Performance Report
2017-2018 Health Plan
Q3 (October 1, 2017-December 31, 2017)

A healthier future. Together.

Prepared by AHS Planning & Performance - March 27, 2018

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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:

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)

Eleven measures are reported quarterly:

- Seven measures include the most current data available (Q3) 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. (Q2 data provided).

Results (October 1, 2017 to December 31, 2017) for the eleven performance measures available are as follows:

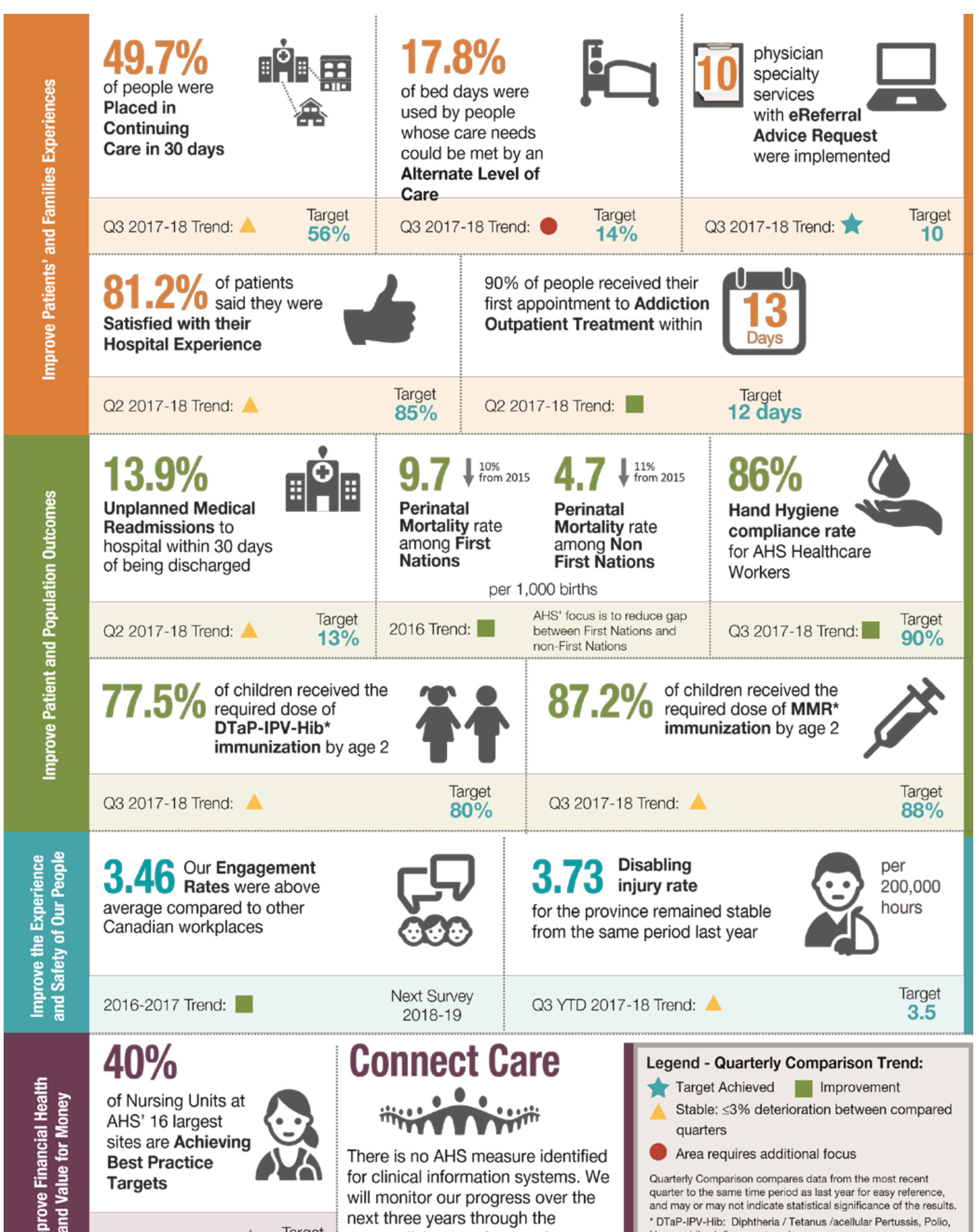
91% (10 out of 11) of the performance measures are better or stable from the same period last year with two measures achieving target (Timely Access to Specialty Care and Percentage of Nursing Units Achieving Best Practice Targets).

9% (1 out of 11) of the performance measures did not improve from the same period as last year. Percentage of alternate level of care patient days – deteriorated due to slower than expected growth in mental health, home care, continuing care and community care. Further explanation is included 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.

Q3 Measures Dashboard

The Q3 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.

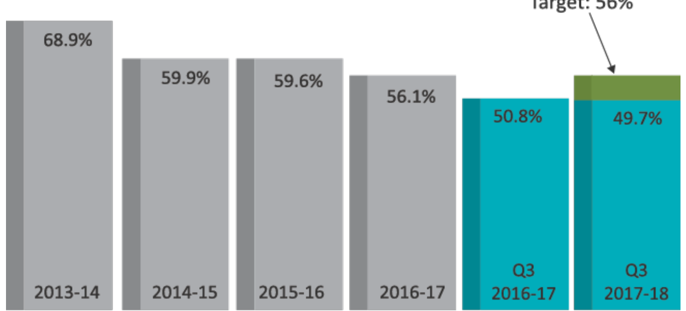
UNDERSTANDING THE MEASURE

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 times and deliver care in a more cost-effective manner. Timely placement can also 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 settings. 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



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.

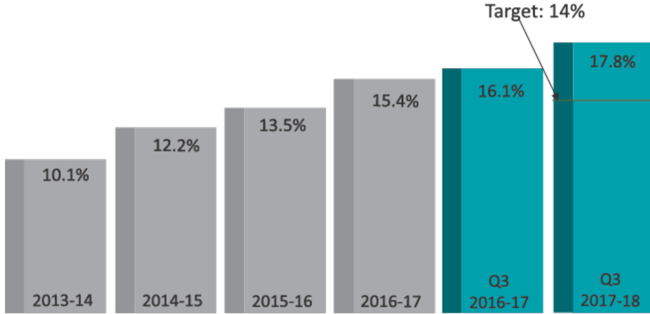
If the percentage of ALC days is high, there may be a need to focus on ensuring timely accessibility to options for ALC patients. Therefore, the lower the percentage the better.

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

For Q3 2017-18, the average wait time for continuing care placement from acute/sub-acute care is 52 days compared to 48 days for the same period last year. The number of people waiting in acute/sub-acute care is 766 as of December 31, 2017 compared with 896 people waiting in September 30, 2017. For Q3 2017-18, there were 1,973 people placed into continuing care from community compared to 1,921 for the same period last year.

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 Q3 year-to-date, AHS opened 532 new continuing care beds – more than the entire 2016-17 year (376 new beds). Since 2010, AHS has opened 6,155 new beds to support individuals who need community-based care and supports (including palliative).

A new continuing care facility was opened in Medicine Hat in October 2017.

In Q3 year-to-date, 106,896 clients with unique needs received home care, an increase of 1.9% from Q3 year-to-date 2016-17 (104,909 clients).

Enhancing Care in the Community (ECC) is the roadmap for improving community-based care and services and reducing reliance on acute care services.

While the current focus of the ECC initiatives is on recruitment to enhance home care capacity, several initiatives were officially launched in Q3 and are showing positive results.

- Expansion of home care, and palliative care services across the province.
- Implementation of emergency medical services (EMS) programs to improve access to care in the community and at home (i.e., Community Paramedic Teams, and Assess, Treat and Refer processes).
- Development of a new model of care in the Edmonton Zone (Virtual Hospital project).
- A Complex Care Hub will start at Rockyview General Hospital in Calgary.
- North Zone is opening enhanced respite day programs in six communities.
- Calgary Zone is developing a palliative home care program focused on rural areas.
- Specialized intensive home care programs will provide more services for clients in the community.
- Community Support Teams will provide support to complex patients residing in appropriate living options requiring extensive interventions.

Q3 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, a total of 92 (out of 176) supportive living sites rolled out AUA (47 Edmonton Zone, 24 South Zone and 21 Central Zone).

- Work is underway to recruit membership for the Housing and Health Services Steering Committee which will address gaps and opportunities in the quality of residential continuing care services.

- AHS is collaborating with providers to increase availability and awareness of GPS locator technology for home care clients living with dementia.

A new Provincial Advisory Council for Seniors and Continuing Care was established in December 2017 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, 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 specialists 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 achieve target.

HOW WE ARE DOING

As of Q3, AHS implemented eReferral Advice Request in ten more specialty services across the zones – effectively meeting its current target. The ten specialties are:

1. Orthopedic Surgery – Hip/Knee Joint Replacement
2. Oncology – Breast
3. Oncology – Lung
4. Nephrology
5. Urology
6. Internal Medicine/Endocrinology
7. Internal Medicine/Adult Gastroenterology
8. Obstetrics and Gynecology
9. Neurological Surgery/Spinal Neurosurgery
10. Internal Medicine/Pulmonary Medicine

The Internal Medicine/General Internal Medicine charter was signed for 2018 implementation.

WHAT WE ARE DOING

Primary Health Care

Alberta Health is working with the Alberta Medical Association (AMA) and AHS to implement the new Primary Care Network (PCN) Governance Framework. This work 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 the 15th Strategic Clinical Network (SCN)™ in Alberta – Primary Health Care Integration Network (PHCIN). PHCIN focuses on improving transitions of care between primary care providers and acute care, emergency departments, specialized services and other community services.

Activities underway to support the Primary Health Care Integration Network:

- Partnered with the Seniors Health Strategic Clinical Network for a pilot project with five PCNs in eight communities focused on managing care of those living with dementia in the community. The second workshop took place in December 2017 with over 100 participants, including PCN staff/physicians and family representatives.

- Work is underway in each zone across four areas of focus: the community; home-to-hospital-to-home transitions (admissions and discharge); access to specialty care and back to primary care; and, system foundations for integration.

- The Coalition for Integration was established to stimulate innovative thinking and solutions to integration challenges faced in Alberta. Membership includes patients and families, health professionals, community-based organizations, primary healthcare delivery organizations, AHS zone operations and provincial programs, Alberta Health, Alberta Human Services and universities. A second meeting was held in October 2017.

- An Integrated Care Partnership (ICP) is a formation of stakeholders who develop a shared understanding of key challenges and opportunities in health service delivery and work together to achieve a shared outcome. To date, three 'proof of concept' ICPs have been developed.

