

Performance Report
2017-2018 Health Plan
Q2 (July 1, 2017-September 30, 2017)

A healthier future. Together.



Prepared by Planning & Performance
January 15, 2018

Table of Contents

Table of Contents 2

Executive Summary 3

 Q2 Measures Dashboard 4

Objective 1: Make the transition from hospital to community-based care options more seamless. 5

Objective 2: Make it easier for patients to move between primary, specialty and hospital care..... 7

Objective 3: Respect, inform, and involve patients and families in their care while in hospital..... 9

Objective 4: Improve access to community and hospital addiction and mental health services for adults, children and families.
..... 11

Objective 5: Improve health outcomes through clinical best practices. 13

Objective 6: Improve the health outcomes of Indigenous people in areas where AHS has influence..... 15

Objective 7: Reduce and prevent incidents of preventable harm to patients in our facilities..... 17

Objective 8: Focus on health promotion and disease and injury prevention. 19

Objective 9: Improve our workforce engagement. 21

Objective 10: Reduce disabling injuries in our workforce. 22

Objective 11: Improve efficiencies through implementation of operational and clinical best practices while maintaining or
improving quality and safety. 24

Objective 12: Integrate clinical information systems to create a single comprehensive patient record. 26

Appendix..... 27

 AHS Performance Measures – Zone and Site Detail 27

Executive Summary

The Alberta Health Services (AHS) 2017-2020 Health Plan and Business Plan provides a roadmap of how AHS will meet its priorities and direction on how it will measure performance through the fiscal year. The quarterly report provides updates on progress.

The 2017-18 quarterly update is designed according to the 12 objectives stated in the 2017-2020 Health Plan and Business Plan. It includes an update on actions and measures from the Action Plan, priorities as stated in Alberta Health's Accountability Letters as well as the 13 AHS Performance Measures. This report will be posted on the AHS public website.

The 13 performance measures are reported as follows:

1. Two measures are not reported quarterly, but are reported at different times based on when the data is available:
 - Perinatal Mortality among First Nations (reported annually)
 - AHS Workforce Engagement (reported every two years)
2. Eleven measures are reported quarterly:
 - Seven measures include the most current data available (Q2) with comparable historical data
 - One measure is a cumulative measure (eReferrals) and cannot be compared to previous period.
 - Three measures rely on patient follow-up, generally after they have been discharged from care. These measures are updated after each quarter has ended and are therefore posted in subsequent quarters. (Q1 data provided).

Q2 results (July 1, 2017 to September 30, 2017) for the eleven performance measures available this quarter are as follows:

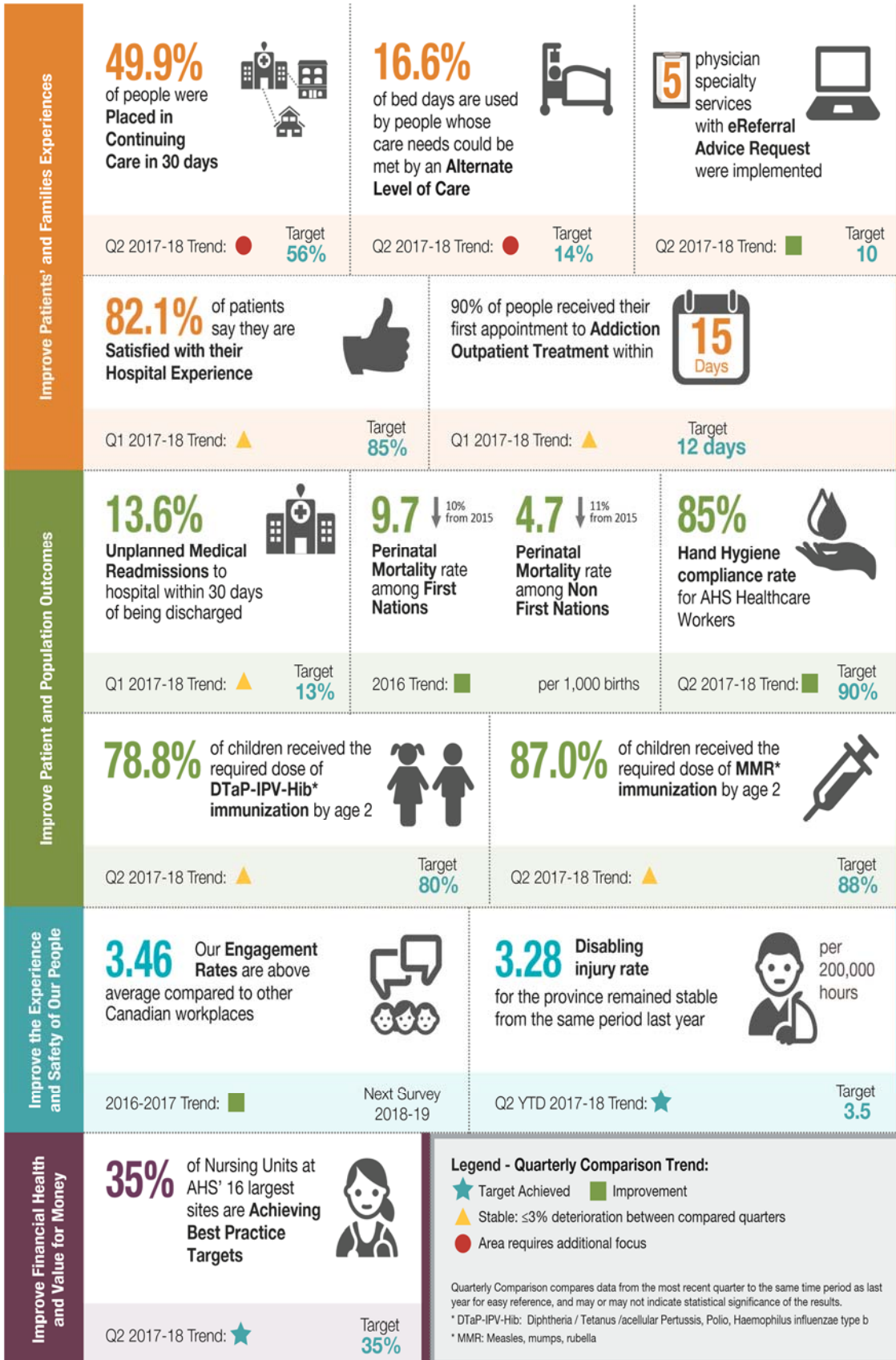
- 82% (9 out of 11) of the performance measures are better or stable from the same period last year with two measures achieving target (Disabling Injury Rate and Percentage of Nursing Units Achieving Best Practice Targets).
- 18% (2 out of 11) of the performance measures (percentage of people placed in continuing care within 30 days and percentage of alternate level of care patient days) did not improve from the same period as last year due to slower than expected growth in mental health, home care, continuing care and community care. Further explanation for those risk areas is included under those specific measures in the Appendix.

AHS has identified actions aligned to our 2017-2020 Health Plan and Business Plan which will help us achieve our targets by year end. Through this process, we know that it takes time to build capacity and mobilize resources, implement initiatives and realize targeted results.

AHS Q2 2017-18 Performance Report

Q2 Measures Dashboard

The Q2 results are summarized below for the 13 performance measures. For more detail, refer to the Appendix.



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

WHY THIS IS IMPORTANT

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

AHS has two performance measures to assess how quickly patients are moved from hospitals into community-based care.

AHS PERFORMANCE MEASURE

People Placed in Continuing Care within 30 Days is defined as 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 client is placed on the waitlist.

UNDERSTANDING THE MEASURE

Timely and appropriate access to Continuing Care Living Options is a major issue in Alberta. By improving access to a few key areas, AHS will be able to improve flow throughout the system, provide more appropriate care, decrease wait time and deliver care in a more cost-effective manner. Timely placement can reduce the 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 lifestyles.

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).

HOW WE ARE DOING

People Placed in Continuing Care within 30 Days
 Quarterly Comparison: ● Area requires additional focus



Source: Meditech and Stratahealth Pathways

AHS PERFORMANCE MEASURE

Percentage of Alternate Level of Care Patient Days is defined as the percentage of all hospital inpatient days when a patient no longer requires the intensity of care provided in a hospital setting and the patient’s care could be provided in an alternate setting. This is referred to as alternate level of care (ALC).

UNDERSTANDING THE MEASURE

Hospital beds are being occupied by patients who no longer need acute care services while they wait to be discharged to a more appropriate setting. These hospital days are captured in hospitalization data as patients are waiting for an alternate level of care.

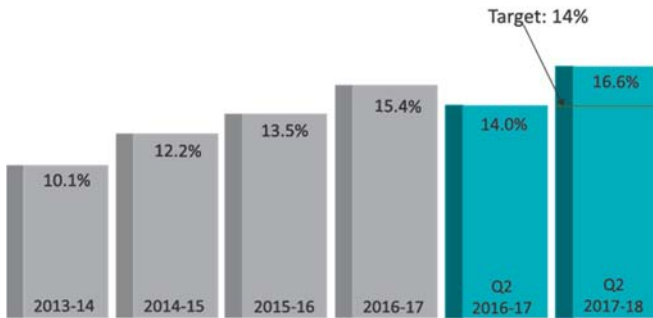
If the percentage of ALC days is high, there may be a need to focus on ensuring timely accessible options for support or care for ALC patients. Therefore, the lower the percentage the better.

The reasons for deterioration are multi-faceted and generally related to difficulties finding appropriate placement or services following hospital discharge. In some areas, this may be due to slower than required growth in mental health, home care, continuing and community care capacity. Increases in ALC percentage appears to be due to a relative increase in patients needing supportive services when discharged to home.

HOW WE ARE DOING

Percentage of alternate level of care patient days

Quarterly Comparison: ● Area requires additional focus



Source: Discharge Abstract Database (DAD) - AHS Provincial

Both performance measures have deteriorated in Q2 compared to the same period as last year due to slower than required growth in home care, continuing care and community care. These changes drove longer wait time and waitlists for placement into Continuing Care Living Options.

For Q2 2017-18, the average wait time for continuing care placement from acute/sub-acute care is 52 days compared to 47 days for the same period last year. The number of people waiting in acute/sub-acute care is 896 as of September 30, 2017 compared with 836 people waiting at the same time last year. For Q2 2017-18, there were 1,762 people placed into continuing care compared to 1,742 for the same period last year.

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

WHAT WE ARE DOING

For Q2 year-to-date, AHS opened 427 new continuing care beds – more than the entire 2016-17 year (376 new beds). Since 2010, AHS has opened 6,050 new beds to support individuals who need community-based care and supports (including palliative). A new continuing care facility was opened in the Central Zone in Q2 (Pioneer House in Lloydminster).

In Q2, 77,164 clients with unique needs received home care, an increase of 1.6% from Q2 2016-17 (75,918 clients).

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

Work continues to develop an *Enhancing Care in the Community* (ECC) strategy and action plan. Key initiatives of ECC phase 1 programming have been identified for implementation.

Q2 highlights to improve quality of care for continuing care residents and those living with dementia include:

- *Appropriate Use of Antipsychotics* (AUA) reduces antipsychotic medication use for continuing care residents. To date, 71 out of 176 supportive living sites (Edmonton and South Zones) rolled out AUA.
- Work to identify a provincial strategy and action plan for improving quality of housing and health services will begin pending the establishment of the provincial Housing and Health Services Steering Committee.
- AHS is collaborating with providers to increase availability and awareness (through educational videos, webinars for case managers, Frequently Asked Questions documents and newspaper articles) of GPS locator technology for home care clients living with dementia.
- A new Provincial Advisory Council for Seniors and Continuing Care is being established to provide input on strategy, policy, planning and service delivery; identify issues; and provide suggestions on ways to improve quality, access and sustainability of continuing care services in Alberta.

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

WHY THIS IS IMPORTANT

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

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

Alberta Netcare eReferral Advice Request provides primary care physicians with the ability to request advice from other physicians or specialty services that support patient care in the community.

AHS PERFORMANCE MEASURE

Timely Access to Specialty Care (eReferrals) is defined as the number of physician specialty services with eReferral Advice Request implemented.

UNDERSTANDING THE MEASURE

Having more services providing advice for non-urgent questions and being able to do so in an electronic format, may prevent patients from waiting for an appointment they don't need, provide them with care sooner, and support them better while they are waiting for an appointment.

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

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

HOW WE ARE DOING

For 2017-18, AHS is implementing eReferral Advice Request for ten more specialty services across the zones. To date, there are five specialties using eReferral Advice Request: Orthopedic Surgery – Hip and Knee Joint Replacement, Oncology – Breast, Oncology – Lung, Nephrology and Urology (new).

