

# **Alberta Health Services Board Quality and Patient Safety Dashboard**

**Background Paper**  
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## Executive Summary

The Quality and Patient Safety Committee of the Board requested the development of a Quality and Patient Safety Dashboard to enable the monitoring of the quality of services provided by Alberta Health Services (AHS). A number of indicators have been proposed that will enable AHS to monitor performance and identify potential areas for improvement. The indicators were developed following consultation with a wide range of stakeholders.

The indicators were identified as appropriate measures of quality if the indicator measures a dimension of quality (using the HQCA matrix), is a measure of a service provided by Alberta Health Services and if the measure could indicate some action that could be taken if the target is not met. Targets were identified using similar national and international targets for comparison.

Data are not available for all the proposed indicators so the dashboard will not be fully populated initially. Many indicators require the implementation of a program or data collection process before they can be calculated.

The Quality and Patient Safety Dashboard will expand over time as new measures are identified and indicators are revised or discarded. All recommendations for refining the Dashboard will be submitted for review by a Steering Committee co-chaired by the Data Integration, Measurement and Reporting and the Quality Performance Improvement departments. The Committee will rely on a variety of sources to identify appropriate measures, methods of calculation and targets, including discussion with the newly formed Clinical Networks, ad hoc data analysis and reviews of the literature.

Indicators of quality will be widely reviewed for validity and wherever possible will be associated with action plans for improvement.

## Introduction

The Quality and Safety Committee of the Board requested the development of a Quality and Patient Safety Dashboard to enable the monitoring of the quality of services provided by Alberta Health Services (AHS). A number of indicators have been proposed that will enable AHS to monitor performance and identify potential areas for improvement, and several dashboards incorporating a variety of indicators have been proposed. The dashboard presented below is focused on indicators of Quality and Patient Safety.

## Purpose

The purpose of the Quality and Patient Safety Dashboard is to provide a mechanism for monitoring quality across the organization and the success of the organization's quality improvement strategies. The goal of a Dashboard is to provide meaningful, insightful and actionable information, at a high enough level of aggregation that variations are readily identifiable. However, each of the indicators proposed for the Quality and Patient Safety Dashboard will be developed so that information about performance is accessible at the individual facility or program level for follow up and action as appropriate and available.

## Consultation Process

Forty indicators were identified and presented to the Quality and Patient Safety Committee of the Board in June, 2009, and the Committee requested an assessment of the appropriateness of the indicators. A document outlining the current knowledge or status of data to support the calculation of each indicator was developed to provide sufficient background for stakeholders to provide their advice about the appropriateness of the proposed indicators. The document was circulated to a broad group of stakeholders who were asked to evaluate the proposed measures and provide feedback via electronic survey. Those stakeholders were then invited to a workshop to discuss the value and relevance of each of the indicators to quality improvement initiatives. The feedback from the workshop is summarized in Table 1 below.

**Table 1: Summary of Feedback on Proposed Indicators**

No.	Consultation Measure	Sector	Feedback
1	Overall patient experience score	Acute	Keep
2	Rate of patient concerns	Acute	Keep/modify
3	% of patient concerns escalated to PCO	Acute	Modify/delete
4	% of Albertans who smoke	Population health	Keep/modify Note: this is a measure of population health but not quality of AHS services

No.	Consultation Measure	Sector	Feedback
5	% of Albertans who are obese	Population health	Keep/modify Note: this is a measure of population health but not quality of AHS services
6	% of Albertans with Type II diabetes	Population health	Keep/modify Note: this is a measure of population health but not quality of AHS services
7	Colorectal cancer screening compliance	Cancer care	Keep/modify
8	Hand hygiene	Acute	Keep
9	IHI Trigger tool (audit tool to identify frequency of adverse events)	Acute	Keep
9a	IHI Never Events	Acute	Keep
10	Hospital Standardized Mortality Ratio	Acute	Modify/delete
11	Compliance with selected clinical pathways	All	Keep
12	Compliance with Accreditation Canada ROPs	Acute	Modify/delete Note: this is a global measure that should be addressed by other indicators
13	Response time to start investigations into serious adverse events	All	Keep
14	Admissions for ambulatory sensitive conditions	Acute	Keep
15	% of diabetic patients with Haemoglobin A1c<8	Primary care	Keep
16	% of patients with hypertension treated to target	Primary care	Keep/modify
17	Home Care Quality Measure	Homecare	Modify
18	End of life quality measure	All	Modify/delete
19	MRSA infection rate (hospital acquired)	Acute	Keep
20	Blood stream infection rate (BSI)	Acute	Keep
21	C-Difficile Infection Rate (hospital acquired)	Acute	Keep
22	Surgical site infection rate	Acute	Keep
23	Staff culture survey score	All	Modify
24	Staff exit rate (separation rate)	All	Modify
25	Physician turnover rate	Physicians	Delete

No.	Consultation Measure	Sector	Feedback
26	% targeted staff trained in quality and safety	All	Modify
27	Average education/ training hours per FTE	All	Delete
28 29 30	Coronary Artery Bypass Grafting (CABG) wait times	Acute	Modify
31	Elective primary knee replacement surgery wait times	Acute	Keep
32	Elective primary hip replacement surgery wait times	Acute	Keep
33 34 35	ED average LOS registration to discharge; registration to admission and ED average EIP	Acute	Modify
36	% of IP days classified as ALC	Acute	Keep
37	% of Albertans with family physician	Physicians	Modify/delete not actionable
38	% of Albertans attached to a primary care network (PCN)	Physicians, Primary care network	Modify/delete not actionable
39	Access to cancer care services	Cancer	Keep and expand
40	% of children receiving scheduled mental health treatment within 30 days	Mental Health and Addictions	Keep and expand

## Analysis

The stakeholder feedback was evaluated to determine the most appropriate measures, considering both the assessment of the proposed measure and the alternatives proposed at the workshop. Some indicators were clearly acceptable by the majority of stakeholders, while clear consensus was not evident for many of the indicators. Moreover, some of the indicators where the general consensus was to keep it as proposed were not clear measures of quality. A final count of twenty-three (23) indicators were identified as appropriate measures of quality using the following criteria:

- the indicator measures a dimension of quality, using the HQCA matrix;
- the indicator measures a service provided by Alberta Health Services; and
- some action could be taken if the target is not met.

The final list of indicators proposed for the Quality and Patient Safety Dashboard are summarized in Table 2 below. Details about each of the proposed indicators, including the method of calculation, the data source, and sources for comparable information from Canada and/or other countries is included in Appendix A.

Many of the proposed indicators are not yet available and some indicators require the implementation or expansion of a program and the development of data collection processes and instruments before data can be made available. Where data is not currently available to support reporting to the

dashboard, a general estimate of the amount of funding that would be required to implement the indicator is included in the Cost column. Estimates are very high level and developed based on current knowledge of the availability of information or the readiness of programs across the organization. A single dollar sign (\$) indicates that the implementation is a relatively small project, i.e. some data is available, but it must be collated manually, such as the number of patient concerns by category, or consultation must occur to validate or establish the appropriate measure, such as the list of Never Events. Two dollar signs (\$\$) indicates that a program already exists but must be expanded to the provincial level, and three dollar signs (\$\$\$) indicates a very large effort is required to provide information to the dashboard. No dollar sign associated with an indicator means that the data is already being reported elsewhere. The timelines were discussed and agreed to by the Data Integration, Measurement and Reporting department.

**Table 2: Proposed Quality and Patient Safety Performance Dashboard Measures**

#	Recommended Measure	Quality Dimension	Timelines	Cost	Data Source
<b>Patients as Partners</b>					
1	Patient satisfaction with care	Acceptability	10/11	\$\$\$	Survey of patients
2	% of commendations	Acceptability	10/11	\$	Patient concerns office
3	Compliance with screening guidelines for: <ul style="list-style-type: none"> <li>• colorectal cancer</li> <li>• breast cancer</li> <li>• cervical cancer</li> </ul>	Appropriateness	11/12 09/10 11/12	\$\$\$  \$\$	Cancer Care CCHS survey Physician claims and program Program/laboratory
4	% of patients who smoke discharged with smoking cessation plan	Effectiveness	11/12	\$\$	No data source; requires expansion of program and data collection process
5	% of patient concerns escalated to PCO	Safety	10/11		Patient concerns office
<b>Accountability for Quality and Patient Safety</b>					
6	Compliance with selected clinical pathways	Appropriateness	11/12	\$\$\$	No data source; requires implementation of process in 10/11
7	Admissions for ambulatory sensitive conditions	Appropriateness	09/10		Discharge Abstract
8	Admission to Acute Care During Last Six Months of Life	Acceptability	11/12	\$\$\$	Discharge Abstract and Vital Statistics
9	% of patients diagnosed with diabetes with controlled blood sugar (haemoglobin A1c<8)	Effectiveness	11/12	\$\$	Laboratory data