CancerControl

Improvements were made in End of Treatment and Transition of Care processes for patients who have completed cancer treatment and are returning to a family physician. Processes have been implemented in five early-stage and curative populations (breast, prostate, testicular, cervical, and endometrial). The remaining three populations are under final review (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 (Medicine Hat) and Central Alberta Cancer Centre (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 planning is on schedule. Internal and external stakeholder engagement is ongoing, including engagement with the City of Calgary. Construction has started at the Foothills Medical Centre site.

- Grande Prairie Cancer Centre construction is proceeding on the current schedule.

- The final phase of renovations to the current space at the Jack Ady Cancer Centre 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 rural and remote areas were met in Q3. However, Q3 results for metro/urban and towns/ communities with a population greater than 3,000 did not meet the target due to the high volume of calls during flu season and long waits in emergency departments.

The target (1 minute and 30 seconds) for time to dispatch of the first ambulance includes verifying the location of the emergency, identifying the closest ambulance and alerting the ambulance crew was met in Q3 (1 minute and 23 seconds). Performance continues to improve and is better than accredited benchmarks.

Implementation of the electronic patient care record (ePCR) for direct delivery and contract operators is on schedule. As of Q3, 99% of contract operators and 100% of 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 at 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 within six weeks of discharge from acute care facilities.

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.

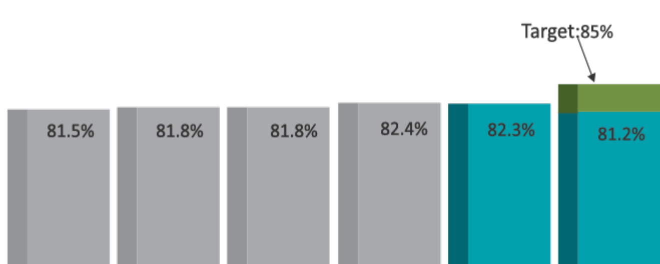
HOW WE ARE DOING

Provincially, AHS has remained stable from the same period last year. The percentage of adults rating their overall hospital stay as 8, 9 or 10 is 81.2% for Q2 2017-18 compared to 82.3% in Q2 2016-17.

This measure is reported a quarter later due 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. Below are just a few examples of initiatives and actions to support patient- and family-centered care across AHS.

AHS began collecting satisfaction with hospital experience for children using the Hospital Assessment of Healthcare Providers and Systems Survey tool in 2015-16 and continues to monitor results quarterly. The child hospital survey assesses the experiences of pediatric patients (17 and younger) and their families with inpatient care. For Q2 2017-18, the AHS Provincial Child Satisfaction with hospital experience was 86.5% compared to 85.4% for the same period last year.

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

A pilot project was completed with Alberta Children's Hospital in the Calgary Zone related to on-demand Video Remote Interpretation which allows the patient, clinician and the interpreter to see each other during virtual meetings. Results from further testing will be used to inform how best to make this technology available to patients and care teams in other locations across Alberta.

Leader Rounding involves management attending clinical rounds to understand how staff are serving patients.

The Leader Rounding Campaign (Be Bold & Try it) was completed with over 85 AHS leaders participating in the challenge in October and over 100 participants attending a dedicated coaching session to prepare for effective leader rounding.

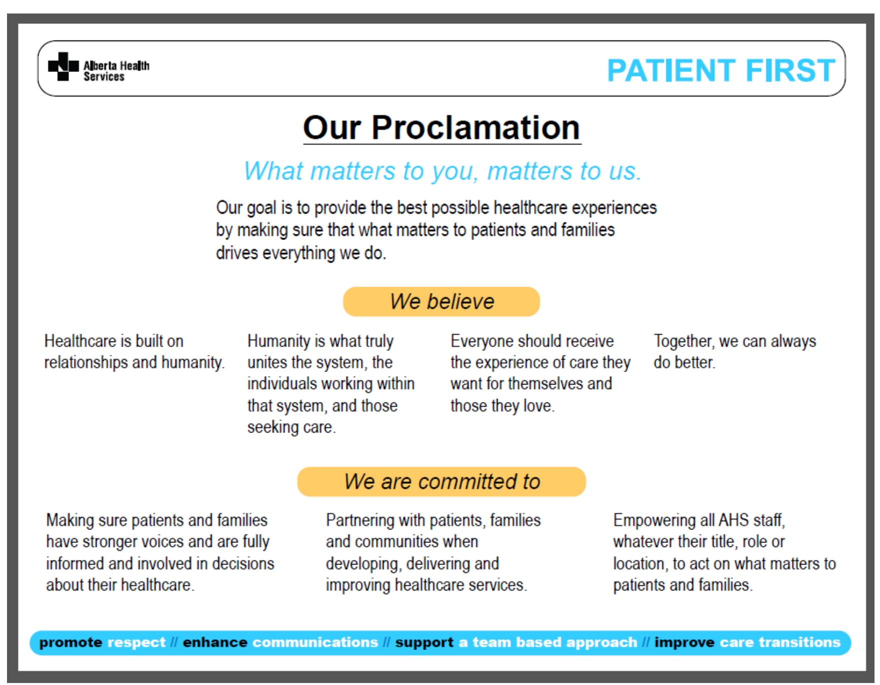
The AHS Quality and Safety Summit has a Patients Included designation based on a demonstrated commitment to incorporating the experiences of patients and families and co-designing health services with patients and family advisors. There were 36 patient advisors that participated in the 3rd Annual Quality & Safety Summit in October 2017.

The Patient First Proclamation (graphic below) was finalized. It illustrates AHS' commitment to patient experience, reminding everyone that we all have a role to play in it.

The annual Patient and Family Centred Care (PFCC) week was held in November. This year's theme was *Navigating Health Care with Compassion* and included four webinars, 16 digital storytelling venues, four Insite blogs, and two interchange articles.

In addition to provincial initiatives, zones continue to implement patient- and family-centred care activities to increase the patient voice and participation in care delivery. Examples include:

- Roll-out of Visitation Policy and Family Presence Policy which welcomes patients and families as partners in care.
- Development and implementation of orientation placemats on inpatient units which is a patient-friendly document that details hospital information.
- Edmonton Zone continues to implement the 15-5 Rule initiative where staff acknowledge patients or family when they are within 15 feet and greet them within 5 feet.
- Collaborative Care is a healthcare approach in which inter-professional teams work together, in partnership with patients and families, to achieve optimal health outcomes. Collaborative Care continues to be implemented, supported by the CoACT program, on over 160 surgery, medicine and mental health units across the province. CoACT is now a permanent AHS program. All 160 units are actively implementing. Work is underway to sustain and spread this effort.



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. This excludes opioid dependency programs.

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 recognizing that there are multiple entry points and that these services assist different populations with different needs and paths to care.

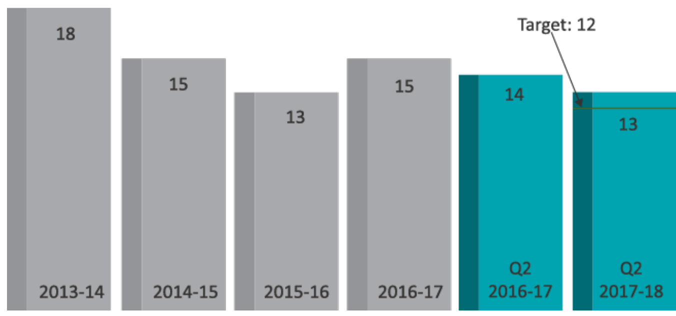
The lower the number the better, as it demonstrates people are waiting for a shorter time to receive adult addiction outpatient services.

HOW WE ARE DOING

Provincial results indicate that we have improved compared to the same period last year.

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: Improvement



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 schedule to complete the Provincial Mental Health Diversion Standards.

The percentage of children offered scheduled community mental health treatment within 30 days dropped to 74% in Q3 year-to-date (YTD) 2017-18 compared to 81% in Q3 YTD 2016-17. However, this is a slight improvement from Q2 YTD 2017-18 (70%). The number of enrolments in scheduled children's mental health services increased by approximately 12% compared to Q3 2016-17.

> The percentage of children aged 0 – 17 years who are offered an appointment for scheduled community mental health treatment within 30 days of referral. Time is from appointment booking to first offered appointment with a mental health therapist.

AHS continues to address challenges in access to scheduled children's mental health services:

- In the Central Zone, mental health therapists were hired in ten schools which has enhanced access by enabling direct referrals to community therapists.

- Recruiting new child psychiatrists within community clinics to enhance access to specialized psychiatric consultations for children in the Edmonton Zone.

- Continued planning on Centralized Intake that will be accessible 24/7 in the Edmonton Zone.

- Establishing a process in the North Zone emergency departments to review challenges and barriers to accessing children's mental health services in the emergency department.

- Investigating the use of alternative methods, including Telehealth, to provide children's mental health services in the South Zone.

- AHS is partnering with Canadian Mental Health Association to assist in recruitment and training for a peer support network for rural communities in the Calgary Zone.

- Rural clinics (e.g. Claresholm Addiction and Mental Health) continue to participate in the rural intake line in the Calgary Zone. This line provides patients and providers with timely information and access to addiction and mental health resources in the communities.

AHS is working with AH and community partners to address the opioid crisis. This work also supports the Minister's Opioid Emergency Response Commission. Q3 highlights include:

- Nearly 10,000 take home Naloxone kits were dispensed to Albertans in Q3. Since July 2015, nearly 38,000 kits have been dispensed – including kits dispensed by the Alberta Community Council on HIV agencies.

- Based on AHS data collected since January 2016, as of December 31, 2017, over 2,800 overdose reversals (naloxone administered to reverse effects of an opioid overdose) were voluntarily reported in Alberta.

- New Opioid Dependency Treatment (ODT) clinics were operationalized 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 number of unique clients in AHS Opioid Dependency Programs increased from 1,361 in Q2 to 1,492 in Q3.

- AHS has agreements with health leaders from Piikani Nation, Kainai Nation, and First Nations Inuit Health Branch (federal) to address the opioid crisis within Indigenous communities and urban settings to provide related services on and off reserve.

- 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 external factors, 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.

Rates may be impacted due to the nature of the population served by a facility (elderly patients and patients with chronic conditions) or 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.

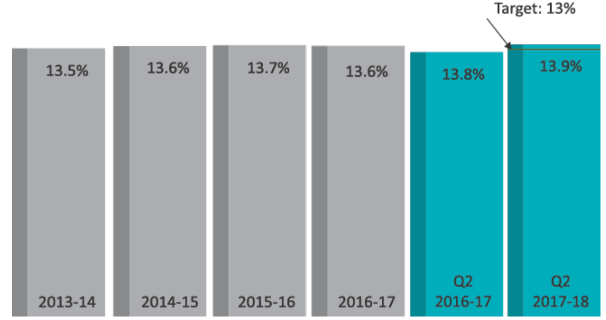
The most recent data for this measure is one quarter behind the reporting period due to various reporting system timelines.

