2022-2025 AHS Public Performance Measure Definitions

Prepared May 31, 2023

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ED WAIT TIME TO SEE A DOCTOR (90TH PERCENTILE IN THE 16 LARGEST SITES)

Definition:	This measure represents the length of time (in hours) that 90% patients wait to see an emergency department physician after being triaged on arrival. Specifically, this measure is the length of time from the earlier of registration or triage time to the time documented for the initial physician assessment.
Rationale:	Patients requiring emergent and urgent treatment should be assessed and treated in a timely fashion. Longer waits may result in poorer patient outcomes or reduced patient satisfaction. This measure is a portion of the overall wait time in the ED that may reflect specific care and process issues to be addressed.
Interpretation:	The 90th percentile wait time presents the amount of time by which 90% of patients have received their initial assessment by a physician. For example, if the 90the percentile value was 1 hour, then 9 out of 10 patients waited 1 hour or less before seeing an ED physician. Multiple factors can influence the indicator results including triage level, patient population and availability of resources. The lower the number the better, as it demonstrates patients are receiving timely assessment and treatment in the emergency department. However, this measure will vary by patient acuity because care is prioritized for patients with the most urgent conditions.
Limitations:	The measure only focuses on emergency departments at the 16 largest hospitals throughout the province. Certain visits (not face-to-face, not physician provider, dead on arrival) are excluded. Hospital data are considered valid for AHS reporting when at least 60% of eligible cases have valid times in the reporting time period. CIHI reports sites when at least 75% of eligible cases have valid times.
Data Sources:	AHS ED Visit Data Repository
Inclusions:	• Top 16 largest sites • Emergency department visits
Exclusions:	• Both registration and triage date/time are unknown, missing or invalid • Visits where physician initial assessment time is missing or invalid • Any visit that is not Face to face visits • Any visit where the most responsible provider services is not a physician • Visits where patient left without triage • Visits where patient left without being seen by a service provider • Visits where patient was dead on arrival (DOA)
Calculation:	Step 1. For each record with valid start and end times, calculate wait time in minutes as: (physician initial assessment time)−minimum (registration time, triage time) Step 2. Calculate summary measure as 90th percentile (in hours).
Benchmarks:	Canadian Institute for Health Information (CIHI)

TOTAL TIME IN ED FOR DISCHARGED PATIENTS (90TH PERCENTILE IN THE 16 LARGEST SITES)

Definition:	The total Emergency Department (ED) time (hours) for discharged patients represents the time interval between the first documented time after a patient arrives at an ED and the time the patient is discharged or transferred from the ED. This measure is typically expressed as the 90th percentile.
Rationale:	ED LOS is used to assess the timeliness of care delivery. Patients that present to an ED should be assessed and treated in a timely fashion. ED LOS for discharged or transferred patients is reported separately from patients who are treated and then admitted to hospital. Due to the relatively lower medical complexity of patients not requiring hospital admission, patients who are treated in an ED and subsequently discharged or transferred will on average have shorter lengths of stay in ED compared to patients who are treated and then admitted to hospital.
Interpretation:	This measure captures the entire time spent in the ED for patients who are treated and then discharged to a place of residence or transferred to another facility, which includes time waiting to be seen by a service provider and time spent receiving services provided in the ED (including diagnostic and treatment). The 90th percentile LOS represents the maximum LOS for 9 out of 10 patients. If the 90th percentile length of stay was 5 hours, then 9 out of 10 patients were treated and discharged within 5 hours or less. The lower the number the better, as it demonstrates patients are receiving timely assessment and treatment in the emergency department.
Limitations:	While the measure is valid for all ED sites and urgent care centers, the performance measure only focuses on top 16 largest ED sites throughout the province.
Data Sources:	AHS ED Visit Data Repository
Inclusions:	• Top 16 largest ED sites • Patients with valid and known registration data/time or triage date/time and valid and known discharge date/time • Patients who were discharged or transferred only.
Exclusions:	• Urgent Care Centres • ED sites other than top 16 sites • Non-admitted ED visit. • Patients leave post registration/triage. • Visits without valid earliest contact time or with latest contact time • Visits calculated time <=0 hours or >7 days • Death at discharge
Calculation:	Step 1. Calculate time patient left ED-minimum (registration time or triage time) Step 2. Calculate summary measure as 90th percentile (in hour)
Benchmarks:	Canadian Institute for Health Information (CIHI)

TOTAL TIME IN ED FOR PATIENTS ADMITTED TO HOSPITAL (90TH PERCENTILE IN THE 16 LARGEST SITES)

Definition:	The total time in Emergency Department (ED) (hours) for patients who visit the ED and were subsequently admitted as an inpatient to the same reporting facility is the total time from the first documented time after arrival at an ED to the time the patient leaves the ED for an inpatient hospital bed. This measure is typically expressed as the 90th percentile.
Rationale:	ED LOS is used to assess the timeliness of care delivery. Patients that present to an ED should be assessed and treated in a timely fashion. ED LOS for admitted patients is reported separately from patients who are treated and then discharged because, due to the relatively higher medical complexity of patients requiring hospital admission and the time required for inpatient admission processes, patients who are treated in an ED and subsequently admitted to hospital will, on average, have longer lengths of stay in ED compared to patients who are treated and then discharged.
Interpretation:	This measure captures the entire time spent in the ED for patients who are subsequently admitted as an inpatient, which includes time waiting to be seen by a service provider in the ED, time spent receiving services provided in the ED (including diagnostic and treatment), and time waiting in ED for inpatient treatment or space. The 90th percentile LOS represents the maximum LOS for 9 out of 10 patients. If the 90th percentile length of stay was 8 hours, then 9 out of 10 patients were treated and admitted within 8 hours or less. The lower the number the better, as it demonstrates patients are receiving timely assessment and treatment in the emergency department, as well as being moved into a hospital bed to receive the right care in the right place.
Limitations:	While the measure is valid for all ED, the performance measure only for top 16 largest sites throughout the province for public reporting
Data Sources:	AHS ED Visit Data Repository
Inclusions:	• Top 16 largest ED sites • Patients with valid and known registration data/time or triage date/time and valid and known time of admission to inpatient. • Patients who were admitted to inpatient.
Exclusions:	• Urgent Care Centres • Small ED sites other than top 16 sites • Patients discharged or transferred. • Patients leave post registration/triage. • Visits without valid earliest contact time or with latest contact time • Visits calculated time <=0 hours or >7 days • Death at discharge
Calculation:	Step 1. Calculate maximum (time patient left ED for inpatient bed or discharge time)-minimum(registration time or triage time) Step 2. Calculate summary measure as 90th percentile (in hour)
Benchmarks:	Canadian Institute for Health Information (CIHI)