#	Recommended Measure	Quality Dimension	Timelines	Cost	Data Source
10	% of patients diagnosed with hypertension with blood pressure control	Effectiveness	13/14	\$\$\$\$	No data source; requires implementation of data collection process in EMR 10/11
11	Falls among seniors receiving continuing care supports	Safety	10/11	\$	RAI Home Care, ACCIS
12	Compliance with hand hygiene policies	Safety	11/12	\$\$	No data source; requires development of program and data collection process in 10/11
13	Never Events	Safety	10/11	\$	No data source; requires definition of events and development of data collection process in 10/11
14	Response time to start investigations into serious adverse events	Safety	10/11	\$	No data source; requires implementation of data collection process in 10/11
15	Hospital Infection rate for: <ul style="list-style-type: none"> <li>• MRSA infection rate (hospital acquired)</li> <li>• Blood stream infection rate</li> <li>• C-Difficile Infection Rate (hospital acquired)</li> <li>• Surgical site infection rate</li> </ul>	Safety	09/10 09/10 10/11 11/12	\$\$\$	Notifiable Disease Reporting  Requires development of definition of wound type
<b>Skilled People and Supportive culture</b>					
16	Positive staff culture	Effectiveness	11/12	\$\$	No data source; requires implementation of data collection process in 10/11
<b>Access</b>					
17	Coronary Artery Bypass Grafting (CABG) wait times	Accessibility	09/10		If definition is expanded \$ Reported elsewhere
18	Elective primary knee replacement surgery wait times by acuity level	Accessibility	09/10		Wait times reporting Reported elsewhere
19	Elective primary hip replacement surgery wait times by acuity level	Accessibility	09/10		Wait times reporting Reported elsewhere
20	Access to cancer care services by provider type	Accessibility	09/10		Cancer Care medical record

#	Recommended Measure	Quality Dimension	Timelines	Cost	Data Source
21	% of children receiving scheduled mental health treatment within 30 days	Accessibility	09/10		Mental Health information system (ARMHIS)
22	% of IP days classified as ALC	Appropriateness	09/10		Provincial Morbidity Database Reported elsewhere
23	ED average LOS registration to discharge; registration to admission	Efficiency	09/10		ACCS data abstracts Reported elsewhere

The proposed indicators were mapped to the Health Quality Matrix developed by the Health Quality Network in 2004. The matrix enables a classification of the indicators along the four areas of need in addition to the six dimensions of quality. The majority of health services can be mapped to a corresponding area of need, so the matrix can be used to determine the health service sectors that do not have an associated quality performance measure.

## Implementation




Data are not available for all of the proposed indicators so the dashboard will not be fully populated at the outset. A Gantt chart indicating availability of data is included in Appendix C but availability is dependent in most cases on:

- a) approval of the indicator and target; and
- b) approval of funding to implement the data collection and analysis process.

Although these indicators have all been reviewed and discussed by a broad range of stakeholders, the proposed targets have not been ratified by the operational owners. All the indicators and the targets must be discussed and approved by the operational owners before the dashboard can be populated.

Data will be presented on a dashboard similar to the sample shown in Table 3. The Dashboard will be updated annually for most measures, and a selection of measures will be updated on a quarterly basis if available and appropriate. The Dashboard will have drill-down capability to present different information to different groups, depending upon their need. For example, the Board requires high level aggregate information that indicates the overall quality of the system at a high level. The Quality and Safety Committee of the Board could be provided with information aggregated to the zone level, and the facility or program would get specific information that informs process change.

**Table 3: Sample Quality and Patient Safety Dashboard**

-  Red indicates the target was not met (large variance)
-  Yellow indicates the target was not met (small variance)
-  Green indicates the target was met

**Note:** All targets require discussion with operational owners prior to populating the Dashboard.

#	Indicator	07/08	08/09	Q1	Q2	Q3	Q4	09/10 Target	Actions (required for each indicator that does not meet the target)
<b>Patients as Partners</b>									
1	Patient satisfaction with acute care services								
2	Length of time to resolve patient concerns								
	% of patient commendations								
3	Compliance with clinical practice guidelines for:								
	<ul style="list-style-type: none"> <li>• Colorectal Cancer screening:               <ul style="list-style-type: none"> <li>○ FOB in 2 years or colonoscopy or sigmoidoscopy in past 5 years</li> </ul> </li> </ul>								
	<ul style="list-style-type: none"> <li>• Breast Cancer (women 50–69)               <ul style="list-style-type: none"> <li>○ no screen</li> <li>○ 1 screen in 2 years</li> </ul> </li> </ul>								







## Next Steps

A dashboard should consist of high level indicators that are specific enough that variations are identifiable, but general enough that facilities and programs are not identifiable. A dashboard can be as simple as a map color coded to show areas where improvement is needed or a graph comparing one area to another. Regardless of the specific format, a dashboard should show the user at a quick glance whether there is anything that needs to be followed.

Ideally, each indicator should have enough detailed information behind it that the user could drill down to site-, program- or unit-specific information that could inform remedial action. The level of information ideal for a Dashboard is too generic for specific hospitals to determine their performance compared to other similar hospitals, so some drill-down capability is necessary.

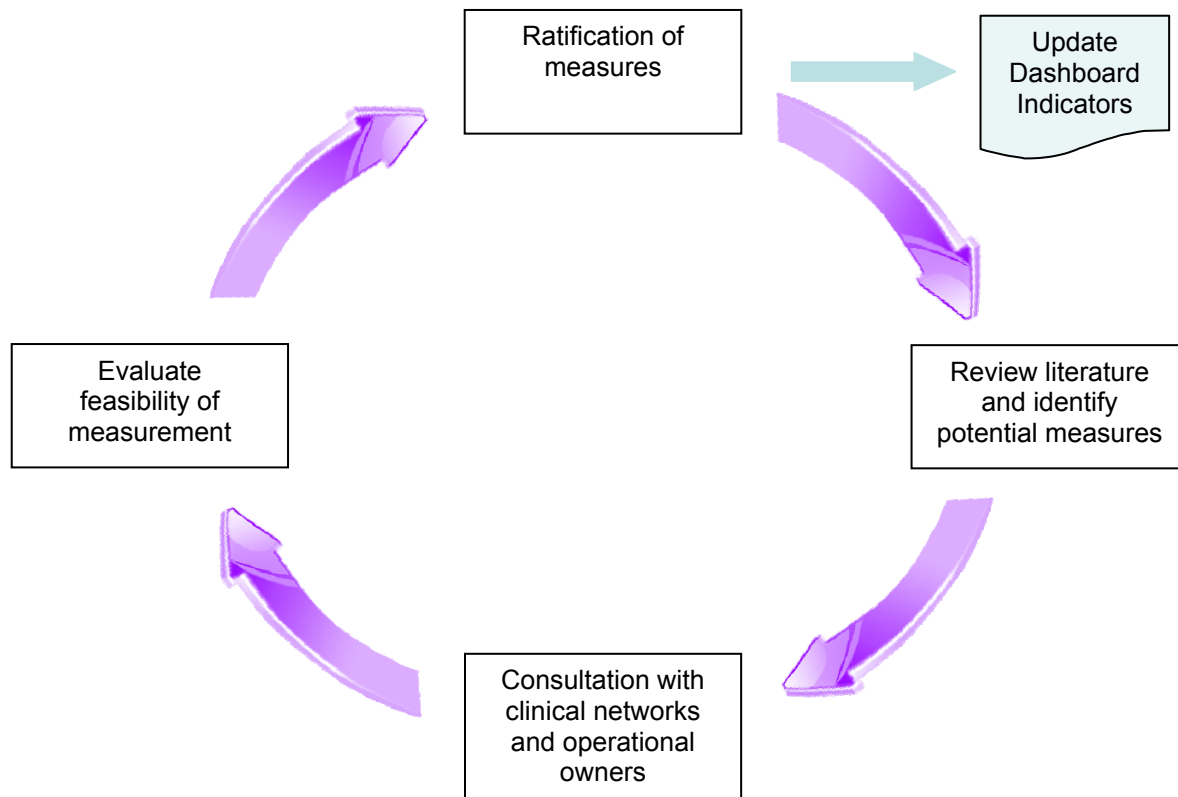
Dashboards are typically delivered electronically, enabling presentation of a variety of complex data in a simple and easy to understand format, with the added capability of drilling down to find more detailed information at the click of a mouse button.

The Quality and Patient Safety Dashboard, when fully implemented, will be distributed electronically and will enable presentation of high level information with site or program specific drill down capability, and will be updated regularly so that the most current information is available to users.

The Quality and Patient Safety Dashboard will expand over time as new measures are identified and indicators are revised or discarded. All recommendations for refining the Dashboard will be submitted for review by the proposed Performance Measurement and Improvement Steering Committee co-chaired by the Data Integration, Measurement and Reporting department and the Quality Performance Improvement department. The Performance Measurement and Improvement Steering Committee will define the principles for changing indicators and will rely on a variety of sources to identify appropriate measures, methods of calculation and targets, including discussion with the newly formed Clinical Networks, ad hoc data analysis and reviews of the literature. The Committee, in consultation with service delivery managers and clinicians will set targets based on literature, best practice, and recommendations from other jurisdictions and will share the recommended indicators with Quality and Patient Safety Committee.

Indicators of quality will be widely reviewed for validity and wherever possible will be associated with action plans for improvement. Ultimately, every program or service should have a series of quality indicators that staff understand and recognize as valid measures of quality, and these indicators should aggregate to a single indicator for the dashboard.

