Alberta Health Services

ANNUAL REPORT 2019-20

Alberta Health Services

The 2019-20 AHS Annual Report was prepared in accordance with the *Fiscal Planning and Transparency Act*, *Regional Health Authorities Act,* and instructions as provided by Alberta Health. The 2019-20 fiscal year spanned from April 1, 2019 to March 31, 2020. All material economic and fiscal implications known as of June 24, 2020 have been considered in preparing the Report.

For more information about our programs and services, please visit
www.ahs.ca or call HealthLink at 811.

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Message from the Board Chair and President & CEO

The 2019-20 Alberta Health Services (AHS) Annual Report is being completed and delivered at a truly historic point in not only the evolution of AHS, but also in the lives of Albertans and the collective experience of our country and the world. The fiscal year concluded with Alberta on the verge of experiencing the peak of the COVID-19 pandemic – one of the most devastating healthcare crises to grip the globe in the past century.

For many Albertans, the potential health risks posed by exposure to the coronavirus are compounded by the extreme economic and social impacts being experienced across the province. Unemployment is high, commodity prices are low, critical services have been restricted, and concepts like 'physical distancing' and 'self-isolation' that were completely foreign to Albertans mere months ago are now common in our daily language.

We are grateful to all Albertans who heeded the warnings, followed the advice of the Government of Alberta and medical experts, and reduced the spread of COVID-19. Without those actions, the devastating toll on Albertans would have been so much worse.

It is not an exaggeration to say that the COVID-19 pandemic, its impacts on the physical and mental health of Albertans, and the demands it has placed on the AHS workforce, is the single-most significant event AHS has experienced since its formation in 2009. At the same time, AHS' strong pandemic response and support provided to all Albertans is a testament to the benefits and importance of a single public provincial healthcare provider; the sharing of information, best practices, and purchasing power was crucial in the entire province battling the novel coronavirus.

The backdrop to the pandemic is a sustained economic downturn in Alberta which has significantly impacted government revenue and spending. This has required a renewed focus on the part of the public sector to be responsible stewards of every tax dollar spent – all while the public healthcare system is under new and constantly changing pressures imposed by the pandemic. The pandemic has exacerbated an already challenging situation and it will be years before the health system can recover financially.

Despite the strain placed on our system as the 2019-20 fiscal year concluded, we could not be more proud of the way our AHS teams have risen to the challenge. One of the most rewarding things we have seen since this pandemic reached Alberta in early March (2020) is that even in the face of an unprecedented public health crisis — where many healthcare services have been changed or paused or restricted — the overall quality of the care being offered remains very high. Even during a pandemic, our strong training and experience guided effective clinical decision-making, and commitment, compassion, and teamwork amplified the truly world-class care being provided to our patients.

The COVID-19 pandemic — and the extraordinary efforts shown in response to it — became the primary focus of the healthcare system as 2019-20 closed. However, in reflecting upon the past year, we must not overlook other key milestones and accomplishments:

- AHS was named one of Canada's Top 100 Employers for the third year in a row and was also named one of Alberta's Top 75 Employers, Canada's Top Employers for Young People, and Canada's Best Diversity Employers. This is attributed to the dedication, collaboration, and hard work of our staff.

- In 2019, Accreditation Canada surveyors conducted more than 1,800 interviews at 28 locations across AHS. Surveyors highlighted our caring, compassionate people and the collaboration that occurs at all levels of the organization. Overall, AHS performed remarkably well on the five foundational standards that were assessed, including meeting all of the Required Organizational Practices (ROPs) in the Governance and Leadership standard sets.

- AHS launched the first wave of Connect Care, Alberta's new provincial electronic clinical information system, in November 2019. More than 17,000 users now have access to the system in Wave 1 sites across Edmonton Zone.

- In collaboration with municipal and provincial partners, AHS supported the northern wildfire response in May 2019 which displaced residents, clients, and patients from their homes, communities, and healthcare facilities.

- AHS received recommendations from the *Blue Ribbon Panel Report on Alberta's Finances* (MacKinnon Report) and the AHS Performance Review by Ernst & Young (EY). Both reports recognized the many strengths of AHS' integrated systems and identified areas where we can continue to lower costs and become more efficient in service delivery. Under the guidance of the Board, AHS began implementing some of the AHS Performance Review recommendations. Much of this work has been put on hold to address the critical work of protecting Albertans from the global pandemic. As we begin relaunching this work, the pandemic has highlighted how carefully we must look at opportunities from both an efficiency and quality and safety lens.