Urology specialty in Edmonton Zone was implemented in September 2017. In the first five weeks, 791 Advice Requests were received, 388 were completed with an average response time of three days and 32% receiving advice on how to continue caring for the patient within primary care.

The following charters were signed for December 2017 implementation:

- Internal Medicine/Endocrinology (Calgary Zone)
- Internal Medicine/Adult Gastroenterology (South, Calgary, Edmonton and North Zones)
- Obstetrics and Gynecology (Calgary Zone)
- Neurological Surgery/Spinal Neurosurgery (Calgary Zone)
- Internal Medicine/Pulmonary Medicine (Calgary Zone)

The following charters were signed for February 2018 implementation:

- Addiction Medicine and Mental Health/Opiate Agonist Therapy (provincial)
- Dermatology (Calgary Zone)
- Neurology (Calgary Zone)
- Paediatrics/Community Paediatrics (Calgary Zone)
- Ophthalmology (Provincial)
- Urology (Central Zone)
- Internal Medicine/Adult Gastroenterology (Central Zone)

WHAT WE ARE DOING

Primary Health Care

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

In September 2017, AHS launched a Strategic Clinical Network (SCN)[™] focused on primary healthcare, which is the 15th SCN[™] in Alberta – called the Primary Health Care Integration Network (PHCIN).

The PHCIN focuses on improving transitions of care between primary healthcare providers and acute care, emergency departments, specialized services and other community services. The following activities are underway to support the PHCIN:

- Partnering with the Seniors Health Strategic Clinical Network for a pilot project with five Primary Care Networks/eight communities to enhance capacity to recognize, diagnose and manage dementia and other geriatric syndromes in the community. The second workshop is scheduled for December 2017.
- Work is underway in each zone across three key areas of focus: keeping care in the community, hospital transitions (admission and discharge) and access to specialty care and back to primary care.
- The second meeting for the Coalition for Integration occurred in October. Work is underway to prepare for an interactive session which aims to build participant awareness and experience with providing advice on problems and opportunities in primary healthcare.

CancerControl

End of Treatment and Transition of Care processes are being improved for patients who have completed cancer treatment and are returning to a family physician. The processes for patients and primary care providers have been implemented in five early-stage and curative populations (breast, prostate, testicular, cervical, and endometrial). Work is underway on the next populations (Hodgkin's, B Cell, lymphoma, and colorectal).

Recruitment is underway to support the expansion of hematology services at the Jack Ady Cancer Centre (in Lethbridge), Margery E. Yuill Cancer Centre (in Medicine Hat) and Central Alberta Cancer Centre (in Red Deer). Where possible, clinical teams collaborate to ensure patients are seen at the nearest site following consultation at a tertiary site in Calgary or Edmonton.

Capital project update in cancer care:

- Calgary Cancer Project: The first phase of design was completed with the involvement of over 80 user meetings and more than 400 user experts. Early permits to facilitate progress on-site was issued by the City of Calgary. Construction began at the Foothills Medical Centre site in September. Development permit approval is expected in Q3.
- Grande Prairie Cancer Centre construction is proceeding on schedule as part of the new hospital project.
- The second phase of the Jack Ady Cancer Centre redevelopment is complete and was opened in Q2. The final phase (renovations to the current space) is scheduled to be completed by March 2018.
- A linear accelerator (Linac) was installed and operationalized to support cancer treatment in spring 2017 at the Tom Baker Cancer Centre in Calgary and the Cross Cancer Institute in Edmonton. Construction is underway to install a second Linac at each site.

Emergency Medical Services (EMS)

Targets for EMS response times for life threatening events in metro/urban, rural and remote areas were met in Q2. However, Q2 results for towns/communities with a population greater than 3,000 (16 minutes and 3 seconds) did not meet the target of 15 minutes but improved from Q1. EMS is developing a priority resource investment strategy that would assist in balancing resources versus demand.

Target (1 minute and 30 seconds) for time to dispatch the first ambulance which includes verifying the location of the emergency, identifying the closest ambulance and alerting the ambulance crew was met in Q2 (1 minute and 21 seconds). Performance continues to improve and is better than accredited benchmarks.

Implementation of the electronic patient care (ePCR) program for direct delivery and contract operators is on schedule. As of Q2, 93% contract operators and 80% direct delivery operators are using ePCR. This program links patient ambulance data with previous patient medical information to help EMS be more informed about a patient's medical history.

Work continues to complete helipad upgrades in Jasper, Fort McMurray, and Medicine Hat Regional Hospital. The helipad upgrade at Rocky Mountain House was completed and was in operation in August 2017.

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

WHY THIS IS IMPORTANT

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

AHS PERFORMANCE MEASURE

Patient Satisfaction with Hospital Experience is defined as the percentage of patients rating hospital care as 8, 9, or 10 on a scale from 0-10, where 10 is the best possible rating. The specific statement used for this measure is, "We want to know your overall rating of your stay at the hospital."

The survey is conducted by telephone on a sample of adults who have been discharged from acute care facilities within six weeks of discharge.

UNDERSTANDING THE MEASURE

Gathering perceptions and feedback from individuals using hospital services is a critical aspect of measuring progress and improving the health system. This measure reflects patients’ overall perceptions associated with the hospital where they received care.

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

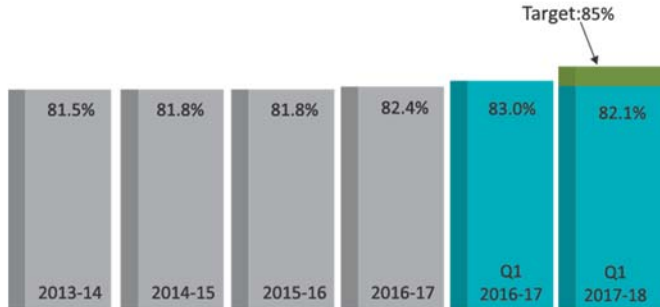
The higher the number the better, as it demonstrates more patients are satisfied with their care in hospital.

HOW WE ARE DOING

Provincially, AHS has shown deterioration from the same period last year. The percentage of adults rating their overall hospital stay as 8, 9 or 10 is 82.1% for Q1 2017-18 compared to 83.0% in Q1 2016-17.

This measure is reported a quarter later due to requirements to follow-up with patients after the reporting quarter.

Patient Satisfaction with Hospital Experience
 Quarterly Comparison: ▲ Stable: ≤3% deterioration



Source: Canadian Hospital Assessment of Healthcare Providers and Systems Survey (CHCAHPS) responses

WHAT WE ARE DOING

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

New surveys for children, youth and their families were designed to help healthcare staff better understand their emergency room experiences and provide better patient- and family-centred care. These surveys were created by the Addiction and Mental Health and Emergency Strategic Clinical Networks.

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

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

To support patient- and family- centred care for Albertans whose first language is not English, AHS provides interpretation and translation services province-wide. Usage of telephone interpretation services in Q1 and Q2 has increased by 10% compared to last year. In addition, 38 entities signed up for access to telephone interpretation services for their patients in the North Zone.

The *Leader Rounding Campaign* (which involves management attending rounds to understand how staff are serving patients) has been completed (Be Bold & Try it). Over 85 AHS leaders participated in the challenge in October and over 100 participants attended a dedicated coaching session to prepare for Leader Rounding.

The AHS Quality and Safety Summit was awarded the *Patients Included* designation based on demonstrated commitment to incorporating the experiences of patients/families, and co-designing the summit together with patients and family advisors.

A *Digital Storytelling Workshop* was hosted in September; ten patient advisors crafted digital stories to be shared and distributed to promote patient- and family- centred care and quality improvement across AHS.

In addition to participating in many of the provincial initiatives noted above, zones continue to implement patient- and family-centred care initiatives to increase the patient voice and participation in care delivery. Other examples of zone activities include:

- Roll out of Family Presence Policy which welcomes patients and families as partners in care and essential members of the care team.
- Creation of Orientation/Accreditation Placemats, a patient friendly document that details hospital information.
- Edmonton Zone continues the *15-5 Rule* initiative where staff acknowledge patients or family when within 15 feet and greet them within 5 feet.

- Ongoing implementation of CoACT, including inclusion of patient and family in rounds and developing the plan of care. Currently, half of all patients admitted to AHS hospitals experience a more collaborative form of care through CoACT. Overall, 160 units in AHS are in the process of implementing different phases of this work.

The **CoACT** program promotes patient centered, team-based care that helps patients, families and care providers communicate and work together to achieve high quality care.

CoACT is an innovative model of care in which care providers collaborate with patients.

Elements of CoACT include integrated plans of care, transition rounds, patient scheduling, standard transition process, right bed first time, home team, home unit and partnerships with support services.

AHS uses Patient Reported Outcomes (PRO) to enhance cancer patient experiences. Site presentations on the PRO dashboard were made to cancer centres across the province and to senior leadership.

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

WHY THIS IS IMPORTANT

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

AHS PERFORMANCE MEASURE

Wait Time for Addiction Outpatient Treatment represents the time it takes to access adult addiction outpatient treatment services, expressed as the number of days that 9 out of 10 clients have attended their first appointment since referral or first contact.

UNDERSTANDING THE MEASURE

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

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

HOW WE ARE DOING

Provincial results indicate that we have remained stable compared to the same period last year (15 days).

The most recent data for this measure is one quarter behind the reporting period due to various reporting system timelines.

Wait Time for Addiction Outpatient Treatment (in days):
 Quarterly Comparison: ▲ Stable: ≤3% deterioration



Source: AHS Addiction and Mental Health

WHAT WE ARE DOING

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

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

Work is on track to develop the Provincial Mental Health Diversion Standards with two standards developed to date. The Provincial Diversion Working Committee supports prevention and intervention programs within communities to enable access to mental health, social and support services before law enforcement needs to be involved.

AHS is partnering with the Canadian Mental Health Association to develop a peer support network for rural communities. In the Calgary Zone, rural clinics are participating in the Rural Centralized Intake Line. This line provides patients and providers with timely information and access to addiction and mental health resources in their communities.

The Calgary Zone Community Paramedic City Centre Team is improving access to mobile healthcare services. There were 272 patient events related to addiction and mental health in Q2.

AHS Q2 2017-18 Performance Report

North Zone continues to focus on implementing the Fort McMurray Wellness & Recovery Plan. Key activities in Q2 included establishing a new rotation schedule for the Indigenous Health Travel Team to allow for longer hours of operation in rural communities. In addition, pathways to address complex mental health needs for children and youth were created between AHS and Fort McMurray school districts.

The percentage of children offered scheduled community mental health treatment within 30 days dropped to 70% for Q2 YTD 2017-18 compared to Q2 YTD 2016-17 (76%). AHS continues to address challenges in access to scheduled children mental health services by:

- Providing services to over 65,000 students in 182 schools and 85 communities. Over 3,800 referrals were made to community-based services and over 900 referrals were made to more intensive treatment since September 2016 (Mental Health Capacity Building in Schools initiative).
- Recruiting new child psychiatrists within community clinics to enhance access to specialized psychiatric consultations for children in the Edmonton Zone.
- Continuing planning on the Centralized Intake that will be accessible 24/7 in the Edmonton Zone.
- Establishing a process in the North Zone emergency departments (ED) to review challenges and barriers to accessing children's mental health services in the ED.
- Investigating the use of alternative methods, including Telehealth, to provide children's mental health services in the South Zone.

AHS is working with AH and community partners to address the opioid crisis. This work also supports the *Minister's Opioid Emergency Response Commission*. Q2 highlights include:

- Over 5,900 take home Naloxone kits were dispensed to Albertans in Q2. Since July 2015, nearly 28,000 kits have been dispensed, which includes kits dispensed by the Alberta Community Council on HIV agencies.