As the system matures, potential indicators will be reviewed and validated in consultation with operational teams and the clinical networks. Significant effort has been invested in the development of indicators of quality around the world, and this work will inform the next group of indicators to be considered. The proposed process for developing measures of quality is cyclical and continuous (see Figure 1).

**Figure 1: Process for Updating Indicators**


Additional measures proposed by the stakeholders during the consultation session as well as the following measures used or proposed in other jurisdictions will be explored for future iterations of the Dashboard:

Indicator	Sector	Source
Assessment for risk of venous thromboembolism in hospitals	Acute Care	AU, UK
Readmission for acute myocardial infarction	Acute Care	CD
Pain assessment in the emergency department	Acute Care	AU
Reperfusion for acute myocardial infarction in hospitals	Acute Care	AU
Stroke patients treated in a stroke unit	Acute Care	AU
Complications of transfusion	Acute Care	AU
Adverse drug events in hospitals	Acute Care	AU, US
Intentional self-harm in hospitals	Acute Care	AU
Complications of anaesthesia	Acute Care	AU
Accidental puncture/laceration in hospitals	Acute Care	AU
Obstetric trauma - third and fourth degree tears	Acute Care	AU
Birth trauma – injury to neonate	Acute Care	AU
Postoperative haemorrhage	Acute Care	AU, UK
Postoperative venous thromboembolism	Acute Care	AU, UK
Unplanned return to operating theatre	Acute Care	AU

Unplanned hospital re-admission	Acute Care	AU, CD, UK
Death in low mortality DRGs	Acute Care	AU, UK
30-day Acute Myocardial Infarction in hospital mortality	Acute Care	CD, UK, US
30-day Stroke in hospital mortality	Acute Care	CD, UK, US
Discharge medication management for acute myocardial infarction	Acute Care	AU, UK
Multi-disciplinary care plans in sub-acute care	Acute Care	AU, UK
Failure to diagnose	Acute Care	AU
Re-admission rate for pneumonia	Acute Care	AU, UK, US
Caesarean section rates	Acute Care	AU, CD, US
Wait times for radiation therapy by tumour group	Cancer Care	AU, CD, US
Child immunization rates	Public Health	AU, CD, UK, US
Developmental health checks in children	Public Health	AU
Malnutrition in residential care facilities	Residential Care	AU
Pressure ulcers in residential care facilities	Residential Care	AU
Oral health in residential care facilities	Residential Care	AU
People receiving a medication review in residential care facility	Residential Care	AU
Visits during acute phase treatment of depression	Mental Health	literature
Hospital readmissions for psychiatric patients	Mental Health	literature
Length of treatment for substance-related disorders	Mental Health	literature
Use of anticholinergic antidepressant drugs among elderly patients	Mental Health	literature
Continuous antidepressant medication treatment in acute phase	Mental Health	literature
Continuous antidepressant medication treatment in continuation phase	Mental Health	literature
Timely ambulatory follow-up after mental health hospitalization	Mental Health	literature
Continuity of visits after hospitalization for dual psychiatric/ substance-related conditions	Mental Health	literature
Racial/ethnic disparities in mental health follow-up rates	Mental Health	literature
Continuity of visits after mental health-related hospitalization	Mental Health	literature
Case management for severe psychiatric disorders	Mental Health	literature
Mortality for persons with severe psychiatric disorders	Mental Health	literature

Note: AU=Australia; CD=Canada; UK=United Kingdom; US=United States

## **Appendix A: Indicator Descriptions**

## Patient satisfaction with acute care

**Description:** Percentage of patients rating hospital as '8, 9 or 10' on a scale of 0-10

**Proposed Representational Owner:** To be determined

**Indicator status:** Available on survey for Calgary only; to be expanded in 2010

**Rationale for indicator:** The six dimensions of quality proposed by the Alberta Health Quality Council reflect the perception of quality from the patient's perspective. This self-reported measure of the patient's experience of the care received in hospital can be used as a general measure of the patient's perception of the quality of care.

**Data Source:** survey of patients discharged from acute care facilities

**Numerator:** Number of patients rating hospital as '8, 9 or 10'

**Denominator:** Number of patients who completed the survey

**Indicator type:** Outcome

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Acceptability

**Organizational Strategy:** Actively engage patients and families as partners in system improvements

**Data Comments:** Data are obtained from Hospital-Consumer Assessment of Healthcare providers and Systems (H-CAHPS) survey administered to sample of 10% of adult patients discharged from acute care hospitals through computer-assisted telephone interviews. Data are currently available for Calgary only but the survey will be expanded to include patients discharged from hospitals across the province. The sample will be stratified by site, so data could be reported by site as well as system.

To meet the needs of Accreditation Canada and collecting patient feedback information for the hospital sites a sample of n=300 per urban site and n=50-100 per rural site is required.

Approximately n=4500 surveys will be completed each year on a three year cycle. Additional samples would be collected in cycle 2 surveys in cycle two for sites that rated low in cycle 1.

The information is gathered using the H-CAHPS survey instrument, which is a standardized tool implemented nationally in the US to evaluate patients' perspectives of hospital care. The survey is also used in Saskatchewan and will become a requirement of Accreditation Canada.

The H-CAPS instrument is well validated and has been used to inform quality improvement in AHS Calgary since 2006.

Time lag for reporting: Approximately six weeks following the closing of the quarter.

**AHS Target:** To be determined

**National or International comparisons available:**

United States: <http://www.hcahpsonline.org/home.aspx>

## Length of time to resolve patient concerns

**Description:** Average length of time between receipt of patient concern and resolution

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** Patients who have concerns with the care they received are encouraged to provide feedback on their experience. Patient experience is considered an indicator of quality<sup>1</sup>.

**Data Source:** Patient Concerns departments collect structured data about patient concerns. All departments can manually collect and quantify the number of concerns received which are further classified into four main categories: access, finance, delivery of care, and environment.

**Numerator:** Length of time between patient reporting concern and resolution

**Denominator:** Number of patient concerns

**Indicator type:** Outcome

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Acceptability

**Organizational Strategy:** Implement a provincial process for tracking and addressing patient concern & commendations.

**Data Comments:** Data are not currently available. Some development is required to standardize reporting.

Time lag from collection to reporting: Approximately four weeks following the closing of the quarter for which the data were collected.

**AHS Target:** to be determined using baseline information

**National or International comparisons available:** not available

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<sup>1</sup> Brook, R; McGlynn, E. Shekelle, P; 2000. Defining and measuring quality of care” a perspective from US researchers, International Journal for Quality in Health care, Volume 12 4):281-295.

## Percentage of patient commendations

**Description:** Number of commendations received as a percentage of total comments submitted

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** Patients who are satisfied with the care they receive are encouraged to provide feedback on their experience. Patient experience is considered an indicator of quality.

**Data Source:** Patient Concerns departments collect structured data about patient commendations. All departments can manually collect and quantify the number of commendations received which are further classified into four main categories: access, finance, delivery of care, and environment.

**Numerator:** Number of patient commendations reported to Patient Concerns departments

**Denominator:** Total number of concerns and commendations

**Indicator type:** Outcome

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Acceptability

**Organizational Strategy:** Implement a provincial process for tracking and addressing patient concern & commendations.

**Data Comments:** data currently available quarterly; no development required.

Time lag from collection to reporting: Approximately four weeks following the closing of the quarter for which the data were collected.

**AHS Target:** to be determined using baseline information

**National or International comparisons available:** not available

## Percentage of patient concerns escalated to PCO

**Description:** Percentage of concerns escalated to the Patient Concerns Officer

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** This indicator is a measure of the proportion of concerns that are not resolved to the satisfaction of the patient or family and must be escalated to the Patient Concerns Officer.

**Data Source:** Patient Concerns departments collect structured data about patient concerns. A small proportion of concerns are escalated to the Patient Concerns Officer for resolution.

**Numerator:** Number of concerns escalated to Patient Concerns Officer

**Denominator:** Total number of concerns received

**Indicator type:** Outcome

**Level of Reporting:** Province

**Frequency of Reporting:** Annually

**Quality Domain:** Acceptability

**Organizational Strategy:** Implement a provincial process for tracking and addressing patient concern & commendations.

**Data Comments:** data currently available; no development required; data available annually due to low numbers.

Time lag from collection to reporting: Approximately four weeks following the closing of the year for which the data were collected.

**AHS Target:** to be determined using baseline information

**National or International comparisons available:** not available

## Percentage of patients discharged from acute care with a smoking cessation plan

**Description:** Percentage of patients who use tobacco are discharged from acute care with a smoking cessation plan.

**Proposed Representational Owner:** To be determined

**Indicator status:** Not available

**Rationale for indicator:** Patients who use tobacco and have significant health concerns should be encouraged to quit using tobacco products, and a plan should be put in place before they are discharged that will ensure they receive the support they require. Programs to implement this process are in various stages of implementation across the organization.