As AHS enters the 2020-21 fiscal year, there are ongoing uncertainties; no one knows how long the pandemic will last, or how many Albertans will be exposed to the virus, or how many will require care. The long-term economic outlook for our province and our country also remains unclear. As Alberta's largest public sector organization, we recognize and reaffirm our responsibility to deliver high quality care while finding efficiencies and carefully managing our finances during a time of fiscal restraint.

It is difficult to say what the long-term impacts of COVID-19 will be on our healthcare system, but we know there are fundamental and lasting changes that will most certainly come about – both in terms of how the system is administered and how care is delivered on the frontline. However, as is always the case in Alberta, springtime brings with it hope and optimism. We have confidence in the expertise and the resiliency of our almost 130,000 physicians, staff, and volunteers to not only help us get through this challenge, but to make a real difference in the lives of the patients they serve.

We are pleased to present this report that highlights our achievements in 2019-20, and look forward to continuing this important work in the year ahead. We will continue to focus on health system sustainability while maintaining our commitment to improved patient outcomes and safety. Together, AHS does amazing things every day.

[Original Signed By]

David Weyant, QC
Board Chair
Alberta Health Services Board

[Original Signed By]

Dr. Verna Yiu
President & CEO
Alberta Health Services
June 24, 2020

Alberta Health Services Responds to COVID-19

The novel coronavirus pandemic that first emerged globally in late 2019 placed demands on our healthcare system and our workforce that have never been experienced in AHS' history. Our response to this unprecedented public health crisis was both swift and strategic, demonstrating our ability to be innovative and nimble. The pandemic has proven that Alberta's healthcare system is a national leader: our COVID-19 testing volumes per capita have outpaced other jurisdictions, our online assessment tool was utilized and shared with other provinces and territories, and our hospitalization rates remained relatively and consistently low throughout. The strength of our response was grounded in our ability to work as one cohesive, integrated, provincial team.

Although the COVID-19 pandemic and our response to it spanned across more than one fiscal year, the information below details AHS' response during 2019-20 (up to March 31, 2020).

AHS' Response to COVID-19: By the Numbers (as of March 31, 2020)

165,000
HealthLink total COVID-19 related calls

3.3 Million
Website visits to AHS COVID-19 public pages

2.8 Million
Online self-assessments by the public

60,000
Online self-assessments by healthcare workers

49
Total hospitalizations

17
Total patients requiring intensive care

48,692
Total tests completed

754
Positive cases identified

10
Drive-thru testing lanes

24
Public Health locations collecting samples

97,000
Procedure masks used daily across AHS (vs. 34,000 used daily pre-pandemic)

9,700
N95 masks used daily across AHS (vs. 3,000 used daily pre-pandemic)

~200
COVID-19 related media requests

AHS' Response to COVID-19: Timeline (as of March 31, 2020)

About Alberta Health Services

Who We Are

AHS is Canada's first and largest province-wide, fully integrated health system, responsible for delivering health services to nearly 4.4 million people living in Alberta.

AHS and its many health service delivery partners, including Covenant Health, work together to deliver high-quality healthcare across this province as well as to some residents of Saskatchewan, British Columbia, and the Northwest Territories.

In 2019-20, AHS was named one of Canada's Top 100 Employers, Alberta's Top 75 Employers, and Canada's Top Employers for Young People for the third year in a row, and also received repeat recognition for being one of Canada's Best Diversity Employers. Throughout AHS, people are working together to create a culture where everyone feels safe, healthy, valued, and included, with opportunities to reach their full potential.

Alberta has urban, rural, and remote populations. Certain geographical areas within our province are home to unique populations and health needs requiring tailored approaches to healthcare delivery.

Virtual health connects patients/families and care providers separated by physical distance using virtual innovations and technology. Last year, Virtual Health supported more than 61,000 virtual connections, which enabled Albertans in remote and rural locations to avoid unnecessary travel.

AHS has more than 103,000 direct AHS employees (excluding Covenant Health and other contracted health service providers), more than 130 midwives, and almost 11,800 staff working in AHS' wholly-owned subsidiaries, such as Carewest, CapitalCare Group, and Alberta Precision Laboratories.

AHS is supported by more than 10,800 practicing physicians, approximately 8,200 of whom are members of the AHS medical staff (physicians, dentists, podiatrists, and oral and maxillofacial surgeons).

