

# **2020-2022 AHS Public Performance Measure Definitions**

**Prepared November 12, 2021**

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## PERCENTAGE OF CLIENTS PLACED IN CONTINUING CARE WITHIN 30 DAYS

<b>Definition:</b>	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.
<b>Rationale:</b>	Timely and appropriate access to a Continuing Care Living Option is a hallmark of a well-coordinated healthcare delivery system. By improving access to a few key areas, AHS will be able to improve flow throughout the system, provide more appropriate care, decrease wait times and deliver care in a more cost-effective manner. Timely placement can reduce stress and burden on clients and family members. AHS wants to offer seniors and persons with disabilities more options for quality accommodations that suit their service needs and lifestyle.
<b>Interpretation:</b>	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).
<b>Limitations:</b>	Wait time excludes days when a client was unavailable for placement due to medical reasons.
<b>Data Sources:</b>	Meditech and Stratahealth Pathways
<b>Inclusions:</b>	Clients who were assessed and approved for a Continuing Care Living Option (designated supportive living levels 3, 4, and 4-dementia or long-term care) and who were admitted during the reporting period.
<b>Exclusions:</b>	<ul style="list-style-type: none"> <li>• Clients who transferred from Continuing Care Living Option to another Continuing Care Living Option.</li> <li>• Clients assessed and approved, but not yet admitted during the reporting period.</li> <li>• Clients in the process of being approved for Continuing Care Living Options.</li> <li>• Clients admitted to another zone from the reporting zone. This is to avoid double counting.</li> <li>• Clients referred for home care services (including designated supportive living levels 1 and 2).</li> <li>• Clients admitted to a sub-acute unit or a rehabilitation unit.</li> <li>• Clients admitted to a hospice or palliative care unit.</li> <li>• Clients admitted to an acute care bed/service from another acute care bed/service (e.g., surgical bed to a medical bed).</li> <li>• Clients transferred to a non-tertiary acute care hospital bed (e.g., repatriated to a community hospital).</li> </ul>
<b>Calculation:</b>	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.
<b>Benchmarks:</b>	Not available

## PERCENTAGE OF ALTERNATE LEVEL OF CARE DAYS

<b>Definition:</b>	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).
<b>Rationale:</b>	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 waiting for an alternate level of care.
<b>Interpretation:</b>	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.
<b>Limitations:</b>	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.
<b>Data Sources:</b>	Discharge Abstract Database (DAD) - AHS Provincial
<b>Inclusions:</b>	Inpatient discharges from an acute care facility
<b>Exclusions:</b>	Patients with invalid birthdate.
<b>Calculation:</b>	The total number of ALC days (numerator), divided by the total number of inpatient days (denominator), expressed as a percentage.
<b>Benchmarks:</b>	Canadian Institute for Health Information (CIHI)

## UNPLANNED MENTAL HEALTH READMISSIONS WITHIN 30 DAYS

<b>Definition:</b>	<p>The percentage of patients (all age groups) receiving treatment in a general hospital or psychiatric hospital for select mental health disorders who have an unplanned readmission to hospital within 30 days of discharge from hospital. This excludes mental health patients requiring planned or scheduled follow-up care. This measure is adjusted for age, sex and risk factors.</p> <p>Reporting is based on the zone of residence of the patient.</p>
<b>Rationale:</b>	<p>Monitoring readmissions within 30 days of discharge can be a useful tool for quality surveillance. For instance, readmission to inpatient care may be an indicator of relapse after an inpatient stay. High rates of 30-day readmissions could also be interpreted as an outcome of poorly coordinated services and/or poor continuity of services after discharge. As such, some inpatient facilities have examined factors associated with readmissions, including patient characteristics, length of stay, discharge planning and linkages with outpatient care. Given the high cost of institutional care, reducing readmission rates can have a substantial effect on mental health spending.</p>
<b>Interpretation:</b>	<p>The lower the proportion of patients being re-hospitalized within 30 days the better, as it often reflects consistent and appropriate care during hospitalization that leads to fewer complications or relapses, as well as coordinated and continuous services during and after hospitalization.</p>
<b>Limitations:</b>	<p>The level of analysis for this measure is the episode of care, which requires the identification of patient transfers within a certain time period. However, there are several non-standardized ways to determine whether a transfer has occurred. Therefore, depending on how a transfer within the episode of care is defined, the readmission rates published elsewhere could differ.</p>
<b>Data Sources:</b>	<p>Discharge Abstract Database (DAD) - AHS Provincial</p>
<b>Inclusions:</b>	<ul style="list-style-type: none"> <li>• Residents of Alberta</li> <li>• Patients who are readmitted as urgent/emergent for mental health issues within 30 days from the discharge date of their initial mental health care episode in an acute care hospital or psychiatric hospital.</li> </ul>
<b>Exclusions:</b>	<ul style="list-style-type: none"> <li>• Any planned readmissions</li> <li>• Non-Alberta residents</li> <li>• Records with invalid Alberta Personal Health Number, date of birth, admission or discharge date</li> <li>• Patients whose discharge was coded as deceased</li> <li>• Cadaveric donor or stillbirth or assisted dying records</li> </ul>
<b>Calculation:</b>	<p>Number of discharged patients readmitted to the hospital within 30 days of initial discharge (numerator), divided by the total number of patients discharged (denominator), expressed as a percentage. Results are risk-adjusted.</p>
<b>Benchmarks:</b>	<p>Canadian Institute for Health Information (CIHI)</p>