**Data Source:** No data exists

**Numerator:** Number of patients who use tobacco discharged with a smoking cessation plan

**Denominator:** Number of patients who use tobacco

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually

**Quality Domain:** Effectiveness

**Organizational Strategy:** Actively engage patients and families as partner in system improvements

**Data Comments:** There is no current source for this information and many areas of the province may not have programs

**AHS Target:** to be determined using baseline information

**National or International comparisons available:** not available

## Compliance with screening guidelines for cervical cancer

**Description:** Screening rates for cervical cancer for women aged 20–69 years.

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** According to the Guideline for Screening for Cervical Cancer:

“More than 45 types of human papillomavirus (HPV) are transmitted by intimate sexual contact, and persistent infection with a carcinogenic type is necessary for cervical cancer to develop. HPV is transmitted so easily that the lifetime cumulative prevalence of high-risk infection approaches 80%. Most of these infections resolve without symptoms and without treatment. A woman’s immune system generally clears the virus, in which case any cervical cell changes the HPV infection may have caused resolve on their own. When the virus is not cleared, persistent carcinogenic HPV infection may cause precancerous tissue changes that can, over many years, progress to invasive cervical cancer. Early detection and treatment during this lengthy precancerous stage can prevent the vast majority of cervical cancer.

Failure to be screened and being under-screened continue to be major risk factors for cervical cancer in Alberta. Over-screening is resulting in excess investigations and inefficient use of resources and potential harm to women.”<sup>2</sup>

This measure could also be considered an indicator of efficiency: new clinical guidelines indicate that the frequency of screening should be decreased to once every three years. Adherence to this new guideline should result in significant cost savings.

**Data Source:** Cervical Cancer Screening Program

**Numerator:** Number of women in target group who have been screened for cervical cancer according to the guidelines

**Denominator:** Number of women aged 20–69 years

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually

**Quality Domain:** Appropriateness

**Organizational Strategy:**

- Actively engage patients and families as partner in system improvements
- Develop and implement strategy to identify potential areas of risk to patient safety

<sup>2</sup> Guidelines for Screening for Cervical Cancer, Toward Optimized Practice (TOP), 2009. see [http://www.topalbertadoctors.org/PDF/complete%20set/Cervical%20Cancer/cervical\\_cancer.pdf](http://www.topalbertadoctors.org/PDF/complete%20set/Cervical%20Cancer/cervical_cancer.pdf) for details

**Data Comments:** data currently available; no development required; data available annually Time lag from collection to reporting: up to three years

**AHS Target:** 75% of women in target age group are screened once every three years

**National or International comparisons available:**

Ontario: 3 - year participation rate: 72%

Australia: 3 - year participation rate: 74.0%

Canada: <http://www.phac-aspc.gc.ca/publicat/ccsic-dccuac/index-eng.php>

Australia: <http://www.health.gov.au/internet/screening/publishing.nsf/Content/facts>

United Kingdom: <http://www.cancerscreening.nhs.uk/cervical/publications/2008review.html>

## Compliance with screening guidelines for breast cancer

**Description:** Screening rates for breast cancer for women aged 50–69 years.

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** Breast cancer is a common form of cancer for women, and mammography screening helps identify breast cancer early when treatment may be more effective. Mammography screening is an appropriate mechanism to reduce the incidence of breast cancer.

**Data Source:** Breast Cancer Screening Program

**Numerator:** Number of women in target group who have been screened for breast cancer in the last two years

**Denominator:** Number of women aged 50–69 years

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually

**Quality Domain:** Appropriateness

**Organizational Strategy:**

- Actively engage patients and families as partner in system improvements
- Develop and implement strategy to identify potential areas of risk to patient safety

**Data Comments:** data currently available; no development required; data available annually

**AHS Target:** 78% of women in target age group are screened every two years

**National or International comparisons available:**

Screening mammogram rate for Canada (2003): 60.7% with lowest provincial rate of 7% and highest provincial rate of 65.7%

Canada: <http://www.phac-aspc.gc.ca/publicat/obcsp-podcs00/index-eng.php>

United Kingdom: <http://www.cancerscreening.nhs.uk/breastscreen/statistics.html>

Australia: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4822.0.55.001>

## Compliance with screening guidelines for colorectal cancer

**Description:** Percentage of survey population between the ages of 50 and 74 who have been screened colorectal cancer.

**Proposed Representational Owner:** To be determined

**Indicator status:** Available from survey

**Rationale for indicator:** Colorectal cancer is the second most frequent cause of death from cancer in Alberta, and early diagnosis and treatment significantly reduces the rate of mortality from this cancer. Screening is an appropriate mechanism to reduce the incidence of colorectal cancer

**Data Source:** Canadian Community Health Survey, Canadian Institute for Health Information (CIHI)

**Numerator:** Number of survey participants from the target population (people aged between 50-74 and defined in the denominator) who are up to date for colorectal cancer screening. ("Up to date" is defined as those who have had at least one of the following screening tests: a FOBT test within 2 years, a flexible sigmoidoscopy within 5 years or a colonoscopy within 10 years.)

**Denominator:** Number of survey participants between ages of 50 and 74.

**Indicator type:** Process

**Level of Reporting:** Province

**Frequency of Reporting:** Annually

**Quality Domain:** Appropriateness

**Organizational Strategy:**

- Actively engage patients and families as partner in system improvements
- Develop and implement strategy to identify potential areas of risk to patient safety

**Data Comments:** Data cannot be reported provincially as it is only available through national survey.

**AHS Target:** 53% of target population are up to date on screening

**National or International comparisons available:**

Canada: <http://www.colorectal-cancer.ca/>

United States: <http://appliedresearch.cancer.gov/icsn/>

## Hand hygiene compliance

**Description:** Self-reported compliance with hand hygiene policies

**Proposed Representational Owner:** To be determined

**Indicator status:** not available

**Rationale for indicator:** Adherence to proper hand hygiene protocols is important to preventing the spread of infections associated with health care, but there is no evidence of whether staff are adhering to these protocols. Survey information can be used to determine general levels of compliance, enabling targeted intervention. Random audits can be used to validate the survey information, identify areas where compliance is lower, and identify potential improvement processes. This is a requirement for accreditation.

**Data Source:** Annual or quarterly front line staff survey; Random audit

**Numerator:** TBD

**Denominator:** TBD

**Indicator type:** Outcome

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually

**Quality Domain:** Safety

**Organizational Strategy:** Implement hand hygiene strategy

**Data Comments:** There is a need to establish standardized approaches to measuring hand hygiene performance across the province, based on the following processes:

- Development of consistent hand hygiene measurement processes for all personnel and practice settings;
- Sufficient resources and trained personnel to monitor and measure, collect and enter data on hand hygiene practices for care providers in all care settings; and
- Development of an electronic data collection instrument and a secure site for data collection and management.

**AHS Target:** to be determined using baseline information

**National or International comparisons available:**

Ontario Health Care Workers (2006): 32% (2008/09): 62.16%

St. Michael's Toronto (April 2008 to March 2009): 29% before and 51% after patient contact

Canadian Average (2001): <50%

Beth Israel Deaconess Medical Centre: ICU: 80%, Medical/ Surgical: 72%

Canada: [http://www.chica.org/links\\_handhygiene.html](http://www.chica.org/links_handhygiene.html);  
<http://news.ontario.ca/mohltc/en/2009/04/reporting-hand-hygiene-rates-in-hospitals.html>  
Australia: <http://www.hha.org.au/ForHealthcareWorkers.aspx>  
United States (Minnesota) <http://www.health.state.mn.us/handhygiene/stats/index.html>

## Alberta Harm Index: Never Events

**Description:** Never events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures are implemented.

**Proposed Representational Owner:** To be determined

**Indicator status:** Not available.

**Rationale for indicator:** Never events are a list of events that should never occur. Identification of these events enables the clinical area responsible to review processes and implement changes to ensure that the Never Events do not recur.

**Data Source:** Not Available

**Numerator:** Number of Never Events

**Denominator:** N/A

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Safety

**Organizational Strategy:** Establish a common list of serious adverse events that the AHS Board should be notified of. This list was named the "AHS Notifiable Adverse Event List".

**Data Comments:** The source of these data would be the Patient Safety Division office and data be compiled by abstracting the modified Urgent Notification to an Emerging Issues Reports that are forwarded to this office. Additional information can be extracted from the Hospital Discharge Abstract, but not all Never Events are recorded there.

**AHS Target:** to be determined using baseline information

**National or International comparisons available:** not available

## Compliance with Select Clinical Pathways

**Description:** Compliance with clinical pathways as defined and approved by Clinical Network

**Proposed Representational Owner:** To be determined

**Indicator status:** Not available

**Rationale for indicator:** Compliance with an approved clinical pathway improves standardization of care and reduces potential error caused by differing approaches.

**Data Source:** TBD

**Numerator:** TBD

**Denominator:** TBD

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Appropriateness

**Organizational Strategy:** Standardize clinical process to reduce unnecessary variation

**Data Comments:** No data is currently available

**AHS Target:** not available

**National or International comparisons available:** not available

## Response time to start investigations into serious adverse events

**Description:** Length of time between date of actual serious adverse event and the date that a formal quality assurance review is accepted in writing by the Chair of a Quality Assurance Committee with AHS Board approved Terms of Reference.

**Proposed Representational Owner:** To be determined

**Indicator status:** Not available

**Rationale for indicator:** Rapid investigation into serious Adverse Events, contact with the family through Disclosure Teams and establishing Root Cause Analysis reviews decreases the likelihood of similar further adverse events and enables analysis into the systems challenges that may have precipitated the occurrence.