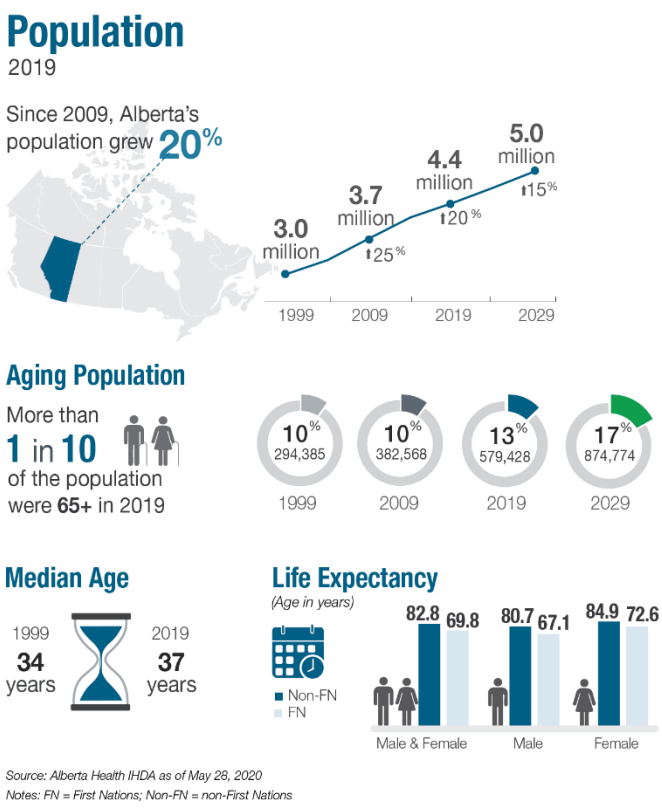
Volunteers are a central part of building environments that support patient- and family-centred care. AHS' nearly 15,100 volunteers (which includes over 1,570 patient and family advisors) contributed over 1.2 million volunteer hours this past year to help keep Albertans safe and healthy. Among their many contributions, volunteers manage patient visits, give input as advisory council members to improve the quality and safety of healthcare, play wayfinding roles, and tend our retail shops to raise funds.

Students from Alberta's universities and colleges, as well as from educational institutions outside of Alberta, receive clinical education in AHS facilities and community locations.

As of March 31, 2020 there were 106 acute care hospitals and five standalone psychiatric facilities; 8,515 acute care beds; 472 sub-acute care beds; 27,774 continuing care beds/spaces (15,665 long-term care beds, 11,853 designated supportive living beds, and 256 community palliative and hospice beds/spaces), and 2,785 addiction and mental health beds/spaces. This is a total of 39,546 AHS operated and contracted beds in service.

Programs and services are offered at more than 850 facilities throughout the province, including hospitals, continuing care facilities (including long-term care, designated supportive living, community palliative and hospice, and contracted care sites), cancer centres, addiction and mental health facilities, and community ambulatory care centres. All facilities and programs are operated in compliance with specific sections of program legislation.

The graphic below depicts how Alberta's population is, and will continue, growing and changing.



Source: Alberta Health IHDA as of May 28, 2020
Notes: FN = First Nations; Non-FN = non-First Nations

AHS Health Plan & Business Plan

The AHS 2017-2020 Health Plan and 2019-2020 Business Plan are public accountability documents spanning three- and one-year time frames, respectively. Developed with engagement from internal and external stakeholders and Alberta Health, the Health Plan and Business Plan describe the actions AHS will take in fulfilling its legislated responsibilities, with a primary focus on the delivery of quality health services. This annual report reflects year three (2019-20) results, based on priorities and measures identified in the AHS 2017-20 Health Plan and 2019-20 Business Plan.

Foundational Strategies

AHS has four foundational strategies that support all of our efforts to deliver safe, high-quality, patient- and family-centred care to Albertans:

Patient First Strategy puts patients and families at the centre of all healthcare activities, decisions, and teams.

Our People Strategy creates a culture in which AHS staff, physicians, and volunteers feel safe, healthy, and valued.

Clinical Health Research, Innovation and Analytics Strategy drives research and innovation to improve patient outcomes and health system performance.

Information Management/Information Technology Strategy puts information at the fingertips of patients, clinicians, and researchers to inform and to improve decision-making.

Vision, Mission & Values

Our Vision tells us where we need to go and where we want to be. *Healthy Albertans. Healthy Communities. Together.*

Our Mission is our reason for being. It defines our purpose, who we serve and how we serve them.
To provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Our five Values are at the heart of everything we do. They inspire, empower, and guide how we work together with patients, clients, families, and each other.

