AHS' 2017-2020 Public Performance Measure Definitions

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PEOPLE PLACED IN CONTINUING CARE WITHING 30 DAYS

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

PERCENTAGE OF ALTERNATE LEVEL OF CARE PATIENT DAYS

Definition:	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 alternative setting. This is referred to as alternate level of care (ALC).
Rationale:	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.
Interpretation:	If the percentage of ALC days is high, there may be a need to focus on ensuring timely accessible options for appropriate support or care for ALC patients. Therefore, the lower the percentage the better.
Limitations:	Classification of ALC days was not historically standardized throughout AHS. Efforts continue to align documentation and coding practices to a common definitional standard. This may result in a shift in reported historical values for percentage of ALC days.
Data Sources:	Discharge Abstract Database (DAD) - AHS Provincial
Inclusions:	Inpatient discharges in an acute care facility
Exclusions:	Stillbirths, cadavers, and patients admitted for organ donation.
Calculation:	The total number of ALC days (numerator), divided by the total number of inpatient days (denominator), expressed in a percentage.
Benchmarks:	Canadian Institute for Health Information (CIHI)

TIMELY ACCESS TO SPECIALTY CARE

Definition:	The number of physician specialty services with eReferral Advice Request implemented. Alberta Netcare eReferral Advice Request provides the ability to request advice from another physician or specialty services that support patient care in the community by primary care physician. Alberta Netcare eReferral is Alberta's first paperless referral solution and offers health care providers the ability to create, submit, track and manage referrals throughout the referral process.
Rationale:	Having more services providing advice for routine 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.
Interpretation:	The number of specialties using eReferral Advice Request is a cumulative measure. The more specialties implementing eReferral, the closer we move to target.
Limitations:	Even if a service is capable of receiving advice requests, it does not mean that the referring providers are using the service.
Data Sources:	AHS Provincial Access Team
Inclusions:	Number of services receiving advice requests
Exclusions:	Multiple sites for same specialty area
Calculation:	Number of unique specialty names
Benchmarks:	Not available

PATIENT SATISFACTION WITH HOSPITAL EXPERIENCE

Definition:	The percentage of patients rating hospital care as 8, 9, or 10 on a scale from 0-10, where 10 is the best possible rating. The specific statement used for this measure is "We want to know your overall rating of your stay at the hospital." The survey is conducted by telephone on a sample of adults who have been discharged from acute care facilities within 6 weeks of discharge.
Rationale:	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.
Interpretation:	The higher the number the better, as it demonstrates more patients are satisfied with their care in hospital.
Limitations:	Survey administration can result in data errors. Processes are in place to mitigate the potential for errors: interviewers are trained to administer the survey consistently according to a prescribed script and 10% of calls are monitored for Quality Assurance. This measure is reported a quarter later due to requirements to follow-up with patients after the reporting quarter.
Data Sources:	Canadian Hospital Assessment of Healthcare Providers and Systems Survey (CHCAHPS) responses.
Inclusions:	All valid responses to specific question for adults aged 18 years and over that were discharged from hospital.
Exclusions:	Respondents who said "Don't Know" or refused to answer the question. Patients under 18 years old. Stayed less than 24 hours, died during hospital stay, psychiatric patients, stayed only in emergency department, day surgery or ambulatory procedure, possible miscarriage, possible still birth and baby length of stay was greater than six days.
Calculation:	The total number of respondents answering 8, 9 or 10 divided by the total number of respondents answering 0-10, expressed as a percentage.
Benchmarks:	Canadian Institute for Health Information (CIHI).

WAIT TIME FOR ADDICTION OUTPATIENT TREATMENT (IN DAYS)

Definition:	Represents the time it takes to access adult addiction outpatient treatment services. It is expressed as the number of days that 9 out of 10 clients have attended their first appointment since referral or first contact.
Rationale:	Timely access to addiction and mental health (AMH) services is important for preventing healthcare, social and economic costs associated with mental illness and substance abuse, as well as the personal harms associated with these illnesses. Getting clients the care they need in a timely manner is critical to improving our services. This involves improving access across the continuum of addiction and mental health services and involves recognizing that there are multiple entry points into addiction and mental health services and that these services assist a variety of different populations with different needs and paths to care.
Interpretation:	The lower the number the better, as it demonstrates people are waiting for a shorter time to receive adult addiction outpatient services. This measure is reported a quarter later due to requirements to follow-up with patients after the reporting quarter.
Limitations:	Addiction data has been collected across the province on a provincial information system (ASIST) since 2000. Since June 2015, Edmonton Zone Addiction Services has implemented a new information system (eClinician) to collect AMH information. However, due to constraints within the eClinician system, the zone continues to use ASIST to register clients. The development of this measure has considered the ability to integrate eClinician data to ensure consistent measurement and provide results regardless of information system. Access measures that focus on wait-times do not account for the appropriateness of the intervention provided or the service intensity or duration.
Data Sources:	AHS Addiction and Mental Health
Inclusions:	Clients receiving adult addiction outpatient treatment services delivered directly by AHS and having attended the first appointments (from referral) within the reporting period. Clients receiving services for their own use of substances and/ or gambling concerns. Clients 18 years of age or older.
Exclusions:	Clients receiving follow-up outpatient treatment services after residential/detox services (e.g., clients of Henwood Treatment Centre or Renfrew Recovery Centre) from staff at the residential or detox site. Clients receiving services in the Opioid Dependency Program. Clients receiving services for someone else's substance use and/ or gambling concerns. Clients receiving outpatient services through contracted or funded agencies.
Calculation:	The indicator "90th percentile in days" measures the number of days within which 9 out of 10 clients wait to receive adult addiction treatment service, with wait time measured as the time between the referral date and the date of first attended appointment.
Benchmarks:	Not available.