HOW WE ARE DOING

The rate of readmissions has remained relatively stable over the past few years. Unplanned medical readmission to hospital results was 13.9% in Q2 2017-18 compared to 13.8% in Q2 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, such as the Patients Collaborating with Teams (PaCT) which focuses on planning for complex patients and the Bridging the Gap initiative which determines solutions for discharge and transition of patients with complex health needs to community family practices.
- Zones implemented clinical care pathways through the SCNs™ – Chronic Obstructive Pulmonary Disease (COPD) and heart failure, Enhanced Recovery After Surgery (ERAS), hip and knee replacement pathway, and Delirium in intensive care units.
- The South Zone Wound Management Service Delivery Approach was developed in Q3 and includes recommendations to improve patient flow, address outcomes such as decreasing or managing pain, and provide information about caregiver support and access to resources.

SCNs™ are working to reduce inappropriate variation and apply consistent clinical standards across AHS.

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 (nearing target of 11%) as of June 2017. Next data update will be available at year-end.

The Provincial Breast Health Initiative will improve breast cancer care through design of provincial pathways (diagnostic assessment, same-day surgery, breast reconstruction). Highlights for Q3 are:

- Completed provincial patient education package: Journey through Breast Cancer. This will be made available to patients and providers in Q4.
- Launched a patient experience survey for perioperative care in Edmonton and Calgary.
- Implemented a pathway to expedite referrals and consults for patients with highly suspicious breast lesions on imaging in Edmonton (November 2017) and Calgary (January 2018).

Standardization of the Emergency Assessment Record has been implemented in 61 out of 72 rural Emergency Departments (85%) as of December 31, 2017.

A total of 27 out of 42 Primary Care Networks as well as the Northern Alberta Renal Program are in the process of implementing the Diabetes Foot Care Clinical Pathway which aims to improve diabetes foot screening rates, early identification and treatment of foot problems and patient self-care recommendations thereby reducing risks of developing a diabetic foot ulcer and subsequent amputations.

A total of 14 sites (compared to seven last year) have implemented Basal Bolus Insulin Therapy (BBIT) in place of subcutaneous sliding scale insulin (SSI) to improve and standardize diabetes care in Alberta hospitals.

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)
- Catch a Break (secondary fracture prevention initiative)
- Glycemic Management Policy
- Insulin Pump Therapy
- Early Hearing Detection and Intervention Program
- Elder Friendly Care in Acute Care

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. An update on ECC initiatives can be found under Objective 1 of this report.

The **Health Analytic Portal** is available to AHS analysts, researchers and external partners who are dedicated to improving healthcare in Alberta. It provides access to a trusted source of secondary use data, information products and supporting services.

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 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.

The lower the number the better. AHS' focus is to reduce the health gap between First Nations and non-First Nations. This measure does not include all Indigenous populations, such as our Inuit and Métis residents.

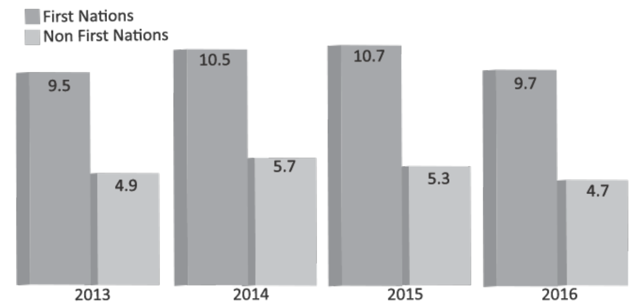
HOW WE ARE DOING

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.

AHS' focus is to reduce the health gap between First Nations and non-First Nations.

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

This is a performance indicator. No target. AHS' focus is to reduce gap between First Nations and non-First Nations.



Source: Alberta Vital Statistics and Alberta First Nations Registry

WHAT WE ARE DOING

Perinatal Mortality

Merck for Mothers uses community-based ways to enhance the support of pregnant Indigenous women to overcome barriers to prenatal care. There are three initiatives in unique communities across Alberta:

- The Maskwacis project focuses on building resilience, promoting positive images of the community, celebrating birth and sharing Indigenous knowledge on pregnancy. The community is developing a photo voice approach within maternity wards and clinics in Ponoka, Wetaskiwin and Red Deer as well as a video on motherhood and parenting. This work also includes enhancement of nurse skillset at Maskwacis Health Services for pregnant and post-partum women.
- Work continues in inner-city Edmonton on the Pregnancy Pathways initiative that will provide safe housing and support services for pregnant Indigenous homeless women.
- The Little Red River project in the North Zone is providing a community-based support model that will add to maternal health resources, engage women early in pregnancy, raise awareness related to healthy pregnancies, enhance prenatal education, strengthen collaborations, and post-natal follow-up care, and facilitate health promotion activities. Engagement with the community has been re-established and progress is underway.

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

Work is underway to develop an antenatal care pathway to support the maternity services corridors of care initiative so that expectant mothers can access evidence-based consistent antenatal care.

Work continues to finalize the North Zone Maternal Infant Strategic Plan which includes objectives to improve pregnancy/infant health outcomes for Indigenous populations.

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. NAS is a group of problems that occur in a newborn who was exposed to addictive opiate drugs while in the mother's womb. Work will include bringing together acute care, addictions and mental health, public health, home visitation and, potentially, outside agencies including Indigenous health agencies.

Engagement and Cultural Competency

AHS supports growth and development of the Indigenous Health Program, Indigenous Wellness Clinic Program in Edmonton and Elbow River Healing Lodge in Calgary. There are also monthly engagement session with urban Indigenous community partners in Lethbridge and Cultural Safety groups in the Central Zone.

South Zone leadership meets quarterly with the health departments for the Kainai and Piikani Nations to discuss common areas for community health services, continuing care, and acute care.

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.

A Truth and Reconciliation planning team is developing a plan to support recommendations from the Truth & Reconciliation Commission and United Nations Declaration on the Rights of Indigenous Peoples. The PPIH SCN Indigenous Health committee is working with the planning team to identify actions for AHS through engagement with Indigenous peoples and communities.

AHS leadership are encouraged to complete cultural competency training sessions to gain better awareness on how to appropriately provide care to patients and families. The percent of senior leaders who have completed the Indigenous Awareness and Sensitivity training increased from 43% in Q2 to 48% in Q3.

Approximately 225 AHS senior leaders attended the Truth Always session in October 2017 and participated in a Blanket Ceremony that helped create awareness about Canadian history from an Indigenous perspective.

Program Development

AHS and the Alberta Cancer Prevention Legacy Fund are 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 include:

- First Nations Cancer Prevention and Screening Practices supports First Nations communities to develop, implement and evaluate comprehensive prevention and screening plans. Community assessments were completed in three First Nations communities (Peerless Trout, Maskwacis, and Blood Tribe) in Q2. In Q3, all three communities identified prevention and screening priorities to implement in their communities.

- Alberta Healthy Communities Approach (AHCA) supports communities to plan, implement and evaluate comprehensive prevention and screening interventions. Three Métis Settlements (East Prairie, Peavine and Gift Lake) have joined the 16 Alberta communities implementing the AHCA.

- Alberta Screening and Prevention (ASaP) focuses on meeting the needs of primary care settings that serve Indigenous patients. The Elbow River Healing Lodge continues to implement and evaluate its new documentation processes for height, weight, diabetes and breast, cervical and colorectal cancer screening in their electronic medical record.

- Zone Comprehensive Prevention and Screening Approach is piloting a framework for a zone-level comprehensive prevention and screening approach. Two Métis Settlements (Gift Lake and Peavine) and one First Nation community (Sucker Creek) received prevention and/or screening supports. One non-Indigenous community (High Prairie) located in local geographic areas where more than 10% of the population self-identified as Indigenous received prevention and/or screening supports.

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 because it is one key way to ensure 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" which 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 a recommended way 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.

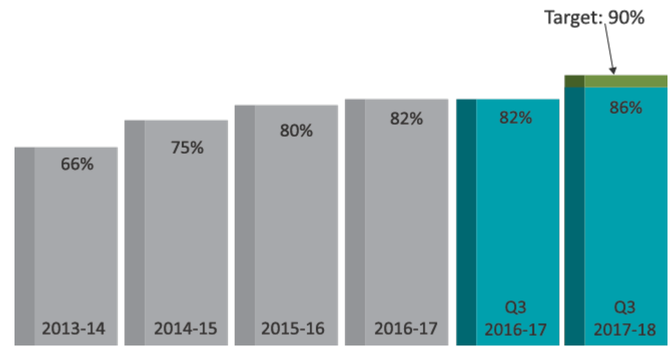
HOW WE ARE DOING

At the provincial level, hand hygiene compliance increased from 82% in Q3 2016-17 to 86% in Q3 2017-18.

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

Hand Hygiene Compliance

Quarterly Comparison: Improvement



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

WHAT WE ARE DOING

AHS continues to develop new communication tools to share hand hygiene results and engage leaders, physicians, and front line healthcare workers in hand hygiene improvements.

The Infection Prevention and Control (IPC) Hand Hygiene program launched a call to action on Global Handwashing Day on October 15, 2017 to increase hand hygiene awareness.

Staff were asked to submit videos of coworkers who go above and beyond the call of duty for hand hygiene. The videos will be used to create a video montage, which will be released on Stop! Clean Your Hands Day in May 2018.

To provide leaders with a framework that aims to connect hand hygiene improvement initiatives with existing AHS resources, the IPC Hand Hygiene program has developed the Leadership Toolkit: Hand Hygiene, Helping Leaders Achieve Success, which has been approved and is expected to be released soon.

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 remain stable and low for the past few quarters (3.0 cases per 10,000 patient days in Q3 year-to-date 2017-18 compared to 3.3 cases in Q3 year-to-date 2016-17). A lower 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 is an interdisciplinary activity that promotes optimal antimicrobial therapy including assessment of the need for antimicrobials, and if antimicrobials are needed, the appropriate selection, dosing, route and duration of antimicrobial therapy.

- The Antimicrobial Stewardship program has initiatives aimed at reducing the risk of hospital-acquired CDI and associated complications in patients who acquire the infection. This includes the use of standard physician patient care orders implemented at the time of CDI diagnosis to standardize treatment and reinforce appropriate infection control measures.

- Infection Prevention and Control works collaboratively with physicians and other health professionals to review CDI cases with a focus on improving care management. Information on hospital-acquired CDI case rates are found on nursing units which care for patient populations identified as high risk for acquiring CDI.

- Zones continue to prioritize at least one initiative targeted at reducing utilization of the 14 select antimicrobials associated with a high risk of CDI.

- AHS launched a provincial initiative to optimize urine tests and reduce antibiotic use.