- Over 600 overdose reversals (naloxone administered to reverse effects of an opioid overdose) were voluntarily reported in Alberta in Q2. Based on AHS data collected since January 2016, as of September 30, 2017, 2,330 overdose reversals were voluntarily reported in Alberta.
- New Opioid Dependency Treatment (ODT) clinics were operational in Grande Prairie, Centennial Centre, High Prairie, and Bonnyville. The expansion of existing ODT Programs in Fort McMurray, Calgary and Edmonton are underway. These services are also provided in Cardston and through telehealth in Ponoka, Wetaskiwin, Rocky Mountain House, Stettler, Camrose, Wainwright, Sylvan Lake, Olds and Drayton Valley. The Grande Prairie ODT program is co-located in the Northern Addiction Centre that also provides detoxification and residential addiction services.
- AHS has scheduled collaborative meetings with health leaders from Piikani Nation, Kainai Nation, and First Nations Inuit Health Branch to address the opioid crisis within Indigenous communities and urban settings.
- Primary care physicians can consult with an opioid dependence specialist on-call for advice regarding prescribing drugs, as well as treating patients with existing opioid dependency. This consultation service was launched in Q2 and is operated by RAAPID (Referral, Access, Advice, Placement, Information & Destination). Callers receive a follow-up call from a physician working at the Edmonton or Calgary Opioid Dependency Program clinics.
- The Rural Opioid Dependency Program, operating out of Centennial Centre, began expanding to new communities in May 2017 and now has 71 clients enrolled in the program within 11 communities.
- Work is underway to develop a pan-Strategic Clinical Network pathway (opioid dependency treatment, acute pain management, and chronic non-cancer pain management). Clinical care pathways outline a sequence of activities for specific diagnosis groups or patient populations to maximize quality of care, efficient use of resources and improve transitions of care.

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

Objective 5: Improve health outcomes through clinical best practices.

WHY THIS IS IMPORTANT

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

AHS PERFORMANCE MEASURE

Unplanned Medical Readmissions is defined as the percentage of medical patients with unplanned readmission to hospital within 30 days of leaving the hospital. This measure excludes admissions for surgery, pregnancy, childbirth, mental health diseases and disorders, palliative care and chemotherapy for cancer.

UNDERSTANDING THE MEASURE

Although readmission may involve factors outside the direct control of the hospital, high rates of readmission act as a signal to hospitals to look more carefully at their practices, including discharge planning and continuity of services after discharge.

Readmissions to hospital may be due to conditions unrelated to the initial discharge. Due to a higher expected readmission rate amongst elderly patients and patients with chronic conditions, this measure will vary due to the nature of the population served by a facility. Rates can also be impacted due to different models of care and healthcare services accessibility. Therefore comparisons between zones should be approached with caution.

The lower the percentage, the better as it demonstrates that fewer people are being readmitted shortly after being discharged.

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

HOW WE ARE DOING

The rate of readmissions has remained relatively stable over the past few years. Unplanned medical readmission to hospital results was 13.6% in Q1 2017-18 compared to 13.3% in Q1 2016-17.

Unplanned Medical Readmissions
Quarterly Comparison: ▲ Stable: ≤3% deterioration



Source: AHS Provincial Discharge Abstract Database (DAD)

WHAT WE ARE DOING

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

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

Clinical care pathways outline a sequence of activities for specific diagnosis groups or patient populations to maximize quality of care, efficient use of resources and improve transitions of care.

- Edmonton Zone is implementing an initiative to prevent social admission for lack of housing and/or capacity assessments in collaboration with community partners. The zone has also began implementation planning for chronic obstructive pulmonary disease management in the community.

SCNs™ are working to reduce inappropriate variation and apply consistent clinical standards across AHS. For example, the *Starting Dialysis on Time at Home on the Right Therapy Project (START)* has seen an increase in the percentage of new patients treated with peritoneal dialysis in the first six months after dialysis initiation to 37% as of June 2017 (exceeding target of 30%). In addition, there has been a reduction to 13% of outpatients starting dialysis too early (target is 11%) as of June 2017.

Other examples of SCN™ initiatives underway to improve health outcomes through clinical best practices include:

- Endovascular Therapy
- National Surgery Quality Improvement Project (NSQIP) and Trauma Quality Improvement Project (TQIP)
- Diabetes Foot Care Clinical Pathway implementation in Primary Care Networks
- Catch a Break (secondary fracture prevention initiative)
- Basal Bolus Insulin Therapy
- Glycemic Management Policy
- Insulin Pump Therapy
- Emergency Department Document Standardization
- Early Hearing Detection and Intervention Program
- Elder Friendly Care in Acute Care

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

AHS continues to increase capacity for evidence-informed practice and policy through enhanced data sharing, research, innovation, health technology assessment and knowledge translation.

The Partnership for Research and Innovation in the Health System (PRIHS) Steering Committee endorsed AHS to proceed with funding focused on Enhanced Care in the Community. Details on these initiatives will be provided in Q3 and year-end reporting.

The *Health Analytic Portal* Release 1 went live in August 2017 to allow stakeholders (i.e., Alberta Health, Alberta Bone and Joint, Health Quality Council of Alberta) the ability to register and interact with selected published reports.

AHS is working on the next releases of the *Health Analytic Portal* that will include the ability for authorized data users to access AHS data assets, starting with Discharge Abstract Database (DAD) and National Ambulatory Care Reporting System (NACRS) and online access to services, such as data education services, metadata, and data consulting and advisory services.

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

WHY THIS IS IMPORTANT

Alberta's Indigenous peoples, many of whom live in rural and remote areas of our province, have poorer health than non-Indigenous Albertans. AHS is building a better understanding of how historical effects and cultural care differences impact these outcomes.

Working together with the AHS Wisdom Council, Indigenous communities, and provincial and federal governments, we will adapt services to better meet the health needs of Indigenous peoples.

AHS PERFORMANCE MEASURE

Perinatal Mortality among First Nations is defined as the number of perinatal deaths per 1,000 total births among First Nations. A perinatal death is a fetal death (stillbirth) or an early neonatal death.

UNDERSTANDING THE MEASURE

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

It allows us to see Alberta's performance on reducing disparity between First Nations and non-First Nations populations.

Monitoring this rate helps AHS develop and adapt population health initiatives and services to better meet the health needs of Indigenous people and reduce the health gap between Indigenous peoples and other Albertans.

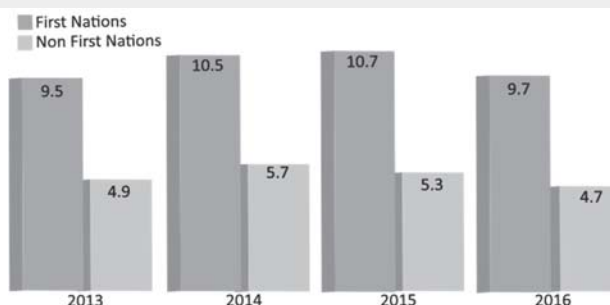
The lower the number the better. AHS also works to reduce the gap between First Nations and non-First Nations populations. This measure does not include all Indigenous populations, such as our Inuit and Metis residents.

HOW WE ARE DOING

Perinatal mortality is reported on an annual basis pending the availability of the most recent census data (2016). It is a performance indicator rather than a performance measure, and therefore no target is identified.

Perinatal mortality among First Nations (per 1,000 births)

This is a performance indicator. No target.



Source: Alberta Vital Statistics and Alberta First Nations Registry

WHAT WE ARE DOING

Perinatal Mortality

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

Midwifery privileges are in place at the Elbow River Healing Lodge to support access to obstetrical services for Indigenous, vulnerable and rural populations. The program will be evaluated by the end of 2017. Further work is underway to identify opportunities for community engagement, education and growth of services.

Work is underway to develop the antenatal care pathway to support the maternity services corridors of care initiative.

Work continues to finalize the North Zone Maternal Infant Strategic Plan.

South Zone has begun to identify strategies to address the incidence of *Neonatal Abstinence Syndrome* (NAS) for Indigenous and non-Indigenous babies born at Chinook Regional Hospital. Work will include bringing together acute care, addictions and mental health, public health, home visitation and, potentially, outside agencies including Indigenous health agencies.

AHS supports improvement of all women's health; maternal, infant, child and youth health; including Indigenous and vulnerable populations. Examples of initiatives include:

- Recruitment is underway to support *MyCHILD Alberta* to increase data capacity to improve outcomes and optimize public sector policies for women and children.
- Edmonton Zone has received 223 Government Assisted Refugees of which 196 are attached to a primary care provider as of August 31, 2017.
- A multi-program North Zone Early Childhood Taskforce is developing a collaborative plan to improve early childhood intervention services.

Engagement and Cultural Competency

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

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

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

Two Listening Day sessions have been held. An Indigenous reconciliation session is planned for fall 2017 to support recommendations from the Truth & Reconciliation Commission and United Nations Declaration on the Rights of Indigenous Peoples.

AHS leadership are encouraged to complete cultural competency training sessions to gain better awareness on how to appropriately provide care to patients and families. To date, 49% (n=79) of senior leaders have completed Indigenous Awareness and Sensitivity and 17% (n=33) have completed the Indigenous People in Alberta Introduction. A “Truth Always” Senior Leaders session occurred in October 2017 to provide leaders information on Indigenous awareness.

Program Development

AHS is working with Indigenous communities to improve prevention and screening. The Alberta Cancer Prevention Legacy Fund (ACPLF) is continuing to work with Indigenous partners to promote prevention and screening initiatives aimed at improving health outcomes

of Indigenous people. Examples of ACPLF projects and the progress made in Q2 include:

- *First Nations (FN) Cancer Prevention and Screening Practices* project supports FN communities to develop, implement and evaluate comprehensive prevention and screening plans. Community assessments were completed in three FN communities (Peerless Trout, Maskwacis, and Blood Tribe). A partnership satisfaction survey showed that all partners and team members are confident that the project has strengthened relationships with FN partners and helped increase awareness of community cancer prevention and screening needs.
- *Alberta Healthy Communities Approach (AHCA)* project supports communities to plan, implement and evaluate comprehensive prevention and screening interventions. Two Métis Settlements (Peavine and Gift Lake) launched the project in Q2. These Métis Settlements will join the 16 Alberta communities already implementing AHCA.
- *Alberta Screening and Prevention (ASaP)* project adapts the ASaP program to better meet the needs of primary care settings that primarily serve Indigenous patients. The Elbow River Healing Lodge expanded their implementation of ASaP (from documentation of height, weight and diabetes screening) by adding new processes to document offers of breast, cervical and colorectal cancer screening in their electronic medical record.
- *Zone Comprehensive Prevention and Screening Approach* project is piloting a framework for a zone-level comprehensive prevention and screening approach. North Zone is improving access to prevention and screening in hard to reach and underserved communities. In Q2, one Métis Settlement (Gift Lake) and two First Nations communities (Little Red River Cree Nation, Peerless Trout) received prevention and or screening supports. Five communities (High Level, La Crete, Ft. Vermillion, Peace River, and High Prairie) in local geographic areas where more than 10% of the population self-identified as Indigenous received prevention and screening supports.

The *Police and Crisis Team (PACT)* program provides clinical assessment and interventions for vulnerable individuals presenting to police with addiction and mental health concerns. In Q2, there were 95 referrals, 26 new enrollments, 65 existing registrants and 12 discharges in the Calgary Zone. In addition, the newly implemented PACT program in Medicine Hat began providing interventions and support.

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

WHY THIS IS IMPORTANT

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

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

AHS PERFORMANCE MEASURE

Hand Hygiene Compliance is defined as the percentage of opportunities in which healthcare workers clean their hands during the course of patient care. Healthcare 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’s “4 Moments of Hand Hygiene.”

The 4 Moments of Hand Hygiene are:

- Before contact with a patient or patient’s environment,
- Before a clean or aseptic procedure,
- After exposure (or risk of exposure) to blood or body fluids, and
- After contact with a patient or patient’s environment.

UNDERSTANDING THE MEASURE

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

The higher the percentage the better, as it demonstrates more healthcare workers are complying with appropriate hand hygiene practices.

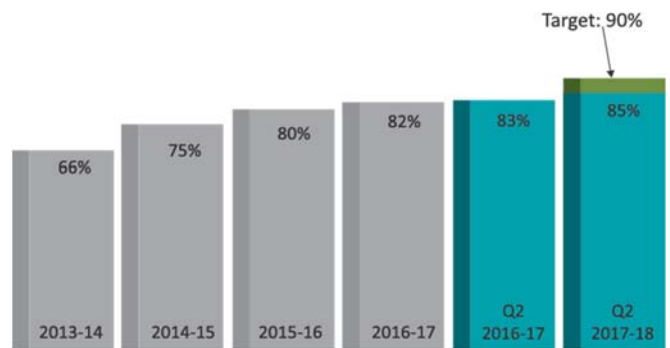
HOW WE ARE DOING

Hand hygiene compliance increased provincially to 85%, an improvement from last year (83%).