## PATIENT SATISFACTION WITH HOSPITAL EXPERIENCE

<b>Definition:</b>	The percentage of patients rating hospital care as 9 or 10 on a scale from 0-10, where 10 is the best possible rating. The specific statement used for this measure is: "Overall what is your experience with this hospital stay? Please answer on a scale where 0 is I had a very poor experience and 10 is I had a very good experience". The survey is conducted by telephone on a sample of adults who have been discharged from acute care facilities, within 6 weeks of discharge.
<b>Rationale:</b>	Gathering perceptions and feedback from individuals using hospital services is a critical aspect of measuring progress and improving the healthcare delivery 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.
<b>Interpretation:</b>	The higher the number the better, as it demonstrates more patients are satisfied with their care in hospital.
<b>Limitations:</b>	<p>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.</p> <p>This measure is reported a quarter later due to requirements to follow-up with patients after the reporting quarter.</p>
<b>Data Sources:</b>	Canadian Hospital Consumer Assessment of Healthcare Providers and Systems (CHCAHPS) survey responses.
<b>Inclusions:</b>	All valid responses to the specific question for adults aged 18 years and over that were discharged from hospital.
<b>Exclusions:</b>	<ul style="list-style-type: none"> <li>• Respondents who said "Don't Know" or did not answer the question</li> <li>• Patients under 18 years old</li> <li>• Those who stayed less than 24 hours, died during hospital stay, psychiatric patients, stayed only in emergency department, day surgery or ambulatory procedure, possible miscarriage, possible still birth and baby length of stay greater than six days.</li> </ul>
<b>Calculation:</b>	The total number of respondents answering 9 or 10 (numerator), divided by the total number of respondents answering 0-10 (denominator), expressed as a percentage.
<b>Benchmarks:</b>	Canadian Institute for Health Information (CIHI)

## UNIQUE MYAHS CONNECT PORTAL USERS

<b>Definition:</b>	Unique MyAHS Connect portal users is the total number of Connect Care health accounts being accessed via MyAHS Connect. This includes the number of patients with direct access to their own health record and any records that are being accessed via a proxy user.
<b>Rationale:</b>	An increase in access to MyAHS Connect will allow more patients to participate in their care journey, interact with their healthcare team and contribute to their Connect Care legal record of care.
<b>Interpretation:</b>	The higher the number the better, as it indicates that more patients are choosing to access their Connect Care health information through the portal.
<b>Limitations:</b>	This measure depends on Connect Care implementation. Connect Care is being phased in across Alberta between November 2019 and early 2023.
<b>Data Sources:</b>	Connect Care dashboard: MyAHS Connect Patient Experience Dashboard
<b>Inclusions:</b>	Unique active patient users with access to their own account and any records that are being accessed via proxy.
<b>Exclusions:</b>	None
<b>Calculation:</b>	This is a cumulative count of unique portal users.
<b>Benchmarks:</b>	Not Available