AHS cares

compassion
accountability
respect
excellence
safety

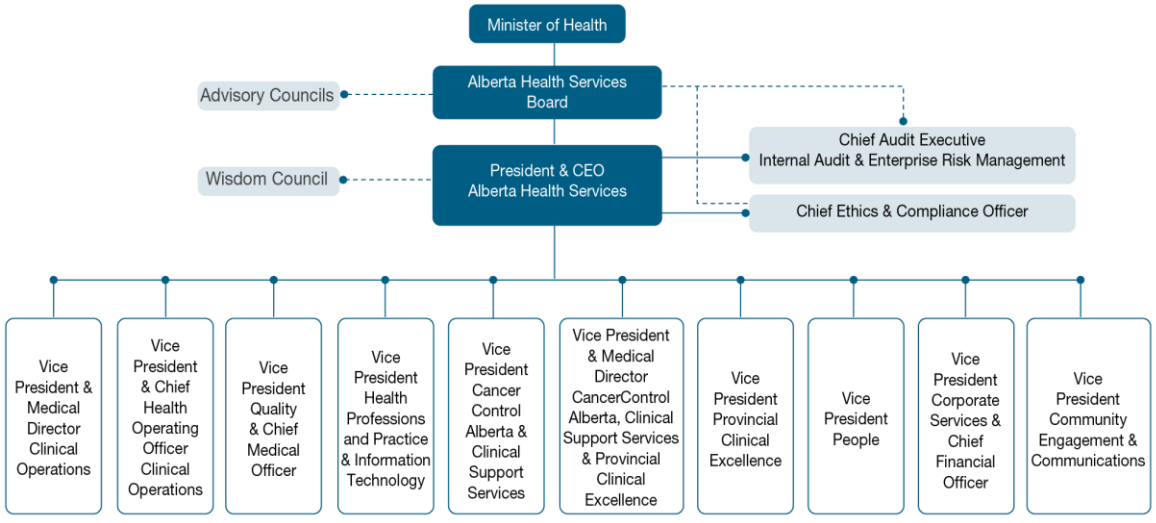
Board Governance

Working in partnership with Alberta Health, the AHS Board is responsible for the governance of AHS to ensure all Albertans have access to high-quality health services across the province. The Board, led by the Board Chair, David Weyant, QC, is accountable to the Minister of Health. The AHS Board has established committees to assist in governing AHS and overseeing the management of AHS' business and affairs: Audit & Risk Committee, Community Engagement Committee, Finance Committee, Governance Committee, Human Resources Committee, and Quality & Safety Committee. The purpose and scope of each committee is in accordance with governance best practices and is consistent with the legislation governing AHS.

The Board Chair is a member of each committee, and the President & Chief Executive Officer is a non-voting ex-officio member of each committee. AHS Board members are David Weyant, QC (Chair), Dr. Brenda Hemmelgarn (Vice-Chair), David Carpenter, Richard Dicerni, Stephen Mandel, Heidi Overguard, Hugh D. Sommerville, QC, Brian Vaasjo, and Glenda Yeates.

Organizational Structure

Reporting directly to the Board, Dr. Verna Yiu is President & Chief Executive Officer (CEO) of AHS and leads over 103,000 caring and dedicated individuals who make up the AHS workforce. With leaders and staff in the organization, AHS is proud to have a culture that exemplifies its values, takes a provincial perspective on issues, and ensures good ideas developed locally are shared across the province. AHS' organizational structure is represented below, arranged under the AHS Executive Leadership Team reporting directly to the President & CEO.



March 16, 2020

Advisory Councils – Working Together to Improve Lives

Advisory Councils help bring the voice of Alberta's communities to healthcare services. Community input allows us to better address the health needs of Albertans and brings decision-making to the local level. AHS is committed to engaging the public in a respectful, open, and accountable manner.

Health Advisory Councils (HACs) work in partnership with the AHS Community Engagement team and zone leaders to bring the local perspective to Alberta healthcare. HACs engage members of the public in communities throughout Alberta and provide advice and feedback from a local perspective on what is working well in the healthcare system and where there are areas in need of improvement. The 12 HACs, which report to the AHS Board, were established in 2009-10 and represent different geographical areas within the province.