UNPLANNED MEDICAL READMISSIONS

Definition:	The percentage of medical patients with unplanned readmission to hospital within 30 days of leaving the hospital.
Rationale:	Readmissions to acute care (hospital) is an important indicator of quality of care and care coordination. High rates of unplanned readmission acts as a signal to hospitals to look more carefully at their practices, including the risk of discharging patients too early and the relationship with community physicians and community-based care.
Interpretation:	Although readmission may involve factors outside the direct control of the hospital, high rates of readmission act as a signal to hospitals to look more carefully at their practices, including discharge planning and continuity of services after discharge. Readmissions to hospital may be due to conditions unrelated to the initial discharge. Due to an expected higher readmission rate amongst elderly patients and patients with chronic conditions, this measure will vary due to the nature of the population served by a facility. Rates can also be impacted due to different models of care and healthcare services accessibility. Therefore comparisons between zones should be approached with caution. The lower the percentage, the better as it demonstrates that fewer people are being readmitted shortly after being discharged.
Limitations:	This indicator is only to provide a general trend of unplanned readmission within 30 days for all causes including related complications, nonrelated instances, accidents, etc. This indicator is limited in capturing readmissions due to complications raised post discharge because it may be difficult to accurately link the diagnosis of a readmission to that of the initial discharge. This measure is reported a quarter later due to requirements to follow-up with patients after the reporting quarter.
Data Sources:	AHS Provincial Discharge Abstract Database (DAD)
Inclusions:	Adult patients (20 and over) who are readmitted as urgent / emergent within 30 days of their initial discharge date for medical inpatient care. Canadian residents.
Exclusions:	Admissions and readmissions for surgery, pregnancy, childbirth, mental health diseases and disorders, palliative care; and readmissions for chemotherapy for cancer. Discharges as death, self-sign-out or patient not returning from a pass.
Calculation:	Number of discharged patients readmitted to the hospital within 30 days of initial discharge divided by the total number of patients discharged, expressed as a percent. This is risk-adjusted.
Benchmarks:	Canadian Institute for Health Information (CIHI)

PERINATAL MORTALITY AMONG FIRST NATIONS

Definition:	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.
Rationale:	This indicator provides important information on the health status of First Nations pregnant women, new mothers and newborns. It allows us to see Alberta's performance on reducing disparity between First Nations and non-First Nations populations. Monitoring this rate helps AHS develop and adapt population health initiatives and services to better meet the health needs of Indigenous people and reduce the health gap between Indigenous peoples and other Albertans.
Interpretation:	The lower the number the better. AHS also works to reduce the gap between First Nations and non-First Nations populations. This measure does not include all Indigenous populations, such as our Inuit and Metis residents.
Limitations:	This measure does not include all Indigenous populations. Data is reported annually pending the availability of the most recent census data (one year behind).
Data Sources:	Alberta Vital Statistics and Alberta First Nations Registry
Inclusions:	The Alberta First Nations Registry identifies as "First Nations" with a First Nations band identifier as well as most Inuit people. Mothers aged 15 and above are included.
Exclusions:	The registry excludes Metis Albertans, out of province residents, and miscarriage capture under 28 of weeks.
Calculation:	The number of stillbirths (at 28 or more weeks gestation) plus the number of infants dying under seven days of age divided by the sum of the number of live births plus the number of stillbirths of 28 or more weeks gestation for a given calendar year, multiplied by 1,000.
Benchmarks:	World Health Organization (WHO)