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

Hand Hygiene Compliance

Quarterly Comparison: ■ Improvement



Source: AHS Infection, Prevention and Control (IPC) Database

WHAT WE ARE DOING

Hand hygiene improvement initiatives continue across AHS including a refresh of the AHS Hand Hygiene Policy and Procedure, creation of an infographic link to hand hygiene results posted to the AHS webpage, and development of zone-specific tools to share results with zone leaders. The *Clean Hands System* was upgraded to increase user experience and to make the review process more efficient.

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

Hospital-acquired *Clostridium difficile* Infections (CDI) rates continue to remain stable and low for the past few quarters (3.0 cases per 10,000 patient days in Q2 2017-18 compared to 3.4 cases in Q2 2016-17). A lower value for this rate is better.

AHS continues to monitor CDI which is influenced by hand hygiene. There are several initiatives that address hospital-acquired CDI including:

- Antimicrobial Stewardship program includes the use of standardized physician-patient care orders implemented at the time of CDI diagnosis to ensure appropriate treatment.
- Infection prevention and control supports patient management by connecting with frontline healthcare workers to promote the use of physician patient care order sets, follow-up on case severity, and provide feedback on case management.
- Zones continue to have at least one initiative targeted at reducing utilization of the 14 select antimicrobials associated with a high risk CDI.
- According to the World Health Organization, the *defined daily dose* (DDD) is the average dose per day for a drug used for its main purpose in adults. It allows the comparison of drug usage between different drugs or healthcare environments. Compared to Q1 2016-17, AHS has seen an overall reduction in the defined daily doses per 100 patient days in Q1 2017-18 for the 14 selected antimicrobials.

Rates of hospital-acquired Methicillin-resistant *Staphylococcus aureus* Blood Stream Infections (MRSA BSI) cases improved from the same period last year (0.15 cases per 10,000 patient days in Q2 2017-18 compared to 0.17 cases in Q2 2016-17). A lower value for this rate is better.

Work is underway to complete the Patient Safety Strategy that will articulate how to make significant improvement in patient safety. A policy suite that is also under development will focus on recognizing and responding to hazards, close calls, and clinical adverse events.

A new Provincial Medication Orders Policy, Medication Orders Procedure, and Verbal and Telephonic Medication Orders Procedure were approved and will become effective February 2018. The policy suite improves patient safety by developing consistent practices for creating and acting upon medication orders in AHS settings.

AHS has implemented 80% (target = 100%) of Health Quality Council of Alberta's (HQCA) recommendations related to parenteral nutrition. Parenteral nutrition is provided to some of our most vulnerable patients and is classified as a high-alert medication because significant harm may occur when it is used incorrectly or without regard to accepted leading practice standards.

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

WHY THIS IS IMPORTANT

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

AHS PERFORMANCE MEASURE

Childhood Immunization is defined as the percentage of children who have received the required number of vaccine doses by two years of age.

- Diphtheria / Tetanus /acellular Pertussis, Polio, Hib (DTaP-IPV-Hib) - 4 doses
- Measles / Mumps / Rubella (MMR) - 1 dose

UNDERSTANDING THE MEASURES

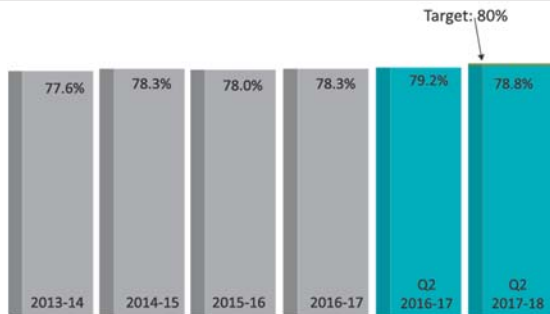
A high rate of immunization for a population reduces the incidence of vaccine-preventable childhood disease, and controls outbreaks. Immunizations protect children and adults from a number of preventable diseases, some of which can be fatal or produce permanent disabilities.

The higher the percentage the better, as it demonstrates more children are vaccinated and protected from preventable childhood diseases.

HOW WE ARE DOING

Provincial rates for childhood immunization (both DTaP-IPV-Hib and MMR) have remained stable from the same period last year, but remain below 2017-18 targets.

Childhood immunization: DTaP-IPV-Hib
 Quarterly Comparison: ▲ Stable: ≤3% deterioration



Source: AHS Provincial Public Health Surveillance Database

Childhood immunization: MMR

Quarterly Comparison: ▲ Stable: ≤3% deterioration



Source: AHS Provincial Public Health Surveillance Database

WHAT WE ARE DOING

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

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

AHS and AH are working with the zones to ensure a consistent approach to disease outbreak reporting, notification and management. Activities in Q2 included:

- Disseminated preventive information in childcare settings (e.g. risk of E coli O121 in raw dough), and presentations to resident physician trainees.
- Completed a standard of practice to detect outbreak clusters occurring in multiple zones.
- Initiated work with AH on a standard of practice to employ an Incident Command System when implementing the Foodborne Illness Response Investigation Procedure.
- Began revision of provincial food-borne illness outbreak protocol with provincial partners (such as, Alberta Agriculture and Food, Alberta Health, and Canadian Food Inspection Agency).
- Participated on national Outbreak Investigation Coordinating Committees, contributing unique surveillance data that helped identify the implicated product and a nation-wide recall.

The 2016-2020 Alberta Sexually Transmitted Blood-Borne Infections (STBBI) Operational Strategy and Action Plan began development in spring 2016, engaging over 350 stakeholders across the province including First Nations' communities and Metis settlements. Five work streams developed recommendations in the spring of 2017 which were approved and prioritized for implementation commencing January 2018.

AHS is implementing a system-wide response to chronic conditions and disease prevention and management by aligning and integrating work being done on chronic disease. The following provincial and zone activities occurred in Q2:

- Teams developed timelines and planned events (s road map) to identify and implement priorities including webinars to showcase effective, geographically appropriate processes for patients without a primary care provider.
- Work is underway to support the AHS Population, Public and Indigenous Health portfolio in the development of the *Alberta Chronic Disease Inventory*. The inventory is a comprehensive, up to date, searchable listing of programs, services and resources focused on chronic disease prevention and management.
- As part of the Diabetes Wellness Initiative, *Empathy Mapping*, conversations are currently planned in High Prairie and catchment area.
- The *South Zone Chronic Pain Approach and Framework for Service Delivery* was completed.

AHS helps to protect the public by mitigating risks and hazards in the environment including food, air and water through health promotion strategies and interventions.

Work continues to finalize a plan to align Alberta Agriculture and Forestry's and AHS' inspection programs overseeing meat facilities. Baseline inspections have commenced. To date, the percentage of meat processing facilities that have been inspected using the completed baseline assessment and inspection tool are as follows: North Zone (53%), Edmonton Zone (19%), Central Zone (27%), Calgary Zone (37%), South Zone (79%) – for a total of 40% completed overall.

AHS' Provincial Addiction Prevention program provides consultation, facilitation, planning support and resource development to reduce risk factors and increase protective factors important to prevent addiction. Updates for Q2 include:

- AHS supported 58 funded community coalitions across the province to implement promotion and prevention activities.
- The *Help4me* website framework has been drafted and includes recommendations provided by youth and youth servicing organization representatives.
- Work continues on the development of the AHS Harm Reduction Policy.
- The Drug Treatment Funding Program, in partnership with AHS, developed capacity to increase access to sustainable, evidence-informed early intervention treatment services for children and youth in Alberta with addiction and/or mental health concerns. The *InRoads* curriculum refresh and enhancement project is underway, including the development of training modules. Ten modules have been submitted to the Accreditation Committee for review.

AHS plays an important role in supporting screening initiatives across the province. Examples for Q2 include:

- Access to cancer screening clinics for rural and remote communities and vulnerable populations and mobile breast cancer screening are led by the Screening for Life Program which also connects Albertans to useful resources and strategies at AlbertaPreventsCancer.ca. This is a joint initiative between AHS Population, Public and Indigenous Health and the Alberta Cancer Prevention Legacy Fund.
- The *Early Hearing Detection and Intervention* (EHDI) project has been implemented in four out of 13 neonatal intensive care units (NICU). EHDI offers screening to newborns for hearing prior to discharge. Two additional NICUs are planned for implementation in Q3.

Objective 9: Improve our workforce engagement.

WHY THIS IS IMPORTANT

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

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

AHS PERFORMANCE MEASURE

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

UNDERSTANDING THE MEASURE

As Alberta’s largest employer, AHS has the opportunity both to create a satisfying workplace and to deliver services in a manner that is sustainable for the future. In order to do this, it is important that AHS fully engages its people and their skills. Monitoring workforce engagement enables us to determine the effectiveness of processes/programs that support employee engagement and strengthen a patient safety culture.

The rate shows the commitment level the workforce has to AHS, their work, and their manager and co-workers. High engagement correlates with higher productivity, safe patient care and willingness to give discretionary effort at work. The higher the rate, the more employees are positive about their work.

HOW WE ARE DOING

Workforce engagement rate

Annual Results: **3.46** (2016-17 baseline year)

No target is established for 2017-18 as the Engagement Survey is performed every two years. The next survey is planned for fall 2018, with a target of 3.67.

Source: Gallup Canada

In 2016, AHS completed a comprehensive workforce engagement and patient safety culture survey. More

than 46,000 individuals – including nurses, emergency medical services, support staff, midwives, physicians and volunteers – participated and expressed what they need to feel safe, healthy and valued at work.

AHS’ engagement survey is conducted every two years with the next survey to be done in fall 2018. AHS’ workforce engagement is 3.46 on a 5-point scale (5 indicates highly engaged). Based on a question asking how satisfied people are with AHS as a place to work: 57% of respondents felt positively, 40% felt neutral, and 3% felt negatively. According to Gallup, AHS currently ranks above average in terms of engagement when compared with other Canadian workplaces.

In November 2017, AHS conducted a pulse survey to assess the extent to which leaders and teams are discussing Our People Survey results, deciding on actions to focus on, and making progress on those agreed upon actions.

WHAT WE ARE DOING



AHS was recognized as one of Canada's Top 100 Employers, achieving one of its Long-Term High Performance Targets three years ahead of schedule.

Our People Strategy’s action plan addresses priority factors influencing workforce engagement at AHS. Actions that will positively impact workforce engagement in 2017-18 include:

- Ongoing discussions and local action planning using Our People Survey results.
- Participating in activities to improve engagement including succession planning, leadership development and cultural awareness training sessions.
- Launching a new *Diversity and Inclusion initiative* with training, communication materials, networking opportunities, consultation, and changes to our physical environments.
- The new *Recruitment Management System (RMS)* was launched in September 2017 with improvements to the recruitment system and hiring processes. These changes will benefit applicants, existing employees and streamline the process for managers.

Objective 10: Reduce disabling injuries in our workforce.

WHY THIS IS IMPORTANT

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

AHS PERFORMANCE MEASURE

Disabling Injury Rate (DIR) is defined as the number of AHS workers injured seriously enough to require modified work or time loss from work per 200,000 paid hours (approximately 100 full time equivalent workers).

UNDERSTANDING THE MEASURE

Our disabling injury rate indicates the extent to which AHS experiences injury in the workplace. This enables us to identify health and safety programs that actively engage our people in creating a safe, healthy and inclusive workplace.

The lower the rate, the fewer disabling injuries are occurring at work.

HOW WE ARE DOING

In Q2, the disabling injury rate for the province deteriorated slightly from the same period last year, but is still meeting target.

Patient handling, manual material handling and other ergonomic factors are the leading causes of injury for AHS employees.

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

Disabling Injury Rate
Quarterly Comparison: ★ Target achieved



Source: AHS Workplace Health and Safety

WHAT WE ARE DOING

Efforts to improve our DIR include targeting interventions to common causes of injuries in high risk areas, and enhancing programs and processes related to physical safety, such as violence, patient handling, and manual material handling. For example, Emergency Medical Services (EMS) has committed to equipping all ambulances with power cots and load systems. Installation will commence in the fall and work is expected to be complete by spring 2018. EMS also continues to trial other equipment to reduce the manual load on EMS staff.

Over the next three years, efforts will be focused on those areas which experience the highest rates of injury over an extended period of time. WHS supports operational areas to ensure staff are appropriately trained on *It's Your Move* and *Move Safe* ergonomic programs, which aims to prevent lifting and handling injuries.

Workplace Health and Safety will continue to provide leaders with ongoing support to monitor and improve the health and safety of our workforce. This will be closely monitored on an ongoing basis.

The Communicable Disease Assessment (CDA) policy was implemented for new AHS employees on April 1, 2017 to ensure employees are assessed for their risk of communicable disease. As of September 30, 2017, there has been good uptake and compliance (87.6%). This is up 4.7% from 2017-18 Q1. WHS will continue to monitor the compliance rate with the CDA policy.