## PERCENTAGE OF SCHEDULED CATARACT SURGERIES PERFORMED WITHIN CIHI BENCHMARK

<b>Definition:</b>	The percentage of scheduled cataract extraction surgeries, for patients 18 years of age and older, completed within the CIHI benchmark of 112 days. This measurement interval is from the ready-to-treat (RTT) date when a patient is medically, functionally and socially ready to receive the scheduled surgery to the date that the surgery is performed.
<b>Rationale:</b>	<p>Providing reasonable access to health services is a major objective and a defining attribute of the publicly-funded healthcare delivery system. Longer waits affect the patient's health status and quality of life, as well as results in more costly health services.</p> <p>Cataract extraction surgery is considered one of the five priority areas noted by Canada's first ministers in 2004 and, as such, one of the measures monitored federally by the Canadian Institute for Health Information (CIHI). There is an ongoing pan-Canadian collaboration organized to develop indicators to reduce wait times across all provinces within Canada.</p>
<b>Interpretation:</b>	The higher the percentage of patients receiving cataract surgery within 112 days the better, as this indicates system capacity to respond to demand.
<b>Limitations:</b>	This indicator does not measure the entire wait time from a patient perspective. Specifically, the RTT wait time does not include the wait between referral from a family practitioner to the time seen by a specialist nor the wait time associated with patient-driven social or functional delays.
<b>Data Sources:</b>	Hospital operating room data (PICIS, VAX, Meditech), the Alberta Wait Times Reporting (AWTR) website, and Contracted Surgical Facilities (Bill 11) database.
<b>Inclusions:</b>	<ul style="list-style-type: none"> <li>• Scheduled/elective procedures for cataract surgery</li> <li>• Patients 18 year of age and older</li> <li>• Includes the 'first eye' only</li> </ul>
<b>Exclusions:</b>	<ul style="list-style-type: none"> <li>• Emergency, emergent and non-scheduled cases</li> <li>• Invalid RTT date</li> <li>• The 'second eye' records are excluded in the wait time calculations</li> <li>• Bilateral eye records are excluded in the wait time calculations</li> </ul>
<b>Calculation:</b>	The number of cataract extraction surgeries completed within 112 days (numerator), divided by the total number of cataract extraction surgeries within the same time period (denominator), expressed as a percentage.
<b>Benchmarks:</b>	Canadian Institute for Health Information (CIHI)



## PERCENTAGE OF SCHEDULED HIP REPLACEMENT SURGERIES PERFORMED WITHIN CIHI BENCHMARK

<b>Definition:</b>	The percentage of scheduled hip replacement surgeries, for patients 18 years of age and older, completed within the CIHI benchmark of 182 days. This measurement interval is from the ready-to-treat (RTT) date when a patient is medically, functionally and socially ready to receive the scheduled surgery to the date that the surgery is performed.
<b>Rationale:</b>	<p>Providing reasonable access to health services is a major objective and a defining attribute of the publicly-funded healthcare delivery system. Longer waits affect the patient's health status and quality of life, as well as results in more costly health services.</p> <p>Hip replacement surgery is considered one of the five priority areas noted by Canada's first ministers in 2004 and, as such, one of the measures monitored federally by the Canadian Institute for Health Information (CIHI). There is an ongoing pan-Canadian collaboration organized to develop indicators to reduce wait times across all provinces within Canada.</p>
<b>Interpretation:</b>	The higher the percentage of patients receiving hip replacement surgery within 182 days the better, as this indicates system capacity to respond to demand.
<b>Limitations:</b>	This indicator does not measure the entire wait time from a patient perspective. Specifically, the RTT wait time does not include the wait between referral from a family practitioner to the time seen by a specialist nor the wait time associated with patient-driven social or functional delays.
<b>Data Sources:</b>	Hospital operating room (OR) data (PICIS, VAX, Meditech, ORM), the Alberta Wait Times Reporting (AWTR) website and EPIC. As EPIC is implemented throughout Alberta, current non-EPIC OR information systems will become legacy systems. As such, EPIC will become the sole OR information system throughout Alberta.
<b>Inclusions:</b>	<ul style="list-style-type: none"> <li>• Scheduled/elective procedures for hip replacement surgery</li> <li>• All patients 18 years of age and older</li> <li>• Hip replacement surgeries identified using the anatomy site data element that distinguishes knee from hip surgeries</li> <li>• Total and partial replacements, resurfacings, primaries and revisions</li> <li>• Bilateral joint replacements are counted as one wait</li> </ul>
<b>Exclusions:</b>	<ul style="list-style-type: none"> <li>• Emergency, emergent and non-scheduled cases</li> <li>• Invalid RTT date</li> </ul>
<b>Calculation:</b>	The number of hip replacement surgeries completed within 182 days (numerator), divided by the total number of hip replacement surgeries within the same time period (denominator), expressed as a percentage.
<b>Benchmarks:</b>	Canadian Institute for Health Information (CIHI)