EMS RESPONSE TIME FOR THE MOST URGENT CALLS

Definition:	Response Time is the time (minutes) elapsed from when a 911 call is received at an EMS dispatch centre until the first ambulance arrives on scene. AHS EMS Dispatch uses the Medical Priority Dispatch System (MPDS) to categorize calls according to the severity of the patient's condition and to dispatch the appropriate emergency medical aid. Calls are triaged into order of increasing urgency: Alpha (lowest urgency), Bravo, Charlie, Delta, and Echo (highest urgency). Response time is calculated based on events thought to be life threatening at the time of the 911 call and includes Delta and Echo events. These events are a subset of the total number of Emergency Events. This measure is expressed as a 90th percentile response time. The measure is reported for four geographical categories (**Metro/Urban, Communities > 3,000, Rural, and Remote**).
Rationale:	This is a measure of the system's responsiveness and ability to provide urgent medical care to patients in the community. Focusing on events that are deemed "life threatening" (i.e., high acuity) at the time of EMS dispatch represents the capability of the system to respond urgently when patients need it most.
Interpretation:	Changes in the response interval are related to sub-processes like dispatch activation interval, unit turn out interval, unit travel time, as well as other system factors relating to unit availability. The 90th percentile is a measure of the response time by which 90% of Delta and Echo calls have been responded to. For example, if the 90th percentile response time is 30 minutes, then 90% of the people triaged into the Delta and Echo urgency have had an ambulance arrive on scene within 30 minutes or less from the time the 911 call was received. The shorter the time the better, as it demonstrates system responsiveness and ability to provide timely medical care to patients in the community.
Limitations:	The measure is limited to Delta and Echo events at the time of the 911 call. The patient's acuity, determined by the practitioner when they arrive on-scene, may be higher or lower than that which was triaged by the 911 call.
Data Sources:	The data for this measure is extracted from the EMS Computer Aided Dispatch (CAD) data.
Inclusions:	• Event level response interval for all 911 generated events with a Delta or Echo determinant categorized by geographical type (Metro/Urban, Communities > 3,000, Rural or Remote).
Exclusions:	• Event level response interval for all 911 generated events with an Alpha, Bravo or Charlie determinant. • Inter-Facility Transfers. • EMS responses with missing timestamps (such as arrive on scene) related to interval calculation are excluded.
Calculation:	The 90th percentile response interval is calculated for all 911 generated Delta and Echo determinant events within a specified geographical type
Benchmarks:	Not available

PERCENTAGE OF EMS EVENTS WITH HOSPITAL TIME LESS THAN 90 MINUTES

Definition:	EMS hospital time is the time (in minutes) elapsed from when an EMS ambulance arrives at the Emergency Department (ED) until that ambulance is available to respond to another call. This measure is reported as the percentage of 911 related EMS transports that have a hospital wait time of 90 minutes or less.
Rationale:	EMS hospital time is a significant portion (≥45% in metro areas) of an ambulance's total time on task. This is a process measure contributing to the EMS system's resource demand.
Interpretation:	Changes in the EMS hospital time can significantly affect resource availability and therefore system capacity. The higher the percentage the better, as it demonstrates EMS teams are spending less time waiting in hospitals and are freed up to respond to other calls. For instance, if the percent of hospital time is 70%, then 70% of the 911 related calls transporting patients to the ED will have ambulances in hospital for 90 minutes or less before being ready to take on another call.
Limitations:	The measure is limited to 911 related events that are transported to the major hospital facilities in the province. Facility list provided below.
Data Sources:	The data for this measure is extracted from the EMS Computer Aided Dispatch (CAD) data.
Inclusions:	• All 911 related events that are transported to the major hospital facilities in the province. Facility list provided below.
Exclusions:	• EMS transports to facilities not on the list below. • Inter-Facility Transfers. • EMS Transports with missing timestamps (transport arrive & unit available) related to interval calculation or destinations not mapped to standard facility names are excluded.
Calculation:	The percentage is calculated by dividing the numerator by the denominator. $$\frac{\text{911 related events transported to the major hospital facilities with a hospital time} \leq 90 \text{ minutes}}{\text{All 911 related events transported to the major hospital facilities}} \times 100\%$$
Benchmarks:	Not available

EMS HOSPITAL TIME (HOURS): 90% OF THE TIME

Definition:	EMS hospital time is the time (hours) elapsed from when an EMS ambulance arrives at the Emergency Department (ED) until that ambulance is available to respond to another call. This measure is reported as the 90th percentile of hospital wait time of 911 related EMS transports.
Rationale:	EMS hospital time is a significant portion (≥45% in metro areas) of an ambulance's total time on task. This is a process measure contributing to the EMS system's resource demand.
Interpretation:	Changes in the EMS hospital time can significantly affect resource availability and therefore system capacity. The 90th percentile is a measure of the maximum time by which 90% of 911 related ambulance transporting patients to the ED have to wait in hospital before being ready to take on another call. For instance, if the 90th percentile of hospital time is 2 hours, then 90% of the 911 related calls transporting patients to the ED will have ambulances in hospital for 2 hours or less before being ready to take on another call. The lower the number the better, as it demonstrates EMS teams are spending less time waiting in hospitals and are freed up to respond to other calls.
Limitations:	The measure is limited to 911 related events that are transported to the major hospital facilities in the province. Facility list provided below.
Data Sources:	The data for this measure is extracted from the EMS Computer Aided Dispatch (CAD) data.
Inclusions:	• All 911 related events that are transported to the major hospital facilities in the province. Facility list provided below.
Exclusions:	• EMS transports to facilities not on the list below. • Inter-Facility Transfers. • EMS Transports with missing timestamps (transport arrive & unit available) related to interval calculation or destinations not mapped to standard facility names are excluded.
Calculation:	Step 1. Calculate the time (hours) elapsed from when an EMS ambulance arrives at the ED until that ambulance is available to respond to another call. Step 2. Calculate the 90TH percentile of the hospital time, the maximum of the hospital time that 90% of those EMS events fall into the time window.
Benchmarks:	Not available