**Data Source:** Not available

**Numerator:** Length of time between adverse event occurrence and completion of investigation

**Denominator:** Not Applicable

**Indicator type:** Not available

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Safety

**Organizational Strategy:** Develop and implement mechanism to learn from serious adverse events

**Data Comments:** A process to measure the response time to start investigations into serious adverse events has been developed, but specific parameters need to be defined. The source of these data would be the Patient Safety Division office and be compiled from a centrally located database. These data can start to be measured once a provincial structure for the Quality Assurance Committees is developed and supported by standardized AHS Board approved Terms of Reference.

**AHS Target:** 5 days (median)

**National or International comparisons available:**

United States: <http://www.nashp.org/pst-state-list/622>

## Admissions for ambulatory sensitive conditions

**Description:** The age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital, per 100,000 population under age 75 years.

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** Hospitalization for an Ambulatory Care Sensitive Condition is considered a measure of access to primary health care. While not all of these admissions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. A disproportionately high rate is presumed to reflect problems accessing appropriate primary care.

**Data Source:** Inpatient Health Records Discharge Abstract (Diagnosis/ Intervention data); Alberta Health Insurance Plan Registry (Population Data).

**Numerator:** Total number of acute care hospitalizations for ambulatory care sensitive conditions (ACSC) under age 75 years

**Denominator:** Total mid-year population under age 75 years

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Appropriateness

**Organizational Strategy:** Clearly identify expectations and assign accountability for quality and patient safety

**Data Comments:** data are readily available. Time lag for reporting: several months

**AHS Target:** 280/100,000

**National or International comparisons available:**

Canadian Rate (2005/06): 0.39% (385 per 100,000) with lowest provincial rate of 0.31% and highest provincial rate of 0.68%

[http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=PG\\_1350\\_E&cw\\_topic=1350&cw\\_rel=AR\\_152](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_1350_E&cw_topic=1350&cw_rel=AR_152)

Canada: <http://www.cihi.ca/hireports/search.jspx?language=en&healthIndicatorSelection=ACSC>  
United States: <http://www.commonwealthfund.org/Content/Performance-Snapshots/Overuse-of-Health-Care-Services/Hospitalizations-for-Ambulatory-Care--8211-Sensitive-Conditions.aspx#>

## Percent of patients diagnosed with diabetes with controlled blood sugar

**Description:** The percentage of patients diagnosed with diabetes who have a haemoglobin A1c test result less than 8.

**Proposed Representational Owner:** To be determined

**Indicator status:** Not available

**Rationale for indicator:** A build-up of glycated hemoglobin within the red cell reflects the average level of glucose to which the cell has been exposed during its life cycle. Measuring glycated hemoglobin assesses the effectiveness of therapy by monitoring long-term serum glucose regulation. The HbA1c level is proportional to average blood glucose concentration over the previous four weeks to three months<sup>3</sup>.

**Data Source:** Patient billing information and/or laboratory data can be used as proxy to identify diabetes patients. Laboratory data is required for A1c levels. Population registry data is required for zone level reporting.

**Numerator:** # of Albertans diagnosed with diabetes with laboratory tests indicating Haemoglobin A1c<8

**Denominator:** # of Albertans diagnosed with diabetes

**Indicator type:** Outcome

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Effectiveness

**Organizational Strategy:** Develop and implement strategy to identify potential areas of risk to patient safety

**Data Comments:** Data is not currently available to support province wide reporting. Data is available in the Edmonton zone only as part of CDM Registry. For PCN practice, clinic and physician practice level reporting patient paneling is required either through panel verification or using administrative billing data as proxy. Diabetes patient identification: Diabetic patient identification used laboratory and administrative billing data to identify potential diabetic patients. Participating physicians and/or CDM nurses using decision support tools have been involved in panel and diagnoses verification processes. Partial data is available in Calgary zone and specific to patients receiving services through CDM infrastructures. A1c levels: Data captured through laboratory repositories

<sup>3</sup> Wikipedia. [http://en.wikipedia.org/wiki/Glycated\\_hemoglobin](http://en.wikipedia.org/wiki/Glycated_hemoglobin)

**AHS Target:** to be determined using baseline information

**National or International comparisons available:**

Canada: <http://www.diabetes.ca/for-professionals/resources/2008-cpg/>

United States: <http://www.ndep.nih.gov/publications/OnlineVersion.aspx?NdepId=NDEP-44k>

## Percent of patients diagnosed with hypertension with blood pressure control

**Description:** Percent of patients diagnosed with hypertension with blood pressure less than or equal to 140/90.

**Proposed Representational Owner:** To be determined

**Indicator status:** Not available

**Rationale for indicator:** Measuring the proportion of patients diagnosed with hypertension who are managing to keep their blood pressure under control is an indicator of the effectiveness of the treatment.

**Data Source:** Not available

**Numerator:** Patients diagnosed with hypertension who have a consistent blood pressure level of  $\leq$  140/90 or 130/80 in the case of patients with diabetes or kidney disease.

**Denominator:** Patients diagnosed with hypertension

**Indicator type:** Outcome

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Effectiveness

**Organizational Strategy:** Develop and implement strategy to identify potential areas of risk to patient safety.

**Data Comments:** Data is not consistently available provincially using individual physician EMRs, paper charts or Netcare (where data is submitted). Regional chronic disease data sources including (SCM, Meditech etc) are not currently consolidated or verified to be the source of truth.

**AHS Target:** to be determined using baseline information

**National or International comparisons available:** not available

## Number of falls while receiving continuing care

**Description:** The prevalence of falls in long term care and the prevalence of falls in home care/long term care.

**Proposed Representational Owner:** To be determined

**Indicator status:**

- Long Term Care: Prevalence of falls (Residents who have fallen within the last 30 days/all residents)
- Home Care/Supportive Living: Prevalence of falls (the number of client who record a fall on follow up assessment/all clients not completely dependent in bed mobility on previous assessment).

**Rationale for indicator:** Falls are a widely recognized indicator of quality of both home care and long term care<sup>4</sup>, and are recognized by the Safer Healthcare Now! Prevention of Harms Campaign through CPSI and the IHI.

**Data Source:** RAI 2.0 and RAI HC.

**Numerator:** Prevalence of falls (the number of clients who have a record of a fall on follow up assessment)

**Denominator:** The number of clients within a Home Care /Supportive Living Facility not completely dependent in bed mobility on previous assessment

**Indicator type:** Outcome

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Safety

**Organizational Strategy:** Develop and implement strategy to identify potential areas of risk to patient safety

**Data Comments:** Data is/will be available from RAI 2.0 (long term care) and RAI HC (home care and supportive living). It is anticipated that ACCIS will be able to accept "live" data in September 2010.

**AHS Target:** 0.5/100 days

**National or International comparisons available:** The annual incidence of falls in long-term care facilities averages about 1.6 falls per bed, with a range of 0.2 to 3.6 falls per bed per year.

<http://www.asaging.org/asav2/han/enews/07fall/top.cfm>

<http://www.longwoods.com/product.php?productid=20968>

<sup>4</sup> J. Hirdes; B. Fries; J. Morris; N. Ikegami; D. Zimmerman; D. Dalby; P. Aliaga; S. Hammer; R. Jones

<http://gerontologist.gerontologyjournals.org/cgi/content/full/44/5/665>

## Admission to Acute Care During Last Six Months of Life

**Description:** Number of admissions to acute care during the last six months of life.

**Proposed Representational Owner:** To be determined

**Indicator status:** Not available

**Rationale for indicator:** This measure indicates the degree to which services were available to enable the patient to remain safely at home during the last six months of life.

**Data Source:** Vital Statistics Deaths, Hospital Discharge Abstract

**Numerator:** Number of admissions to an acute care hospital during the last six months of life

**Denominator:** Number of deaths

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually

**Quality Domain:** Accessibility

**Organizational Strategy:** Actively engage patients and families as partner in system improvements

**Data Comments:** Data is not currently received from Alberta Registries.

**AHS Target:** To be determined

**National or International comparisons available:** not available

## MRSA Infection Rate (Hospital Acquired)

**Description:** The number of reported cases of Methicillin Resistant Staphylococcus Aureus (MRSA) infection acquired by patients in acute care hospitals in Alberta.

**Proposed Representational Owner:** To be determined

**Indicator status:** Not available

**Rationale for indicator:** Infections caused by methicillin-resistant Staphylococcus aureus (MRSA) have been identified as the second public reporting indicator and reporting will start in April 2010. Province-wide MRSA reporting has been identified as a major Infection Prevention and Control indicator for Accreditation in 2010. Hospital cases identified at the hospital, either inpatient, in the emergency department or in haemodialysis will be followed up by an IPC.

**Data Source:** Laboratory / Infection Control: All clinically significant isolates of MRSA are sent to the Provincial Laboratory of Public Health (PLPH).