## PERCENTAGE OF SCHEDULED KNEE REPLACEMENT SURGERIES PERFORMED WITHIN CIHI BENCHMARK

<b>Definition:</b>	The percentage of scheduled knee replacement surgeries, for patients 18 years of age and older, completed within the CIHI benchmark of 182 days. This measurement interval is from the ready-to-treat (RTT) date when a patient is medically, functionally and socially ready to receive the scheduled surgery to the date that the surgery is performed.
<b>Rationale:</b>	<p>Providing reasonable access to health services is a major objective and a defining attribute of the publicly-funded healthcare delivery system. Longer waits affect the patient's health status and quality of life, as well as results in more costly health services.</p> <p>Knee replacement surgery is considered one of the five priority areas noted by Canada's first ministers in 2004 and, as such, one of the measures monitored federally by the Canadian Institute for Health Information (CIHI). There is an ongoing pan-Canadian collaboration organized to develop indicators to reduce wait times across all provinces within Canada.</p>
<b>Interpretation:</b>	The higher the percentage of patients receiving knee replacement surgery within 182 days the better, as this indicates system capacity to respond to demand.
<b>Limitations:</b>	This indicator does not measure the entire wait time from a patient perspective. Specifically, the RTT wait time does not include the wait between referral from a family practitioner to the time seen by a specialist nor the wait time associated with patient-driven social or functional delays.
<b>Data Sources:</b>	Hospital operating room (OR) data (PICIS, VAX, Meditech, ORM), the Alberta Wait Times Reporting (AWTR) website and EPIC. As EPIC is implemented throughout Alberta, current non-EPIC OR information systems will become legacy systems. As such, EPIC will become the sole OR information system throughout Alberta.
<b>Inclusions:</b>	<ul style="list-style-type: none"> <li>• Scheduled/elective procedures for knee replacement surgery</li> <li>• All patients 18 years of age and older</li> <li>• Knee replacement surgeries identified using the anatomy site data element that distinguishes knee from knee surgeries</li> <li>• Total and partial replacements, resurfacings, primaries and revisions</li> <li>• Bilateral joint replacements are counted as one wait</li> </ul>
<b>Exclusions:</b>	<ul style="list-style-type: none"> <li>• Emergency, emergent and non-scheduled cases</li> <li>• Invalid RTT date</li> </ul>
<b>Calculation:</b>	The number of knee replacement surgeries completed within 182 days (numerator), divided by the total number of knee replacement surgeries within the same time period (denominator), expressed as a percentage.
<b>Benchmarks:</b>	Canadian Institute for Health Information (CIHI)

## TOTAL ALBERTA RESIDENTS WHO RECEIVED A COVID-19 VACCINATION

<b>Definition:</b>	A cumulative count of Albertans who received at least one dose of the COVID-19 vaccine at the time of reporting.
<b>Rationale:</b>	An effective vaccine will protect the recipient by lowering the chance of getting COVID-19 and/or providing protection against severe illness if the person encounters the coronavirus. In Canada, all COVID-19 vaccines approved by Health Canada are highly effective at preventing serious illness, hospitalization and death—results indicate that the first dose is up to 80% effective in preventing severe illness. Widespread vaccination makes the virus less likely to spread through community transmission and is less likely to infect as many people (i.e., attempting to reach “population immunity” or “herd immunity”). In fact, limiting the spread through communities will restrict the virus’ opportunity to continue to mutate into new variants.
<b>Interpretation:</b>	A larger number translates into better coverage as it indicates more Albertans have received a COVID-19 vaccine.
<b>Limitations:</b>	<p>Out-of-province individuals and records missing postal codes are excluded. In addition, some First Nations communities that do not submit immunization data to the Immunization and Adverse Reaction to Immunization (Imm/ARI) database are not included.</p> <p>Data completeness, however, depends on the vaccine information provided by Albertans who received dose(s) out of province or out of country (OOP/OOC). Note that, it is not mandatory to share OOP/OOC vaccine information when receiving the vaccine in Alberta. As well, validity of the OOP/OOC doses depends on the number of doses they received with respect to the number of days between doses (for vaccines where two doses are recommended by vaccine manufacturers).</p>
<b>Data Sources:</b>	AHS-administered vaccine data is extracted from the AHS Meditech system; non-AHS-administered vaccine data is extracted from the Immunization and Adverse Reaction to Immunization (Imm/ARI) database managed by Alberta Health. The non-AHS vaccine providers include pharmacies, First Nations sites and non-AHS outreach programs.
<b>Inclusions:</b>	<ul style="list-style-type: none"> <li>• All Albertans determined by postal code of residence.</li> <li>• All Albertans who received at least one dose of vaccine:             <ul style="list-style-type: none"> <li>○ Within Alberta that are approved by Health Canada and are offered in the province (Pfizer-BioNTech, Moderna, AstraZeneca, COVISHIELD and Janssen);</li> <li>○ Out of province that are approved by Health Canada;</li> <li>○ Out of country that are approved by Health Canada or approved by respective countries.</li> </ul> </li> </ul>
<b>Exclusions:</b>	Non-Alberta residents
<b>Calculation:</b>	Unique count of Albertans who received at least one dose of COVID-19 vaccine.
<b>Benchmarks:</b>	Not available

