

Measure	Definition	Understanding this Measure
<b>PRIMARY CARE</b>		
<b>Ambulatory Care Sensitive Conditions</b>	Rate of hospital admissions for health conditions that may be prevented or managed more appropriately by a primary health care provider. The conditions included in this measure are angina, asthma, chronic obstructive pulmonary disease (COPD), diabetes, epilepsy, heart failure and pulmonary edema and hypertension. The rate is calculated as the number of admissions for every 100,000 people and is age standardized and annualized to enable comparison over time.	Hospitalization of a person with an ACSC is considered a measure of access to primary health care services. It is assumed that appropriate care could prevent the onset of this type of illness or condition, control an acute illness or condition, or manage a chronic disease or condition, preventing admission to a hospital. A high ACSC rate is presumed to reflect problems in obtaining access to appropriate primary care.
<b>Family Practice Sensitive Conditions</b>	Percent of emergency department or urgent care centre visits for health conditions that may be more appropriately managed at a family physician's office. Examples of these conditions include conjunctivitis and migraines.	Treatment at family physician offices when appropriate allows for proper follow-up and better patient outcomes. The expectation is that more effective provision of primary care services would result in improvement in this measure. Use of emergency department (ED) and urgent care services for these conditions may also result in higher costs and potentially longer patient waits in ED, than when patients visit more appropriate health care providers in the community for their needs.
<b>CONTINUING CARE</b>		
<b>Number of Clients Placed into Continuing Care from Acute/Subacute Hospital</b>	The number of clients placed into continuing care living options from acute/sub-acute care (hospitals) during the reporting period. Continuing care living options include long-term care or designated supportive living (supportive living level 3, 4, and 4-dementia) facilities.	The higher the number, the better, to be interpreted in conjunction with numbers waiting for placement from acute care, as well as impact of ALC (alternate level of care days) within Acute Care settings. As demand remains high, a higher number placed can demonstrate better meeting need for long-term care or designated supportive living space.
<b>Number of Clients Placed into Continuing Care from Community</b>	The number of clients placed in continuing care living options from the community (includes home). Continuing care living options include long-term care or designated supporting living (supportive living level 3, 4, and 4-dementia) facilities.	The higher the number, the better, as it primarily demonstrates capacity meeting need for long-term care or designated supportive living spaces from the Community.
<b>Persons Waiting in Acute/Subacute Hospital Bed for Continuing Care Placement</b>	People waiting in acute/sub-acute (hospital) beds for continuing care placement is a count of the number of persons who have been assessed and approved for placement in continuing care, who are waiting in a hospital acute care or sub-acute bed. The numbers presented are a snapshot on the last day of the reporting period.	Access to continuing care services is in significant demand in Alberta. Alberta Health Services is using multiple strategies to provide both seniors and persons with disabilities more options for quality accommodations specific to their service needs and lifestyles. Moving patients out of hospitals to more appropriate care settings produces better quality of care, reduces acute care pressures and may reduce costs.
<b>Persons Waiting in Community (home) for Continuing Care Placement</b>	People waiting in community for continuing care placement is a count of the number of persons who have been assessed and approved for placement in continuing care, who are waiting in the community. The numbers presented represent a snapshot on the last day of the reporting period.	Access to continuing care services is in significant demand in Alberta. Alberta Health Services is using multiple strategies to provide both seniors and persons with disabilities more options for quality accommodations specific to their service needs and lifestyles.
<b>Average Wait Time in Hospital Bed for Continuing Care Placement</b>	The average number of days a client waited from the time they were assessed and approved (ready to treat) for a living option, to time of admission.	These are wait times for individuals whose last location prior to placement was an acute or sub-acute care (hospital) setting. Wait time can also include time spent in community.
<b>Unique Home Care Clients</b>	This measure is defined as the total number of unique clients who are active registrations or referrals to a Home Care Program during the reporting period. This includes clients in all age groups within former categories of short-term, long-term, and palliative, as well as day programs and supportive living settings. Individuals of all age groups (Pediatrics - 0 to 18; Adults 19 to 64; Seniors 65 and Older) are eligible for, and receive Home Care services.	Access to continuing care services, including home care and other support services, is a major goal of Alberta Health Services to help people remain independent for as long as possible. Providing appropriate care in the community can help reduce emergency room and hospital visits, while providing a cost-effective approach to care and most importantly, improving the lives of those who require community care services and their families. This measure is used to monitor and report on access to home care in Alberta, as indicated by the volume of individual clients who are accessing home care services at a specific point in time or for a specific period of time.