AHS is committed to providing psychological safety with an increased focus on aggression and violence in the workplace. Examples to note in Q2:

- The number of workplace violence incidents reported on *MySafetyNet* in Q2 was 512. Of all violent incidents in Q2, 99% are patient to worker and 10% resulted in a lost time injury at the time of reporting. AHS expects to see a continuing rise due to efforts to reduce the under-reporting of violent events.

MySafetyNet is an online provincial health and safety system where staff can report work related incidents, hazards, and illness/injury; access immunization records; and connect for help when ill or injured outside of work.

- EMS staff participated in *Non-Violent Crisis Intervention* training.
- A new brochure was created to support employees who have experienced patient aggression and violence. A post-incident checklist for managers is also available. These resources aim to protect the physical and psychological safety of staff while balancing respect for patient and family dignity and autonomy. Printed copies have been distributed across the province.

Leadership, culture, and competency are key variables determining safety outcomes in an organization. All new leaders are required to complete *Leading Health and Safety in the Workplace: Fundamentals* training. This is a key deliverable under Our People Strategy. At the end of 2017-18 Q2, 10.7% of all AHS leaders had completed the course. A 2.4% increase from 2017-18 Q1.

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

WHY THIS IS IMPORTANT

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

AHS PERFORMANCE MEASURE

Nursing Units Achieving Best Practice Targets is defined as the percentage of nursing units at the 16 busiest sites meeting Operational Best Practice (OBP) labour targets.

UNDERSTANDING THE MEASURE

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

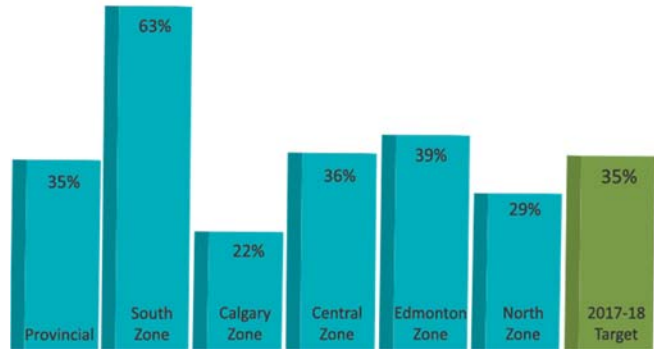
Using comparative data from across the county, AHS has developed OBP targets for all nursing inpatient units. These targets are designed to achieve more equitable service delivery across the province with the measure used to monitor leadership’s ability to meet the targets and reduce variations in the cost of delivering high quality services at AHS’ sites.

A higher percentage means more efficiencies have been achieved across AHS.

HOW WE ARE DOING

Provincially, Q2 results met the 2017-18 target of 35%. While not all zones and sites are achieving the provincial target, 38% are meeting or exceeding the 2017-18 target in Q2.

Nursing Units Achieving Best Practice Targets
Quarterly Comparison: ★ Target Achieved



Source: AHS Finance Statistical General Ledger (STAT GL)

WHAT WE ARE DOING

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

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

The Clinical Appropriateness initiative is multi-faceted, and requires leadership and support from a number of program areas, including AHS Clinical Support Services, AHS Quality and Healthcare Improvement, Strategic Clinical Networks, clinical operations, and physicians. Strong partnership and collaboration with primary care providers, the Alberta Medical Association (AMA) and other external groups will be necessary for the Clinical Appropriateness initiative to be successful.

AHS Q2 2017-18 Performance Report

A list of over 60 initiatives has been developed, with an estimated savings of \$10M. Initiatives are prioritized as “short, medium and long term” and will be implemented accordingly. Examples of initiatives underway and early results include:

- Q2 target was met as AHS saw a 16% decrease in CT lumber spine exams performed in Q2 compared to the same period last year. In Q2 YTD 2016-17, there was 1.38 exams per 1,000 residents. In Q2 YTD 2017-18, there was 1.16 exams per 1,000 residents. A lower value demonstrates improved efficiencies.
- Work continues on implementing a streamlined *Low Molecular Weight Heparin (LMWH)* formulary based on clinician engagement and contracting process. LMWH is a class of anticoagulant medications. They are used in the prevention of blood clots and treatment of venous thromboembolism and myocardial infarction.
- As of September 2017, we have seen a reduction in MRIs for chronic knee pain of 3.5%.
- Transition to a new brand of atropine prefilled syringes, which are more cost effective, for use primarily in patient codes and urgent procedures. The new syringes have different concentration, which requires staff awareness when the change is made. In working with key stakeholders, it was determined the switch could be made safely with educational support.
- AHS has implemented criteria for icatibant, a drug used to treat swelling attacks in people with hereditary angioedema (a disorder resulting in severe swelling of the body). The updated criteria has resulted in significantly lower usage of icatibant.

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

The following Q2 updates are provided on planning activities underway with Alberta Health:

- The goal of *Zone Health Care Planning* is to develop a population health driven strategic plan. Initiatives identified will support quality, accessible care in the community and a sustainable health system, reduce the reliance on acute care and enhance care in the community. Engagement sessions were held in Calgary and Central Zones for community initiatives and acute care streams. Both zones are on track to meet submission timelines.
- Service and access guidelines develop consistent principles for healthcare planning that supports equitable access to services across the province. Subject matter experts have been engaged to assist with the development of guidelines for basic medical/ surgical (initial rural focus), emergency health and primary care services.
- Provincial Interventional Cardiac Service Plan identifies the need for cardiac services in a coordinated and evidence-based approach. A needs assessment and options analysis overview are currently being completed.

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

WHY THIS IS IMPORTANT

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

The AHS provincial Clinical Information System (CIS) is part of the Connect Care initiative. With a single comprehensive record and care plan for every patient, the quality and safety of the care we deliver is improved, and our patients and their families across the healthcare system will have a better experience.

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

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

AHS PERFORMANCE MEASURE

There is no AHS measure for this specific AHS objective.

HOW WE ARE DOING

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

WHAT WE ARE DOING

In Q2, negotiations with Epic Systems Corporation were completed, and the AHS Board approved the signing of the contract effective October 2017. In the coming months, AHS will confirm which current health information systems will be replaced using new integrated technology.

AHS has started developing the foundation for Connect Care, building on the work AHS clinicians are already doing to support patient care. We will continue to work with teams across the province as we complete this planning work.

The number of active Alberta Netcare users increased by 7.6% (46,068 users) compared to the same period last year (42,815 users).

Alberta Netcare is a secure and confidential electronic system of Alberta patient health information collected through a point of service in hospitals, laboratories, testing facilities, pharmacies and clinics.

AHS has three interactive dashboards that present information on the health services Albertans use, the illnesses they're diagnosed with, and the costs associated with those diagnoses. The information has no personally identifying information and is compiled from a variety of health system data sources. The dashboards are a demonstration project under the Secondary Use Data Project, a joint initiative between AHS, Alberta Innovates and other partners.

Appendix

AHS Performance Measures – Zone and Site Detail

AHS has 13 performance measures that enable us to evaluate our progress and allow us to link our objectives to specific results. Through the engagement process, we determined our objectives and identified their corresponding performance measures. Both the objectives and performance measures are specific, relevant, measurable and attainable. Provincial results are found under each objective in the front section of this report. This appendix provides zone and site drill-down information for performance measures as well as variance explanations for those areas showing deterioration.

Two measures will be reported annually (Perinatal Mortality among First Nations and AHS Workforce Engagement). The remaining 11 measures will be reported quarterly. Of these, eight measures include the most current data available (Q2 2017-18) and three measures rely on patient follow-up and therefore reflect an earlier time period (Q1 2017-18).

Targets were established using historical performance data, benchmarking with peers, and consideration of pressures that exist within zones and sites. This approach resulted in a set of targets that, if achieved, would reflect an improvement in the performance of our Health Plan’s 12 objectives. Targets were endorsed by AHS and Alberta Health as published in the AHS 2017-2020 Health Plan and Business Plan.

In addition, AHS monitors several additional measures using a broad range of indicators that span the continuum of care that include population and public health, primary care, continuing care, addiction, mental health, and access to cancer care, emergency department and surgery. AHS continues to monitor these additional measures to help support priority-setting and local decision-making. These additional measures are tactical as they inform the performance of an operational area; or reflect the performance of key drivers of strategies not captured in the Health Plan.

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

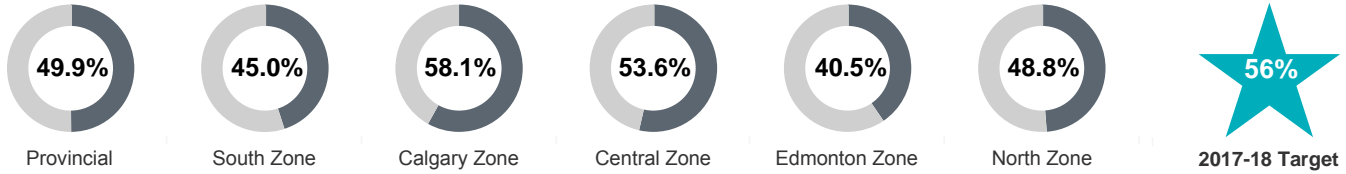
1. People Placed in Continuing Care in 30 Days	..... p.28
2. Percentage of Alternate Level of Care Patient Days	..... p.29
3. Timely Access to Specialty Care	<i>Only provincial results reported – see p. 7</i>
4. Patient Satisfaction with Hospital Experience	..... p.30
5. Wait Time for Addiction Outpatient Treatment	..... p.31
6. Unplanned Medical Readmissions	..... p.32
7. Perinatal Mortality Among First Nations	<i>Not reported quarterly</i>
8. Hand Hygiene Compliance	..... p.33
9. Childhood Immunization: DTaP-IPV Hib	..... p.34
10. Childhood Immunization: MMR	..... p.35
11. AHS Workforce Engagement	<i>Not reported quarterly</i>
12. Disabling Injuries in AHS Workforce	..... p.36
13. Nursing Units Achieving Best Practice Targets	..... p.37

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).

Trend Legend:

- Target achieved ★
- Improvement ■
- Stable: ≤3% deterioration between compared quarters ▲
- Area requires additional focus ●

Percentage Placed in Continuing Care within 30 Days, Q2 2017-18



Percentage Placed in Continuing Care within 30 Days Trend

Zone Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q2 2016-17	Q2 2017-18	Trend	Q2YTD 2017-18	2017-18 Target
Provincial	68.9%	59.9%	59.6%	56.1%	53.0%	49.9%	●	51.2%	56%
South Zone	77.2%	59.5%	47.6%	45.9%	48.0%	45.0%	●	46.0%	56%
Calgary Zone	72.0%	57.1%	58.4%	57.4%	59.3%	58.1%	★	57.4%	56%
Central Zone	40.7%	54.6%	61.5%	60.3%	64.0%	53.6%	●	55.8%	56%
Edmonton Zone	78.4%	66.2%	64.5%	55.8%	42.6%	40.5%	●	45.6%	56%
North Zone	59.9%	58.8%	58.7%	57.5%	54.4%	48.8%	●	44.3%	56%

Understanding Our Results

This measure has continued to deteriorate in Q2 compared to the same period as last year due to slower than required growth in home care, continuing care and community care.

For Q2 year-to-date 2017-18, AHS opened 427 new continuing care beds – more than the entire 2016-17 year (376 new beds). In the South Zone, a new 100-bed long-term care and supported living facility opened in Medicine Hat in late October. In Central Zone, a new 44-bed supported living facility has recently opened in Lloydminster.

As new beds are opened, it is expected that they will be filled initially with people who have been waiting for longer periods of time and as a result the measure will show a deterioration before improving in the long run.

Total Clients Placed

	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
FY 2015-16	887	2,722	1,060	2,506	704	7,879
FY 2016-17	925	2,438	1,352	2,575	673	7,963
Q2 2016-17	200	499	328	568	147	1,742
Q2 2017-18	202	587	304	509	160	1,762

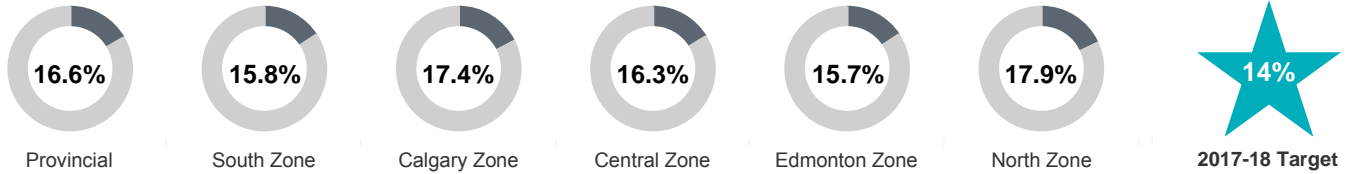
Source: AHS Seniors Health Continuing Care Living Options Report, as of October 23, 2017

This measure is defined as the percentage of all hospital inpatient days when a patient no longer requires the intensity of care in the hospital setting and the patient's care could be provided in an alternate setting. This is referred to as alternate level of care (ALC).