NUMBER OF CASES ON THE SURGICAL WAITLIST IN ADULT SITES

Definition:	The total number of cases booked and waiting for scheduled surgery at an acute care hospital or Charter surgical facility (CSF). Cases must have a valid Alberta Coding Access Targets for Surgery (ACATS) code.
Rationale:	The count of cases reported represents a snapshot of the surgical wait list on the date of reporting. A patient may be counted as more than one case on the wait list, e.g., separately booked cataract eye surgeries. This metric is monitored as one aspect of monitoring if AHS is meeting surgical demand, as the measure may vary with seasonality, across services, provider case management, as well as surgical case capacity. A longer wait list alone may not indicate meeting or not meeting demand. Rather this measure must be considered in conjunction with other factors.
Interpretation:	The lower the number the better, as it demonstrates fewer patients are waiting for scheduled surgery.
Limitations:	Waitlist data only can be tracked back to 2020-21 fiscal year.
Data Sources:	Operating Room Information Systems extracted to Provincial OR data repository. (Picis OR Manager (Calgary), Meditech, Picis OR Manager (Edmonton), VAX, Connect Care
Inclusions:	Cases are included if they are completed in a Main OR at an adult acute care facility or at a chartered surgical facility (CHF).
Exclusions:	Alberta Children Hospital, Stollery Children Hospital are excluded. Exclusions: cases of scheduled C Sections, pregnancy terminations, or self-pay procedures are not included in the count. Cases are not included if they can be completed in a minor procedure space or other space not considered a Main Operating Room. Cases are excluded if they are Emergent (including up to 'Urgent within 3 Days'). Some surgical cases do not have ACATS targets. Case with missing schedule date or completion date are excluded. Cases with invalid data for Wait Status Calculation are excluded.
Calculation:	The count of cases reported represents a snapshot of the surgical wait list on the date of reporting.
Benchmarks:	Not Available

NUMBER OF CASES ON WAITLIST OUTSIDE CLINICALLY RECOMMENDED WAIT TIMES AT ALL ADULT SURGICAL SITES

Definition:	The total number of cases booked and waiting for scheduled surgery where the wait time exceeds the clinical target guideline established in Alberta Coding Access Targets for Surgery (ACATS). Wait time is measured from when the patient is medically and socially ready to proceed with surgery (ready to treat date).
Rationale:	AHS has a goal of reducing the percentage of waiting cases that are outside of the clinically recommended target. To do so will require monitoring on multiple levels of service system and ensuring waitlist management practices are optimized. The percentage is important to monitor independently of the count of cases since a well-managed high-capacity process may be able to deliver additional surgical volume while keeping cases within Clinical Guidelines.
Interpretation:	The lower the number the better, as it demonstrates fewer patients are waiting for scheduled surgery out of clinical guideline time window.
Limitations:	Waitlist data can only be tracked back to 2020-21 fiscal year.
Data Sources:	Operating Room Information Systems extracted to Provincial OR data repository. (Picis OR Manager (Calgary), Meditech, Picis OR Manager (Edmonton), VAX, Connect Care
Inclusions:	Cases are included if they are completed in a Main OR at an adult acute care facility or at a chartered surgical facility.
Exclusions:	Alberta Children Hospital, Stollery Children Hospital are excluded. cases of scheduled C Sections, pregnancy terminations, or self-pay procedures are not included in the count. Cases are not included if they will be completed in a minor procedure space or other space not considered a Main Operating Room. Cases are excluded if they are Emergent (including up to 'Urgent within 3 Days'). Some surgical cases do not have ACATS or pCATS targets. Case with missing schedule date or completion date are excluded. Cases with invalid data for Wait Status Calculation are excluded.
Calculation:	Count of cases booked and waiting for scheduled surgery where the wait time exceeds the ACATS clinical target guideline.
Benchmarks:	Not available

PERCENTAGE OF CASES ON WAITLIST OUTSIDE CLINICALLY RECOMMENDED WAIT TIMES AT ALL ADULT SURGICAL SITES

Definition:	The total number of cases booked and waiting for scheduled surgery where the wait time exceeds the clinical target guideline established in Alberta Coding Access Targets for Surgery (ACATS). Wait time is measured from when the patient is medically and socially ready to proceed with surgery (ready to treat date).
Rationale:	The primary goal of the Alberta Surgery Initiative is to complete surgeries within their clinical target as associated with their assigned ACATS target. The goal is therefore to see this number higher in the long run. However, in the short term, while higher than ideal numbers of cases are exceeding clinical target while waiting, a short-term goal may be to complete a higher percentage of completed cases when Out of Window to ensure those cases waiting longest are attended to.
Interpretation:	The lower the number the better, as it demonstrates fewer patients are waiting longer than clinically recommended timeframes
Limitations:	Waitlist data can only be tracked back to 2020-21 fiscal year.
Data Sources:	Operating Room Information Systems extracted to Provincial OR data repository. (Picis OR Manager (Calgary), Meditech, Picis OR Manager (Edmonton), VAX, Connect Care
Inclusions:	Cases are included if they are completed in a Main OR at an adult acute care facility or at a chartered surgical facility.
Exclusions:	Alberta Children Hospital, Stollery Children Hospital are excluded. cases of scheduled C Sections, pregnancy terminations, or self-pay procedures are not included in the count. Cases are excluded if they are Emergent (including up to 'Urgent within 3 Days'). Cases with invalid data for Wait Status Calculation are excluded. Some surgical cases do not have ACATS or pCATS targets. Case with missing schedule date or completion date are excluded.
Calculation:	Numerator/Denominator expressed as per cent. Numerator: Count of cases booked and waiting for scheduled surgery where the wait time exceeds the ACATS clinical target guideline. Denominator: Count of cases booked and waiting for scheduled surgery with the ACATS clinical target guideline.
Benchmarks:	Not available

PERCENTAGE OF SURGERIES COMPLETED WITHIN CLINICALLY RECOMMENDED WAIT TIMES AT ALL SURGICAL SITES

Definition:	The percentage of completed surgery cases where the wait time was within the Pediatric Coding Access Targets for Surgery (pCATS) or Alberta Coding Access Targets for Surgery (ACATS) clinical target guideline. Wait time is measured from when the patient is medically and socially ready to proceed with surgery (ready to treat date) to the date of surgery.
Rationale:	AHS is committed to ensuring all Albertans receive timely access to surgical services. Performing surgeries within recommended timeframes supports improved health outcomes and patient experience and provides opportunities to ensure operating room time is optimized where possible.
Interpretation:	The higher the percentage the better, as it demonstrates more procedures are being completed within clinically recommended wait times.
Limitations:	As AHS continues to focus on surgical recovery and completing surgeries for those waiting the longest, it is expected that the percentage of surgeries completed within target will deteriorate in the short-term, followed by improvement in the long-term.
Data Sources:	Operating Room Information Systems extracted to Provincial OR data repository. (Picis OR Manager (Calgary), Meditech, Picis OR Manager (Edmonton), VAX, Connect Care
Inclusions:	Cases are included if they are completed in a Main OR at an adult acute care facility or at a chartered surgical facility.
Exclusions:	Cases are excluded if they are Emergent (including up to 'Urgent within 3 Days'). Cases with invalid data for Wait Status Calculation are excluded. Cases of scheduled C Sections, pregnancy terminations, or self-pay procedures are not included in the count. Some surgical cases do not have ACATS or pCATS targets. Case with missing schedule date or completion date are excluded.
Calculation:	Numerator/Denominator expressed as per cent. Numerator: Count of surgical cases which were completed within the pCATS or ACATS clinical target guideline. Denominator: Count of completed scheduled surgical cases with a pCATS or ACATS clinical target guideline.
Benchmarks:	Not available