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<b>CANCER WAIT TIMES</b>		
<b>Medical Oncology Access (referral to first consult 90<sup>th</sup> percentile in weeks)</b>	This is the number of days from the date that a referral was received from a physician outside a cancer facility (e.g. family physician or surgeon) to the date that the first consultation with a medical oncologist occurred. The 90 <sup>th</sup> percentile time indicates that 90 per cent of patients receive their first consultation in this time or less.	Medical oncology referrals include those for medical, surgical, and gynecological oncologists where care planning may be for surgery, chemotherapy, and other interventions not including radiation. Alberta Health Services is striving to meet the needs of cancer patients by monitoring timeliness of access to oncology services. Improved access can be attained through capacity and process improvements. We are standardizing and automating triage and referral processes in order to improve how quickly patients are able to access specialized cancer care. Significant increases in capacity have also been made with additional facilities now available across the province.
<b>Radiation Oncology Access (referral to first consult 90<sup>th</sup> percentile in weeks)</b>	This is the number of days from the date that a referral was received from a physician outside a cancer facility (e.g. family physician or surgeon) to the date that the first consultation with a radiation oncologist occurred. The 90 <sup>th</sup> percentile time indicates that 90 per cent of patients receive their first consultation in this time or less.	This indicator helps to measure performance in the consultation process and access to radiation services for patients. Alberta Health Services is striving to meet the needs of cancer patients by monitoring timeliness of access to oncology services. Improvements to the triage and referral process, standardization and automation all work towards improving capacity and outcomes for patients. The addition of new facilities has also increased capacity.
<b>Radiation Therapy Access (ready to treat to first therapy 90<sup>th</sup> percentile in weeks)</b>	This time is measured from the date the patient was physically ready to commence treatment, to the date that the patient received his/her first radiation therapy. 90 per cent of patients receive radiation therapy within this length of time or less (measured from when they are ready to treat).	Timely access to radiation therapy for cancer diagnosis can impact treatment effectiveness and outcomes. Data is reported on patients who receive radiation therapy at the Cross Cancer Institute in Edmonton, the Tom Baker Cancer Centre in Calgary, and the Jack Ady Cancer Centre in Lethbridge. From 2013/14 data for patients from the Central Alberta Cancer Centre is included. The data applies only to patients receiving external beam radiation therapy.
<b>ACUTE CARE</b>		
<b>Acute Care Occupancy (Busiest Sites)</b>	This measure of occupancy is the ratio of inpatients currently in hospital compared to the total hospital beds available, averaged over the reporting period. The measure includes only the Top 16 busiest* hospitals in the province. The measure includes all patients in hospital once registered as an inpatient regardless of location (includes operating room and while waiting in emergency department for instance). Over capacity and closed beds are not included.	Hospital occupancy may be used as a proxy measure of hospital access. A hospital with high occupancy may experience longer times to place patients in a unit location. Large urban and suburban hospitals will typically have higher occupancy than rural facilities.
<b>Acute Length of Hospital Stay to Expected Length of Stay Ratio (ALOS to ELOS Ratio)</b>	The ratio of acute days of patient stay in acute hospital care compared to the expected length of stay for typical patients at all hospitals. The acute (actual) stay for a patient reflects days of hospital stay less any time when the patient is classified as Alternate Level of Care (ALC). This measure enables comparison of acute length of stay in hospital to expected length of stay after adjusting for factors such as patient age, sex, diagnosis and other risk factors. The expected length of stay is based on comparison to similar patients in national databases.	This measure gauges how efficiently beds are utilized and care is delivered in the hospitals in Alberta. An ALOS to ELOS ratio which is below one represents an overall higher 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 resources.
<b>Hospital Acquired Clostridium difficile Infection Rate (per 10,000 patient days)</b>	The number of <i>Clostridium difficile</i> infections ( <i>C-diff</i> ) acquired in hospital every 10,000 patients days. A rate of 4.0 means approx. 100 patients per month acquire <i>C-diff</i> infections in Alberta. <i>C-diff</i> infection cases include patients with a new infection or re-infection while in hospital. Patients are considered to have <i>C-diff</i> if they exhibit symptoms and there is confirmation by a laboratory test or colonoscopy.	Some individuals carry <i>C-diff</i> in their intestines while others may acquire it while in hospital. <i>C-diff</i> is the most frequently identified cause of hospital-acquired diarrhea. This infection complicates and prolongs hospital stays and creates risk for patients. Infections impact resources and costs in the health care system. Monitoring <i>C-diff</i> trends provide important information about effectiveness of infection prevention and control strategies.