Rates of hospital-acquired Methicillin-resistant Staphylococcus aureus Blood Stream Infections remained stable compared to the same period last year.

AHS Linen and Environmental Services provides designated equipment cleaners for cleaning of shared patient care equipment (wheelchairs, commodes, etc.) in the Edmonton and Calgary zones.

Infection Prevention and Control in collaboration with Linen and Environmental Services completed a best practice review of hard surface disinfectants (used to clean patient environments). Based on these findings, a rollout of standardized products is planned for 2018-19.

Work continues on the Patient Safety Strategy that will articulate how to make significant improvement in patient safety. A policy suite went live in November – focusing on recognizing and responding to hazards, close calls, and clinical adverse events.

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 currently implemented 90% (target = 100%) of Health Quality Council of Alberta's (HQCA) recommendations related to parenteral nutrition. Parenteral nutrition (intravenous feeding) 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.

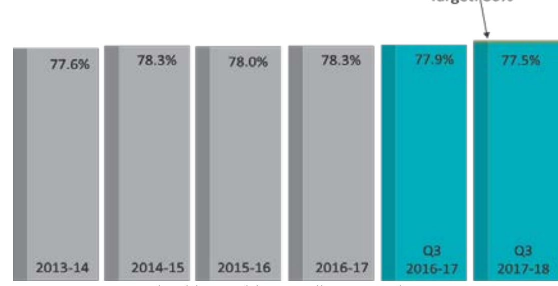
The higher the percentage the better, as it demonstrates more children are vaccinated and protected from preventable childhood diseases.

HOW WE ARE DOING

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

Childhood immunization: DTaP-IPV-Hib

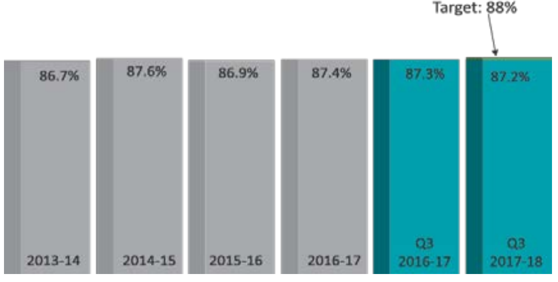
Quarterly Comparison: ▲ Stable: ≤3% deterioration



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 federal 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. Highlights include:

- 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.
- Provided in-service to community healthcare practitioners in Calgary on healthcare setting inspections (e.g. physician offices, dental offices).
- 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 Forestry, 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.

Implementation of the 2016-2020 Alberta Sexually Transmitted Blood-Borne Infections (STBBI) Operational Strategy and Action Plan is on schedule. An Implementation Steering Committee and working groups have been formed to support this work.

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.

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.

- As of December 31, 2017, the percentage of meat processing facilities that have been inspected using the new baseline assessment and inspection tool are as follows: North Zone (50%), Edmonton Zone (47%), Central Zone (49%), Calgary Zone (59%), South Zone (100%) – 57% completed overall.
- An online course provided by the National Collaborating Centre Environmental Health on the theory and food safety hurdles of producing safe ready-to-eat meat products was disseminated to AHS inspectors throughout the province.

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.

- AHS supported 30 funded community coalitions across the province to implement promotion and prevention activities.
- The Help4me website framework has been submitted to government and includes recommendations provided by youth and youth servicing organization representatives.
- Work continues on the development of the AHS Harm Reduction Policy.
- The InRoads curriculum refresh and enhancement project is underway, including the development of training modules. All eleven modules reviewed by the Continuing Medical Education Accreditation Committee and were approved for accreditation. The modules will be available through AHS My Learning Link and the Primary Health Care E-Learning Portal by March 31, 2018.

AHS plays an important role in supporting screening initiatives across the province.

- The Early Hearing Detection and Intervention (EHDI) project was implemented in 11 out of 13 neonatal intensive care units (NICU). The remaining two NICUs will be completed by March 31, 2018. EHDI offers screening to newborns for hearing prior to discharge.
- Additional screening activities can be found under page 16.

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.

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.

Enhancing workforce engagement will contribute to achieving a culture where people feel supported, valued and able to reach their full potential

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

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 out of 5 (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

An Our People Pulse Survey was conducted in November 2017. This survey did not measure engagement, but assessed use of the 2016 Our People Survey results to identify and act on ways to improve engagement locally.

The Our People Pulse Survey asked three questions:
1. *I received feedback on the 2016 Our People Survey.*
2. *Following the 2016 Our People Survey, my team participated in an effective conversation to develop agreed-upon actions.*
3. *My group has made progress on these agreed-upon actions.*

Leaders received access to their pulse survey results within 48 hours of the survey close. Preliminary analysis suggests employees, physicians and volunteers agree they received feedback on the 2016 Our People Survey results. Questions 2 and 3 – which relate to developing and making progress on actions to improve engagement – showed the most room for improvement.

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 and Pulse results.
- To instill a sense of pride in our people and connection to our leaders, AHS launched Five Questions in October 2017 which profiles leaders across the organization by asking them a series of personal and professional questions.
- This quarter, AHS launched a one-stop shop of LGBTQ (Lesbian, Gay, Bisexual, Transgender and Queer) health-related information accessible to all Albertans and AHS staff on the AHS internal and external website. These resources reflect AHS' commitment to diversity and inclusion and empowering our people with resources they need to do their jobs and live our values every day.

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. AHS' strategy for health and safety 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 better the performance, as it indicates fewer disabling injuries occurring at work.

HOW WE ARE DOING

The Q3 year-to-date (YTD) 2017-18 DIR of 3.73 increased from previous year's Q3 YTD rate of 3.64. The rate is below target but remains stable.

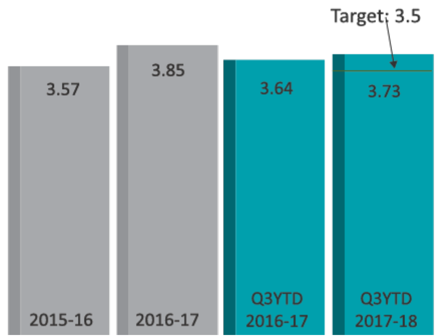
Patient handling, manual material handling and other ergonomic factors are the leading causes of injury for AHS employees.

Disabling Injury Rate rose above target in this quarter, largely due to an increase in occupational related exposures in a more severe influenza (flu) season.

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: ▲ Stable: ≤3% deterioration



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.

Emergency Medical Services (EMS) has committed to equipping all ambulances with power cots and load systems to reduce the frequency of front-line crews having to physically lift patients in and out of ambulances. Training is 80% complete. As of February 1, 2018, the installation of the Stryker power system in all ambulances in Edmonton was completed. On target to complete all installation by March 31, 2018.

Efforts have been focused on those areas which experience the highest rates of injury over an extended period of time. Workplace Health and Safety (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.

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 December 31, 2017, there has been good uptake and compliance (90%).

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

EMS is working to address stigma surrounding mental illness and establish resiliency among their employees and leaders with the Road to Mental Readiness (R2MR) program. As of December 31, 2017, 91% (2,717) EMS leaders, paramedics, dispatchers, and professional support staff have completed the R2MR training.

AHS is enhancing training and supports for front-line staff and first responders at highest risk of exposure to hazardous substances, including illicit opioids. A new online course, Opioids: Illicit Fentanyl Awareness, was made available in December to help employees recognize fentanyl and other illicit opioids, assess risk of exposure and response, as well as determine appropriate personal protective equipment.

AHS continues to review safety protocols and guidelines to ensure staff can do their jobs in the safest possible way. A hazard assessment tool specific to opioids and clear procedures to assess and dispose of unknown substances is under development. WHS is on track to have the new resources available early in 2018.

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 Q3 2017-18, 14% of AHS leaders had completed the course, a 3% increase from Q2 2017-18.

As a part of their governance and oversight role, the Occupational Health & Safety department of the Government of Alberta performs proactive strategic inspections of AHS worksites. These visits support operations with important learnings and identify how improvements can be made together. This program runs September to June and sixty sites across AHS are participating. In Q3, there were 11 strategic inspections and the identified learnings for improvement including hazard identification, assessment and control, training in safe client handling programs, fall protection, waste handling and violence.

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 is focusing on the 16 largest hospitals in Alberta, including clinical support services and corporate services.

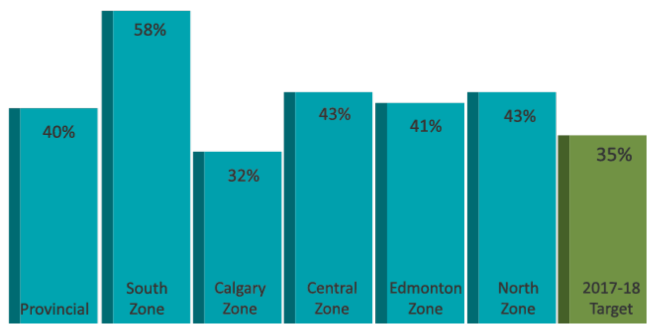
Using comparative data from across the county, AHS has developed OBP targets for nursing inpatient units. These targets are designed to achieve more equitable service delivery across the province with the measure used to monitor leadership's ability to meet the targets and reduce variations in the cost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

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

HOW WE ARE DOING

Provincially, Q3 results met the 2017-18 target of 35%. While not all zones and sites are achieving the provincial target, most are meeting or exceeding this target.

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



Source: AHS Finance Statistical General Ledger (STAT GL)

WHAT WE ARE DOING

Achieving results from operational best practice initiatives will be critical to AHS' financial health and sustainability. With Phase 3 of planning completed, action plans have been prepared for acute care, clinical support services, and corporate services. Monitoring reports are continuing to be developed. For Q3, operational areas were asked to provide an update on the progress towards implementation of identified initiatives.

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 **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.

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.

To reduce unnecessary diagnostic testing, AHS has developed over 60 initiatives, with an estimated savings of $10M. Many of these initiatives are being undertaken as part of AHS' commitment to the Choosing Wisely Canada campaign. Initiatives are prioritized as "short, medium and long term" and will be implemented accordingly. Examples of initiatives underway and early results include:

- Q3 target was met as AHS saw a 14% decrease in CT lumbar spine exams performed in Q3 compared to the same period last year. In Q3 year-to-date 2016-17, there was 1.32 exams per 1,000 residents. In Q3 year-to-date 2017-18, there was 1.13 exams per 1,000 residents. A lower value demonstrates improved efficiencies and reducing unnecessary diagnostic testing.

- Work continues on implementing a streamlined Low Molecular Weight Heparin (LMWH) formulary which is a class of anticoagulant medications used in the prevention of blood clots and treatment of venous thromboembolism and myocardial infarction.

- South and Calgary Zones began implementation of LMWH dose rounding and are achieving targets. Central Zone plans to implement in March 2018. Dose rounding reduces drug waste and promotes safe administration as the majority of doses are provided in a pre-filled syringe.

