0.92**
Northern Lights Regional Health Centre	0.95	0.96	0.93	0.93	0.89	↑	0.95
Queen Elizabeth II Hospital	0.93	0.93	0.87	0.87	0.86	↑	0.93
All Other Hospitals	0.92	0.91	0.91	0.91	0.90	↑	0.91

N/A: No results available. South Health Campus opened February 2013. ***Trend:** ↑ Improvement → Stability ↓ Area requires additional focus
The ALOS/ELOS ratio is calculated using the Expected Length of Stay (ELOS) from the 2014 Case Mix Group Plus (CMG+) for each inpatient case. The CMG+ methodology is updated on a yearly basis by the Canadian Institute for Health Information (CIHI). There were significant methodology differences between the 2014 and 2015 CMG+ methodologies producing results which are not comparable from 2014/15 to 2015/16. To address this limitation, the 2015/16 results in this Q2 report are calculated using the 2014 CMG+ methodology.

Total Discharges	2012-13	2013-14	2014-15	Q4 YTD	
				2014-15 Last Year	2015-16 Current
Provincial	**385,536**	**393,765**	**401,331**	**401,331**	**404,513**
South Zone	31,640	31,093	31,125	31,125	30,485
Calgary Zone	130,842	136,598	140,563	140,563	143,057
Central Zone	45,619	44,589	45,691	45,691	45,578
Edmonton Zone	132,337	135,970	139,052	139,052	141,282
North Zone	45,098	45,515	44,900	44,900	44,111

Early Detection of Cancer

Measure Definition

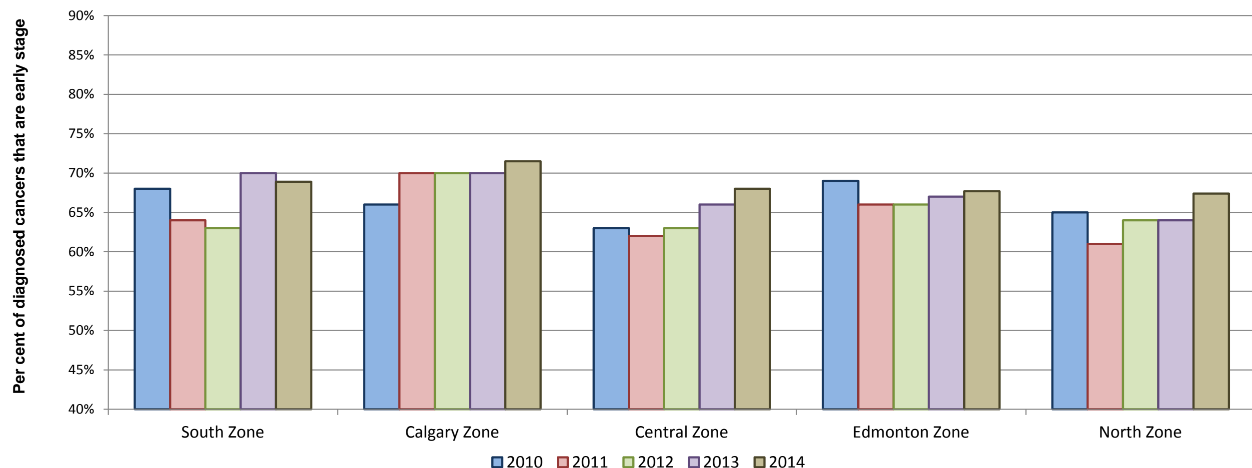
The percentage of patients with breast, cervical and colorectal cancers who were diagnosed at early stages 1 or 2. This measure covers the three most common cancers; breast, cervical and colorectal. It represents the percentage of invasive cancer cases diagnosed in the stages (Stage I, and II (and stage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

Understanding this Measure

Patients whose cancers are captured at early stages have higher survival rates than those who were diagnosed at later stages. Provincial cancer screening programs aim to diagnose cancers at the earliest stage possible in the target population. This measure is developed to reflect both screening effectiveness and efficiency of clinical diagnosis pathways. Data is published annually. Note: 2014 most recent data available. The target for 2014-15 was 67%. Source: Alberta Cancer Registry.

How Do We Compare?

Alberta ranked 2nd best nationally for breast cancers and 8th nationally for colorectal cancers diagnosed in early stages out of nine provinces. AHS' improvement activity is focused on colorectal cancer.



Early Detection of Cancer – Actions

Zone	Actions
Provincial/ Strategic Clinical Network	• Continue to work to incorporate a full spectrum of screening program activities within the Alberta Breast Cancer Screening Program. • Work is underway within the zones to offer cervical cancer screening to clients during clinic visits as per provincial screening guidelines. • The number of individuals between the ages of 50-74 who had Fecal Immunochemical Test (FIT) from April 1, 2015 to March 31, 2016 is 253,425. In Q4 (January to March), FIT volume was 58,630. • The Screen Test Mobile Mammography van reached more than 100 rural and remote communities, providing access to breast cancer screening for women who live in those communities.
South	• Monitor and evaluate FIT implementation, targeting clinics with low FIT test return rates through Central Intake clinic, and following up with primary physician offices. • Develop and implement clear follow-up processes for patients with positive FIT results. • Implementation of Alberta Colorectal Cancer Screening Program (ACRCSP) guidelines for positive FIT results. Site-based scorecards for physicians are shared quarterly. • Continue to promote Breast and Cervical Cancer Screening in collaboration with Primary Care Networks (PCNs).
Calgary	• The Colon Cancer Screening Center has significantly reduced routine referrals for colonoscopy, decreasing wait times as a direct result of the uptake in FIT testing. • The ABCSP offers a mobile breast screening mammography program at a fixed site at the Holy Cross in Calgary. • A “Man Van” for PSA (Prostate-specific antigen) testing is completed at the Prostate Cancer Center/ Southern Alberta Institute of Urology. • Expanded Hereditary Cancer group sessions – 25% increase in capacity. • Integration of Ovarian Cancer Genetic Testing at the Oncology Bedside is under development.
Central	• Reviewed and targeted compliance with quality reporting for colon cancer screening colonoscopies. • Continuing to collaborate with physicians to use new data collection form to meet ACRCSP reporting requirements as well as reconciliation of pathology results.
Edmonton	• Primary Care, GI (gastrointestinal) and SCOPE have partnered to address overall GI access. A total of 5,717 secondary colonoscopies were completed (target 5,203).
North	• The Enhanced Access to Cancer Screening (EACS) program completed a two-year pilot project to increase access to cervical and colorectal cancer screening in rural and remote communities through the Screen Test mobile unit. Staff delivered 24 EACS clinics, serving nearly 1,600 northern Alberta residents in 67 different communities. • Standards of practice for Public Health Promotion and Aboriginal Health were implemented. • Work continues with First Nation communities to increase cancer screening as well as develop standards and training materials for Aboriginal Health staff for education and awareness.