HAND HYGIENE COMPLIANCE

Definition:	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."
Rationale:	Hand hygiene is the single most effective strategy to reduce the transmission of infection in the healthcare setting. Direct observation is recommended to assess hand hygiene compliance rates for healthcare workers.
Interpretation:	The higher the percentage the better, as it demonstrates more healthcare workers are complying with appropriate hand hygiene practices.
Limitations:	Provides information on only a small percentage of all hand hygiene opportunities occurring in healthcare settings since compliance monitoring can only be performed for limited times by human observers. The observer's interpretation of the definitions of the 4 Moments for Hand Hygiene and the situation can impact the reliability of the data. This is known as Observer Bias and Selection Bias. There is the potential influence the observer may have on the behaviour of healthcare providers, since the healthcare provider is mindful of being observed.
Data Sources:	AHS Infection, Prevention and Control (IPC) Database
Inclusions:	Hand hygiene performed according to the 4 Moments for Hand Hygiene: • 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.
Exclusions:	Hand hygiene performed outside of the 4 Moments for Hand Hygiene. Activities that do not involve patient contact or patient environment contact.
Calculation:	Hand hygiene compliance is calculated by dividing the number of compliant observations by the total number of compliant and non-compliant observations recorded by a trained Hand Hygiene Reviewer during a review.
Benchmarks:	Not available.

CHILDHOOD IMMUNIZATION

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

AHS WORKFORCE ENGAGEMENT

Definition:	Calculated as the average score of our workforce's responses to AHS' Our People Survey which utilized a five-point scale, with one being "strongly disagree" and five being "strongly agree."
Rationale:	As Alberta's largest employer, AHS has the opportunity both to create a satisfying workplace and to deliver services in a manner that is sustainable for the future. In order to do this, it is important that AHS fully engages its people and their skills. Monitoring workforce engagement enables us to determine the effectiveness of processes/programs that support employee engagement and strengthen a patient safety culture.
Interpretation:	Workforce Engagement 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.
Limitations:	Survey completed every two years. Responses are provided in real time and may be influenced by external factors such as email access, network outages, staffing changes.
Data Sources:	Gallup Canada, AHS' Our People Survey's third party contractor.
Inclusions:	AHS employees as identified in ePeople on August of the survey year (2016).
Exclusions:	Workforce engagement excludes physicians, volunteers and midwives as they are calculated separately. Residents, students, contractors, anyone on any type of leave of absence (LOA), volunteer associations, AHS subsidiaries including Carewest, Capital Care and Calgary Laboratory Services.
Calculation:	The rate is determined by proprietary calculations from Gallup and not available to AHS.
Benchmarks:	Third party provider benchmark data (Gallup Canada).

DISABLING INJURIES IN AHS WORKFORCE

Definition:	The 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).
Rationale:	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.
Interpretation:	The lower the rate, the fewer disabling injuries are occurring at work.
Limitations:	Late reported cases and status changes may affect the number of accepted disabling injury claims during the year. These cases will be added to the fiscal year's number by end Q1 of the following year.
Data Sources:	AHS Workplace Health & Safety and Disability Management and Workers Compensation Board (WCB). e-Manager Payroll Analytics (EPA) (for paid hours).
Inclusions:	All WCB - accepted AHS disabling injury claims that were submitted by employees and volunteers (and not physicians). Paid hours (for employees) plus volunteer hours (for volunteers). Disabling Injury refers to an injury that: • was incurred at an AHS workplace, • was reported to WCB and the associated claim was approved by WCB, and • required a) modification of the employee's duties or b) lost time from work.
Exclusions:	Physicians, Foundations and AHS subsidiaries Capital Care Group, Calgary Laboratory Services, Carewest.
Calculation:	The number of Total Disabling Injury Claims divided by paid hours, expressed as a rate.
Benchmarks:	Results should not be compared to WCB injury rate indicators for other industries within Alberta or other provinces.

NURSING UNITS ACHIEVING BEST PRACTICE TARGETS

Definition:	The percentage of nursing units at the 16 busiest sites meeting Operational Best Practice (OBP) labour targets.
Rationale:	Operational Best Practice is one of the ways to reduce costs, while maintaining and/or improving care to ensure a sustainable future. This initiative began more than a year ago and initially is focusing on the 16 busiest hospitals in Alberta, clinical support services and corporate services.
Interpretation:	Using comparative data from across the country, 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.
Limitations:	University of Alberta Hospital targets include Stollery data as they share the same site code. Unavailability of separate data for this two sites creates problems in data reporting.
Data Sources:	AHS Finance Statistical General Ledger (STAT GL)
Inclusions:	All nursing units such as medical, surgical, intensive care, and neonatal intensive care units, etc.
Exclusions:	Emergency Departments, normal newborns in bassinets and nursing units that have no worked hours and/or patient days are excluded from the calculation.
Calculation:	The number of inpatient nursing units achieving target divided by the total number of inpatient nursing units, expressed as a percentage.
Benchmarks:	Canadian Institute for Health Information (CIHI)