NUMBER OF HOME CARE CLIENTS SERVED

Definition:	The total number of unique individuals with an active registration in the Home Care Program (HCP).
Rationale:	AHS strives to provide Albertans with care where they want it most: in their homes and communities. By providing home care services that are responsive to changing needs, Albertans are supported to safely manage their own care while reducing reliance on acute and emergency services. Monitoring this measure can help evaluate system capacity and barriers to access and allow the health care system to strategize ways to: • Enhance home care options and access to self-managed care to continue the shift towards home and community care to support Albertans with disabilities and chronic conditions and their caregivers. • Create new continuing care spaces where they are most needed, in an efficient and cost-effective manner.
Interpretation:	Clients receiving home care services (regardless of location of care) are included (home living, day program, non-designated supportive living, designated supportive living, long-term care, hospital, etc.). Clients are counted once regardless of the number of services the client may have received. The higher the number the better, as it demonstrates improvement in home care services capacity.
Limitations:	There are differences between the zones in health administration, service availability, staffing and adoption of electronic documentation that may lead to differences in the measure results.
Data Sources:	• Meditech: South Zone, Central Zone, Edmonton Zone, North Zone • PARIS: Calgary Zone
Inclusions:	Individuals of all age groups are eligible for and receive Home Care Services. Home Care clients with an active registration at least one day during the reporting period.

Exclusions:	• Clients who are discharged prior to the specified reporting period
	• Clients who have a referral, but no case open date are excluded
	• Clients who are served only by Hospital Transition Services in Calgary and Edmonton
	• Clients who are served only by Community Aids to Independent Living
	• Clients who have not yet been discharged but are considered “inactive” or “stale” by the following parameters:
	  ○ Acute Client with no service activity for 6 months
	  ○ End-of-life Client with no service activity for 6 months
	  ○ Rehabilitation Client with no service activity for 6 months
	  ○ Wellness Client with no service activity for 12 months
	  ○ Awaiting Bed of Choice Client with no service activity for 12 months
	  ○ Long-term Supportive Client with no service activity for 6 months
	  ○ Maintenance Client with no service activity for 6 months
	  ○ Short Stay Client with no service activity for 6 months.

Calculation:	Arithmetic sum of the number of unique home care clients considering inclusion and exclusion criteria.
Benchmarks:	Not available

PERCENTAGE OF CLIENTS PLACED IN CONTINUING CARE WITHIN 30 DAYS

Definition:	The percentage of clients admitted to a Continuing Care Living Option (i.e., designated supportive living levels 3, 4, and 4-dementia or long-term care) within 30 days of the assessed and approved date. The assessed and approved date refers to the date the client is placed on the waitlist for a Continuing Care Living Option following the completion of the assessment and approval process, within the same zone.
Rationale:	Timely and appropriate access to a Continuing Care Living Option is a hallmark of a well-coordinated healthcare delivery system. By improving access to a few key areas, AHS will be able to improve flow throughout the system, provide more appropriate care, decrease wait times and deliver care in a more cost-effective manner. Timely placement can reduce stress and burden on clients and family members. AHS wants to offer seniors and persons with disabilities more options for quality accommodations that suit their service needs and lifestyle.
Interpretation:	This measure monitors the percentage of people who are quickly moved from hospitals and communities into community-based continuing care. The higher the percentage the better, as it demonstrates capacity is available for long-term care or designated supportive living (levels 3, 4, and 4-dementia).
Limitations:	Wait time excludes days when a client was unavailable for placement due to medical reasons.
Data Sources:	Meditech and Stratahealth Pathways
Inclusions:	Clients who were assessed and approved for a Continuing Care Living Option (designated supportive living levels 3, 4, and 4-dementia or long-term care) and who were admitted during the reporting period.
Exclusions:	• Clients who transferred from Continuing Care Living Option to another Continuing Care Living Option. • Clients assessed and approved, but not yet admitted during the reporting period. • Clients in the process of being approved for Continuing Care Living Options. • Clients admitted to another zone from the reporting zone. This is to avoid double counting. • Clients referred for home care services (including designated supportive living levels 1 and 2). • Clients admitted to a sub-acute unit or a rehabilitation unit. • Clients admitted to a hospice or palliative care unit. • Clients admitted to an acute care bed/service from another acute care bed/service (e.g., surgical bed to a medical bed). • Clients transferred to a non-tertiary acute care hospital bed (e.g., repatriated to a community hospital).
Calculation:	The number of clients placed within 30 days of being assessed and approved (numerator), divided by the total number of clients placed during the reporting period (denominator), expressed as a percentage.
Benchmarks:	Not available

PERCENTAGE OF POSTINGS OPEN GREATER THAN 90 DAYS FOR STAFF POSITION

Definition:	The percentage of postings open greater than 90 days. This measure is also known as the 90 Day Rate.
Rationale:	On average, within AHS it takes 60-65 days to fill a posting. AHS actively hires into vacant positions across the organization to ensure the best outcomes and experience for Albertans seeking care. Postings open longer than 3 months or 90 days are taking longer than average to fill and can indicate recruitment challenges. Fewer postings open greater than 90 days suggests teams are operating with the optimal number of people to ensure quality and safety. This measure can help identify positions that are harder to fill or have additional barriers.
Interpretation:	The 90 Day Rate is reported monthly. Posting period is calculated from posting original open date (first day posting opened on the AHS job boards). The posting end date is the most recent close date if the posting closes within the reporting month or month end date if the posting closes after the reporting month end. Re-postings are included in a single count if the posting is greater than 90 days. The lower the percentage the better, as it demonstrates AHS is able to fill more vacant positions in a timely manner.
Limitations:	All data excludes hire/transfer with no posting as these positions are not considered to be recruited. A posting does not represent a position. A posting may be open several times during a month, across months, consecutively, or non-consecutively, or years. For this reason, monthly counts cannot be summed to represent an annual total. Monthly totals represent a distinct count of postings.
Data Sources:	Oracle Taleo, the Human Resources Recruitment System
Inclusions:	Posted external/internal or internal only
Exclusions:	• Hire/Transfer with no posting • Does not include wholly owned subsidiaries of AHS (i.e., Capital Care Group, Carewest, and Alberta Precision Laboratories Ltd) • Does not include Covenant, voluntaries, or foundations.
Calculation:	The distinct count of all postings that are open for longer than 90 days (numerator) is divided by the distinct count of all open postings (denominator)
Benchmarks:	Not available