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<b>EMERGENCY DEPARTMENT</b>		
<b>Emergency Department Length of Stay (LOS) for Admitted Patients (median time in hours at the Busiest Sites*)</b>	The length of time in the emergency department from the start of visit in the ED until the time they are admitted and leave the ED at the Busiest* emergency departments. This is calculated as the median time which means that 50 percent of patients stay in the emergency department (ED) this length of time or less.	ED patients requiring hospital admission should be admitted to the appropriate inpatient environment in a timely fashion. Total time spent can be a measure of access to the health care system and a reflection of efficient use of resources. As such this measure can reflect performance of the entire system. It is influenced by our ability to manage complex patients in primary care, efficiencies in the 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. Long wait times in ED for admitted patients suggests pressures in acute care bed capacity which is impacted by many factors.
<b>Emergency Department patients treated and admitted to hospital within 8 hours (LOS ≤ 8 hours) (%)</b>	This measures the percentage of patients admitted from Emergency Department (ED) with a total stay of eight hours or less. The total time is from start of patient visit in the ED until they are admitted and leave the ED.	See note above. This measure is reported for the Busiest* emergency departments as well as for All Sites in the province.
<b>Emergency Department Length of Stay (LOS) for Discharged Patients (median time in hours at the Busiest Sites*)</b>	The length of time in the emergency department from the start of visit in the ED until the time they are discharged at the Busiest* emergency departments. This is calculated as the median time which means that 50 percent of patients stay in the emergency department this length of time or less.	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 emergency department before being discharged. Many patients seen in the emergency may not require admission to hospital but may require other treatment during their ED stay. Excessive wait times for care can result in treatment delays. Reasons for variation of length of stay across sites include complexity of patients, capacity limitations, operational efficiency and access to other primary care options (family physicians, walk-in clinics).
<b>Emergency Department patients treated and discharged within 4 hours (LOS ≤ 4 hours) (%)</b>	This measures the percentage of patients discharged from Emergency Department (ED) with a total stay of four hours or less. The total time is from the start of visit in the ED until they are discharged and leave the ED.	See note above. This measure is reported for the Busiest* emergency departments as well as for All Sites in the province.
<b>Emergency Department Time to Physician Initial Assessment (TPIA) (median time in hours at the Busiest Sites*)</b>	The length of time in the emergency department before being seen by a physician at the Busiest* emergency departments. This is calculated as the median time which means that 50 per cent of patients wait this length of time or less to be seen by a physician. This time is measured from the start of visit in the emergency department and when they are first seen by a physician.	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 also ensure people do not leave without being seen. In emergency departments every effort is made to ensure sickest patients are seen in priority.
<b>Emergency Department Patients Left Without Being Seen and Left Against Medical Advice</b>	This measures the percentage of patients who attend an Emergency Department (ED) or Urgent Care Centre (UCC) with the visit ending as “Left Without Being Seen (LWBS)” or “Left Against Medical Advice (LAMA)”. This quantifies the visits which terminated prematurely for any reason. The same methodology is applied at all sites. These visits are identified through their discharge disposition codes which may include various scenarios.	Patients who visit an Emergency Department or Urgent Care Centre then leave for unknown reasons before being seen by an ED/UCC physician or leave prior to the diagnosis or completion of other aspects of care may be at risk and represent utilization of the system without closure. Lengthy wait times in Alberta ED’s can result in higher rates for this measure as patients may be unsure about care or unable to wait this length of time. Where alternative care sites are available, patients may seek care in another location and hence higher rates for this measure may be found in urban centres with multiple Emergency Departments and Urgent Care Centres or other clinical options available. This performance measure can assist in quantifying this patient population for risk and resource impact of ED/UCC services.
<b>SURGERY WAIT TIMES</b>		
<b>Surgical wait times are reported as RTT (Ready to Treat to Treatment)</b>	<b>Ready to Treat to Treatment (RTT)</b> represents the wait time beginning when the patient is ready for surgery and ending on the date the surgery is completed. RTT does not include delays due to patient medical, functional, or social reasons. AHS and national reporting on wait times has shifted to use of RTT as it better represents how long the patient will wait for the service and the steps along the way. DTT (Decision to Treat to Treatment) is no longer reported.	