## HAND HYGIENE COMPLIANCE

<b>Definition:</b>	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 for Hand Hygiene”.
<b>Rationale:</b>	Performing 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.
<b>Interpretation:</b>	The higher the percentage the better, as it demonstrates more healthcare workers are complying with appropriate hand hygiene practices.
<b>Limitations:</b>	<p>Provides information on only a small percentage of all hand hygiene opportunities occurring in healthcare settings since compliance monitoring can only be performed a limited number of times by human observers.</p> <p>The observer’s interpretation of the definitions of the 4 Moments for Hand Hygiene and individual situations can impact the reliability of the data. This is known as Observer Bias and Selection Bias.</p> <p>There is also the potential influence the observer may have on the behaviour of healthcare providers, since the healthcare provider is mindful of being observed.</p>
<b>Data Sources:</b>	AHS Infection, Prevention and Control (IPC) Database
<b>Inclusions:</b>	<p>Hand hygiene performed according to the 4 Moments for Hand Hygiene:</p> <ul style="list-style-type: none"> <li>• Before contact with a patient or patient’s environment,</li> <li>• Before a clean or aseptic procedure,</li> <li>• After exposure (or risk of exposure) to blood or body fluids, and</li> <li>• After contact with a patient or patient’s environment.</li> </ul>
<b>Exclusions:</b>	<ul style="list-style-type: none"> <li>• Hand hygiene performed outside of the 4 Moments for Hand Hygiene.</li> <li>• Activities that do not involve patient contact or patient environment contact.</li> </ul>
<b>Calculation:</b>	The number of compliant observations (numerator), divided by the total number of compliant and non-compliant observations recorded by a trained Hand Hygiene Reviewer during a review (denominator), expressed as a percentage.
<b>Benchmarks:</b>	Not available

## AMULATORY CARE SENSITIVE CONDITIONS HOSPITALIZATION RATE

<b>Definition:</b>	This measure represents the hospitalization rate of Alberta residents for conditions where appropriate ambulatory care could potentially prevent or reduce the need for admission to hospital. It is expressed as the rate per 100,000 population younger than age 75 years, age-standardized to the 2011 Canadian population.
<b>Rationale:</b>	Ambulatory Care Sensitive Conditions (ACSC) are medical conditions that can be treated in community settings. Hospitalizations due to ACSC may be considered indirect measures of how effectively the healthcare delivery system is able to manage chronic conditions, particularly with regard to accessing appropriate primary healthcare and care in community settings.
<b>Interpretation:</b>	A lower ACSC rate may be an indication of effective management of these chronic conditions and better overall patient health, as well as better utilization of resources through avoidance of unnecessary hospitalizations. A high ACSC rate may reflect problems in obtaining access to appropriate primary care services. However, not all hospitalizations for these conditions are preventable.
<b>Limitations:</b>	The Alberta population data is based on mid-year estimates; however, the measure is reported quarterly. Therefore, quarterly population data are estimated via interpolation and may not reflect the exact population at the time. In addition, the list of ambulatory care sensitive conditions is based on the CIHI indicator definition; however, it may not include all conditions that could be considered ambulatory care sensitive conditions.
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• AHS provincial Discharge Abstract Database</li> <li>• Postcensal Canadian population estimate</li> <li>• Population Health based on the Patient/Care-Based Funding (PCBF) Population database</li> </ul>
<b>Inclusions:</b>	<ul style="list-style-type: none"> <li>• Age &lt; 75 years</li> <li>• Gender recorded as male or female</li> <li>• Alberta residents</li> <li>• Most responsible diagnosis (MRDx) of any of the following conditions:             <ol style="list-style-type: none"> <li>1. Grand mal status and other epileptic convulsions</li> <li>2. Chronic obstructive pulmonary disease (COPD)</li> <li>3. Asthma</li> <li>4. Diabetes</li> <li>5. Heart failure and pulmonary edema (excluding cases with cardiac procedures)</li> <li>6. Hypertension (excluding cases with cardiac procedures)</li> <li>7. Angina (excluding cases with cardiac procedures)</li> </ol> </li> </ul>
<b>Exclusions:</b>	<ul style="list-style-type: none"> <li>• Death before discharge</li> <li>• Admission category recorded as newborn, stillbirth or cadaver</li> </ul>
<b>Calculation:</b>	ACSC cases per 100,000 population, standardized by age using 2011 Canadian population
<b>Benchmarks:</b>	Canadian Institute for Health Information (CIHI)