**Numerator:** Number of reported cases of methicillin resistant Staphylococcus aureus (MRSA) infection acquired by patients in acute care hospitals in Alberta

**Denominator:** Number of patients in acute care hospitals in Alberta

**Indicator type:** Outcome

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Safety

**Organizational Strategy:** Develop strategy for achieving compliance with AHW IPC Standards.

**Data Comments:**

**AHS Target:** 1.5/1000 admissions

**National or International comparisons available:**

Canadian rate for MRSA infections for 2000, 2001, 2002, 2003 were 1.09, 1.14, 1.38, 1.61 per thousand admissions. St. Michaels Toronto (Apr - June 2009): 0.07 per thousand admissions

<http://www.stmichaelshospital.com/indicators/index.php>

<http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/05vol31/dr3103a-eng.php>

Canada: <http://www.phac-aspc.gc.ca/nois-sinp/projects/index-eng.php>

## Bloodstream Infection (BSI) Rates

**Description:** The number of reported cases of Bloodstream Infections acquired by patients in acute care hospitals in Alberta.

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** Blood Stream Infection has been identified as an indicator to be included in the AHS Public Reporting initiative. Although not all blood stream infections are a result of contact with the health care system, the rate of identified infections can indicate quality concerns.

**Data Source:** Available

**Numerator:** Number of reported cases of Bloodstream Infections (BSI) acquired by patients in acute care hospitals in Alberta

**Denominator:** Number of patients in acute care hospitals in Alberta

**Indicator type:** Outcome

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Safety

**Organizational Strategy:** Develop strategy for achieving compliance with AHW IPC Standards.

**Data Comments:** All inpatient blood cultures found to be positive for bacteria by local microbiology laboratories are reported to the facility specific Infection Prevention and Control programs. Depending on the micro-organism identified in the blood, further surveillance involving clinical criteria (obtained from patient medical records) and ICP judgment will be required to satisfy the case definition.

**AHS Target:** 1.5/1000 CLI days

**National or International comparisons available:**

Safer Health Care Now campaign goal for CLI-BSI infection is <1.9 per thousand CLI days

St. Michaels Toronto (Apr - June 2009): 1.2 per thousand CLI days

Beth Israel Deaconess Medical Centre: 0.97 per thousand CLI days

<http://www.saferhealthcarenow.ca/EN/Interventions/CLI/Pages/default.aspx>

<http://www.stmichaelshospital.com/indicators/index.php>

<http://www.bidmc.org/QualityandSafety/QualityandSafetyImprovementsatWork.aspx>

Canada: <http://www.phac-aspc.gc.ca/nois-sinp/projects/index-eng.php>

## Clostridium Difficile (C. Difficile) Infection Rates (Hospital Acquired)

**Description:** The number of reported cases of Clostridium difficile infections (CDI) acquired by patients in acute care hospitals.

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** Province-wide C. Difficile Infection rate reporting has been identified as a major Infection Prevention and Control indicator for Accreditation in 2010. C. difficile infection is associated with inappropriate exposure to antimicrobials.

**Data Source:** Notifiable Disease Reporting

**Numerator:** Number of reported cases of Clostridium difficile infections (CDI) acquired by patients in acute care hospitals in Alberta

**Denominator:** Number of patients in acute care hospitals in Alberta

**Indicator type:** Outcome

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Safety

**Organizational Strategy:** Develop strategy for achieving compliance with AHW IPC Standards.

**Data Comments:**

**AHS Targets:** 0.6 cases per 1,000 patient days

**National or International comparisons available:**

St. Michaels Toronto (Apr to June 2009): 0.4 *C. difficile* per 1,000 patient days

<http://www.stmichaelshospital.com/indicators/infection.php>

Canada: <http://www.phac-aspc.gc.ca/nois-sinp/projects/index-eng.php>

## Surgical Site Infection Rate

**Description:** The number of reported cases of surgical site infection acquired by patients in acute care hospitals.

**Proposed Representational Owner:** To be determined

**Indicator status:** Not available

**Rationale for indicator:** Province wide SSI reporting has been identified as an Infection Prevention and Control indicator for accreditation in 2010. Surgical site infections are an indicator of poor quality care.

**Data Source:** Not available

**Numerator:** Number of reported cases of Surgical Site Infections (SSI) acquired by patients in acute care hospitals in Alberta

**Denominator:** Number of surgical patients in acute care hospitals in Alberta

**Indicator type:** Outcome

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Safety

**Organizational Strategy:** Develop strategy for achieving compliance with AHW IPC Standards.

**Data Comments:** Data is not currently available

**AHS Target:** clean: <2%, clean-contaminated: 6% to 9%, contaminated: 13% to 20%, and dirty: >30%

**National or International comparisons available:**

The infection rates for the traditional classification of operative procedures were as follows: clean (<2%), clean-contaminated (6% to 9%), contaminated (13% to 20%), and dirty (>30%).

<http://www.worldwidewounds.com/2005/september/Gottrup/Surgical-Site-Infections-Overview.html>

<http://www.cawc.net/open/wcc/5-2/attrell.pdf>

Canada: <http://www.phac-aspc.gc.ca/nois-sinp/projects/index-eng.php>

## Positive staff culture

**Description:** Percentage of staff indicating satisfied or very satisfied with job

**Proposed Representational Owner:** To be determined

**Indicator status:** No province wide data are currently available.

**Rationale for indicator:** Evidence suggests that staff satisfaction with their job and employer are more motivated to achieve a higher level of performance. [http://www.agili-t.com/pdf/en/patient\\_safety\\_culture.pdf](http://www.agili-t.com/pdf/en/patient_safety_culture.pdf). Assessment of staff and physician satisfaction is a requirement for Accreditation.

**Data Source:** No coordinated surveys have been conducted across the province

**Numerator:** Number of staff indicating satisfied or very satisfied with job

**Denominator:** Number of staff completing the survey

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually

**Quality Domain:** Effectiveness

**Organizational Strategy:**

- Pursue a just and trusting culture
- Pursue a culture of Quality and Safety

**Data Comments:** Former regions were not coordinated on instruments used, methods used, frequency of data collection or sampling frames. Some regions collected data using the patient safety culture tool and work life pulse tool within the accreditation process, however a consistent process and methodology was not in place. An annual province-wide survey is proposed that would include data on experience and culture measures.

**AHS Target:** 65% satisfied or very satisfied

**National or International comparisons available:**

Toronto: [http://www.stjoe.on.ca/about/performance/pdf/scorecard08/patient\\_safety.pdf](http://www.stjoe.on.ca/about/performance/pdf/scorecard08/patient_safety.pdf)

## Coronary Artery Bypass Grafting (CABG) Wait Times

**Description:** Coronary Artery Bypass Grafting (CABG) Wait times by priority or urgency category. Categories include:

- Urgent Median Wait Time <= 1 week
- Semi - urgent Wait Time <= 2 weeks
- Non-urgent Wait Time <= 6 weeks.

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** Coronary Artery Bypass Graft (CABG) surgery is a surgical procedure performed to relieve angina and reduce the risk of death from coronary artery disease. Timely bypass surgery can increase patient's chances of living a longer life.

Wait times for surgical procedures are an indicator of the public's access to the health care system and a reflection of efficient use of health care resources. The indicator will help the organization to develop wait-time reduction strategies and will enable the system to provide patients access to appropriate health services and information when they need it. A variety of factors can impact the wait times such as the demographics of the population, treatment patterns of physicians, the number of emergency surgeries, which have higher priorities in use of resources, nurse shortages, or job action (Statistics Canada).

**Data Source:** Alberta Waitlist Registry

**Numerator:** Number of patients having their surgeries within 1 week, 2 weeks and 6 weeks after put on the wait list

**Denominator:** Total number of patients registered in Alberta Waitlist Registry for CABG surgery

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Accessibility

**Organizational Strategy:** Develop wait time reduction strategies

**Data Comments:** In Edmonton, this data is available from 2001 onward. In Calgary paper copies exist as far back as 2000 but best reported from 2004 forward through the PWS reporting system. APPROACH data can be mined from the last 10 years in Calgary.

**NOTE:** This indicator will be replaced with a more appropriate measure following consultation.

**AHS Target:** Urgent: 70% < 1 week; Semi-urgent 90% < 2 weeks; Non-urgent 30% 6-10 weeks

**National or International comparisons available:**

Ontario Target: PI: Immediate, PII: 2 weeks, PIII: 6 weeks, PIV: 26 weeks (See link for definitions)

St. Michaels Toronto (2008): 100% patients within 6 weeks

[http://www.health.gov.on.ca/transformation/wait\\_times/providers/wt\\_target.html](http://www.health.gov.on.ca/transformation/wait_times/providers/wt_target.html)

[http://www.health.gov.on.ca/english/media/news\\_releases/archives/nr\\_05/nr\\_121605.html](http://www.health.gov.on.ca/english/media/news_releases/archives/nr_05/nr_121605.html)

<http://www.stmichaelshospital.com/indicators/index.php>

Canada: [http://www.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=wait\\_times\\_e](http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=wait_times_e),

[http://www.waittimealliance.ca/wait\\_times.htm](http://www.waittimealliance.ca/wait_times.htm), <http://www.hc-sc.gc.ca/hcs-sss/qual/acces/wait-attente/index-eng.php>

## Elective Primary Knee Replacement Surgery Wait Times

**Description:** Elective primary Knee replacement surgery wait times

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** Knee replacement surgery has the potential to result in considerable improvement in functional status, pain relief, as well as other gains in health-related quality of life (CIHI). Wait times for surgical procedures are an indicator of the public's access to the health care system and a reflection of efficient use of health care resources. The indicator will help the organization to develop wait-time reduction strategies and will enable the system to provide patients access to appropriate health services and information when they need it. A variety of factors can impact the wait times such as the demographics of the population, treatment patterns of physicians, the number of emergency surgeries, which have higher priorities in use of resources, nurse shortages, or job action (Statistics Canada).