IN SUMMARY

The province and 4 zones have demonstrated an improvement from the previous reporting period.

Early detection of cancer through regular screening following clinical practice guidelines can identify unsuspected cancers at a stage when early intervention can positively affect the outcome for colorectal, breast, cervical or prostate cancers.

The changes to colorectal cancer screening participation are gradual and may be affected by many factors, including an individual’s knowledge and attitude toward colorectal cancer screening, access to services, as well as seasonal variation and service interruptions.

DID YOU KNOW

Fecal Immunochemical Test (FIT) *is the primary screening test for colorectal cancer for people at average risk of the disease.*

Early Detection of Cancer – Zone Details

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

Early Detection of Cancer	2008	2009	2010	2011	2012	2013	2014	Trend *	2015-16 Target
Provincial	**64%**	**65%**	**67%**	**66%**	**67%**	**68%**	**69%**	**↑**	**70%**
South Zone	60%	66%	68%	64%	63%	70%	69%	↓	70%
Calgary Zone	66%	69%	66%	70%	70%	70%	72%	↑	71%
Central Zone	62%	61%	63%	62%	63%	66%	68%	↑	69%
Edmonton Zone	65%	65%	69%	66%	66%	67%	68%	↑	70%
North Zone	65%	61%	65%	61%	64%	64%	67%	↑	69%

***Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

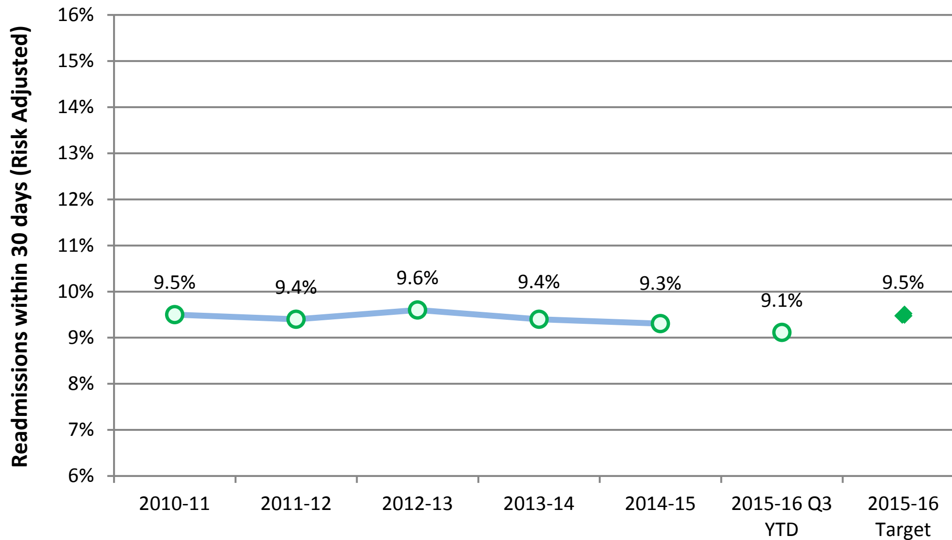
Mental Health Readmissions

Measure Definition

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

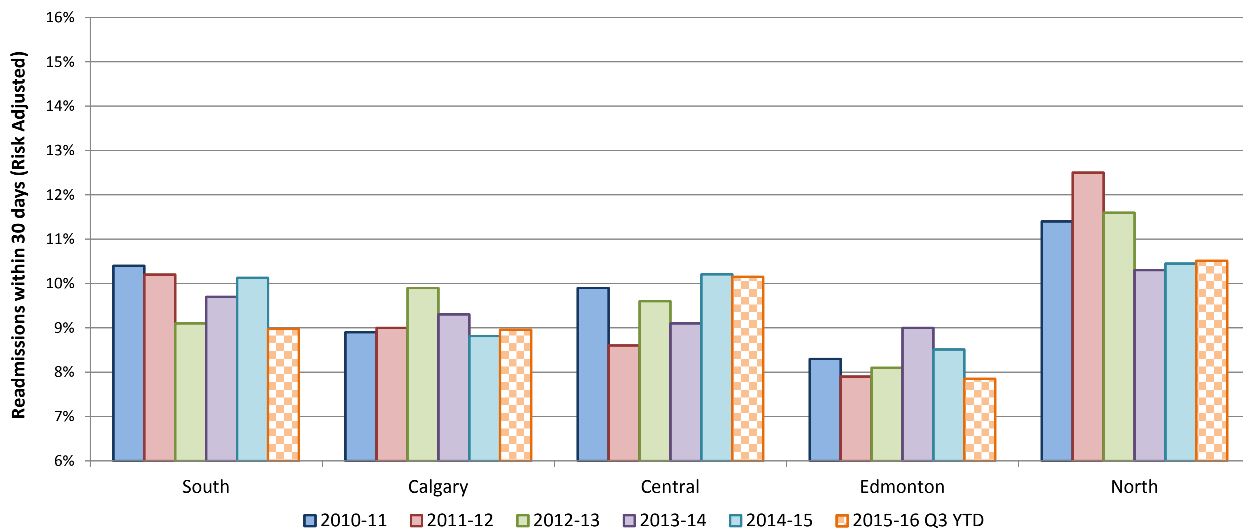
Understanding this Measure

Hospital care for people diagnosed with a mental illness typically aims to stabilize acute symptoms. Once stabilized, the individual can be discharged, and subsequent care and support are ideally provided through primary care, outpatient and community programs in order to prevent relapse or complications. While not all readmissions can be avoided, monitoring readmissions can assist in monitoring of appropriateness of discharge and follow-up care. NOTE: This measure relies on patient follow up after a patient's original discharge date for a period up to 90 days. Therefore reporting results reflect patients discharged in an earlier time period (i.e., Q3 YTD).



How Do We Compare?

Alberta ranked 2nd best nationally out of ten provinces and better than the national rate.



Mental Health Readmissions – Actions

Zone	Actions
Provincial/ Strategic Clinical Network (SCN)	• Community Treatment Orders (CTO's) are utilized to support clients who live in the community and reduce time spent in hospital. CTOs were issued for 337 new clients from April 2015 to December 31, 2015, and 887 individuals actively on CTO as of December 31, 2015.
South	• Developing case management approaches for complex needs patients with Primary Care Networks. • Collaborating with psychiatrists to monitor readmission rates and developing a plan to address higher rates. • Working with police services to embed mental health and addictions workers within departments to improve community support to high risk community clients. • Opened permanent medical detoxification facility and residential treatment program in Medicine Hat.
Calgary	• Patients contacted within seven days of discharge to provide post-discharge support and reinforcement of discharge recommendations. • An evaluation of 30-day readmission rate trends is in progress. Patient characteristics associated with higher risk of readmission are leaving against medical advice (a large proportion are patient elopements), previous psychiatric admissions, and unstable living conditions.
Central	• Discharge Continuity Project continues to link inpatient and community services, and addresses the suicide risk management policy. • Enhanced mental health liaisons to support rural facilities, emergency department (ED), and other agencies continues. • Enhanced discharge planning/transition occurring via Centennial Centre for persons with Development Disabilities continues. • Advocated for additional supports and partner with Child and Family Services for community living.
Edmonton	• Consolidated and expanded existing community addiction and mental health services into new outpatient clinic in Leduc. • Completed the implementation of the electronic medical record (eClinician), including 98 clinical departments, across 50 sites, with 1,100 staff and physician users. • New Rutherford Health Centre construction began. • Construction underway on the Concurrent Disorders Capable Treatment Continuum Project. This is a SafeCom-funded project at the Royal Alexandra Hospital; adding psychiatric ICU beds, Complex Medical Detox Beds and Safe Observation & Assessment Beds.
North	• Continue implementation of Triple Aim project on High Utilization in Grande Prairie. Local clinical team is collaborating with Corrections to enhance discharge planning to the community. • Readmission chart audits being completed to identify opportunities for improvement in high volume readmission communities. • Aboriginal Mental Health Travel Team engagement in Area 8 initiated with Addiction and Mental Health leadership to assess needs and gaps.

IN SUMMARY

Q3 results have remained stable or shown improvement compared to the same period last year for provincial and four zones. Provincial and four zones have achieved 2015-16 target.

DID YOU KNOW

Community Treatment Orders (CTOs) *are an important tool to supporting individuals with serious and persistent mental health illness stay in the community. A treatment and care plan is set up, outlining service providers and supports required for the client to stay well in the community.*

Mental Health Readmissions – Zone Details

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

Mental Health Readmissions within 30 days (Risk Adjusted)	2012-13	2013-14	2014-15	Q3 YTD		Trend *	2015-16 Target
				2014-15 Last Year	2015-16 Current		
Provincial	**9.6%**	**9.4%**	**9.3%**	**9.3%**	**9.1%**	**↑**	**9.5%**
South Zone	9.1%	9.7%	10.4%	10.1%	9.0%	↑	9.1%
Calgary Zone	9.9%	9.3%	8.9%	8.8%	9.0%	↓	9.8%
Central Zone	9.6%	9.1%	9.9%	10.2%	10.1%	↑	9.6%
Edmonton Zone	8.1%	9.0%	8.5%	8.5%	7.9%	↑	8.1%
North Zone	11.6%	10.3%	10.2%	10.5%	10.5%	→	11.0%

***Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

Mental Health Discharges (Index)*	2012-13	2013-14	2014-15	Q3 YTD	
				2014-15 Last Year	2015-16 Current
Provincial	**12,780**	**13,508**	**13,917**	**10,366**	**10,922**
South Zone	1,509	1,507	1,488	1,137	1,107
Calgary Zone	4,340	4,753	5,122	3,786	4,009
Central Zone	1,539	1,483	1,628	1,224	1,435
Edmonton Zone	3,292	3,444	3,410	2,518	2,623
North Zone	2,100	2,321	2,269	1,701	1,748

* Total number of hospital stays for select Mental Health diagnoses.