## AHS WORKFORCE ENGAGEMENT

<b>Definition:</b>	Calculated as the average score of the workforce’s responses to AHS’ Our People Survey which utilizes a five-point scale, with one being “strongly disagree” and five being “strongly agree”.
<b>Rationale:</b>	As Alberta’s largest employer, AHS has the opportunity 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 strengthens a patient-centered culture.
<b>Interpretation:</b>	<p>The 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, safer patient care and willingness to give discretionary effort at work.</p> <p>The higher the rate the better, as it demonstrates more employees feel positively about their work.</p>
<b>Limitations:</b>	<p>Survey completed every two years.</p> <p>Responses are provided in real time and may be influenced by external factors such as email access, network outages and staffing changes.</p>
<b>Data Sources:</b>	Gallup Canada, AHS’ Our People Survey third party contractor.
<b>Inclusions:</b>	AHS employees as identified in ePeople in August of the survey year.
<b>Exclusions:</b>	Workforce engagement excludes physicians, volunteers and midwives as they are calculated separately. Residents, students, contractors, anyone on a leave of absence (LOA), volunteer associations, AHS subsidiaries including Carewest, Capital Care and Alberta Precision Laboratories.
<b>Calculation:</b>	The rate is determined by proprietary calculations from Gallup and not available to AHS.
<b>Benchmarks:</b>	Third party provider benchmark data (Gallup Canada)

## DISABLING INJURIES IN AHS WORKFORCE

<b>Definition:</b>	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).
<b>Rationale:</b>	Our disabling injury rate indicates the extent to which AHS experiences injuries in the workplace, enabling us to identify health and safety programs that actively engage our people in creating a safe, healthy and inclusive workplace.
<b>Interpretation:</b>	The lower the rate the better, as this demonstrates fewer disabling injuries are occurring at work.
<b>Limitations:</b>	Late-reported cases and status changes may affect the number of accepted disabling injury claims during the year. These cases are added to the fiscal year's total by the end of Q1 the following year.
<b>Data Sources:</b>	AHS Workplace Health & Safety and Disability Management and Workers Compensation Board (WCB). e-Manager Payroll Analytics (EPA) (for paid hours).
<b>Inclusions:</b>	<ul style="list-style-type: none"> <li>• All WCB-accepted AHS disabling injury claims that were submitted by employees and volunteers.</li> <li>• Paid hours (for employees) and volunteer hours (for volunteers).</li> <li>• Disabling injuries refers to an injury that: <ul style="list-style-type: none"> <li>○ Was incurred at an AHS workplace,</li> <li>○ Was reported to WCB and the associated claim was approved by WCB, and</li> <li>○ Required a) modification of the employee's duties or b) lost time from work.</li> </ul> </li> </ul>
<b>Exclusions:</b>	Physicians, Foundations and AHS subsidiaries including Capital Care Group, Alberta Precision Laboratories and Carewest.
<b>Calculation:</b>	The number of total disabling injury claims (numerator), divided by paid and volunteer hours (denominator), expressed as a rate per 200,000 paid and volunteer hours.
<b>Benchmarks:</b>	Results should not be compared to WCB injury rate indicators for other industries within Alberta or other provinces.