- As of end December 2017, we have seen a reduction in MRIs for chronic knee pain of 2.4%.

- Transition to a new brand of atropine in prefilled syringes are more cost effective and are primarily used in patient codes and urgent procedures.

- AHS has implemented criteria for icatibant, a drug used to treat swelling attacks affecting airways 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 under Objective #5.

In December 2017, the Government of Alberta announced a new provincial laboratory services entity that will ultimately help improve the quality and timeliness of care for Albertans. Transition planning for this consolidation is progressing. Preliminary discussions underway with AHS leadership and Alberta Health to determine an interim governance structure and next steps. The consolidation of lab services across the province into an AHS wholly-owned subsidiary will leverage existing infrastructure, accounting systems and corporate services, while optimizing innovation in laboratory diagnostics to accommodate growing demands.

Q3 updates on planning activities underway with Alberta Health include:

- Through joint Alberta Health-AHS agreement, the service and access guidelines initiative is on pause due to competing initiatives that require significant clinical and administrative engagement and input (e.g. Connect Care, Enhancing Care in the Community and PCN Governance).

- Provincial Interventional Cardiac Service (ICS) Plan identifies the need for cardiac services in a coordinated and evidence-based approach. A needs assessment and options analysis overview were submitted for review, and expert review of assumptions/conclusions and methodological approach in key areas was conducted. Consultations with the ICS Oversight committees are scheduled in Q4 in preparation for final documents.

> 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.

- The Central Zone Healthcare Plan has been approved by the AHS Executive Leadership Team. The plan is being submitted to the AHS Board for approval and formal submission to Alberta Health.

- The Calgary Zone Healthcare Plan is on track to meet deadlines. Community initiatives have been confirmed through extensive engagement; acute care priorities were identified and are currently being confirmed with acute care departments.

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

The AHS Board approved the signing of the contract with Epic Systems Corporation effective October 2017.

Complete current state assessment work and scope definition for the Connect Care program was completed. In Q3, a new governance structure was established. A Terms of Reference and Charter will be developed in Q4.

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.

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. Access to Netcare is restricted to registered healthcare providers working at an accredited Alberta health care provider.

The number of active Alberta Netcare users increased by 7.9% (43,350 users) in Q3 2017-18 compared to the same period last year (40,350 users).

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 an extensive 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.

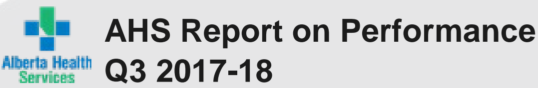
Two measures are reported annually (Perinatal Mortality among First Nations and AHS Workforce Engagement). The remaining 11 measures are reported quarterly. Of these, eight measures include the most current data available (Q3 2017-18) and three measures rely on patient follow-up and therefore reflect an earlier time period (Q2 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 a performance improvement in the areas 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.

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 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 *Only provincial results reported – see p. 7*
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 *Not reported quarterly*
8. Hand Hygiene Compliance p.33
9. Childhood Immunization: DTaP-IPV Hib p.34
10. Childhood Immunization: MMR p.35
11. AHS Workforce Engagement *Not reported quarterly*
12. Disabling Injuries in AHS Workforce p.36
13. Nursing Units Achieving Best Practice Targets p.37

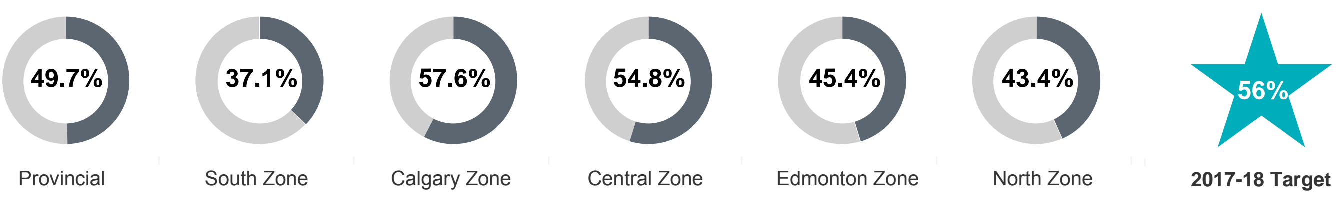


PEOPLE PLACED IN CONTINUING CARE WITHIN 30 DAYS

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* ■ (green square)
- *Stable: ≤3% deterioration between compared quarters* ▲
- *Area requires additional focus* ● (red circle)

Percentage Placed in Continuing Care within 30 Days, Q3 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	Q3 2016-17	Q3 2017-18	Trend	Q3YTD 2017-18	2017-18 Target
Provincial	**68.9%**	**59.9%**	**59.6%**	**56.1%**	**50.8%**	**49.7%**	▲	**50.7%**	**56%**
South Zone	77.2%	59.5%	47.6%	45.9%	45.1%	37.1%	●	42.9%	56%
Calgary Zone	72.0%	57.1%	58.4%	57.4%	50.7%	57.6%	★	57.5%	56%
Central Zone	40.7%	54.6%	61.5%	60.3%	50.3%	54.8%	■	55.5%	56%
Edmonton Zone	78.4%	66.2%	64.5%	55.8%	52.2%	45.4%	●	45.5%	56%
North Zone	59.9%	58.8%	58.7%	57.5%	54.5%	43.4%	●	44.0%	56%

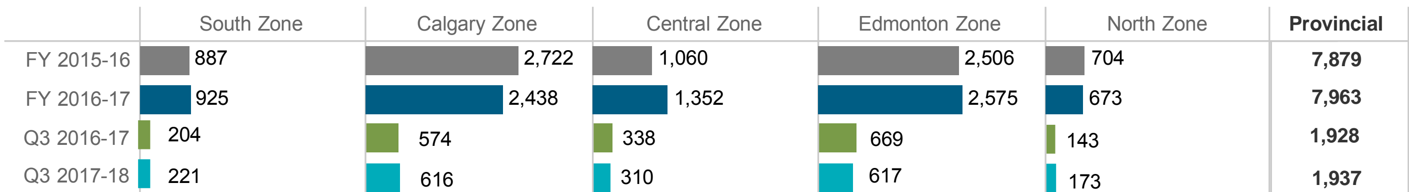
Understanding Our Results

Provincially, this measure has been stable in Q3 compared to the same period as last year. Several zones continue to deteriorate due to slower than required growth in home care, continuing care and community care.

For Q3 year-to-date, AHS opened 532 new continuing care beds – more than the entire 2016-17 year (376 new beds). Since 2010, AHS has opened 6,155 new beds to support individuals who need community-based care and supports (including palliative). A new continuing care facility was opened in Medicine Hat in October 2017.

As new continuing care 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.

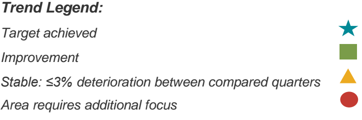
Total Clients Placed



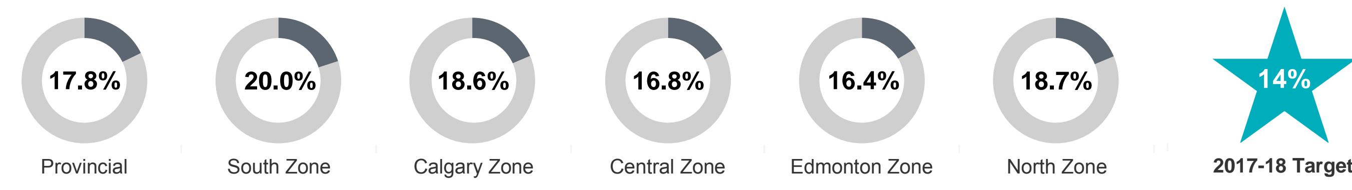
Source: AHS Seniors Health Continuing Care Living Options Report, as of February 22, 2018

PERCENTAGE OF ALTERNATE LEVEL OF CARE PATIENT DAYS

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).



Percentage of ALC Patient Days, Q3 2017-18



Percentage of ALC Patient Days Trend

Zone Name	Site Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q3 2016-17	Q3 2017-18	Trend	Q3YTD 2017-18	2017-18 Target
Provincial	**Provincial**	**10.1%**	**12.2%**	**13.5%**	**15.4%**	**16.1%**	**17.8%**	●	**17.4%**	**14%**
South Zone	**South Zone**	**6.9%**	**9.0%**	**12.6%**	**13.9%**	**13.9%**	**20.0%**	●	**16.1%**	**14%**
	Chinook Regional Hospital	5.0%	4.4%	7.8%	8.6%	9.1%	12.0%	★	11.8%	14%
	Medicine Hat Regional Hospital	9.2%	14.6%	18.9%	18.9%	19.7%	30.8%	●	23.6%	14%
	Other South Hospitals	7.1%	9.4%	11.5%	17.3%	14.2%	14.7%	●	11.6%	14%
Calgary Zone	**Calgary Zone**	**11.7%**	**15.2%**	**16.7%**	**16.9%**	**18.4%**	**18.6%**	▲	**18.5%**	**14%**
	Alberta Children's Hospital	0.0%	0.2%	1.3%	1.2%	1.1%	4.0%	★	2.5%	14%
	Foothills Medical Centre	11.5%	15.7%	14.7%	15.2%	15.5%	18.9%	●	18.2%	14%
	Peter Lougheed Centre	11.0%	14.6%	13.6%	16.8%	20.3%	13.7%	★	13.5%	14%
	Rockyview General Hospital	13.7%	16.2%	21.9%	22.2%	25.1%	25.5%	▲	25.7%	14%
	South Health Campus	12.1%	14.4%	20.4%	17.6%	15.7%	17.7%	●	18.5%	14%
	Other Calgary Hospitals	17.5%	26.4%	27.2%	21.0%	22.4%	19.9%	■	21.6%	14%
Central Zone	**Central Zone**	**13.0%**	**13.1%**	**12.0%**	**15.3%**	**16.4%**	**16.8%**	▲	**16.1%**	**14%**
	Red Deer Regional Hospital Centre	10.3%	11.4%	8.8%	12.4%	16.0%	14.9%	■	12.9%	14%
	Other Central Hospitals	14.9%	14.4%	14.3%	17.2%	16.8%	18.1%	●	18.3%	14%
Edmonton Zone	**Edmonton Zone**	**7.8%**	**9.1%**	**9.5%**	**14.0%**	**15.1%**	**16.4%**	●	**15.8%**	**14%**
	Grey Nuns Community Hospital	8.7%	10.2%	9.2%	11.1%	11.8%	14.0%	★	11.3%	14%
	Misericordia Community Hospital	8.0%	10.8%	12.8%	14.7%	16.3%	17.5%	●	16.7%	14%
	Royal Alexandra Hospital	8.4%	10.6%	11.0%	18.5%	19.4%	19.7%	▲	18.8%	14%
	Stollery Children's Hospital	0.1%	0.0%	1.8%	0.6%	0.0%	0.8%	★	0.3%	14%
	Sturgeon Community Hospital	10.7%	12.3%	12.3%	18.9%	23.6%	25.7%	●	22.5%	14%
	University of Alberta Hospital	6.8%	6.0%	6.2%	11.7%	12.5%	15.0%	●	16.1%	14%
	Other Edmonton Hospitals	9.2%	11.8%	12.1%	12.1%	14.2%	13.3%	★	13.8%	14%
North Zone	**North Zone**	**11.7%**	**13.8%**	**18.5%**	**16.4%**	**12.1%**	**18.7%**	●	**22.2%**	**14%**
	Northern Lights Regional Health Centre	9.4%	7.4%	18.5%	12.0%	0.4%	14.4%	★	9.9%	14%
	Queen Elizabeth II Hospital	8.5%	14.0%	20.4%	15.2%	11.6%	15.0%	●	27.3%	14%
	Other North Hospitals	13.2%	14.9%	17.9%	17.5%	14.2%	20.9%	●	22.4%	14%

Understanding Our Results

This measure has broadly deteriorated in Q3 compared to the same period as last year. This measure also shows a longer-term trend towards deterioration year over year.