VACANCY RATE FOR ALL AHS POSITIONS

Definition:	The number of vacant positions as a percentage of total filled and vacant positions.
Rationale:	Albertans expect high-quality care delivered by skilled and compassionate professionals. Vacancy rates help identify areas or positions with the highest staffing needs. This measure supports evidence-based planning to ensure availability of the appropriate health workforce to effectively deliver services.
Interpretation:	Vacancy rate is reported at a point in time (i.e., at end of a month, quarter, or year). A high vacancy rate means that there are jobs available, but they remain unfilled. It can also be a sign of a high demand for personnel, or a low applicant supply in the job market. The lower the rate the better, as it demonstrates AHS is able to fill positions needed to provide and support care to patients and families.
Limitations:	Does not include wholly owned subsidiaries of AHS (i.e., Capital Care Group, Carewest, and Alberta Precision Laboratories Ltd) Does not include Covenant, voluntaries, or foundations.
Data Sources:	ePeople: Position Management
Inclusions:	All employee classes
Exclusions:	• Union: Other (non-AHS employees; e.g., Trusts, Foundations) • Does not include wholly owned subsidiaries of AHS (i.e., Capital Care Group, Carewest, and Alberta Precision Laboratories Ltd) • Does not include Covenant, voluntaries, or foundations.
Calculation:	The distinct count of all vacant positions AHS (numerator) is divided by the distinct count of all filled and vacant positions in AHS (denominator)
Benchmarks:	Not available

CHILD AND YOUTH WAIT TIMES FOR CORE COMMUNITY OUTPATIENT AMH SERVICES (MEDIAN DAYS)

Definition:	Represents the number of days that 50% of individuals with age at 18 or younger having received their first scheduled therapeutic appointment for basic, core mental health outpatient/community treatment services since the date the referral was received.
Rationale:	Providing young Albertans with the care they need in a timely manner is essential to improving health outcomes. Long wait times for AMH outpatient services contributes to overreliance on urgent and emergency care services. This measure helps evaluate system capacity to meet patient demand.
Interpretation:	This measure describes the number of days within which 50% of clients have their first therapeutic appointments scheduled after the time of referral. The lower the number the better, as it demonstrates children and youth are waiting for a shorter time to receive community outpatient AMH services.
Limitations:	Results are more influenced by sites or zones with higher volumes. The data quality is dependent on timely and accurate data entry. Access measures that focus on wait-times do not account for the appropriateness of the intervention provided or the service intensity or duration.
Data Sources:	AHS Addiction and Mental Health (AMH) consolidated repository
Inclusions:	• Patients with age at 18 or younger. • Basic, core services offered in the community including integrated addiction and mental health programs. Outpatient treatment refers to non-residential treatment delivered in community clinics and hospital outpatient settings. • All priority/urgency levels, except crisis services. • Any scheduled therapeutic appointment, regardless of mode of delivery. • All referrals for new clients or clients that are being referred for a new episode of care. • Self-referral and walk-ins that lead to scheduled appointments system delays.
Exclusions:	• Brief intervention including screening and early intervention, referral/transitional service between inpatient and community (e.g., student health program, consultation, liaison, and shared care and diversion services). • Specialized treatment (e.g., day hospital, opioid dependence program, eating disorder programs, non-inpatient forensic programs, Community Extension Team; standalone addiction treatment services). • Rehabilitation (e.g., shared care, vocational rehabilitation). • Urgent and crisis services. • Single session walk-in services where no wait time is expected. • Days when the client was unavailable (i.e., client cancellation). • Clients receiving outpatient services through contracted or funded agencies.
Calculation:	The indicator (median) measures the number of days within which 5 out of 10 clients wait to receive treatment service, with wait time measured as the time between the referral date and the date of earlies scheduled appointment regardless of whether the appointment was attended.
Benchmarks:	Not available

30-DAY HOSPITAL READMISSION RATE FOR AMH ISSUES

Definition:	The percentage of patients (all age groups) receiving treatment in a general hospital or psychiatric hospital for select mental health disorders who have an unplanned readmission to hospital within 30 days of discharge from hospital. This excludes mental health patients requiring planned or scheduled follow-up care. This measure is adjusted for age, sex and risk factors.
Rationale:	Hospital care for mental illnesses aims to stabilize acute symptoms with subsequent care and support being provided through outpatient and community programs. Lower readmission rates suggest appropriate discharge planning and follow-up care in the community. This measure helps evaluate care continuity and appropriateness of services and processes.
Interpretation:	The lower the percentage the better, as it demonstrates fewer patients are being readmitted after discharge and it often reflects consistent and appropriate care during hospitalization that leads to fewer complications or relapses, as well as coordinated and continuous services during and after hospitalization. This measure is reported based on the zone of residence of the patients.
Limitations:	The level of analysis for this measure is the episode of care, which requires the identification of patient transfers within a certain time period. However, there are several non-standardized ways to determine whether a transfer has occurred. Therefore, depending on how a transfer within the episode of care is defined, the readmission rates published elsewhere could differ.
Data Sources:	Discharge Abstract Database (DAD) - AHS Provincial
Inclusions:	• Residents of Alberta • Patients who are readmitted as urgent/emergent for mental health issues within 30 days from the discharge date of their initial mental health care episode in an acute care hospital or psychiatric hospital.
Exclusions:	• Any planned readmissions • Non-Alberta residents • Records with invalid Alberta Personal Health Number, date of birth, admission or discharge date • Patients whose discharge was coded as deceased. • Cadaveric donor or stillbirth or assisted dying records
Calculation:	Number of discharged patients readmitted to the hospital within 30 days of initial discharge (numerator), divided by the total number of patients discharged (denominator), expressed as a percentage. Results are risk-adjusted.
Benchmarks:	Canadian Institute for Health Information (CIHI)

CHILDHOOD IMMUNIZATION RATE AT 2 YEARS

Definition:	The percentage of children who have received the required number of vaccine doses by two years of age for: • Diphtheria/Tetanus/acellular Pertussis, Polio, Hib (DTAP-IPV-Hib) (4 doses) • Measles/Mumps/Rubella (MMR) (1 dose)
Rationale:	A high rate of immunization for a population reduces the incidence of vaccine-preventable childhood diseases and controls outbreaks. Immunizations protect children and adults from a number of preventable diseases, some of which can be fatal or produce permanent disabilities.
Interpretation:	The measure is reported annually in calendar year. The higher the percentage the better, as it demonstrates more children are vaccinated and protected from preventable childhood diseases.
Limitations:	Excludes children who have never come in contact with the health system (i.e., home births).
Data Sources:	AHS Provincial Public Health Surveillance Database
Inclusions:	All children by age 2 (including 2) registered in the health system.
Exclusions:	Children out of the health system and/or living out of Alberta and First Nations communities.
Calculation:	The number of two-year olds administered immunization with required effective doses divided by the mid-year population estimate of two-year olds, expressed as a percentage.
Benchmarks:	Limited comparable data is available.