Surgical Readmissions

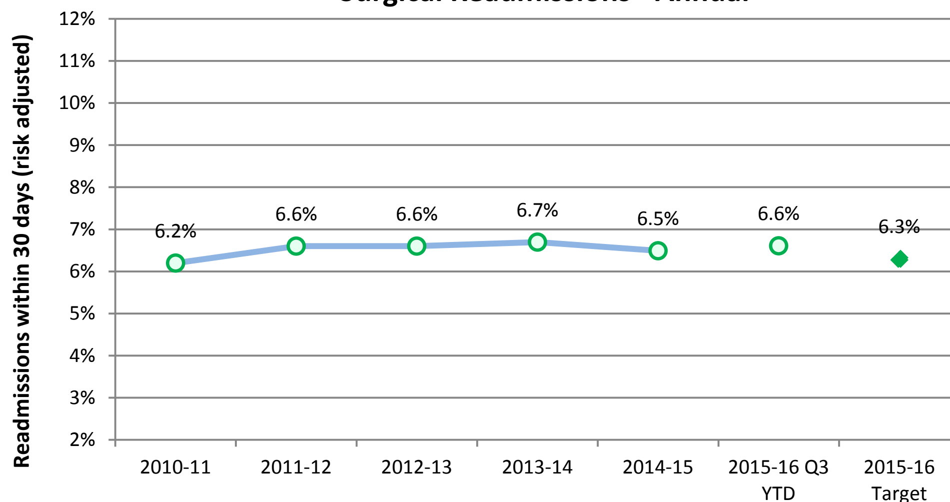
Measure Definition

The percentage of surgical patients with unplanned readmission to hospital within 30 days of leaving the hospital. Excludes surgical patients who require scheduled follow up care.

Understanding this Measure

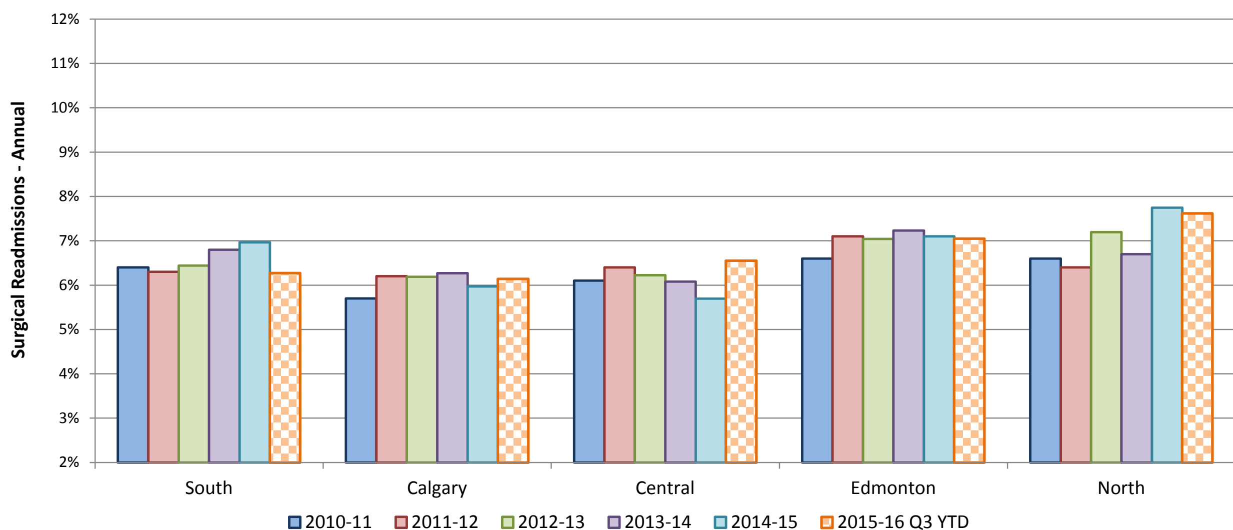
Unplanned readmissions to hospitals are used to measure quality of surgical care and follow-up. Readmission rates are also influenced by a variety of other factors, including the effectiveness of the care transition to the community.

NOTE: This measure relies on patient follow up after a patient's original discharge date for a period up to 90 days. Therefore reporting results reflect patients discharged in an earlier time period (i.e., Q3 YTD).



How Do We Compare?

Alberta ranked 5th best nationally out of ten provinces and the same as the national rate.



Surgical Readmissions – Actions

Zone	Actions
Provincial/ Strategic Clinical Network (SCN)	• Business case approved for spread of Enhanced Recovery After Surgery (ERAS) protocols to three other centers in Alberta and 10 more pathways. Compliance with the protocol has increased at all sites from 63 per cent in 2014-15 to 73 per cent in 2015-16. ERAS protocol for colorectal surgeries were implemented in six sites in Calgary and Edmonton. • National Surgery Quality Improvement Project (NSQIP) underway in five sites across Alberta. This program is supported by the Surgery SCN. • Sustain, spread and optimize Adult Coding Access Targets for Surgery (aCATS). This program is also supported by the Surgery SCN.
South	• Implementation of NSQIP to improve surgical and trauma care by using clinical data to understand performance. • Preliminary work on aCATs is underway with some targeted areas receiving introductory education and support.
Calgary	• ERAS pathway implemented for colorectal surgery at Peter Lougheed Centre and Foothills Medical Centre (FMC). • Implementation of NSQIP pilot project at Rockyview General Hospital is underway. • Data collection for Trauma Quality Improvement Program (TQIP) at FMC has started with the first report due in June 2016. • Head and Neck surgical pathway was implemented at FMC to reduce length of stay, including intensive care unit high observation guidelines.
Central	• Red Deer Regional Hospital Centre (RDRHC) NSQIP team developed a dashboard highlighting surgical care for quality initiatives. The team is focusing on venous thromboembolism prophylaxis, pain management, early removal of Foley catheters and transfusion rates. • Safe Surgical Checklist for surgical sites continues to have an overall compliance rate of greater than 95%. • aCATS has been implemented in all surgical sites. • Standardized order sets for specific surgical procedures have been developed with new ones being initiated.
Edmonton	• Engagement of surgeons and utilization of aCATS tool for waitlist management is ongoing, including sharing and reviewing of data. • Implemented restorative care activities for fractured hip patients to support improved readiness for discharge. • Implemented a new process for moving hip patients to surgical site when identified as surgical to reduce length of time to the operating room.
North	• Continuing to monitor safe surgery checklist compliance. • Surgical chart audits ongoing to identify root cause of readmissions.