The reasons for deterioration are multi-faceted and generally related to difficulties finding appropriate placement or services following hospital discharge. In some areas, this is 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.

Larger fluctuations are generally expected at sites having fewer discharges such as the "other hospitals" group.

Total ALC Discharges

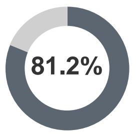
	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	**Provincial**
FY 2015-16	624	4,684	1,085	3,046	815	**10,254**
FY 2016-17	674	5,027	1,327	5,518	967	**13,513**
Q3 2016-17	169	1,264	322	1,431	196	**3,382**
Q3 2017-18	183	1,523	341	1,968	244	**4,259**

Source(s): AHS Provincial Discharge Abstract Database (DAD), as of February 5, 2018

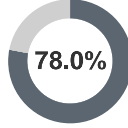
This measure reflects patients' overall perceptions associated with the hospital where they received care. The higher the number, the better, as it demonstrates more patients are satisfied with their care in hospital.

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

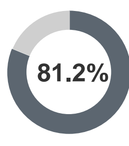
Patient Satisfaction with Hospital Experience, Q2 2017-18



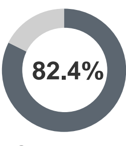
Provincial



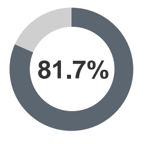
South Zone



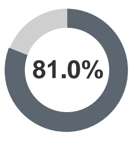
Calgary Zone



Central Zone



Edmonton Zone



North Zone

2017-18 Target

Patient Satisfaction with Hospital Experience Trend

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**	**81.5%**	**81.8%**	**81.8%**	**82.4%**	**82.3%**	**81.2%**	▲	**81.7%**	**85%**
South Zone	**South Zone**	**81.7%**	**81.8%**	**80.9%**	**82.2%**	**84.3%**	**78.0%**	●	**79.7%**	**85%**
	Chinook Regional Hospital	80.5%	76.6%	78.2%	82.3%	86.1%	77.2%	●	79.3%	85%
	Medicine Hat Regional Hospital	80.7%	85.7%	81.3%	81.3%	81.5%	77.4%	●	78.1%	85%
	Other South Hospitals	83.5%	88.3%	87.2%	85.5%	87.8%	82.8%	●	84.8%	85%
Calgary Zone	**Calgary Zone**	**80.1%**	**83.2%**	**82.0%**	**83.0%**	**84.1%**	**81.2%**	●	**81.9%**	**85%**
	Foothills Medical Centre	76.6%	80.8%	80.8%	80.3%	81.7%	79.8%	▲	80.2%	85%
	Peter Lougheed Centre	80.9%	79.9%	77.2%	78.7%	80.3%	74.8%	●	75.6%	85%
	Rockyview General Hospital	82.9%	85.4%	81.7%	85.1%	85.0%	82.8%	▲	83.3%	85%
	South Health Campus	91.9%	89.7%	90.1%	90.9%	92.9%	89.4%	★	90.2%	85%
	Other Calgary Hospitals	79.3%	90.3%	92.9%	92.2%	94.0%	91.5%	★	93.0%	85%
Central Zone	**Central Zone**	**83.5%**	**84.8%**	**83.4%**	**85.0%**	**85.4%**	**82.4%**	●	**84.1%**	**85%**
	Red Deer Regional Hospital Centre	81.1%	83.0%	82.2%	82.7%	84.6%	82.0%	●	82.9%	85%
	Other Central Hospitals	84.5%	86.7%	84.8%	87.0%	86.9%	83.2%	●	85.5%	85%
Edmonton Zone	**Edmonton Zone**	**81.5%**	**80.3%**	**81.6%**	**80.8%**	**79.2%**	**81.7%**	■	**81.2%**	**85%**
	Grey Nun's Community Hospital	86.4%	87.2%	86.1%	86.4%	84.4%	86.2%	★	85.2%	85%
	Misericordia Community Hospital	78.5%	75.3%	77.2%	79.8%	77.7%	75.7%	▲	74.9%	85%
	Royal Alexandra Hospital	79.9%	76.5%	77.3%	76.6%	75.9%	78.6%	■	78.4%	85%
	Sturgeon Community Hospital	89.8%	87.6%	89.8%	88.0%	86.8%	92.9%	★	91.2%	85%
	University of Alberta Hospital	77.1%	80.2%	83.5%	80.4%	78.0%	82.0%	■	81.7%	85%
	Other Edmonton Hospitals	70.9%	85.3%	86.3%	85.7%	87.1%	84.4%	●	86.2%	85%
North Zone	**North Zone**	**81.0%**	**80.6%**	**81.3%**	**83.2%**	**81.7%**	**81.0%**	▲	**81.7%**	**85%**
	Northern Lights Regional Health	75.4%	74.7%	78.6%	82.2%	-*	79.1%	-	81.1%	85%
	Queen Elizabeth II Hospital	76.0%	77.2%	78.6%	80.3%	78.5%	76.8%	▲	77.3%	85%
	Other North Hospitals	83.4%	83.7%	83.5%	84.8%	81.4%	83.0%	■	83.5%	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 that 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**
	Q2 2016-17	4,861	20,426	7,356	21,806	6,371	**60,820**
	Q2 2017-18	4,916	20,124	7,133	21,570	6,418	**60,161**
Q2 2017-18	Number of Completed Surveys	522	2,040	792	2,209	737	6,300
	Margin of Error (±)	3.56%	1.70%	2.65%	1.61%	2.83%	0.96%

Source: AHS Canadian Hospital Consumer Assessment of Healthcare Providers and Systems (CH-CAHPS) Survey, as of February 5, 2018

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.*
- ** Northern Lights Regional Health Centre last year's data not comparable due to impact of temporary closure of the hospital and displacement of the population due to the wildfires in Q1.*

WAIT TIME FOR ADDICTION OUTPATIENT TREATMENT (in days)

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, Q2 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	Q2 2016-17	Q2 2017-18	Trend	Q2YTD 2017-18	2017-18 Target
Provincial	**18**	**15**	**13**	**15**	**14**	**13**	■	**14**	**12**
Urban									
Calgary Zone	21	9	5	6	6	0	★	1	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	14	14	▲	14	12
North Zone	16	16	19	27	22	24	●	24	12

Addiction Outpatient Treatment Wait Time Trend by Zone (Average)

Zone Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q2 2016-17	Q2 2017-18	Q2YTD 2017-18
Provincial	**7.0**	**6.5**	**5.8**	**7.3**	**7.1**	**5.8**	**6.5**
Urban							
Calgary Zone	7.7	7.4	7.9	11.4	11.3	7.7	9.8
Edmonton Zone	6.4	5.1	1.2	0.9	0.7	0.2	0.5
Rural							
South Zone	5.0	7.8	7.8	8.7	9.0	6.9	7.3
Central Zone	7.3	6.2	6.0	6.2	6.2	5.8	5.6
North Zone	7.5	7.3	8.2	11.1	10.3	10.3	10.7

Understanding Our Results

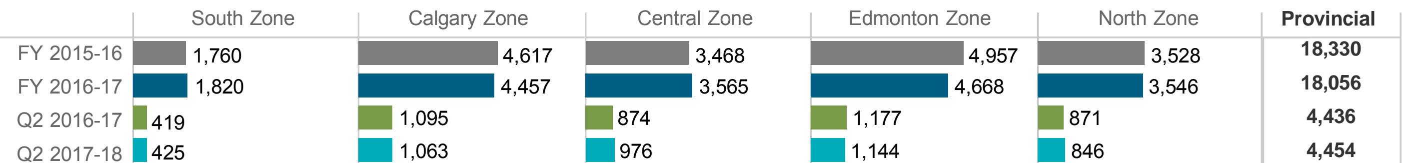
Provincially, wait times for outpatient addiction treatment has shown improvement from the same reporting period as last year.

Although, North Zone demonstrates a deterioration, Q2 wait time (24 days) has improved since Q1 (26 days) and previous year (27 days). Work continues to address issues related to the complexity and acuity of cases referred and wait times in areas without walk-in clinics.

Urban: Both Edmonton and Calgary zones have experienced a significant improvement from last fiscal year. The vast majority of clients in both urban settings 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 enrollments in the Central Zone has a big increase. 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



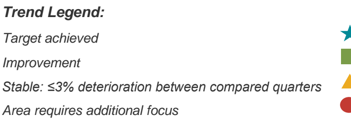
Source: Addiction System for Information and Service Tracking (ASIST) Data Research View for Treatment Service, Standard Data Product, Clinical Activity Reporting Application (CARA), Geriatric Mental Health Information System (GMHIS), eClinician, as of February 14, 2018
Notes:
- This quarter is a quarter 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.
- Results may change due to data updates in the source information system or revisions to the measure inclusion and exclusion criteria.

AHS Report on Performance
Q3 2017-18

UNPLANNED MEDICAL READMISSIONS

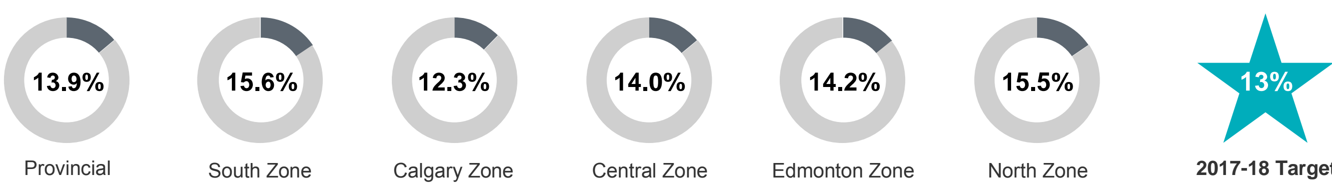
The measure is defined as the percentage of medical patients with unplanned readmission to hospital within 30 days of leaving the hospital. The lower the percentage, the better as it demonstrates that fewer people are being readmitted shortly after being discharged.