BREAST CANCER SCREENING PARTICIPATION RATE

Definition:	Percentage of eligible Alberta women, 50-74 years old, who completed at least one screening mammogram within a 30-month period.
Rationale:	Breast cancer is the most common form of cancer in Alberta women other than non-melanoma skin cancer. Approximately 1-in-8 women is expected to develop breast cancer during her lifetime, and 1-in-31 will die from the disease. Breast cancer is most frequently diagnosed among women ages 55-64; the median age at diagnosis is 62 years. Mammography is the recommended method of breast cancer screening for the average risk population. It is the only screening modality shown to reduce breast cancer mortality. It might take some women up to 30 months to be screened due to acceptability, accessibility, promotion of screening and capacity of a screening program.
Interpretation:	The Alberta Breast Cancer Screening Program (ABCSP) is a provincial screening program that uses a population-based approach to planning, coordinating, implementing, monitoring, and evaluating breast cancer screening. The measure is reported annually in fiscal year. The higher the rate the better, as it demonstrates more eligible Albertans are being screened for breast cancer, increasing the chances of early detection which may mean less treatment and less time spent recovering.
Limitations:	• The Alberta Government eliminated health care premiums in 2008, thereby removing the need for people to update personal information to receive insured health services. Since then, some people have moved out of Alberta but their invalid PHNs remain in the population database. This contributes to a slight underestimate in the screening mammogram participation rate. • The Schedule of Medical Benefits was revised on April 1, 2015 to expand the X 27 D fee code from 50-69 to 50-74. Prior to this date, screening mammogram for women 70+ are billed under X 27 E.
Data Sources:	• Alberta Health Care Insurance Plan (AHCIP) Registry File – Demographic • Provincial Cancer Screening (PCS) – ABCSP • Alberta Health Claims data
Inclusions:	• Alberta women aged 50-74 at the index date which is defined as the midpoint in a two-year period.
Exclusions:	• Women with missing or incomplete PHN or date of birth. • Women with an invasive breast cancer before the 30-month period (In situ cancers are not excluded). • Women with only breast cancer diagnostic services during the 30-month period
Calculation:	Dividing the total number of Alberta screen-eligible women, 50-74 years old, who have completed at least one mammogram in each 30-month period (numerator) by the total number of Alberta screen-eligible women, 50-74 years old, in the same two-year period (denominator), expressed as the percentage.
Benchmarks:	Canadian Partnership Against Cancer

CERVICAL CANCER SCREENING PARTICIPATION RATE

Definition:	Percentage of Alberta screen-eligible women, 25-69 years old, who completed at least one screening Pap test within a three-year period (42-month).
Rationale:	Cervical cancer accounts for 1.3% of all new female cancers and 1.1% of all female cancer deaths. Approximately 1 out of 123 women is expected to develop cervical cancer during her lifetime, and 1 out of 454 will die from the disease. Regular screening and follow-up on abnormal Papanicolaou (Pap) test results, as well as getting the Human Papillomavirus (HPV) vaccine are the best ways to prevent cervical cancer.
Interpretation:	The Alberta Cervical Cancer Screening Program (ACCSP) is a provincial screening program that works to increase the number of women and people with a cervix, aged 25 to 69, who get screened regularly for cervical cancer using Pap tests to check the cells of the cervix for abnormalities. The measure is reported annually in fiscal year. The higher the rate the better, as it demonstrates more eligible Albertans are being screened for cervical cancer, increasing the chances of early detection which may mean less treatment and less time spent recovering.
Limitations:	Some women who are not currently considered eligible for Pap tests are not currently removed from denominator (i.e., data for women with hysterectomy are not completed). This leads to an underestimate in the screening Pap test participation rate.
Data Sources:	• Cervical Cancer Screening database – Screening Pap tests • Alberta Health Care Insurance Plan (AHCIP) Registry File – Demographics • Alberta Cancer Registry Database- Resolved cervical cancers • Provincial Inpatient and Ambulatory Databases– Hysterectomy data • Colposcopy database - colposcopy exams
Inclusions:	• Alberta women aged 25-69 at the midpoint in a three-year period. • Pap tests (SPap and CPap) were identified in ACCSP. • Colposcopy exams were also identified in Colposcopy database
Exclusions:	• Women with a missing or invalid PHN or date of birth. • Women with a cervical cancer (invasive cancer/in-situ cancer) prior to the 42-month reporting period. • Women who had a complete hysterectomy prior to the 42-month reporting period. • Women with “Inactive” of ACCSP Program status prior to the 42-month reporting period.
Calculation:	Dividing the total number of Alberta screen-eligible women, 25-69 years old, who have completed at least one Pap test in each 42-month reporting period (numerator) by the total number of Alberta screen-eligible women, 25-69 years old, in the same three-year period (denominator), expressed as percentage.
Benchmarks:	Canadian Partnership Against Cancer

COLORECTAL CANCER SCREENING PARTICIPATION RATE

Definition:	Percentage of Alberta screen-eligible individuals, 50-74 years old, who had Fecal (Fecal Immunochemical Test (FIT) /Fecal Occult Blood Test (FOBT)) test in past two years and/or sigmoidoscopy/colonoscopy in the past five years.
Rationale:	Colorectal cancer is one of the most diagnosed cancers and is the second most common cause of cancer-related death in men and the third most common in women. Colorectal cancer will account for 11% of all cancer deaths in Canada. Age is the most important risk factor for cancer development. Over half (56%) of colorectal cancer cases are expected to occur in Canadians who fall within the age covered by the screening guidelines (50 to 74 years). 42% of colorectal cancer deaths are expected to occur among Canadians who fall within the age 50 to 74 years. Since 2013, colorectal cancer incidence rates have declined steeply in males (-4.3% per year) and females (-3.4% per year). This decline is likely due in part to increased screening for the disease, which can identify treatable precancerous polyps and reduce cancer incidence.
Interpretation:	The measure is reported annually in fiscal year. The higher the rate the better, as it demonstrates more eligible Albertans are being screened for colorectal cancer, increasing the chances of early detection which may mean less treatment and less time spent recovering.
Limitations:	• Some people have moved out of Alberta, but their invalid PHNs remain in the provincial population database. This might cause population overestimation. • Individuals with a total colectomy prior to the year of interest are not available to be excluded in the screen eligible population. Thus, the denominator is over estimated. • Historical address information is incomplete; therefore, the most recent primary address was selected for reporting, even for historical study periods.
Data Sources:	• Alberta Health Care Insurance Plan (AHCIP) Registry File • Provincial Cancer Screening (PCS) • National Ambulatory Care Reporting System (NACRS), Discharge Abstract Database (DAD), Alberta Health Claims data
Inclusions:	Alberta residents aged 50-74 with valid residence postal code at midpoint in a two-year period.
Exclusions:	• Individuals with a missing or invalid provincial health number. • Individuals with an invasive colorectal cancer prior to the beginning of the target five years.
Calculation:	Calculated by dividing the total number of Alberta screen-eligible individuals, 50-74 years old, who had FT test in past two years and/or sigmoidoscopy/colonoscopy in the past five years (numerator) by the total number of Alberta screen-eligible individuals, 50-74 years old (denominator), and expressed as the percentage.
Benchmarks:	Canadian Partnership Against Cancer