Trend Legend:

- Target achieved ★
- Improvement ■
- Stable: ≤3% deterioration between compared quarters ▲
- Area requires additional focus ●

Percentage of ALC Patient Days, Q2 2017-18



Percentage of ALC Patient Days Trend - Busiest Sites

Zone Name	Site Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q2 2016-17	Q2 2017-18	Trend	Q2YTD 2017-18	2017-18 Target
Provincial	Provincial	10.1%	12.2%	13.5%	15.4%	14.0%	16.6%	●	17.3%	14%
South Zone	South Zone	6.9%	9.0%	12.6%	13.9%	12.0%	15.8%	●	14.0%	14%
	Chinook Regional Hospital	5.0%	4.4%	7.8%	8.6%	8.7%	13.3%	★	11.7%	14%
	Medicine Hat Regional Hospital	9.2%	14.6%	18.9%	18.9%	14.7%	22.0%	●	19.2%	14%
	Other South Hospitals	7.1%	9.4%	11.5%	17.3%	15.7%	9.0%	★	9.8%	14%
Calgary Zone	Calgary Zone	11.7%	15.2%	16.7%	16.9%	15.1%	17.4%	●	18.4%	14%
	Alberta Children's Hospital	0.0%	0.2%	1.3%	1.2%	1.4%	2.4%	★	1.8%	14%
	Foothills Medical Centre	11.5%	15.7%	14.7%	15.2%	13.6%	14.6%	●	17.9%	14%
	Peter Lougheed Centre	11.0%	14.6%	13.6%	16.8%	14.2%	13.4%	★	13.5%	14%
	Rockyview General Hospital	13.7%	16.2%	21.9%	22.2%	20.2%	24.9%	●	25.8%	14%
	South Health Campus	12.1%	14.4%	20.4%	17.6%	16.1%	20.5%	●	19.0%	14%
	Other Calgary Hospitals	17.5%	26.4%	27.2%	21.0%	19.3%	24.8%	●	22.4%	14%
Central Zone	Central Zone	13.0%	13.1%	12.0%	15.3%	12.7%	16.3%	●	15.6%	14%
	Red Deer Regional Hospital Centre	10.3%	11.4%	8.8%	12.4%	9.1%	11.8%	★	11.5%	14%
	Other Central Hospitals	14.9%	14.4%	14.3%	17.2%	15.1%	19.4%	●	18.4%	14%
Edmonton Zone	Edmonton Zone	7.8%	9.1%	9.5%	14.0%	13.9%	15.7%	●	15.4%	14%
	Grey Nuns Community Hospital	8.7%	10.2%	9.2%	11.1%	15.3%	11.0%	★	9.9%	14%
	Misericordia Community Hospital	8.0%	10.8%	12.8%	14.7%	15.8%	16.8%	●	16.2%	14%
	Royal Alexandra Hospital	8.4%	10.6%	11.0%	18.5%	18.3%	17.5%	■	18.3%	14%
	Stollery Children's Hospital	0.1%	0.0%	1.8%	0.6%	2.2%	0.0%	★	0.0%	14%
	Sturgeon Community Hospital	10.7%	12.3%	12.3%	18.9%	15.5%	22.2%	●	20.9%	14%
	University of Alberta Hospital	6.8%	6.0%	6.2%	11.7%	8.8%	17.9%	●	16.7%	14%
	Other Edmonton Hospitals	9.2%	11.8%	12.1%	12.1%	12.3%	12.1%	★	14.1%	14%
North Zone	North Zone	11.7%	13.8%	18.5%	16.4%	13.9%	17.9%	●	23.7%	14%
	Northern Lights Regional Health Centre	9.4%	7.4%	18.5%	12.0%	1.5%	4.7%	★	7.3%	14%
	Queen Elizabeth II Hospital	8.5%	14.0%	20.4%	15.2%	8.2%	10.7%	★	31.8%	14%
	Other North Hospitals	13.2%	14.9%	17.9%	17.5%	17.5%	22.3%	●	23.1%	14%

Understanding Our Results

This measure has broadly deteriorated in Q2 compared to the same period as last year. This measure also shows a longer-term trend towards deterioration.

The reasons for deterioration are multi-faceted and generally related to difficulties finding appropriate placement or services following hospital discharge. In some areas, this may be due to slower than required growth in mental health, home care, continuing and community care capacity. Increases in ALC percentage appears to be due to a relative increase in patients needing supportive services when discharged to home.

Also, increased coding practices and improved ALC reporting accuracy has resulted in higher ALC activity. Larger fluctuations are generally expected at sites having fewer discharges.

Total ALC Discharges

	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
FY 2015-16	624	4,684	1,085	3,046	815	10,254
FY 2016-17	674	5,027	1,327	5,518	967	13,513
Q2 2016-17	147	1,139	276	1,135	203	2,900
Q2 2017-18	140	1,437	338	2,121	228	4,264

Source(s): AHS Provincial Discharge Abstract Database (DAD), as of November 6, 2017

-Q2 YTD results at the Queen Elizabeth II Hospital continue to reflect the closure of a temporary subacute transition unit with many patients discharged to continuing care facilities in May 2017. This resulted in higher than normal number of ALC days in Q1. As subsequent quarters are added to this year-to-date measure, results are expected to return to historically lower values.

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

Trend Legend:

Target achieved

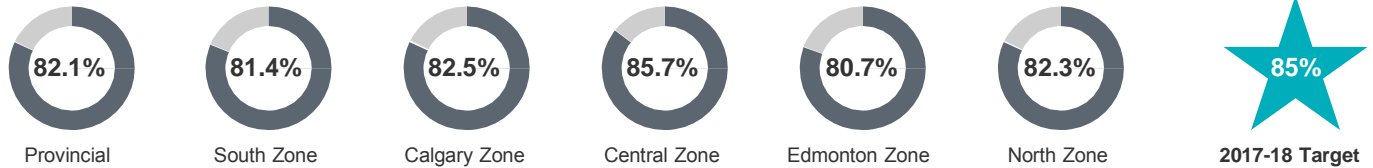
Improvement

Stable: ≤3% deterioration between compared quarters

Area requires additional focus



Patient Satisfaction with Hospital Experience, Q1 2017-18



Patient Satisfaction with Hospital Experience Trend - Busiest Site

Zone Name	Site Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q1 2016-17	Q1 2017-18	Trend	Q1YTD 2017-18	2017-18 Target
Provincial	Provincial	81.5%	81.8%	81.8%	82.4%	83.0%	82.1%	▲	82.1%	85%
South Zone	South Zone	81.7%	81.8%	80.9%	82.2%	82.2%	81.4%	▲	81.4%	85%
	Chinook Regional Hospital	80.5%	76.6%	78.2%	82.3%	80.6%	81.5%	■	81.5%	85%
	Medicine Hat Regional Hospital	80.7%	85.7%	81.3%	81.3%	82.4%	78.8%	●	78.8%	85%
	Other South Hospitals	83.5%	88.3%	87.2%	85.5%	87.8%	86.6%	★	86.6%	85%
Calgary Zone	Calgary Zone	80.1%	83.2%	82.0%	83.0%	83.2%	82.5%	▲	82.5%	85%
	Foothills Medical Centre	76.6%	80.8%	80.8%	80.3%	81.4%	80.5%	▲	80.5%	85%
	Peter Lougheed Centre	80.9%	79.9%	77.2%	78.7%	80.8%	76.3%	●	76.3%	85%
	Rockyview General Hospital	82.9%	85.4%	81.7%	85.1%	83.1%	83.9%	■	83.9%	85%
	South Health Campus	91.9%	89.7%	90.1%	90.9%	90.1%	91.0%	★	91.0%	85%
Central Zone	Other Calgary Hospitals	79.3%	90.3%	92.9%	92.2%	94.0%	94.2%	★	94.2%	85%
	Central Zone	83.5%	84.8%	83.4%	85.0%	87.1%	85.7%	★	85.7%	85%
	Red Deer Regional Hospital Centre	81.1%	83.0%	82.2%	82.7%	85.2%	83.9%	▲	83.9%	85%
Edmonton Zone	Other Central Hospitals	84.5%	86.7%	84.8%	87.0%	86.4%	87.6%	★	87.6%	85%
	Edmonton Zone	81.5%	80.3%	81.6%	80.8%	81.6%	80.7%	▲	80.7%	85%
	Grey Nun's Community Hospital	86.4%	87.2%	86.1%	86.4%	87.8%	84.3%	●	84.3%	85%
	Misericordia Community Hospital	78.5%	75.3%	77.2%	79.8%	81.4%	74.2%	●	74.2%	85%
	Royal Alexandra Hospital	79.9%	76.5%	77.3%	76.6%	77.9%	78.2%	■	78.2%	85%
	Sturgeon Community Hospital	89.8%	87.6%	89.8%	88.0%	86.9%	89.5%	★	89.5%	85%
	University of Alberta Hospital	77.1%	80.2%	83.5%	80.4%	80.2%	81.4%	■	81.4%	85%
Other Edmonton Hospitals	70.9%	85.3%	86.3%	85.7%	84.1%	87.8%	★	87.8%	85%	
North Zone	North Zone	81.0%	80.6%	81.3%	83.2%	83.1%	82.3%	▲	82.3%	85%
	Northern Lights Regional Health	75.4%	74.7%	78.6%	82.2%	90.9%	83.0%	●	83.0%	85%
	Queen Elizabeth II Hospital	76.0%	77.2%	78.6%	80.3%	81.5%	77.7%	●	77.7%	85%
	Other North Hospitals	83.4%	83.7%	83.5%	84.8%	82.3%	83.9%	■	83.9%	85%

Understanding Our Results:

Provincially, patient satisfaction with their hospital experience is stable across the reporting period but not at target levels to date.

There are a number of contributing factors can led to the deterioration in performance such as experiencing higher unit occupancies overall and greater ALC patients leading to an increase in transfer numbers, off-service patients and co-ed patients. There were also higher numbers of staff vacancies in a number of areas. Historically these issues resulted in patients and families being less satisfied with care.

AHS will keep monitoring their results and continue with team engagement and quality improvement. Deteriorations above 3% are noted at other selected facilities; however, these results appear to be within the consistent range over a longer time period.

Total Eligible Discharges

	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
FY 2015-16	19,737	61,044	29,272	82,559	25,934	218,546
FY 2016-17	19,840	83,208	29,531	89,005	25,333	246,917
Q1 2016-17	5,124	21,708	7,544	23,113	6,164	63,653
Q1 2017-18	4,894	21,392	7,582	22,533	6,670	63,071

Q1 2017-18	Number of Completed Surveys	520	2,171	842	2,359	756	6,648
	Margin of Error (±)	3.35%	1.60%	2.37%	1.59%	2.72%	0.92%

Source: AHS Canadian Hospital Consumer Assessment of Healthcare Providers and Systems (CH-CAHPS) Survey, as of November 1, 2017

Notes:

- This quarter is a quarter later due to requirements to follow-up with patients after end of reporting quarter.

- Reported values are within the margin of error range 19 times out of 20.

This measure represents the time it takes to access adult addiction outpatient treatment services, expressed as the number of days that 9 out of 10 clients have attended their first appointment since referral or first contact. The lower the number the better, as it demonstrates people are waiting for a shorter time to receive adult addiction outpatient services.