Trend Legend:



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

Unplanned Medical Readmissions, Q2 2017-18



Unplanned Medical Readmissions Trend

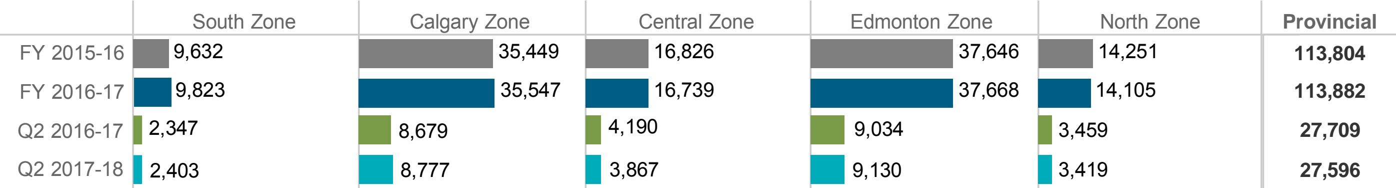
Zone Name	Site Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q2 2016-17	Q2 2017-18	Trend	Q2YTD 2017-18	2017-18 Target
Provincial	**Provincial**	**13.5%**	**13.6%**	**13.7%**	**13.6%**	**13.8%**	**13.9%**	▲	**13.8%**	**13%**
South Zone	**South Zone**	**14.1%**	**13.5%**	**14.2%**	**13.9%**	**13.9%**	**15.6%**	●	**14.2%**	**13%**
	Chinook Regional Hospital	13.2%	13.5%	14.1%	13.3%	13.0%	14.0%	●	12.4%	13%
	Medicine Hat Regional Hospital	14.4%	12.5%	14.0%	13.8%	14.2%	15.5%	●	14.6%	13%
	Other South Hospitals	15.0%	14.7%	14.4%	14.9%	14.7%	17.4%	●	15.7%	13%
Calgary Zone	**Calgary Zone**	**12.2%**	**12.2%**	**12.3%**	**12.3%**	**12.3%**	**12.3%**	★	**12.4%**	**13%**
	Foothills Medical Centre	12.2%	12.1%	12.3%	12.4%	12.8%	12.7%	★	12.3%	13%
	Peter Lougheed Centre	12.1%	12.2%	12.8%	13.1%	12.7%	13.5%	●	13.0%	13%
	Rockyview General Hospital	12.0%	11.9%	11.9%	12.0%	11.7%	11.8%	★	12.4%	13%
	South Health Campus	12.3%	12.3%	12.0%	11.3%	11.3%	10.9%	★	12.1%	13%
	Other Calgary Hospitals	12.8%	13.7%	12.5%	13.0%	12.3%	12.1%	★	12.2%	13%
Central Zone	**Central Zone**	**14.5%**	**14.9%**	**15.0%**	**14.9%**	**15.1%**	**14.0%**	■	**14.8%**	**13%**
	Red Deer Regional Hospital Centre	14.0%	13.8%	13.9%	13.0%	13.8%	12.2%	★	13.5%	13%
	Other Central Hospitals	14.6%	15.3%	15.4%	15.6%	15.7%	14.9%	■	15.3%	13%
Edmonton Zone	**Edmonton Zone**	**13.5%**	**13.8%**	**13.6%**	**13.6%**	**14.1%**	**14.2%**	▲	**14.1%**	**13%**
	Grey Nuns Community Hospital	12.6%	12.3%	13.2%	12.7%	13.4%	13.1%	★	13.3%	13%
	Misericordia Community Hospital	13.0%	13.7%	13.5%	15.0%	16.3%	14.9%	■	14.3%	13%
	Royal Alexandra Hospital	13.2%	14.0%	13.7%	13.0%	13.0%	14.5%	●	14.3%	13%
	Sturgeon Community Hospital	12.3%	13.6%	13.4%	13.1%	12.0%	13.8%	●	13.5%	13%
	University Of Alberta Hospital	14.6%	14.6%	14.2%	14.4%	15.2%	14.6%	■	14.7%	13%
	Other Edmonton Hospitals	13.4%	12.8%	11.9%	12.8%	13.6%	12.5%	★	12.7%	13%
North Zone	**North Zone**	**15.0%**	**15.3%**	**15.3%**	**15.2%**	**15.4%**	**15.5%**	▲	**15.1%**	**13%**
	Northern Lights Regional Health Centre	13.4%	12.8%	13.4%	14.3%	- *	15.1%	-	15.3%	13%
	Queen Elizabeth II Hospital	12.6%	11.9%	13.3%	13.3%	15.3%	11.8%	★	11.5%	13%
	Other North Hospitals	15.5%	16.1%	15.9%	15.5%	15.7%	16.1%	▲	15.6%	13%

Understanding Our Results

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

In monitoring these measures at a site level, it is important to examine longer term trends over time. We expect there to be fluctuations in hospitals due to smaller sites having low number of discharges and therefore more susceptible to variations (such as "other hospitals"). AHS monitors these fluctuations to see if deterioration in performance represents a trend over time or part of expected variation. The fluctuation is within normal range.

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	9,823	35,547	16,739	37,668	14,105	**113,882**
Q2 2016-17	2,347	8,679	4,190	9,034	3,459	**27,709**
Q2 2017-18	2,403	8,777	3,867	9,130	3,419	**27,596**

Source(s): AHS Provincial Discharge Abstract Database (DAD), as of February 5, 2018
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 (2016).
** Northern Lights Regional Health Centre last year's data not comparable due to impact of temporary closure of the hospital and displacement of the population due to the wildfires in Q1.*

AHS Report on Performance Q3 2017-18

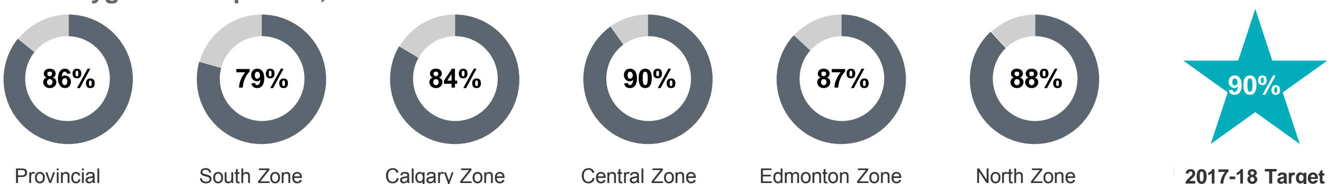
HAND HYGIENE COMPLIANCE

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, Q3 2017-18



Hand Hygiene Compliance Trend

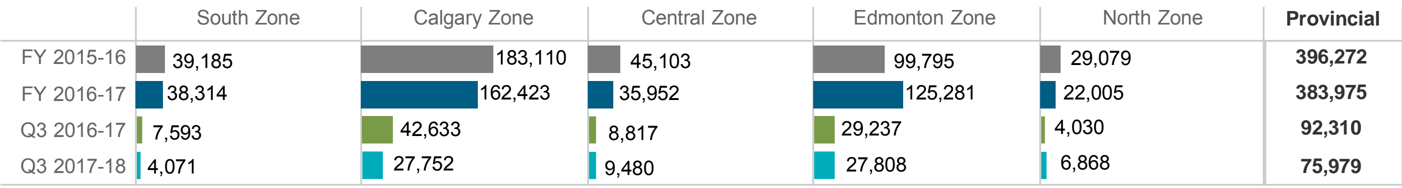
Zone Name	Site Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q3 2016-17	Q3 2017-18	Trend	Q3YTD 2017-18	2017-18 Target
Provincial	**Provincial**	**66%**	**75%**	**80%**	**82%**	**82%**	**86%**	■	**85%**	**90%**
South Zone	**South Zone**	**78%**	**82%**	**82%**	**84%**	**83%**	**79%**	●	**79%**	**90%**
	Chinook Regional Hospital	81%	85%	82%	83%	80%	77%	●	75%	90%
	Medicine Hat Regional Hospital	76%	77%	82%	87%	85%	79%	●	85%	90%
	Other South Sites	79%	85%	83%	83%	84%	86%	■	79%	90%
Calgary Zone	**Calgary Zone**	**59%**	**71%**	**78%**	**81%**	**80%**	**84%**	■	**83%**	**90%**
	Alberta Children's Hospital	57%	74%	77%	80%	81%	83%	■	81%	90%
	Foothills Medical Centre	52%	66%	76%	83%	82%	85%	■	84%	90%
	Peter Lougheed Centre	62%	77%	85%	79%	75%	81%	■	78%	90%
	Rockyview General Hospital	62%	68%	74%	84%	87%	86%	▲	89%	90%
	South Health Campus	59%	59%	69%	76%	76%	71%	●	77%	90%
	Other Calgary Sites	63%	77%	80%	79%	78%	86%	■	84%	90%
Central Zone	**Central Zone**	**64%**	**74%**	**81%**	**78%**	**77%**	**90%**	★	**85%**	**90%**
	Red Deer Regional Hospital Centre	75%	69%	78%	78%	76%	85%	■	84%	90%
	Other Central Sites	57%	77%	82%	78%	77%	91%	★	85%	90%
Edmonton Zone	**Edmonton Zone**	**57%**	**74%**	**79%**	**83%**	**85%**	**87%**	■	**86%**	**90%**
	Grey Nuns Community Hospital *	64%	75%	73%	83%	87%	90%	★	89%	90%
	Misericordia Community Hospital *	71%	77%	75%	80%	85%	86%	■	86%	90%
	Royal Alexandra Hospital	62%	75%	81%	84%	85%	87%	■	86%	90%
	Stollery Children's Hospital	58%	75%	79%	80%	79%	82%	■	80%	90%
	Sturgeon Community Hospital	59%	81%	84%	86%	87%	88%	■	88%	90%
	University of Alberta Hospital	43%	70%	74%	85%	87%	89%	■	88%	90%
	Other Edmonton Sites	58%	73%	79%	82%	83%	86%	■	85%	90%
North Zone	**North Zone**	**66%**	**81%**	**87%**	**88%**	**85%**	**88%**	■	**87%**	**90%**
	Northern Lights Regional Health Centre	56%	64%	88%	87%	-**	81%	-	83%	90%
	Queen Elizabeth II Hospital	68%	91%	96%	91%	90%	98%	★	91%	90%
	Other North Sites	66%	74%	85%	88%	85%	89%	■	88%	90%

Understanding Our Results

Overall there was continued and sustained improvement in the provincial hand hygiene rates in Q3.