USERS REGISTERED ON MYAHS CONNECT PATIENT PORTAL:

Definition:	This meause is the total number of Connect Care health accounts being accessed via MyAHS Connect. This includes the number of patients with direct access to their own health record and any records that are being accessed via a proxy user.
Rationale:	MyAHS Connect is a patient portal that offers secure online access to a person's AHS record of care, allowing Albertans to be active participants in their care, leading to improved health and wellbeing and supports informed use of healthcare resources. An increase in access to MyAHS Connect will allow more patients to participate in their care journey, interact with their healthcare team and contribute to their Connect Care legal record of care.
Interpretation:	The higher the number the better, as it demonstrates more Albertans have access to the portal and can be more involved in their care and decision making.
Limitations:	This measure depends on Connect Care implementation. Connect Care is being phased in across Alberta between November 2019 and early 2023.
Data Sources:	Connect Care dashboard: MyAHS Connect Patient Experience Dashboard
Inclusions:	Unique active patient users with access to their own account and any records that are being accessed via proxy.
Exclusions:	None
Calculation:	This is a cumulative count of unique portal users.
Benchmarks:	Not Available

NUMBER OF VIRTUAL VISITS (ACUTE, COMMUNITY AND AMBULATORY)

Definition:	This measure records the total number of scheduled and completed video visits. Video visits may include a variety of scenarios, such as patient visits, provider to provider consultations, and patient group education classes. It includes the use of the following technologies: Telehealth, AHS Zoom Enterprise, and MyAHS Connect Video Visits.
Rationale:	Connecting patients and providers through innovation and technology has been steadily increasing over the past several years and accelerated further due to the COVID-19 pandemic (as of 2020). Virtual care during the pandemic has transformed the system, changing the way clinicians deliver care. Patients and providers can now choose between three video visit platforms to leverage how to receive or provide virtual care. This indicator can be used to monitor the current state and uptake of virtual care delivery within AHS (i.e., patient use and growth of innovative models of care), as well as to measure patient access to care.
Interpretation:	The higher the number the better, as it demonstrates higher uptake of video and telephone visits to deliver virtual care and may suggest improved patient access to healthcare.
Limitations:	Video visit utilization is influenced by external factors. For instance pandemic response measures which switched all appointments to virtual, rapidly accelerating the number of video visits in 2020 and 2021. During 2022-23 a new baseline will emerge as the pandemic restrictions become lifted, in-person appointments resume, and video visit utilization begins to stabilize.
Data Sources:	• Connect Care for MyAHS Connect Video Visit utilization, • iScheduler for traditional telehealth utilization, and • AHS Zoom Enterprise for Zoom utilization.
Inclusions:	• All scheduled completed video visits.
Exclusions:	• Cancelled scheduled video visits. • Unscheduled video visits such as Zoom instant meetings and unscheduled video encounters in Connect Care. • Scheduled and unscheduled telephone calls are not included in this count.
Calculation:	This is a count of the number of scheduled and completed video visits using Telehealth, AHS Zoom Enterprise, and MyAHS Connect Video Visit technologies.
Benchmarks:	Not available

VACANCY RATES FOR RURAL/REMOTE STAFF POSITIONS

Definition:	The number of vacant positions in rural and remote areas of Alberta as a percentage of the total filled and vacant positions in rural and remote areas.
Rationale:	All Albertans, regardless of where they live, expect high-quality care delivered by skilled and compassionate professionals. Vacancy rates help identify areas or positions with the highest staffing needs. This measure supports evidence-based planning to ensure availability of the appropriate health workforce to effectively deliver services.
Interpretation:	Vacancy rate is reported at a point in time (i.e., at end of a month, quarter, or year). A high vacancy rate means that there are jobs available, but they remain unfilled. It can also be a sign of a high demand for personnel, or a low applicant supply in the job market. The lower the rate the better, as it demonstrates AHS is able to fill positions needed to provide and support care to patients and families
Limitations:	Does not include wholly owned subsidiaries of AHS (i.e., Capital Care Group, Carewest, and Alberta Precision Laboratories Ltd). Does not include Covenant, voluntaries, or foundations.
Data Sources:	• ePeople: Employee Extract & Termination Report • AHSDRR: Postal Code Translator File (PCTL) Local Geographic Area (LGA) Mapping
Inclusions:	• All employee classes • LGA: Rural and remote geographic areas
Exclusions:	• Union: Other (non-AHS employees, e.g., Trusts, Foundations) • LGA: Urban and metro geographic areas.
Calculation:	The distinct count of all vacant positions in Rural & Remote geographic areas at AHS (numerator) is divided by the distinct count of all filled and vacant positions in Rural & Remote geographic areas in AHS (denominator).
Benchmarks:	Not available