IN SUMMARY

The Q3 provincial results have shown deterioration from last year. Three zones remained stable or showed an improvement from last year.

AHS is committed to working with its Strategic Clinical Networks to ensure quality of surgical care and follow-up. Reducing the frequency with which patients return to the hospital can both improve care and lower costs.

DID YOU KNOW

National Surgery Quality Improvement Project (NSQIP) *uses clinical data to measure and improve performance thereby reducing the rate of preventable surgical complications.* ***Trauma Quality Improvement Program (TQIP)*** *works to enhance the quality of care for trauma patients.*

Adult Coding Access Targets for Surgery (aCATS) *helps deliver exceptional surgical care in a safe and timely manner. It is a standardized diagnosis-based system to help prioritize surgeries offered throughout the province.*

Enhanced Recovery After Surgery (ERAS) *helps patients get back to normal as quickly as possible by providing new and consistent ways of managing care before, during and after surgery.*

Surgical Readmissions – Zone and Site Details

The percentage of surgical patients with unplanned readmission to hospital within 30 days of leaving the hospital. Excludes surgical patients who require scheduled follow up care.

Surgical Readmissions within 30 days (Risk Adjusted)	2012-13	2013-14	2014-15	Q3 YTD		Trend *	2015-16 Target
				2014-15 Last Year	2015-16 Current		
Provincial	**6.6%**	**6.7%**	**6.5%**	**6.5%**	**6.6%**	**↓**	**6.3%**
South Zone Total	**6.4%**	**6.8%**	**6.8%**	**7.0%**	**6.3%**	**↑**	**6.2%**
Chinook Regional Hospital	6.9%	6.7%	7.8%	8.2%	5.9%	↑	6.7%
Medicine Hat Regional Hospital	5.5%	7.2%	5.1%	5.0%	6.8%	↓	5.4%
All Other Hospitals	7.8%	4.9%	5.9%	6.9%	8.7%	↓	7.3%
Calgary Zone Total	**6.2%**	**6.3%**	**6.0%**	**6.0%**	**6.1%**	**↓**	**6.1%**
Foothills Medical Centre	6.6%	6.8%	6.1%	6.1%	6.4%	↓	6.4%
Peter Lougheed Centre	6.0%	5.6%	6.0%	5.9%	6.2%	↓	5.9%
Rockyview General Hospital	6.2%	6.2%	6.2%	6.1%	5.9%	↑	6.1%
South Health Campus	N/A	6.8%	5.9%	6.1%	6.5%	↓	6.1%
All Other Hospitals	1.4%	2.5%	1.6%	2.1%	1.8%	↑	1.7%
Central Zone Total	**6.2%**	**6.1%**	**5.6%**	**5.7%**	**6.6%**	**↓**	**6.1%**
Red Deer Regional Hospital Centre	6.1%	6.1%	5.9%	5.9%	6.7%	↓	6.0%
All Other Hospitals	6.6%	6.0%	4.6%	5.0%	6.1%	↓	6.4%
Edmonton Zone Total	**7.0%**	**7.2%**	**7.0%**	**7.1%**	**7.1%**	**→**	**6.5%**
Grey Nuns Community Hospital	6.5%	5.9%	5.8%	6.0%	6.6%	↓	6.2%
Misericordia Community Hospital	6.2%	6.9%	7.3%	7.1%	6.5%	↑	6.0%
Royal Alexandra Hospital	7.5%	7.5%	7.0%	7.2%	6.9%	↑	7.0%
Sturgeon Community Hospital	5.0%	5.5%	5.9%	6.1%	5.9%	↑	5.0%
University of Alberta Hospital	7.7%	8.2%	7.7%	7.7%	8.0%	↓	7.1%
All Other Hospitals	4.7%	4.1%	4.7%	5.7%	4.8%	↑	4.5%
North Zone Total	**7.2%**	**6.7%**	**7.5%**	**7.7%**	**7.6%**	**↑**	**6.7%**
Northern Lights Regional Health Centre	8.3%	6.5%	7.6%	7.9%	7.0%	↑	7.6%
Queen Elizabeth II Hospital	6.8%	7.2%	7.8%	8.0%	7.9%	↑	6.6%
All Other Hospitals	7.0%	6.0%	7.0%	7.2%	7.6%	↓	6.8%

N/A indicates statistically unreliable rates due to low volumes
***Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

Eligible Surgical Cases (Index)*	2012-13	2013-14	2014-15	Q3 YTD	
				2014-15 Last Year	2015-16 Current
Provincial	**89,090**	**90,811**	**92,530**	**69,189**	**69,557**
South Zone	5,522	5,471	5,432	4,076	4,060
Calgary Zone	35,301	36,315	37,846	28,263	29,060
Central Zone	7,640	7,784	7,859	5,809	5,907
Edmonton Zone	35,774	36,295	36,672	27,495	27,043
North Zone	4,853	4,946	4,721	3,546	3,487

*Total number of hospital stays for surgery for eligible conditions. Transfers are excluded.