While normal fluctuations in compliance are anticipated, downward trends in compliance rates are monitored and investigated. In some cases, the drop in compliance at the site is due to an increased proportion of observations occurring within a unit or program identified to be struggling with hand hygiene compliance. Hand hygiene improvement initiatives are undertaken which include increased frequency of monitoring to document and further stimulate improved 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**
Q3 2016-17	7,593	42,633	8,817	29,237	4,030	**92,310**
Q3 2017-18	4,071	27,752	9,480	27,808	6,868	**75,979**

Source: AHS Infection, Prevention and Control Database, as of February 5, 2018

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.*
- *** No data collected for Northern Lights Regional Health Centre in Q3 2016-17 due to staff shortage. Also reflected in lower volumes in North Zone.*

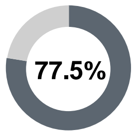
CHILDHOOD IMMUNIZATION RATE

DIPHTHERIA, TETANUS, PERTUSSIS, POLIO, HIB (DTaP-IPV-Hib)

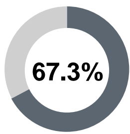
This measure is defined as the percentage of children who have received the required number of vaccine doses by two years of age. A high rate of immunization for a population reduces the incidence of vaccine preventable childhood diseases, and controls outbreaks. Immunizations protect children and adults 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* ●

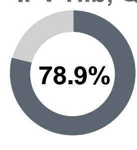
Childhood Immunization Rate: DTaP-IPV-Hib, Q3 2017-18



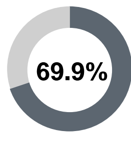
Provincial



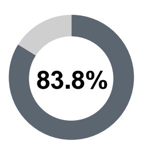
South Zone



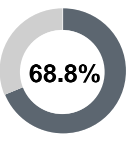
Calgary Zone



Central Zone



Edmonton Zone



North Zone

2017-18 Target

Childhood Immunization Rate: DTaP-IPV-Hib Trend

Zone Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q3 2016-17	Q3 2017-18	Trend	Q3YTD 2017-18	2017-18 Target
Provincial	**77.6%**	**78.3%**	**78.0%**	**78.3%**	**77.9%**	**77.5%**	▲	**78.3%**	**80%**
South Zone	64.6%	67.9%	65.7%	67.8%	68.7%	67.3%	▲	69.5%	80%
Calgary Zone	81.4%	82.6%	81.5%	81.4%	81.2%	78.9%	▲	79.8%	80%
Central Zone	71.1%	71.1%	70.9%	70.6%	69.3%	69.9%	■	71.0%	80%
Edmonton Zone	84.0%	84.0%	84.6%	84.0%	83.1%	83.8%	★	84.6%	80%
North Zone	67.2%	66.6%	66.5%	67.7%	66.0%	68.8%	■	69.2%	80%

Understanding Our Results

Provincially, immunization rates in Q2 are steady, but most of zones are below the target except Edmonton.

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**
Q3 2016-17	1,013	4,940	1,321	4,475	1,632	**13,381**
Q3 2017-18	996	5,136	1,350	4,610	1,752	**13,844**

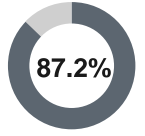
Source: AHS Public Health Surveillance Database, as of January 22, 2018
- The targets here are 2017-18 AHS Target. Alberta Health have higher targets for DTaP-IPV-Hib - 97% and for MMR - 98%, by two years of age.

CHILDHOOD IMMUNIZATION RATE
MEASLES, MUMPS, RUBELLA (MMR)

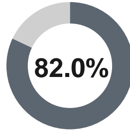
This measure is defined as the percentage of children who have received the required number of vaccine doses by two years of age. A high rate of immunization for a population reduces the incidence of vaccine preventable childhood diseases and controls outbreaks. Immunizations protect children and adults 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* ●

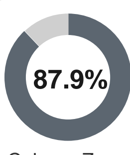
Childhood Immunization Rate: MMR, Q3 2017-18



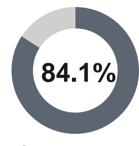
Provincial



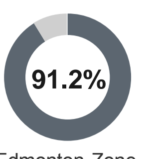
South Zone



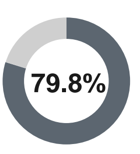
Calgary Zone



Central Zone



Edmonton Zone



North Zone

2017-18 Target

Childhood Immunization Rate: MMR Trend

Zone Name	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Q3 2016-17	Q3 2017-18	Trend	Q3YTD 2017-18	2017-18 Target
Provincial	**86.7%**	**87.6%**	**86.9%**	**87.4%**	**87.3%**	**87.2%**	▲	**87.1%**	**88%**
South Zone	81.1%	83.9%	78.8%	81.0%	81.4%	82.0%	■	81.6%	88%
Calgary Zone	88.3%	89.6%	89.2%	89.6%	89.5%	87.9%	★	87.8%	88%
Central Zone	81.2%	80.8%	81.1%	82.3%	82.7%	84.1%	■	84.6%	88%
Edmonton Zone	91.7%	92.2%	91.9%	91.8%	90.8%	91.2%	★	91.2%	88%
North Zone	79.6%	80.3%	78.5%	77.8%	78.3%	79.8%	■	79.8%	88%

Understanding Our Results

Provincially, immunization rates in Q3 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**
Q3 2016-17	1,013	4,940	1,321	4,475	1,632	**13,381**
Q3 2017-18	996	5,136	1,350	4,610	1,752	**13,844**

Source: AHS Public Health Surveillance Database, as of January 22, 2018
- 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.

DISABLING INJURIES IN AHS WORKFORCE

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: Q3YTD 2017-18

Provincial

2017-18 Target

Disabling Injury Rate by AHS Portfolio

Level of Portfolio	Portfolios or Departments	FY 2015-16	FY 2016-17	Q3YTD 2016-17	Q3YTD 2017-18	Trend	2017-18 Target
Province	**Provincial**	**3.57**	**3.85**	**3.64**	**3.73**	▲	**3.5**
Zone	South Zone Clinical Operations	3.54	3.50	3.25	3.26	★	3.5
	Calgary Zone Clinical Operations	3.54	3.86	3.68	4.01	●	3.5
	Central Zone Clinical Operations	4.00	4.14	4.18	4.95	●	3.5
	Edmonton Zone Clinical Operations	3.59	3.83	3.56	3.72	●	3.5
	North Zone Clinical Operations	4.33	3.78	2.93	3.49	★	3.5
Provincial Portfolios	Cancer Control	1.71	1.43	1.26	0.68	★	3.5
	Capital Management	2.37	3.77	3.28	3.25	★	3.5
	Collaborative Practice, Nursing & Health Profession	4.93	4.23	5.81	7.13	●	3.5
	Community Engagement and Communications	0.00	0.00	0.00	0.00	★	3.5
	Contracting, Procurement & Supply Management	2.70	3.74	4.11	2.89	★	3.5
	Diagnostic Imaging	1.81	2.90	2.63	3.79	●	3.5
	Emergency Medical Services	12.92	15.09	15.53	14.13	■	3.5
	Finance	0.16	0.33	0.44	0.67	★	3.5
	Health Information Management	1.29	2.19	1.90	1.36	★	3.5
	Information Technology (IT)	0.25	0.16	0.22	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	1.10	1.68	★	3.5
	Linen & Environmental Services	7.62	8.00	7.67	6.36	■	3.5
	Nutrition Food Services	5.91	5.38	4.86	5.15	●	3.5
	People, Legal, and Privacy	0.74	0.50	0.27	0.38	★	3.5
	Pharmacy Services	1.09	1.69	1.73	1.10	★	3.5
	Population Public & Indigenous Health	1.29	1.13	0.95	0.54	★	3.5
	Research, Innovation and Analytics	0.27	0.26	0.00	0.48	★	3.5

Understanding Our Results

Provincially Disabling Injury Rate remain stable when compared to last year but several zones rose above target in this quarter, largely due to an increase in occupational related exposures in a more severe influenza (flu) season. 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.

Within Diagnostic Imaging a significant increase in disabling injuries in Q3 was found to be musculoskeletal injuries resulting from patient handling and falls. At this point WHS is investigating and monitoring the data.

Injuries within Nutrition & Food Services are due to manual material handling.

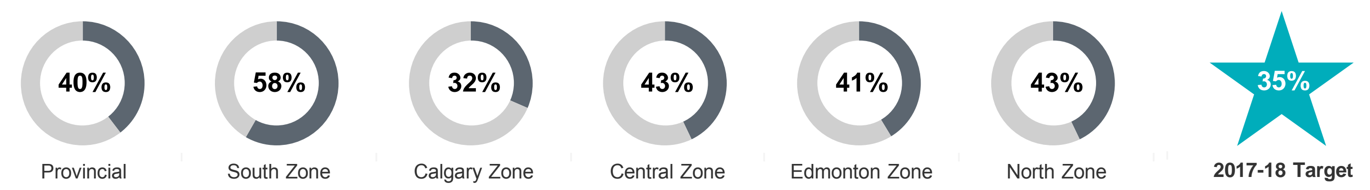
Source: WCB Alberta and e-Manager Payroll Analytics (EPA), 2017-18 September YTD data as of December 31, 2017; Data retrieval date: February 1, 2018
Notes:
- Community Engagement & Communications and Internal Audit & Enterprise Risk Management reporting of "0.00" is accurate and reflects these two portfolios having very safe and healthy work environments.
- Q3 results are reported year-to-date to align with AHS People, Legal and Privacy reporting to the AHS Human Resources Committee of the Board.

NURSING UNITS ACHIEVING BEST PRACTICE TARGETS

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, Q3 2017-18



Percentage of Nursing Units Achieving Best Practice Targets

Zone Name	FY 2015-16	FY 2016-17	Q3 2016-17	Q3 2017-18	Trend	Q3YTD 2017-18	2017-18 Target
Provincial	**20%**	**28%**	**34%**	**40%**	★	**36%**	**35%**
South Zone	63%	58%	63%	58%	★	67%	35%
Calgary Zone	15%	20%	24%	32%	■	25%	35%
Central Zone	7%	14%	43%	43%	★	36%	35%
Edmonton Zone	15%	29%	34%	41%	★	39%	35%
North Zone	33%	33%	33%	43%	★	36%	35%

Understanding Our Results

In Q3, provincial and most zones have achieved target of 35%. Work continues at the site and nursing unit level to reduce variation in the cost of delivering high quality services.

Source: AHS General Ledger (no allocations); Worked Hours - Finance consolidated trial balance, Patient Days – Adult & Child - Finance statistical General Ledger, as of February 5, 2018
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.