Trend Legend:

Target achieved

Improvement

Stable: ≤3% deterioration between compared quarters

Area requires additional focus



Addiction Outpatient Treatment Wait Time, Q1 2017-18



Addiction Outpatient Treatment Wait Time Trend by Zone (90th Percentile)

Zone Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q1 2016-17	Q1 2017-18	Trend	Q1YTD 2017-18	2017-18 Target
Provincial	18	15	13	15	15	15	▲	15	12
Urban									
Calgary Zone	21	9	5	6	1	3	★	3	12
Edmonton Zone	17	14	0	0	0	0	★	0	12
Rural									
South Zone	13	20	21	26	28	21	■	21	12
Central Zone	20	16	14	15	15	14	■	14	12
North Zone	16	16	19	27	22	26	●	26	12

Addiction Outpatient Treatment Wait Time Trend by Zone (Average)

Zone Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q1 2016-17	Q1 2017-18	Q1YTD 2017-18
Provincial	7.0	6.5	5.9	7.5	6.7	7.3	7.3
Urban							
Calgary Zone	7.7	7.4	7.9	11.4	9.0	11.7	11.7
Edmonton Zone	6.4	5.1	1.6	1.4	1.3	1.3	1.3
Rural							
South Zone	5.0	7.8	7.9	8.7	9.8	7.5	7.5
Central Zone	7.3	6.2	6.0	6.2	6.0	5.4	5.4
North Zone	7.5	7.3	8.3	11.2	10.6	11.0	11.0

Understanding Our Results

Results for Q1 do not meet the provincial target of 12 days. However, there is no variation from baseline results for 2016-17. The increase in waiting time can be a result of a few factors including an increase in the complexity and acuity of cases referred, an increase in time required to address the opioid crisis, as well as higher wait times in the rural zones.

Urban: The vast majority of clients in both urban settings – Edmonton and Calgary – are walk-ins. The large downtown clinic offers walk-in services but the satellite services (suburban clinics) generally do not offer walk-in services and are scheduled.

Rural: Although the overall provincial volume of new enrolments is not increasing, the volume of new enrolments in the rural zones is increasing. Wait times in rural areas can be influenced significantly by service models used to serve populations in rural and remote areas, such as the use of traveling clinics and services that are not operated 5 days a week. Additionally, waiting time will increase with staff vacancies. Although there is a higher turnover rate of staff in remote communities, active recruitment is underway.

Total Enrollments

	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
FY 2015-16	1,759	4,617	3,468	5,051	3,529	18,424
FY 2016-17	1,817	4,453	3,547	4,538	3,526	17,881
Q1 2016-17	445	1,146	901	1,179	839	4,510
Q1 2017-18	447	1,139	944	1,111	928	4,569

Source: Addiction System for Information and Service Tracking (ASIST) Data Research View for Treatment Service, Standard Data Product, Clinical Activity Reporting Application (CARA), Geriatric Mental Health Information System (GMHIS), as of November 2, 2017

Notes:

- This quarter is a quarter later due to requirements to follow-up with patients after end of reporting quarter.

- Average wait time is also provided to provide further context for the interpretation of the wait time performance measure. Trend and target are not applicable.

The measure is defined as the percentage of medical patients with unplanned readmission to hospital within 30 days of leaving the hospital. The lower the percentage, the better as it demonstrates that fewer people are being readmitted shortly after being discharged.

Trend Legend:

Target achieved

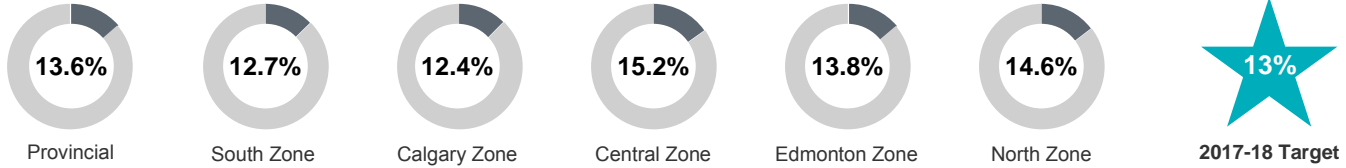
Improvement

Stable: ≤3% deterioration between compared quarters

Area requires additional focus



Unplanned Medical Readmissions, Q1 2017-18



Unplanned Medical Readmissions Trend - Busiest Sites

Zone Name	Site Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q1 2016-17	Q1 2017-18	Trend	Q1YTD 2017-18	2017-18 Target
Provincial	Provincial	13.5%	13.6%	13.7%	13.6%	13.3%	13.6%	▲	13.6%	13%
South Zone	South Zone	14.1%	13.5%	14.2%	13.9%	14.1%	12.7%	★	12.7%	13%
	Chinook Regional Hospital	13.2%	13.5%	14.1%	13.2%	15.3%	10.8%	★	10.8%	13%
	Medicine Hat Regional Hospital	14.4%	12.5%	14.0%	13.7%	13.0%	13.4%	★	13.4%	13%
	Other South Hospitals	15.0%	14.7%	14.4%	14.9%	13.7%	13.9%	▲	13.9%	13%
Calgary Zone	Calgary Zone	12.2%	12.2%	12.3%	12.3%	12.1%	12.4%	★	12.4%	13%
	Foothills Medical Centre	12.2%	12.1%	12.3%	12.3%	11.8%	11.7%	★	11.7%	13%
	Peter Lougheed Centre	12.1%	12.2%	12.8%	13.1%	12.6%	12.6%	★	12.6%	13%
	Rockyview General Hospital	12.0%	11.9%	11.9%	12.0%	11.6%	13.0%	★	13.0%	13%
	South Health Campus	12.3%	12.3%	12.0%	11.3%	11.9%	13.1%	★	13.1%	13%
	Other Calgary Hospitals	12.8%	13.7%	12.5%	13.0%	14.2%	12.2%	★	12.2%	13%
	Central Zone	14.5%	14.9%	15.0%	14.9%	14.6%	15.2%	●	15.2%	13%
Central Zone	Red Deer Regional Hospital Centre	14.0%	13.8%	13.9%	13.0%	12.0%	14.5%	●	14.5%	13%
	Other Central Hospitals	14.6%	15.3%	15.4%	15.6%	15.6%	15.5%	■	15.5%	13%
Edmonton Zone	Edmonton Zone	13.5%	13.8%	13.6%	13.6%	13.3%	13.8%	●	13.8%	13%
	Grey Nuns Community Hospital	12.6%	12.3%	13.2%	12.7%	13.5%	13.4%	★	13.4%	13%
	Misericordia Community Hospital	13.0%	13.7%	13.5%	15.0%	14.7%	13.6%	■	13.6%	13%
	Royal Alexandra Hospital	13.2%	14.0%	13.7%	13.0%	12.3%	13.8%	●	13.8%	13%
	Sturgeon Community Hospital	12.3%	13.6%	13.4%	13.1%	13.0%	13.3%	★	13.3%	13%
	University Of Alberta Hospital	14.6%	14.6%	14.2%	14.4%	13.9%	14.7%	●	14.7%	13%
	Other Edmonton Hospitals	13.4%	12.8%	11.9%	12.8%	13.1%	12.7%	★	12.7%	13%
North Zone	North Zone	15.0%	15.3%	15.3%	15.1%	14.5%	14.6%	▲	14.6%	13%
	Northern Lights Regional Health Centre	13.4%	12.8%	13.4%	14.3%	17.8%	15.2%	■	15.2%	13%
	Queen Elizabeth II Hospital	12.6%	11.9%	13.3%	13.2%	12.6%	11.2%	★	11.2%	13%
	Other North Hospitals	15.5%	16.1%	15.9%	15.5%	14.5%	15.0%	●	15.0%	13%

Understanding Our Results

Provincially unplanned hospital readmission rates remain stable but slightly higher than the target level.

Increases above 3% are noted at a few facilities across the province; however, an examination of longer term trends indicates that the fluctuations are within normal ranges for the sites.

Total Discharges

	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
FY 2015-16	9,632	35,449	16,826	37,646	14,251	113,804
FY 2016-17	9,824	35,550	16,741	37,674	14,106	113,895
Q1 2016-17	2,456	9,014	4,299	9,766	3,551	29,086
Q1 2017-18	2,384	9,369	4,063	9,494	3,604	28,914

Source(s): AHS Provincial Discharge Abstract Database (DAD), as of November 14, 2017

Notes:

- This quarter is a quarter later due to requirements to follow up with patients after end of reporting quarter.

- This indicator measures the risk-adjusted rate of urgent readmission to hospital for the medical patient group, which is adapted from the CIHI methodology.

This measure is defined as the percentage of opportunities in which healthcare workers clean their hands during the course of patient care. Direct observation is recommended to assess hand hygiene compliance rates for healthcare workers. The higher the percentage the better, as it demonstrates more healthcare workers are complying with appropriate hand hygiene practices.

Trend Legend:

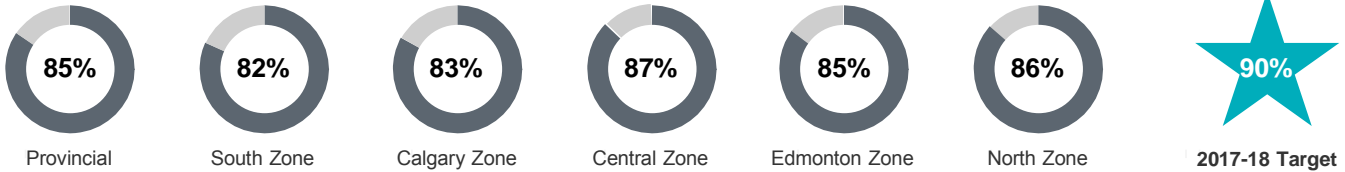
Target achieved

Improvement

Stable: ≤3% deterioration between compared quarters

Area requires additional focus

Hand Hygiene Compliance, Q2 2017-18



Hand Hygiene Compliance Trend - Busiest Sites

Zone Name	Site Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q2 2016-17	Q2 2017-18	Trend	Q2YTD 2017-18	2017-18 Target
Provincial	Provincial	66%	75%	80%	82%	83%	85%		84%	90%
South Zone	South Zone	78%	82%	82%	84%	85%	82%		79%	90%
	Chinook Regional Hospital	81%	85%	82%	83%	81%	72%		71%	90%
	Medicine Hat Regional Hospital	76%	77%	82%	87%	89%	87%		85%	90%
	Other South Sites	79%	85%	83%	83%	83%	80%		77%	90%
Calgary Zone	Calgary Zone	59%	71%	78%	81%	82%	83%		83%	90%
	Alberta Children's Hospital	57%	74%	77%	80%	80%	82%		81%	90%
	Foothills Medical Centre	52%	66%	76%	83%	85%	84%		84%	90%
	Peter Lougheed Centre	62%	77%	85%	79%	82%	76%		77%	90%
	Rockyview General Hospital	62%	68%	74%	84%	83%	89%		90%	90%
	South Health Campus	59%	59%	69%	76%	74%	80%		80%	90%
	Other Calgary Sites	63%	77%	80%	79%	77%	86%		83%	90%
Central Zone	Central Zone	64%	74%	81%	78%	84%	87%		82%	90%
	Red Deer Regional Hospital Centre	75%	69%	78%	78%	77%	83%		83%	90%
	Other Central Sites	57%	77%	82%	78%	85%	88%		82%	90%
Edmonton Zone	Edmonton Zone	57%	74%	79%	83%	83%	85%		85%	90%
	Grey Nuns Community Hospital *	64%	75%	73%	83%	80%	87%		87%	90%
	Misericordia Community Hospital *	71%	77%	75%	80%	75%	85%		85%	90%
	Royal Alexandra Hospital	62%	75%	81%	84%	83%	87%		86%	90%
	Stollery Children's Hospital	58%	75%	79%	80%	80%	79%		80%	90%
	Sturgeon Community Hospital	59%	81%	84%	86%	85%	89%		88%	90%
	University of Alberta Hospital	43%	70%	74%	85%	85%	87%		87%	90%
	Other Edmonton Sites	58%	73%	79%	82%	81%	84%		84%	90%
North Zone	North Zone	66%	81%	87%	88%	90%	86%		87%	90%
	Northern Lights Regional Health Centre	56%	64%	88%	87%	91%	83%		83%	90%
	Queen Elizabeth II Hospital	68%	91%	96%	91%	93%	90%		89%	90%
	Other North Sites	66%	74%	85%	88%	90%	87%		87%	90%

Understanding Our Results

Overall there was continued and sustained improvement in the provincial hand hygiene rates in Q2.

A deterioration may be related to the auditing processes resulting in lower observations. Hand Hygiene teams will re-launch the campaign with hand hygiene champions on each unit and will have focused attention to bring the compliance rates up to target level.

Compliance rates are always closely monitored and when we see a drop in compliance, actions are taken to increase engagement in Hand Hygiene practices.

Total Observations (excludes Covenant Sites)

	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
FY 2015-16	39,185	183,110	45,103	99,795	29,079	396,272
FY 2016-17	38,314	162,423	35,952	125,281	22,005	383,975
Q2 2016-17	9,920	41,217	7,721	31,078	5,932	95,868
Q2 2017-18	3,613	33,061	8,358	30,015	6,863	81,910

Source: AHS Infection, Prevention and Control Database, as of October 20, 2017

Notes:

- * 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 (Q1 & Q2) and fall (Q3 & Q4). These are not included in the Edmonton Zone and Provincial totals.