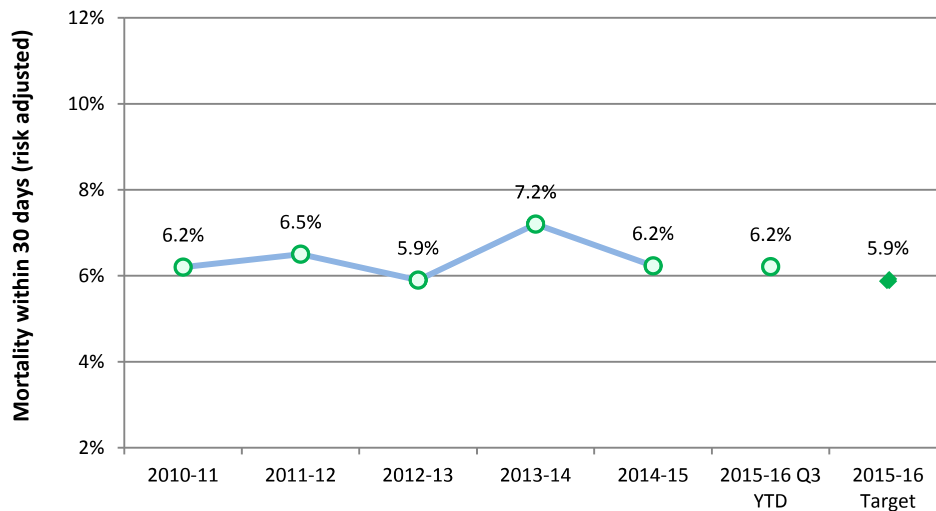
Heart Attack Mortality

Measure Definition

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

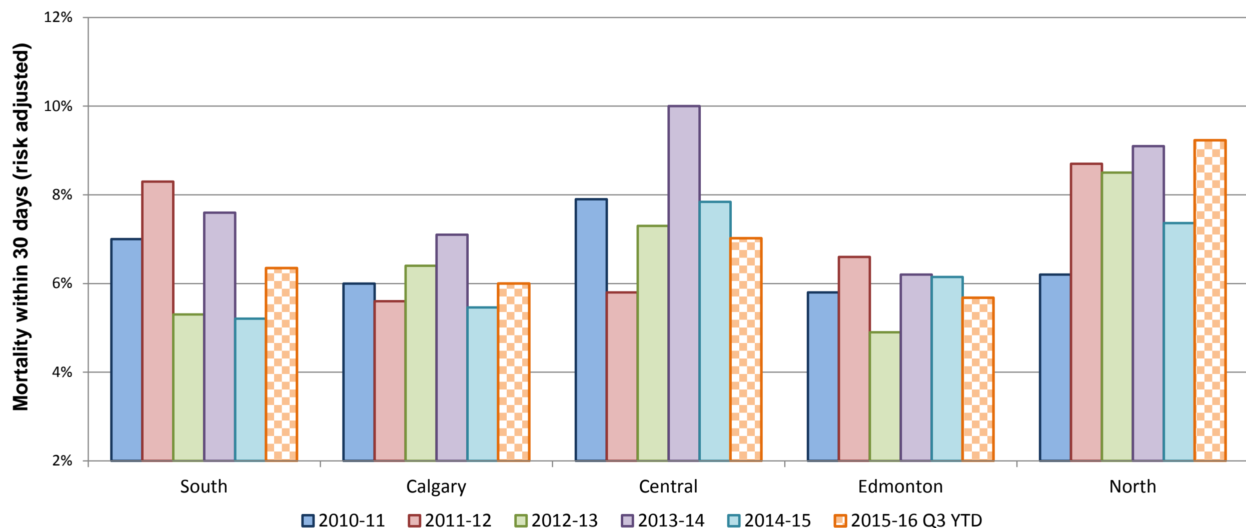
Understanding this Measure

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. NOTE: This measure relies on patient follow up after a patient's original discharge date for a period up to 90 days. Therefore reporting results reflect patients discharged in an earlier time period (i.e., Q3 YTD).



How Do We Compare?

Alberta ranked 4th best nationally out of ten provinces and the same as the national rate.



Heart Attack Mortality – Actions

Zone	Actions
Provincial/ Strategic Clinical Network (SCN)	• Provincial implementation of ST-segment elevation myocardial infarction (STEMI) standardized orders sets with Cardiovascular Health and Stroke SCN. • Sites have specific plans to address heart attack mortality including public education and awareness about the signs of a heart attack, ensuring that standard clinical pathways and medication administration guidelines are in place at all sites, and training rural ED registered nursing staff to the current Heart and Stroke ACLS (Advanced Cardiac Life Support) standards.
South	• Monitor and evaluate implementation of best practice guideline for NSTEMI.
Calgary	• Ongoing implementation of best practice guidelines and protocols and monitoring cardiac outcomes. • Completed the Cardiac Services Review in conjunction with the Cardiovascular Health and Stroke SCN. • Ongoing efforts in cardiac sciences care pathways and monitoring of the mortality rates continue.
Central	• Worked with the Cardiovascular Health and Stroke SCN to develop a provincial dashboard to track mortality metrics in a more effective and accurate way.
Edmonton	• ED STEMI is being prepared for roll out in Q1 2016-17. • 192 patients have been enrolled in the REMCON STEMI research study; recruitment of patients to the study will continue. • Ongoing education related to STEMI care was provided to over 450 individuals bringing the year-to-date total to 588 students and staff through a mixture of class lectures and two multi-zone symposiums. • Supporting EMS learning and development teams to deliver face-to-face simulation style education sessions with front-line staff to reinforce STEMI diagnosis and care pathway is ongoing.
North	• Survey circulated to assess utilization of chest pain high risk stratification scoring tools.

IN SUMMARY

Compared to the same period last year, two zones have demonstrated improvement. Two zones have also achieved 2015-16 target.

Every day at AHS, cardiologists and EMS work collaboratively to diagnose patients who are in transit to the hospital. They can jump into action immediately upon the patient's arrival to the ED to initiate an appropriate treatment plan.

The decline in heart attack mortality rates is attributed to medical advances, new pharmaceuticals, and reductions in major risk factors, such as a decline in tobacco use.