## ANNUAL RATE OF CHANGE IN OPERATIONAL EXPENDITURES

<b>Definition:</b>	This measure reports year-over-year change in operational expenditures, expressed as a percentage.
<b>Rationale:</b>	AHS' goal is to provide safe, high-quality healthcare while ensuring sustainable levels of health spending. Responsible fiscal management will ensure the long-term sustainability of Alberta's healthcare delivery system.
<b>Interpretation:</b>	<p>Operating expenses are incurred during regular, day-to-day operation (e.g., salaries and benefits, contract payments, drugs, medical supplies, and other expenses such as utilities, rent, amortization and supplies, etc.). A lower annual rate of change in operational expenditures demonstrates AHS is maintaining strong fiscal stewardship of public resources and operating within the budget approved by the AHS Board and the Minister of Health.</p> <p>A negative percentage indicates an overall lower operating cost compared to previous years. Conversely, a positive percentage indicates an overall higher operating cost compared to previous years.</p>
<b>Limitations:</b>	None
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• AHS' Consolidated Statement of Operations (AHS' Consolidated Annual Audited Financial Statements)</li> <li>• Underlying data from AHS' general ledger (e-Manager)</li> </ul>
<b>Inclusions:</b>	All operational expenses included in AHS' consolidated statement of operations.
<b>Exclusions:</b>	Estimated incremental expenses incurred to respond to the COVID-19 pandemic.
<b>Calculation:</b>	The difference between the current and previous fiscal period consolidated expenses (numerator), divided by the current fiscal period consolidated expense (denominator).
<b>Benchmarks:</b>	Not Available



## COST OF A STANDARD HOSPITAL STAY

<b>Definition:</b>	The ratio of a hospital's total acute inpatient care expenses to the number of acute inpatient weighted cases related to the inpatients for which the hospital provided care.
<b>Rationale:</b>	<p>The indicator was developed to increase cost-efficiency in hospitals.</p> <p>The indicator can provide insight into the total cost to treat an average inpatient with a Resource Intensity Weight (RIW) of 1.</p>
<b>Interpretation:</b>	Cost of a standard hospital stay (CSHS) is an indicator that measures the relative cost-efficiency of a hospital's ability to provide acute inpatient care. This indicator compares a hospital's total acute inpatient care expenses to the number of acute inpatient weighted cases related to the inpatients that it provided care for. The result is the hospital's average full cost of treating the average acute inpatient. A high cost of a standard hospital stay indicates a relatively high cost of treating the average acute inpatient; a low cost of a standard hospital stay indicates that the cost of treating the average acute inpatient is relatively low.
<b>Limitations:</b>	<p>AHS differs from the Canadian Institute for Health Information (CIHI) implementation in the following ways:</p> <ol style="list-style-type: none"> <li>1. AHS data uses AHS and Covenant Health general ledgers as opposed to the CIHI general ledger which contains various financial allocations specific to CIHI's requirements. CIHI performs their calculations based on their minimum reporting standards (includes the first 5 digits of the functional code), while AHS uses full 11-digit functional codes. This roll-up may lead to slight differences in the reported numbers between AHS and CIHI.</li> <li>2. When discrepant data are discovered, AHS resolves the discrepancy within the data warehouse; however, the data does not get resubmitted to CIHI.</li> <li>3. Corporate allocations that are included in the CIHI ledger are completed manually by AHS Finance Business Improvements prior to being submitted to CIHI. Corporate Allocations for the AHS version of the CSHS are done via a prorated methodology.</li> <li>4. Calculating the CSHS requires splitting costs into three groups: Inpatient, Other Patient, and Non-Patient. This split often requires national average values. CIHI's national average values are more up-to-date than those available for the AHS calculation.</li> </ol>
<b>Data Sources:</b>	AHS General Ledger, Covenant Health General Ledger and Stat General Ledger Provincial Inpatient Discharge Abstract Database (DAD)
<b>Inclusions:</b>	<ul style="list-style-type: none"> <li>• All Resource Intensity Weights associated with an inpatient stay</li> <li>• Inpatient cost</li> <li>• Inpatient proportion of the corporate cost</li> </ul>
<b>Exclusions:</b>	<ul style="list-style-type: none"> <li>• Non-inpatient activity data without RIW</li> <li>• Other Patient Costs</li> <li>• Non-Patient Costs</li> </ul>
<b>Calculation:</b>	A facility's total inpatient cost (numerator), divided by its total acute inpatient weighted cases (denominator).
<b>Benchmarks:</b>	Canadian Institute for Health Information (CIHI)