- "Other Sites" include any hand hygiene observations performed at an AHS operated program, site, or unit including acute care, continuing care, and ambulatory care settings such as Cancer Control, Corrections, EMS, hemodialysis (e.g., NARP and SARP), home care, and public health.

This measure is defined as the percentage of children who have received the required number of vaccine doses by two years of age. 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. The higher the percentage the better, as it demonstrates more children are vaccinated and protected from preventable childhood diseases.

Trend Legend:

Target achieved

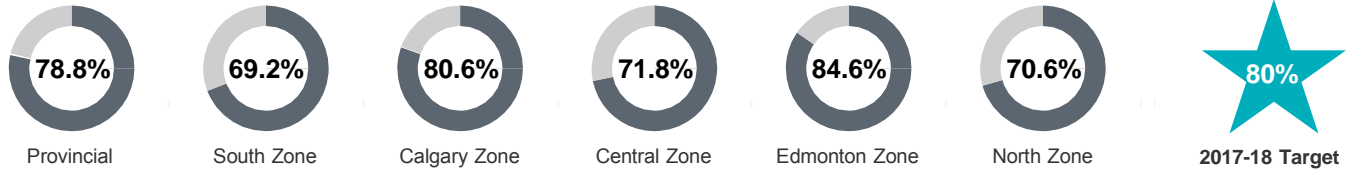
Improvement

Stable: ≤3% deterioration between compared quarters

Area requires additional focus



Childhood Immunization Rate: DTaP-IPV-Hib, Q2 2017-18



Childhood Immunization Rate: DTaP-IPV-Hib Trend

Zone Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q2 2016-17	Q2 2017-18	Trend	Q2YTD 2017-18	2017-18 Target
Provincial	77.6%	78.3%	78.0%	78.3%	79.2%	78.8%	▲	78.6%	80%
South Zone	64.6%	67.9%	65.7%	67.8%	69.5%	69.2%	▲	70.4%	80%
Calgary Zone	81.4%	82.6%	81.5%	81.4%	82.3%	80.6%	★	80.2%	80%
Central Zone	71.1%	71.1%	70.9%	70.6%	69.4%	71.8%	■	71.4%	80%
Edmonton Zone	84.0%	84.0%	84.6%	84.0%	85.3%	84.6%	★	84.9%	80%
North Zone	67.2%	66.6%	66.5%	67.7%	69.6%	70.6%	■	69.4%	80%

Understanding Our Results

Provincially, immunization rates in Q2 are steady.

AHS continues to raise awareness in geographical areas where immunization rates are low.

Total Eligible Population

	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
FY 2015-16	4,104	19,602	6,240	16,870	7,451	54,267
FY 2016-17	4,157	20,424	5,833	17,578	7,146	55,138
Q2 2016-17	1,083	5,376	1,608	4,572	1,979	14,618
Q2 2017-18	1,126	5,492	1,449	4,737	1,930	14,734

Source: AHS Public Health Surveillance Database, as of October 20, 2017

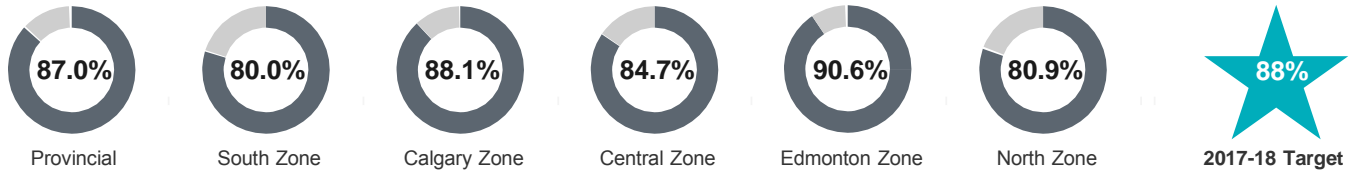
- The targets here are 2017-18 AHS Target. Alberta Health have higher targets for DTaP-IPV-Hib - 97% and for MMR - 98%, by two years of age.

This measure is defined as the percentage of children who have received the required number of vaccine doses by two years of age. 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. The higher the percentage the better, as it demonstrates more children are vaccinated and protected from preventable childhood diseases.

Trend Legend:

- Target achieved ★
- Improvement ■
- Stable: ≤3% deterioration between compared quarters ▲
- Area requires additional focus ●

Childhood Immunization Rate: MMR, Q2 2017-18



Childhood Immunization Rate: MMR Trend

Zone Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q2 2016-17	Q2 2017-18	Trend	Q2YTD 2017-18	2017-18 Target
Provincial	86.7%	87.6%	86.9%	87.4%	87.8%	87.0%	▲	87.0%	88%
South Zone	81.1%	83.9%	78.8%	81.0%	82.0%	80.0%	▲	81.5%	88%
Calgary Zone	88.3%	89.6%	89.2%	89.6%	90.7%	88.1%	★	87.8%	88%
Central Zone	81.2%	80.8%	81.1%	82.3%	80.5%	84.7%	■	84.8%	88%
Edmonton Zone	91.7%	92.2%	91.9%	91.8%	92.6%	90.6%	★	91.2%	88%
North Zone	79.6%	80.3%	78.5%	77.8%	78.1%	80.9%	■	79.8%	88%

Understanding Our Results

Provincially, immunization rates in Q2 are steady.

AHS continues to raise awareness in geographical areas where immunization rates are low.

Total Eligible Population

	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
FY 2015-16	4,104	19,602	6,240	16,870	7,451	54,267
FY 2016-17	4,157	20,424	5,833	17,578	7,146	55,138
Q2 2016-17	1,083	5,376	1,608	4,572	1,979	14,618
Q2 2017-18	1,126	5,492	1,449	4,737	1,930	14,734

Source: AHS Public Health Surveillance Database, as of October 20, 2017

- The targets here are 2017-18 AHS Target. Alberta Health have higher targets for DTaP-IPV-Hib - 97% and for MMR - 98%, by two years of age.

This measure is defined as the number of AHS workers injured seriously to require modified work or time loss from work per 200,000 paid hours (approximately 100 full time equivalent workers). Our disabling injury rate enables us to identify Workplace Health & Safety (WHS) programs that provide AHS employees, volunteers and physicians with a safe and healthy work environment and keep them free from injury. The lower the rate, the fewer disabling injuries are occurring at work.

Trend Legend:

- ★ Target achieved
- Improvement
- ▲ Stable: ≤3% deterioration between compared quarters
- Area requires additional focus



Disabling Injury Rate: Q2YTD 2017-18



Disabling Injury Rate by AHS Portfolio

Level of Portfolio	Portfolios or Departments	FY 2015-16	FY 2016-17	Q2YTD 2016-17	Q2YTD 2017-18	Trend	2017-18 Target
Provincial	Provincial	3.57	3.85	3.19	3.28	★	3.5
Zone	South Zone Clinical Operations	3.54	3.50	2.85	2.57	★	3.5
	Calgary Zone Clinical Operations	3.54	3.86	3.06	3.41	★	3.5
	Central Zone Clinical Operations	4.00	4.14	3.74	4.15	●	3.5
	Edmonton Zone Clinical Operations	3.59	3.83	3.09	3.45	★	3.5
	North Zone Clinical Operations	4.33	3.78	2.60	3.31	★	3.5
Provincial Portfolios	Cancer Control	1.71	1.43	1.01	1.00	★	3.5
	Capital Management	2.37	3.77	3.38	2.35	★	3.5
	Collaborative Practice, Nursing & Health Profession	4.93	4.23	4.50	6.99	●	3.5
	Community Engagement and Communications	0.00	0.00	0.00	0.00	★	3.5
	Contracting, Procurement & Supply Management	2.70	3.74	3.05	3.03	★	3.5
	Diagnostic Imaging	1.81	2.90	2.77	3.43	★	3.5
	Emergency Medical Services	12.92	15.09	14.32	12.77	■	3.5
	Finance	0.16	0.33	0.33	1.00	★	3.5
	Health Information Management	1.29	2.19	1.82	0.82	★	3.5
	Information Technology (IT)	0.25	0.16	0.11	0.21	★	3.5
	Internal Audit and Enterprise Risk Management	0.00	0.00	0.00	0.00	★	3.5
	Laboratory Services	1.31	1.55	1.14	1.41	★	3.5
	Linen & Environmental Services	7.62	8.00	6.92	5.51	■	3.5
	Nutrition & Food Services	5.91	5.38	4.22	4.61	●	3.5
	People, Legal, and Privacy	0.74	0.50	0.20	0.19	★	3.5
	Pharmacy Services	1.09	1.69	1.01	0.77	★	3.5
	Population, Public & Indigenous Health	1.29	1.13	0.82	0.61	★	3.5
	Research, Innovation and Analytics	0.27	0.26	0.00	0.71	★	3.5

Understanding Our Results

Efforts to improve our DIR include targeting interventions to common causes of injuries in high risk areas, and enhancing programs and processes related to physical safety, such as violence, patient handling, and manual material handling.

Analyses conducted by AHS Workplace Health & Safety (WHS) determined that higher rates within the Collaborative Practice, Nursing & Health Profession were due to the way paid hours are attributed within the casual workforce. WHS nonetheless continues to support the portfolio in addressing these injuries.

Injuries within Nutrition & Food Services are due to manual material handling, while within the Central Zone, they are primarily musculoskeletal in nature related to the repositioning of patients.

Over the next three years, AHS efforts will be focused on those areas which experience the highest rates of injury over an extended period of time.

Source: WCB Alberta and e-Manager Payroll Analytics (EPA), 2017-18 September YTD data as of October 23, 2017

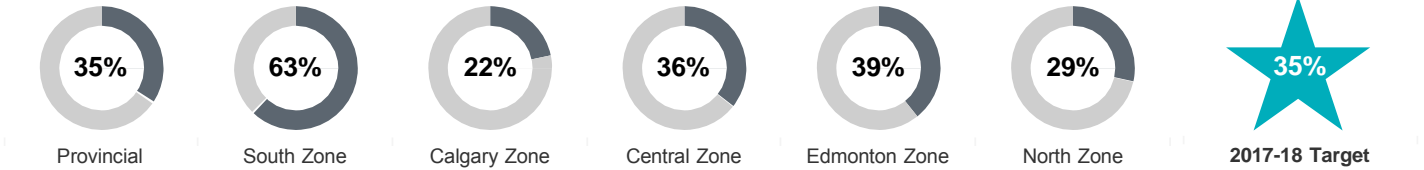
Notes:
 - Community Engagement & Communications and Internal Audit & Enterprise Risk Management reporting of "0.00" is accurate and reflects these two portfolios having very safe and healthy work environments.
 - Q2 results are reported year-to-date to align with AHS People, Legal and Privacy reporting to the AHS HR Committee of the Board.

This measure is defined as the percentage of nursing units at the 16 busiest sites meeting Operational Best Practice (OBP) labour targets. A higher percentage means more efficiencies have been achieved across AHS.

Trend Legend:

- ★ Target achieved
- Improvement
- ▲ Stable: ≤3% deterioration between compared quarters
- Area requires additional focus

Percentage of Nursing Units Achieving Best Practice Targets, Q2 2017-18



Percentage of Nursing Units Achieving Best Practice Targets

Zone Name	FY 2015-16	FY 2016-17	Q2 2016-17	Q2 2017-18	Trend	Q2YTD 2017-18	2017-18 Target
Provincial	22%	31%	25%	35%	★	35%	35%
South Zone	63%	63%	46%	63%	★	58%	35%
Calgary Zone	17%	21%	18%	22%	■	25%	35%
Central Zone	7%	29%	14%	36%	★	36%	35%
Edmonton Zone	17%	31%	27%	39%	★	39%	35%
North Zone	33%	33%	20%	29%	■	29%	35%

Understanding Our Results

Within Q2, the 16 largest sites continue to work towards reducing variation in the cost of delivering high quality services. While not all sites are yet achieving the provincial target in the second quarter, provincially, the Q2 results met the 2017-18 target of 35%.

Source: AHS General Ledger (no allocations); Worked Hours - Finance consolidated trial balance, Patient Days – Adult & Child - Finance statistical General Ledger, as of October 31, 2017
 Notes:
 - Data quality issues were identified in historical data which potential over stated efficiencies. Work continues in data quality but historical data can't be retroactively corrected.