TURNOVER RATES FOR RURAL/REMOTE STAFF POSITIONS

Definition:	The distinct count of employees in rural and remote areas who have left the organization voluntarily. This measure is presented as a percentage of the total distinct count of employees in rural and remote areas within Alberta Health Services.
Rationale:	The turnover (voluntary termination) rate is a metric that measures the percentage of employees leaving a company of their free will. Turnover can be costly to an organization because departing employees frequently need to be replaced. AHS is committed to ensuring staff, physicians, midwives and volunteers have the supports and resources they need to thrive in the workplace. This measure can help identify areas that are experiencing workforce challenges and may be an indicator of workplace satisfaction.
Interpretation:	Turnover rate is reported as an annual metric. Data is annualized for periods less than a full year to aid in interpreting trends over time. An increase in voluntary turnover can point to issues that require organizational attention, such as: a lack of competitiveness in salary, a drop in leadership credibility, poor retention practices or an improved external job market. The lower the rate the better, as it demonstrates strong staff retention which provides continuity of knowledge and patient care, as well as controls expenses and time associated with recruiting and training new employees.
Limitations:	Does not include wholly owned subsidiaries of AHS (i.e., Capital Care Group, Carewest, and Alberta Precision Laboratories Ltd). Does not include Covenant, voluntaries, or foundations.
Data Sources:	• ePeople: Employee Extract & Termination Report • AHSDRR: Postal Code Translator File (PCTL) Local Geographic Area (LGA) Mapping
Inclusions:	• Status: Terminated, Active, leave of absence (LOA) • LGA: Rural and remote geographic areas • Termination Reason Group: Voluntary, Retirement
Exclusions:	• Union: Other (non-AHS employees, e.g., Trusts, Foundations) • Employee Class: Casuals, Students • LGA: Metro and urban geographic areas
Calculation:	Step 1: Distinct count of employees in Rural & Remote areas who voluntarily terminated from AHS over the reporting period (numerator) is divided by the Distinct count of employees in Rural & Remote areas over the reporting period (denominator). Step 2: Step1 results are divided by number of months.
Benchmarks:	Not available

SURGICAL SITE INFECTION RATE (14 LARGE VOLUME ADULT ACUTE CARE SITES)

Definition:	The percentage of surgical cases with infections within 30 days after surgery date in a site. The measure is reported by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP), which is a nationally validated, outcomes-based approach to measure and improve the quality of surgical care.
Rationale:	AHS is committed to delivering high-quality care while ensuring patient safety by reducing preventable harm. Lower rates of surgical site infections contribute to improved health outcomes and lower readmission rates. This measure is an indicator of care quality and supports evidence-based process improvements
Interpretation:	The measure provides an overview of the assessment of quality of care in the surgical service. Together with other the comparative outcome statistics, the measure help guide the user towards areas for process improvement. This measure is lagged by two quarters. The lower the rate the better, as it demonstrates fewer infections are occurring as a result of surgical procedures.
Limitations:	NSQIP abstracted adult patient cases only are a 15-20% sample of all surgical cases at each site. The surgical cases reported are not randomly sampled.
Data Sources:	Data Sources: Patient charted information (source will vary based on charting platform used at each individual site) including Alberta Netcare. NSQIP database
Inclusions:	Top 14 largest adult hospitals Adult patients >=18 years old There are eleven Surgical Specialty Areas available from which hospitals can select cases: General, Vascular, Thoracic, Cardiac, Orthopedics, Obstetrics, Neurosurgery, Urology, Otolaryngology, Plastics, Gynecology
Exclusions:	• The patient is under the age of 18 years. • The patient for the case in question has been assigned with an ASA score of 6 (Brain-dead organ donor). • Cases involving Hyperthermic Intraperitoneal Chemotherapy • Trauma and Abuse Cases:
Calculation:	The total number of surgical cases with infection occurrence in 30 days post-surgery (numerator), divided by the total number of selected surgical cases, expressed as a percentage.
Benchmarks:	Not available

ADULT PATIENT SATISFACTION WITH HOSPITAL EXPERIENCE

Definition:	The percentage of patients rating hospital care as 9 or 10 on a scale from 0-10, where 10 is the best possible rating. The specific statement used for this measure is: "Overall what is your experience with this hospital stay? Please answer on a scale where 0 is I had a very poor experience and 10 is I had a very good experience". The survey is conducted by telephone on a sample of adults who have been discharged from acute care facilities, within six weeks of discharge.
Rationale:	Gathering feedback from individuals using hospital services is a critical part of improving the care and services AHS provides. Effective communication and care coordination is linked to higher patient satisfaction ratings. This measure is an indicator of system performance from the patient's perspective. This measure monitors patients' overall perceptions associated with the hospital where they received care, based on survey ratings, using a scale from 0-10, where 10 is the best possible rating.
Interpretation:	The higher the number the better, as it demonstrates more patients are satisfied with their care in hospital.
Limitations:	Survey administration can result in data errors. Processes are in place to mitigate the potential for errors such as training interviewers to administer the survey consistently according to a prescribed script, monitoring 10% of calls monitored for quality assurance, etc.. This measure is reported a quarter later due to requirements to follow-up with patients after the reporting quarter.
Data Sources:	Canadian Hospital Consumer Assessment of Healthcare Providers and Systems (CHCAHPS) survey responses.
Inclusions:	All valid responses to the specific question for adults aged 18 years and over that were discharged from hospital.
Exclusions:	• Respondents who said "Don't Know" or did not answer the question • Patients under 18 years old • Those who stayed less than 24 hours, died during hospital stay, psychiatric patients, stayed only in emergency department, day surgery or ambulatory procedure, possible miscarriage, possible still birth and baby length of stay greater than six days.
Calculation:	The total number of respondents answering 9 or 10 (numerator), divided by the total number of respondents answering 0-10 (denominator), expressed as a percentage.
Benchmarks:	Canadian Institute for Health Information (CIHI)

RATIO OF ACUTE LENGTH OF STAY TO EXPECTED LENGTH OF STAY IN 14 HIGHEST VOLUME ADULT SITES

Definition:	The ratio of the total number of patient days, excluding alternate level of care (ALC) days, in inpatient acute care hospitals compared to the total acute length of stay that is expected based on factors such as patient age, diagnoses and interventions.
Rationale:	Monitoring this ratio can help healthcare teams ensure care appropriateness and efficiency. Retrospective reviews of this measure can help to identify opportunities for improvement in both areas. This measure gauges how efficiently beds and resources are utilized in the hospital. An improvement in this measure can translate into the ability to treat more patients with existing beds and resources.
Interpretation:	A ratio greater than one indicates the acute length of stay was longer than expected (an overall poorer than expected efficiency). A ratio less than one indicates the acute stay was shorter than expected, potentially representing greater efficiency and indicates that more patients are able to be treated for a given inpatient bed. For ALOS/ELOS ratios above 1, there may be opportunities to safely reduce the acute care stay of patients.
Limitations:	ALOS/ELOS ratios based on small volumes of typical discharges should be used with caution. Generally, there may be increased variation in a measure calculated based on small volumes, therefore, the measure may not accurately reflect health service delivery.
Data Sources:	AHS provincial Discharge Abstract Database (DAD)
Inclusions:	• Typical acute inpatient discharges only • Acute days and subacute days

Exclusions:	• Alternate level of care (ALC) days
	• Atypical cases including any of the following:
	  ○ Deaths
	  ○ Transfers
	  ○ Voluntary sign-outs
	  ○ Long-stay cases

Calculation:	The total number of acute care days for inpatient acute care discharges (numerator), divided by total number of Expected Length of Stay (ELOS) days for inpatient acute care discharges (denominator), expressed as a ratio.
Benchmarks:	Canadian Institute for Health Information (CIHI)