## ACUTE LENGTH OF STAY COMPARED TO EXPECTED LENGTH OF STAY RATIO

<b>Definition:</b>	The ratio of the total number of patient days, excluding alternate level of care (ALC) days, in inpatient acute care hospitals compared to the total acute length of stay that is expected based on factors such as patient age, diagnoses and interventions.
<b>Rationale:</b>	Monitoring this ratio can help healthcare teams ensure care appropriateness and efficiency. Retrospective reviews of this measure can help to identify opportunities for improvement in both areas. This measure gauges how efficiently beds and resources are utilized in the hospital. An improvement in this measure can translate into the ability to treat more patients with existing beds and resources.
<b>Interpretation:</b>	A ratio greater than one indicates the acute length of stay was longer than expected (an overall poorer than expected efficiency). A ratio less than one indicates the acute stay was shorter than expected, potentially representing greater efficiency and indicates that more patients are able to be treated for a given inpatient bed. For ALOS/ELOS ratios above 1, there may be opportunities to safely reduce the acute care stay of patients.
<b>Limitations:</b>	ALOS/ELOS ratios based on small volumes of typical discharges should be used with caution. Generally, there may be increased variation in a measure calculated based on small volumes, therefore, the measure may not accurately reflect health service delivery.
<b>Data Sources:</b>	AHS provincial Discharge Abstract Database (DAD)
<b>Inclusions:</b>	<ul style="list-style-type: none"> <li>• Typical acute inpatient discharges only</li> <li>• Acute days and subacute days</li> </ul>
<b>Exclusions:</b>	<ul style="list-style-type: none"> <li>• Alternate level of care (ALC) days</li> <li>• Atypical cases including any of the following: <ul style="list-style-type: none"> <li>○ Deaths</li> <li>○ Transfers</li> <li>○ Voluntary sign-outs</li> <li>○ Long-stay cases</li> </ul> </li> </ul>
<b>Calculation:</b>	The total number of acute care days for inpatient acute care discharges (numerator), divided by total number of Expected Length of Stay (ELOS) days for inpatient acute care discharges (denominator), expressed as a ratio.
<b>Benchmarks:</b>	Canadian Institute for Health Information (CIHI)

## OVERALL UNPLANNED READMISSIONS

<b>Definition:</b>	The percentage of medical, surgical, pediatric and obstetric patients with an unplanned readmission to hospital within 30 days of leaving the hospital.
<b>Rationale:</b>	Readmissions to acute care (hospital) is an important indicator of quality of care and care coordination. High rates of unplanned readmissions 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.
<b>Interpretation:</b>	<p>Although readmissions 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.</p> <p>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 by different models of care and healthcare service accessibility. Therefore, comparisons between zones should be approached with caution.</p> <p>The lower the percentage the better, as it demonstrates that fewer people are being readmitted shortly after being discharged.</p>
<b>Limitations:</b>	This indicator is only to provide a general trend of unplanned readmissions within 30 days for all causes including related complications, non-related 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.
<b>Data Sources:</b>	Record-level data downloaded directly from CIHI
<b>Inclusions:</b>	Episodes involving inpatient care <ul style="list-style-type: none"> <li>• Canadian residents with valid health card number</li> <li>• Gender recorded as male or female</li> </ul>
<b>Exclusions:</b>	<ul style="list-style-type: none"> <li>• Discharges coded as death, self-sign-out or patient not returning from a pass</li> <li>• Records with an admission category of cadaveric donor or stillbirth</li> <li>• An episode that started or ended in a day surgery setting.</li> <li>• Presence of at least one record in the episode with major clinical categories (MCC) of Mental Diseases and Disorders</li> <li>• Presence of at least one record in the episode with palliative care coded as most responsible diagnosis.</li> </ul>
<b>Calculation:</b>	Number of discharged patients readmitted to the hospital within 30 days of initial discharge (numerator), divided by the total number of patients discharged (denominator), expressed as a percentage. Results are risk-adjusted.
<b>Benchmarks:</b>	Canadian Institute for Health Information (CIHI)