DID YOU KNOW

NSTEMI (Non–ST-segment elevation myocardial infarction) *occurs by developing a complete blockage of a minor coronary artery or a partial blockage of a major coronary artery previously affected by atherosclerosis.*

STEMI (ST-segment elevation myocardial infarction) *occurs by developing a complete blockage of a major coronary artery previously affected by atherosclerosis.*

NSTEMI and STEMI are both commonly known as heart attack.

Heart Attack Mortality – Zone Details

The probability of dying in hospital within 30 days of being admitted for a heart attack. AHS is performing at the same level as the national average of 7.1%.This measure represents hospital deaths occurring within 30 days of first admission to a hospital with a diagnosis of acute myocardial infarction (AMI), often called a heart attack. This measure is risk adjusted for age, sex and other conditions.

Heart Attack (AMI) Mortality within 30 days	2012-13	2013-14	2014-15	Q3 YTD		Trend *	2015-16 Target
				2014-15 Last Year	2015-16 Current		
Provincial	**5.9%**	**7.2%**	**6.2%**	**6.1%**	**6.2%**	**↓**	**5.9%**
South Zone	5.3%	7.6%	6.4%	5.2%	6.4%	↓	5.3%
Calgary Zone	6.4%	7.1%	4.9%	5.5%	6.0%	↓	6.3%
Central Zone	7.3%	10.0%	7.2%	7.8%	7.0%	↑	7.1%
Edmonton Zone	4.9%	6.2%	6.8%	6.1%	5.7%	↑	4.9%
North Zone	8.5%	9.1%	7.2%	7.4%	9.2%	↓	8.2%

Note: Risk adjusted rate of in-hospital death within 30 days for first admission to hospital for a heart attack diagnosis.
* **Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

Heart Attack Cases (Index)*	2012-13	2013-14	2014-15	Q3 YTD	
				2014-15 Last Year	2015-16 Current
Provincial	**5,337**	**5,475**	**5,408**	**4,117**	**4,044**
South Zone	360	320	315	241	218
Calgary Zone	1,794	1,951	1,876	1,417	1,418
Central Zone	542	509	544	398	378
Edmonton Zone	2,283	2,334	2,304	1,774	1,761
North Zone	356	361	369	287	269

*Total number of hospital stays where a first heart attack was diagnosed.

Stroke Mortality

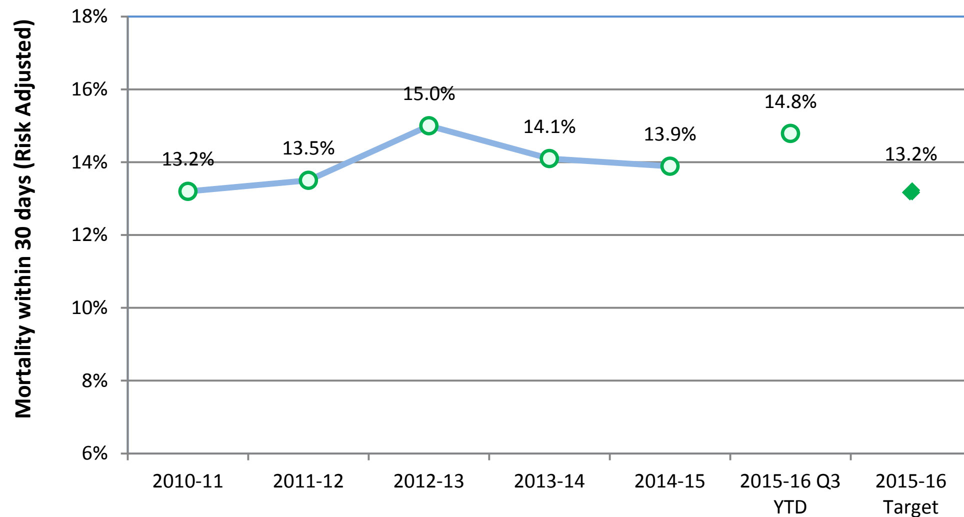
Measure Definition

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

Understanding this Measure

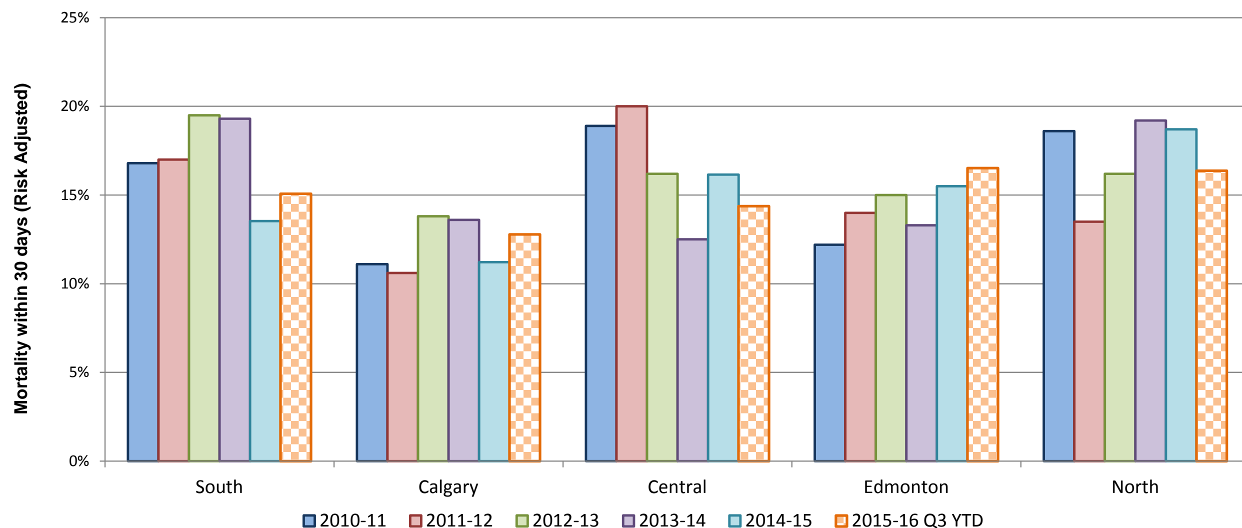
Stroke is a significant cause of death and disability in the Canadian population. This rate may be influenced by a number of factors, including effectiveness of emergency treatments and quality of care in hospitals.