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<b>Cataract Surgery (90th percentile time in weeks)</b>	This measure represents the time until the cataract surgery was completed. Only scheduled surgeries on the first eye are included. The 90 <sup>th</sup> percentile time indicates that 90 per cent of patients receive their first surgery in this time or less.	Providing reasonable access to health service is a major objective of Alberta Health Services. Longer wait times may affect quality of life and impact clinical outcomes. Cataract surgeries are frequently completed at contract providers. For further comparison of wait times across Canada see CIHI's report on <i>Wait Times for Priority Procedures in Canada, 2015</i> .
<b>Coronary Artery Bypass Graft (CABG) Urgency III – Scheduled (90<sup>th</sup> percentile time in weeks)</b>	This measure represents the wait time for coronary artery bypass graft surgery (CABG). For the RTT measure the start time is when the patient is ready for surgery. The 90 <sup>th</sup> percentile time indicates that 90 per cent of patients receive their first surgery within this time or less. Emergent/urgent cases are not included.	Wait times for surgical procedures are used as an indicator of access to the health care system and reflect availability and the efficient use of resources. Access in combination with a high quality of service delivery will help ensure optimal patient outcomes.  For further comparison of wait times across Canada see CIHI's report on <i>Wait Times for Priority Procedures in Canada, 2015</i> .
<b>Hip Replacement Surgery (90th percentile time in weeks)</b>	This measure represents the time until hip replacement (arthroplasty) surgery was completed. Emergency cases are not included. The 90 <sup>th</sup> percentile time indicates that 90 per cent of patients receive their first surgery in this time or less.	See note above.
<b>Knee Replacement Surgery (90th percentile time in weeks)</b>	This measure represents the time until knee replacement (arthroplasty) surgery was completed. Emergency cases are not included. The 90 <sup>th</sup> percentile time indicates that 90 per cent of patients receive their first surgery in this time or less.	See note above.
<b>Hip Fracture Repair within 48 hours</b>	This measure is the percentage of hip fracture surgeries performed within 48 hours of admission. Cases included are all discharges which had a pre-admission hip fracture recorded and where hip fracture surgery was performed.	There is strong evidence to suggest that hip fracture surgical procedures delayed by more than 48 hours are associated with poorer outcomes, specifically with respect to length of hospital stay, self-reported pain, 30-day mortality and one-year mortality. Measuring the delay to hip fracture surgery provides an opportunity for hospitals to monitor and improve access to this health care service.
<b>MENTAL HEALTH</b>		
<b>Children Scheduling Mental Health Access (% offered appointment with 30 days)</b>	Percentage of children aged 0 – 17 years who are offered an appointment for scheduled community mental health treatment within 30 days of referral. Time is from appointment booking to first offered appointment with a mental health therapist.	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. Monitoring the percentage of children who have symptoms or problems that require attention but are not considered urgent or emergent (scheduled treatment) can help manage and resolve system delays and maintain service capacity, while ensuring that children most in need of treatment receive it immediately.
<b>Children Receiving Mental Health Treatment (% receiving appointment within 30 days)</b>	Percentage of children aged 0 – 17 years who received community mental health treatment within 30 days. Time from appointment booked to face-to-face scheduled assessment with a mental health therapist.	See note above.
<b>HEALTH INFORMATION</b>		
<b>Health Link Service Level</b>	This measures the percentage of calls to Health Link 811 (HLA) that are answered within two minutes.	One of Health Link's goals is to help people make informed decisions about their health situation and about the care that is appropriate for their symptoms. Slow response times could discourage some callers. Historically, callers perceive the wait time as very good to excellent when the service level of "80 per cent of calls answered within 2 minutes" is met.

<b>Busiest Sites :</b>
<b>This group of 16 acute care hospitals are included where indicated for measures of Emergency Department LOS for Admitted Patients, Emergency Department TPIA, and Acute Care Occupancy</b>
<b>South Zone Total</b>
Chinook Regional Hospital
Medicine Hat Regional Hospital
<b>Calgary Zone Total</b>
Alberta Children’s Hospital
Foothills Medical Centre
Peter Lougheed Centre
Rockyview General Hospital
South Health Campus
<b>Central Zone Total</b>
Red Deer Regional Hospital Centre
<b>Edmonton Zone Total</b>
Grey Nuns Community Hospital
Misericordia Community Hospital
Royal Alexandra Hospital
Stollery Children’s Hospital
Sturgeon Community Hospital
University of Alberta Hospital
<b>North Zone Total</b>
Northern Lights Regional Health Centre
Queen Elizabeth II Hospital
<b>This site is also included, along with the above, for a total of 17 sites, for the measure of Emergency Department LOS for Discharged Patients</b>
Edmonton Zone: Northeast Community Health Centre

**Notes:**

Emergency Department (ED) Measures are reported for the Busiest Emergency Departments as well as for All ED sites combined.

Northeast Health Centre in Edmonton Zone is classified as an Emergency Department and therefore is included in the measures for ED where patients are Discharged (median for Busiest Sites and % Discharged within 4 hours).

However, Northeast Health Centre is not included in measures where patients are Admitted from Emergency Department. Since it is a standalone ED with no hospital beds, patients are not admitted to this site. Also, it is not included in the Acute Care Occupancy measure.

Sites designated as Urgent Care Centres are not included in Emergency Department measures.