**Data Source:** Comparable data for this measure may be available from the Alberta Bone and Joint Health Institute (ABJHI) for the three jurisdictions with central intake, Calgary, Red Deer and Edmonton

**Numerator:** Number of patients having knee surgery within <26 weeks, 26 weeks, > 26 weeks

**Denominator:** Total number of patients waiting for joint replacement surgery

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Accessibility

**Organizational Strategy:** Develop wait time reduction strategies

**Data Comments:** Comprehensive, accurate information on wait time for hip and knee replacements is not available across the province. OR wait time data submitted to the Alberta Waitlist Registry is not suitable for reporting this measure because the detail is not available to identify joint replacements.

**AHS Target:** 90% in 26 to 30 weeks

**National or International comparisons available:**

Ontario Target: PI: Immediate, PII: 6 weeks, PIII: 12 weeks, PIV: 26 weeks (See link for definitions)  
Ontario (2008): 32.8 weeks for knee surgery

St. Michaels Toronto (2008): 16.6 weeks for knee surgery

[http://www.health.gov.on.ca/transformation/wait\\_times/providers/wt\\_target.html](http://www.health.gov.on.ca/transformation/wait_times/providers/wt_target.html)

[http://canadaonline.about.com/od/healthcarewaittimes/Wait\\_Times\\_for\\_Health\\_Care\\_in\\_Canada.htm](http://canadaonline.about.com/od/healthcarewaittimes/Wait_Times_for_Health_Care_in_Canada.htm)

[http://www.ices.on.ca/file/ICESAccess\\_atlas\\_2nd\\_ed\\_Chapter1.pdf](http://www.ices.on.ca/file/ICESAccess_atlas_2nd_ed_Chapter1.pdf)

[http://www.health.gov.on.ca/english/media/news\\_releases/archives/nr\\_05/nr\\_121605.html](http://www.health.gov.on.ca/english/media/news_releases/archives/nr_05/nr_121605.html)

Canada: [http://www.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=wait\\_times\\_e](http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=wait_times_e),

[http://www.waittimealliance.ca/wait\\_times.htm](http://www.waittimealliance.ca/wait_times.htm), <http://www.hc-sc.gc.ca/hcs-sss/qual/acces/wait-attente/index-eng.php>

## Elective Primary Hip Replacement Surgery Wait Times

**Description:** Elective primary Hip replacement surgery wait times

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** Hip replacement surgery has the potential to result in considerable improvement in functional status, pain relief, as well as other gains in health-related quality of life (CIHI). Wait times for surgical procedures are an indicator of the public's access to the health care system and a reflection of efficient use of health care resources. The indicator will help the organization to develop wait-time reduction strategies and will enable the system to provide patients access to appropriate health services and information when they need it. A variety of factors can impact the wait times such as the demographics of the population, treatment patterns of physicians, the number of emergency surgeries, which have higher priorities in use of resources, nurse shortages, or job action (Statistics Canada).

**Data Source:** Comparable data for this measure may be available from the Alberta Bone and Joint Health Institute (ABJHI) for the three jurisdictions with central intake, Calgary, Red Deer and Edmonton

**Numerator:** Number of patients having their hip & knee surgery within <26 weeks, 26 weeks, > 26 weeks

**Denominator:** Total number of patients waiting for joint replacement surgery

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Accessibility

**Organizational Strategy:** Develop wait time reduction strategies

**Data Comments:** Comprehensive, accurate information on wait time for hip and knee replacements is not available across the province. OR wait time data submitted to the Alberta Waitlist Registry is not suitable for reporting this measure because the detail is not available to identify joint replacements.

**AHS Target:** 90% in 26 to 45 weeks

**National or International comparisons available:**

Ontario Target: PI: Immediate, PII: 6 weeks, PIII: 12 weeks, PIV: 26 weeks (See link for definitions)

Ontario (2008): 26.8 weeks for hip surgery

St. Michaels Toronto (2008): 13.1 weeks for hip surgery

[http://www.health.gov.on.ca/transformation/wait\\_times/providers/wt\\_target.html](http://www.health.gov.on.ca/transformation/wait_times/providers/wt_target.html)

[http://canadaonline.about.com/od/healthcarewaittimes/Wait\\_Times\\_for\\_Health\\_Care\\_in\\_Canada.htm](http://canadaonline.about.com/od/healthcarewaittimes/Wait_Times_for_Health_Care_in_Canada.htm)

[http://www.ices.on.ca/file/ICESAccess\\_atlas\\_2nd\\_ed\\_Chapter1.pdf](http://www.ices.on.ca/file/ICESAccess_atlas_2nd_ed_Chapter1.pdf)

[http://www.health.gov.on.ca/english/media/news\\_releases/archives/nr\\_05/nr\\_121605.html](http://www.health.gov.on.ca/english/media/news_releases/archives/nr_05/nr_121605.html)

Canada: [http://www.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=wait\\_times\\_e](http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=wait_times_e),

[http://www.waittimealliance.ca/wait\\_times.htm](http://www.waittimealliance.ca/wait_times.htm), <http://www.hc-sc.gc.ca/hcs-sss/qual/acces/wait-attente/index-eng.php>

## Emergency Department Average Length of Stay

**Description:** The length of stay (LOS) in Emergency Department from registration to discharge or admission

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** The Emergency Department (ED) length of stay (LOS) is the time from when a patient is triaged until they are discharged or admitted to the hospital (i.e. leave the emergency department). The top 14 Emergency Department sites in terms of high patient volume (annual visits greater than 40,000 in 2006/07) have been identified as improvement targets regarding waiting times in Emergency. It is important to understand the extent to which patients are waiting in EDs, because waiting for care can result in delays to treatment for individual patients and reduced efficiency in the flow of patients that require admission from the ED onto an in-patient ward. Delays in some door-to-treatment times have been found in recent studies to be associated with ED overcrowding or longer ED wait times (Statistics Canada).

**Data Source:** ACCS data abstracts

**Numerator:** Length of Stay in hours

**Denominator:** Number of ER Visits

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Efficiency

**Organizational Strategy:** Develop wait time reduction strategies

**Data Comments:** Provincial ACCS data is available from all sites.

**AHS Target:** Uncomplicated cases: 90% of patients discharged within 5 hours, Complicated cases: 90% of patients admitted within 14 hours

**National or International comparisons available:**

Ontario:

- Uncomplicated cases (Oct 2008): 90% of patients spent a maximum of 4.6 hours in the ER
- Complicated cases (Oct 2008): 90% of patients spent a maximum of 13.5 hours

[http://www.health.gov.on.ca/english/media/news\\_releases/archives/nr\\_09/feb/nr\\_20090219.html](http://www.health.gov.on.ca/english/media/news_releases/archives/nr_09/feb/nr_20090219.html)

## Percentage of inpatient days classified as alternate level of care

**Description:** Percentage of Inpatient (IP) days classified as Alternative Level of Care (ALC) days.

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** Access to services is a significant indicator of quality. Patients who are waiting in an acute care facility for access to services provided either in the community or in a long term care facility are not able to receive the services they require, and are obstructing access to an acute care bed.

**Data Source:** Provincial Morbidity Database

**Numerator:** Number of IP days classified as ALC

**Denominator:** Total Number of IP Days

**Indicator type:** Process

**Level of Reporting:** Provincial, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Appropriateness

**Organizational Strategy:** Develop wait time reduction strategies

**Data Comments:** Data currently available; no development required; data available annually Time lag from collection to reporting: Approximately two years following the financial year for which data were collected

**AHS Target:** 12% rural, 4% urban

**National or International comparisons available:**

[http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=download\\_form\\_e&cw\\_sku=UEDWTHLENPDF&cw\\_ctt=1&cw\\_dform=N](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=download_form_e&cw_sku=UEDWTHLENPDF&cw_ctt=1&cw_dform=N)

## Access to cancer care services by provider type

**Description:** The time from patient referral to consultation with an oncologist

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** Access to services is a significant indicator of quality. Waiting for care results in a delay to receive treatment, and potentially increases the severity of the condition.

**Data Source:** ARIA

**Numerator:** TBD

**Denominator:** TBD

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually

**Quality Domain:** Accessibility

**Organizational Strategy:**

- Develop wait time reduction strategies
- Improve access to preventive and early intervention services

**Data Comments:** Data is currently available but missing some referral dates. Referral date is the date a fax or phone call is received from a referring physician outside of Cancer Care. Consult date is the first date a patient meets with an oncologist to discuss treatment option for a given condition.