NOTE: This measure relies on patient follow up after a patient's original discharge date for a period up to 90 days. Therefore reporting results reflect patients discharged in an earlier time period (i.e., Q3 YTD).



How Do We Compare?

Alberta ranked 4th best nationally out of ten provinces, and the same as the national rate.



Stroke Mortality – Actions

Zone	Actions
Provincial/ Strategic Clinical Network (SCN)	• The Cardiovascular Health & Stroke SCN's Stroke Unit Equivalent Care project is based on a multidisciplinary model of care that has been proven to prevent death and disability. This project has been transferred to clinical operations. • Redesign aspects of the provincial stroke system of care to improve access to endovascular therapy. • The Door-to-Needle (DTN) quality improvement initiative, currently underway, aims to improve stroke outcomes through rapid clinical and imaging evaluation and treatment with anticoagulation therapy. • Across Alberta, 17 hospitals are participating in QuICR. • The new Stroke Ambulance treats patients from centres with thrombolysis by having a portable CT scanner in an ambulance, with qualified staff able to diagnose and treat, and able to travel to patients across Northern Alberta on short notice. • Initiatives are also in place to increase the use of standardized stroke order sets to ensure best practices are implemented.
South	• Continued implementation, monitoring, and evaluation of Rural Stroke Action plan: ESD, SUEC and community support of stroke patients. • Continue work with SCN to implement best practices in stroke care.
Calgary	• Continued improvement in DTN times for tPA for acute stroke; and a reduction in median DTN times. • Incorporate quality review of Alberta stroke strategy guidelines in the action plan including SUEC at primary stroke centres. • Significant increase in access to endovascular therapy for patients at Foothills Medical Centre.
Central	• DTN times for tPA administration in suitable stroke candidates continues to show marked improvement through the QuICR study with several times under 30 minutes. • Standardized education and process review of Hyperacute Stroke Algorithms was delivered via tele-education to other Primary Stroke Centers and urban facilities. • Interdisciplinary stroke rounds continue to support improved communication of patient status at Red Deer Regional Hospital Centre (RDRHC). • Stroke Early Supportive Discharge Program continues at RDRHC. • Stroke Rehab services continue at RDRHC and Two Hills, as well as Primary Stroke Centers' services in Wainwright, Lloydminster and Camrose.
Edmonton	• Completed TIA (Transient Ischemic Attack) urgent imaging order sets and process maps for evaluation. • Stroke Clinic Triage process changed to allow registered nurses to triage rather than waiting for the fellow or physician. This allows for patients to be triaged and booked into clinic on the same day. • Stroke database established at all stroke sites.
North	• Continue to reinforce use of stroke order sets at all sites. • All primary stroke sites are continuing to make improvements through QuICR. There were 50 tPA administrations in 2015 – up from 33 in 2014.

IN SUMMARY

Two zones have shown an improvement in Q3 year to date compared to the same time as last year.

AHS aims to reduce median door-to-needle (DTN) time—the total time from when a patient enters the emergency room, is given a stroke diagnosis, and receives tPA—to 60 minutes or less. Administering the clot-busting drug tPA within 60 minutes of a stroke has shown to reduce mortality, reduce treatment complications, lessen disabilities and shorten inpatient hospital stays.

DID YOU KNOW

*The **Stroke Action Plan** addresses the quality of and access to stroke care in rural and small urban stroke centres across Alberta.*

***Endovascular therapy** is a stroke treatment that removes the large stroke-causing clots from the brain, and substantially improves the chance for a better outcome for patients.*

***Quality Improvement & Clinical Research (QuICR),** Alberta Stroke Program, aims to improve stroke outcomes through rapid diagnosis and treatment. The faster patients are treated, the greater the probability for improved functional health outcomes.*

Stroke Mortality – Zone Details

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

Stroke Mortality within 30 days	2012-13	2013-14	2014-15	Q3 YTD		Trend *	2015-16 Target
				2014-15 Last Year	2015-16 Current		
Provincial	**15.0%**	**14.1%**	**13.9%**	**14.0%**	**14.8%**	**↓**	**13.2%**
South Zone	19.5%	19.3%	12.5%	13.5%	15.1%	↓	14.8%
Calgary Zone	13.8%	13.6%	11.7%	11.2%	12.8%	↓	12.3%
Central Zone	16.2%	12.5%	16.3%	16.2%	14.4%	↑	14.3%
Edmonton Zone	15.0%	13.3%	14.7%	15.5%	16.5%	↓	13.3%
North Zone	16.2%	19.2%	20.3%	18.7%	16.4%	↑	14.5%

***Trend:** ↑ Improvement → Stability ↓ Area requires additional focus

Stroke Cases (Index)*	2012-13	2013-14	2014-15	Q3 YTD	
				2014-15 Last Year	2015-16 Current
Provincial	**3,329**	**3,316**	**3,568**	**2,706**	**2,732**
South Zone	198	242	285	219	190
Calgary Zone	1,313	1,251	1,311	995	1,017
Central Zone	314	299	326	238	267
Edmonton Zone	1,265	1,305	1,410	1,082	1,098
North Zone	239	219	236	172	160

*Total number of hospital stays where a first stroke was diagnosed.