**AHS Target:** 4 weeks

**National or International comparisons available:**

Ontario (2007): 57% of patients seen by Oncologist within target (14 days)

[http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=download\\_form\\_e&cw\\_sku=UEDWTHLENPDF&cw\\_ctt=1&cw\\_dform=N](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=download_form_e&cw_sku=UEDWTHLENPDF&cw_ctt=1&cw_dform=N)

Canada: [http://www.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=wait\\_times\\_e](http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=wait_times_e),  
[http://www.waittimealliance.ca/wait\\_times.htm](http://www.waittimealliance.ca/wait_times.htm), <http://www.hc-sc.gc.ca/hcs-sss/qual/acces/wait-attente/index-eng.php>

## Percentage of children receiving scheduled mental health treatment within 30 days of referral

**Description:** Percentage of children receiving "Scheduled" mental health treatment within 30 days. This indicator measures the number of weeks between receipt of a referral by the community mental health clinic, and child's first fact-to-face assessment with a mental health therapist.

**Proposed Representational Owner:** To be determined

**Indicator status:** Available

**Rationale for indicator:** Access to services is a significant indicator of quality. There are a variety of community care approaches that effectively serve individuals with mental illness. Many of these approaches have been successful in reducing emergency room and hospital visits, in providing a more cost-effective approach to care and most importantly, in improving the lives of those with mental illness and their families.

**Data Source:** ARMHIS (Alberta Regional Mental Health Information System)

**Numerator:** Number of children receiving scheduled mental health treatment within 30 days from the referral date

**Denominator:** Total number of children receiving mental health services

**Indicator type:** Process

**Level of Reporting:** Province, zone

**Frequency of Reporting:** Annually, quarterly

**Quality Domain:** Accessibility

**Organizational Strategy:**

- Develop wait time reduction strategies
- Improve access to preventive and early intervention services

**Data Comments:** The data is not available from Chinook Health Region. It is anticipated that former Chinook area data will commence in the current fiscal year (2009 - 2010)

**AHS Target:** 60% within 15 days (baseline median wait time is 15 days, 2007/08)

**National or International comparisons available:**

Canada: <http://publications.cpa-apc.org/media.php?mid=383&xwm=true>

## Appendix B: Indicator Alignment with the Quality Matrix

### The Six Dimensions of Quality

Areas of Need	Acceptability	Accessibility	Appropriateness	Effectiveness	Efficiency	Safety
Being Healthy			<ul style="list-style-type: none"> <li>compliance with screening guidelines for:               <ul style="list-style-type: none"> <li>Colorectal cancer</li> <li>Breast cancer</li> <li>Cervical cancer</li> </ul> </li> </ul>			
Getting Better	<ul style="list-style-type: none"> <li>Patient satisfaction</li> <li>length of time to resolve patient concerns</li> <li>% of patient commendations</li> </ul>	<ul style="list-style-type: none"> <li>Coronary Artery Bypass Grafting wait times</li> <li>Elective primary knee replacement surgery wait time by acuity level</li> <li>Elective primary hip replacement surgery wait time by acuity level</li> <li>% of children receiving “scheduled” mental health treatment within 30 days</li> <li>Access to cancer care services</li> </ul>	<ul style="list-style-type: none"> <li>Compliance with select clinical pathways</li> <li>Admissions for ambulatory sensitive conditions</li> </ul>	<ul style="list-style-type: none"> <li>% of patients who smoke discharged with cessation plan</li> <li>positive staff culture</li> <li>staff tenure</li> </ul>	<ul style="list-style-type: none"> <li>ED Average LOS registration to discharge; registration to admission</li> </ul>	<ul style="list-style-type: none"> <li>% of patients concerns escalated to PCO</li> <li>Hand hygiene</li> <li>Never Events</li> <li>Response time to start investigation into serious adverse events</li> <li>Hospital Infection rates for               <ul style="list-style-type: none"> <li>MRSA infection rate</li> <li>Blood stream infection rate</li> <li>C-Difficile infection rate</li> <li>Surgical site infection rate</li> </ul> </li> </ul>
Living with Illness or Disability			<ul style="list-style-type: none"> <li>% of IP days classified as ALC</li> </ul>	<ul style="list-style-type: none"> <li>% of patients diagnosed with diabetes with controlled blood sugar</li> <li>% of patients with Hypertension with blood pressure control</li> </ul>		<ul style="list-style-type: none"> <li>falls while receiving continuing care</li> </ul>
End of Life		<ul style="list-style-type: none"> <li>Admission to Acute Care during Last Six Months of Life</li> </ul>				

Source: HQCA , Alberta Quality Matrix for Health

## Appendix C: Availability of Data for Dashboard

	Measure	09/10	10/11	11/12	12/13
1	Patient satisfaction with care				
2	length of time required to resolve patient concerns % of patient commendations				
3	Compliance with screening guidelines for: <ul style="list-style-type: none"> <li>• colorectal cancer</li> <li>• breast cancer</li> <li>• cervical cancer</li> </ul>				
4	% of patients who smoke discharged with smoking cessation plan				
5	% of patient concerns escalated to PCO				
6	Compliance with selected clinical pathways				
7	Admissions for ambulatory sensitive conditions				
8	Admission to Acute Care during Last Six Months of Life				
9	% of patients diagnosed with diabetes with controlled blood sugar				
10	% of patients with hypertension with blood pressure control				
11	Falls while receiving continuing care				
12	Compliance with hand hygiene policies				
13	Never Events				
14	Response time to start investigations into serious adverse events				
15	Hospital Infection Rate for: <ul style="list-style-type: none"> <li>• MRSA infection rate (hospital acquired)</li> <li>• Blood stream infection rate</li> <li>• C-Difficile Infection Rate (hospital acquired)</li> <li>• Surgical site infection rate</li> </ul>				
16	Positive staff culture				
17	Coronary Artery Bypass Grafting (CABG) wait times				
18	Elective primary knee replacement surgery wait times				
19	Elective primary hip replacement surgery wait times				
20	Access to cancer care services				
21	% of children receiving scheduled mental health treatment within 30 days				
22	ED average LOS registration to discharge; registration to admission				
23	% of IP days classified as ALC				
Total Number of indicators		13 46%	9 32%	6 21%	1 3%

## Appendix D: Link between Quality and Patient Safety Indicators and Strategic Direction

#	Indicator	Strategic Direction
1	Patient satisfaction with acute care services	Responsive to consumers and communities - Patient experience
2	Length of time to resolve patient concerns	Responsive to consumers and communities - Patient experience
	% of patient commendations	Responsive to consumers and communities - Patient experience
3	Compliance with clinical practice guidelines for:	Improving population health - Burden of disease
	<ul style="list-style-type: none"> <li>• Colorectal Cancer screening:               <ul style="list-style-type: none"> <li>○ FOB in 2 years or colonoscopy or sigmoidoscopy in past 5 years</li> </ul> </li> <li>• Breast Cancer (women 50–69)               <ul style="list-style-type: none"> <li>○ no screen</li> <li>○ 1 screen in 2 years</li> </ul> </li> <li>• Cervical Cancer (women 18-70 yrs)               <ul style="list-style-type: none"> <li>○ no screen;</li> <li>○ 1 screen in 3 years</li> <li>○ 2+ screens in 3 years</li> </ul> </li> </ul>	
4	% of patients who smoke discharged with smoking cessation plan	Improving population health - Healthy communities
5	% of patient concerns escalated to PCO	Responsive to consumers and communities
6	Compliance with selected clinical pathways	Living with our means - Eliminating waste, duplication and inappropriate care
7	Admissions for ambulatory sensitive conditions per 100,000	Improving population health - Burden of disease
8	Admission to Acute Care During Last Six Months of Life	Responsive to consumers and communities
9	% of diabetic patients with controlled blood sugar (haemoglobin A1c<8)	Improving population health - Burden of disease
10	% of patients with hypertension with blood pressure control	Improving population health - Burden of disease
11	Falls while receiving continuing care	Learning and improving -
12	Compliance with hand hygiene policies	Learning and improving - Infection prevention and control
13	Never Events	Learning and improving - Learning from mistakes
14	Response time to start investigations into serious adverse events	Learning and improving - Learning from mistakes
15	Hospital Infection Rate for:	

#	Indicator	Strategic Direction
	<ul style="list-style-type: none"> <li>MRSA infection rate (hospital acquired)</li> </ul>	Learning and improving - Infection prevention and control
	<ul style="list-style-type: none"> <li>Blood stream infection rate</li> </ul>	Learning and improving - Infection prevention and control
	<ul style="list-style-type: none"> <li>C-Difficile Infection Rate (hospital acquired)</li> </ul>	Learning and improving - Infection prevention and control
	<ul style="list-style-type: none"> <li>Surgical site infection rate</li> </ul>	Learning and improving - Infection prevention and control
16	Positive staff culture	Fit for the future
17	Coronary Artery Bypass Grafting (CABG) Heart Surgery wait times	Decreasing wait time - Surgery
	Urgent	
	Semi- urgent	
	Non-urgent	
18	Elective primary knee replacement surgery wait times	Decreasing wait time - Surgery
19	Elective primary hip replacement surgery wait times	Decreasing wait time - Surgery
20	Access to cancer care services by provider type	Improving Access - Cancer care
	Medical Oncologist Radiation Oncologist	
21	% of children receiving scheduled mental health treatment within 30 days	Improving Access - Addiction and Mental Health
22	Emergency Department average length of stay	Decreasing wait-time - Emergency Department
	Registration to discharge decision (patient not admitted)	
	Registration to admission decision (patient admitted)	
23	Percent of IP days classified as ALC:	Improving Access - Continuing care
	rural	
	urban	