1. True North – La Crete, High Level & Area
2. Peace – Peace River, Grande Prairie & Area
3. Lesser Slave Lake – Slave Lake, High Prairie & Area
4. Wood Buffalo – Fort McMurray & Area
5. Lakeland Communities – Lac La Biche, Redwater, Cold Lake & Area
6. Tamarack – Hinton, Edson, Whitecourt & Area
7. Oldman River – Lethbridge & Area
8. Greater Edmonton – Edmonton & Area
9. Yellowhead East – Camrose, Lloydminster & Area
10. David Thompson – Red Deer & Area
11. Prairie Mountain – Calgary & Area
12. Palliser Triangle – Medicine Hat & Area

Each Health Advisory Council has up to 15 members, with each individual serving three-year terms for a maximum of six years. Recruitment for membership is an ongoing activity as vacancies arise when members complete their six-year maximum terms or leave the councils for other volunteer opportunities. The 2019-20 fiscal year marked the 10-year anniversary of HACs in Alberta. A review was launched which led to nine months of engagement involving 30 conversations with 17 different stakeholder groups. As a result, AHS is introducing HAC 2.0, a new model that will bring role clarity, strengthen partnerships between councils and AHS, expanded community engagement efforts, and enhance council satisfaction.

Wisdom Council provides guidance and recommendations on the development and implementation of culturally appropriate and innovative health service delivery for Indigenous Peoples. It is comprised of Indigenous Peoples with wide-ranging backgrounds, including traditional knowledge-holders, youth, nursing professionals, and health consultants. In 2019-20, the council revised its terms of reference to recognize knowledge keepers as distinct members within the Wisdom Council Elders Circle. Elders can now opt to continue to serve after their membership term ends by providing guidance to all Alberta Health Advisory Councils, including to continue as members on the Wisdom Council. This council also remains committed to helping AHS understand the importance of how and why there is a need to implement Truth and Reconciliation calls to action and the principles of the *United Nations Declaration on the Rights of Indigenous Peoples*.

Alberta Clinician Professional Practice Council is a forum for clinicians to share knowledge, experience, and expertise to inform decision-making on key AHS programs. The council consists of frontline clinician members, senior operational leaders, and practice leaders. Its role is to advise and give feedback on strategies related to patient outcomes, access, clinical practices, quality healthcare, and patient safety. Feedback gathered in 2019-20 will help guide, design, and form strategies, resources, and services across the organization.

Addiction and Mental Health Provincial Advisory Council advises AHS on programs and services for province-wide addiction and mental health treatment. It provides recommendations from the system-access perspective that seeks to improve quality of services and patient satisfaction. For example, council members participated in reviewing and ranking grant applications in 2019-20 and provided a lens of lived-experience to help improve the use of addiction and mental health research for system and service delivery planning.

Cancer Provincial Advisory Council provides advice related to priorities for cancer services, including screening and prevention, diagnosis, treatment and care, and research and draws upon others' knowledge as required. Members are experts in cancer-related fields, have a loved one touched by cancer, or are cancer survivors. Over the past year, council members supported the introduction of a provincial population-based screening program for lung cancer based on statistics related to the impact of screening and also wrote a letter of support for the proposed phased implementation of the program.

Seniors and Continuing Care Provincial Advisory Council aims to improve the delivery of AHS services to seniors and those in the continuing care system (home care, designated supportive living, and long-term care) across Alberta. For example, in 2019-20, council members reviewed the Alberta Continuing Care Facility Directory in advance of its launch and provided feedback that sought to improve usability of the website so Albertans can easily find information about care for themselves and family members.

Sexual Orientation, Gender Identity and Expression Provincial Advisory Council aims to create a safer and more welcoming healthcare environment for sexual and gender minority (lesbian, gay, bisexual, transgender, queer, and 2 Spirit, or LGBTQ2S+) patients and their families. Over the past year, the council developed a practical tool for AHS employees, physicians, volunteers, and contracted service providers to support the creation of safer and more welcoming care for LGBTQ2S+ patients and their families.

Patient and Family Advisory Group is a committee of patients and family members from across Alberta, who volunteer their time and experience to improve the quality, safety, and experience of healthcare services. Together with senior and executive leaders, physicians, clinicians, and clinical support teams, advisors work to ensure the voices of patients and families are included in the design and planning of policies (e.g., family presence and visitation policies) and services within AHS. In 2019-20, group members represented patients and families during the AHS Performance Review by providing a lens of lived-experience, which was imperative to gaining an accurate, holistic understanding of the organization. Group members continue to be involved in the improvement and implementation work that resulted from the review.

Strategic Clinical Networks™ (SCNs™) bring together clinicians, researchers, patients, and policymakers to drive innovation and research, standardize care, share best practices, improve access to services, and improve health system sustainability. AHS SCNs™ partner with approximately 140 patient and family advisors who bring the voice of patients and families to their work. Advisors are involved as core committee members, working group members, leadership meeting members, and Patient & Community Engagement Researchers (PaCERs). SCN advisors also participate in **Patient Engagement Reference Group (PERG)** meetings to facilitate consultations, networking, and partnership-building between advisors and SCN leaders.

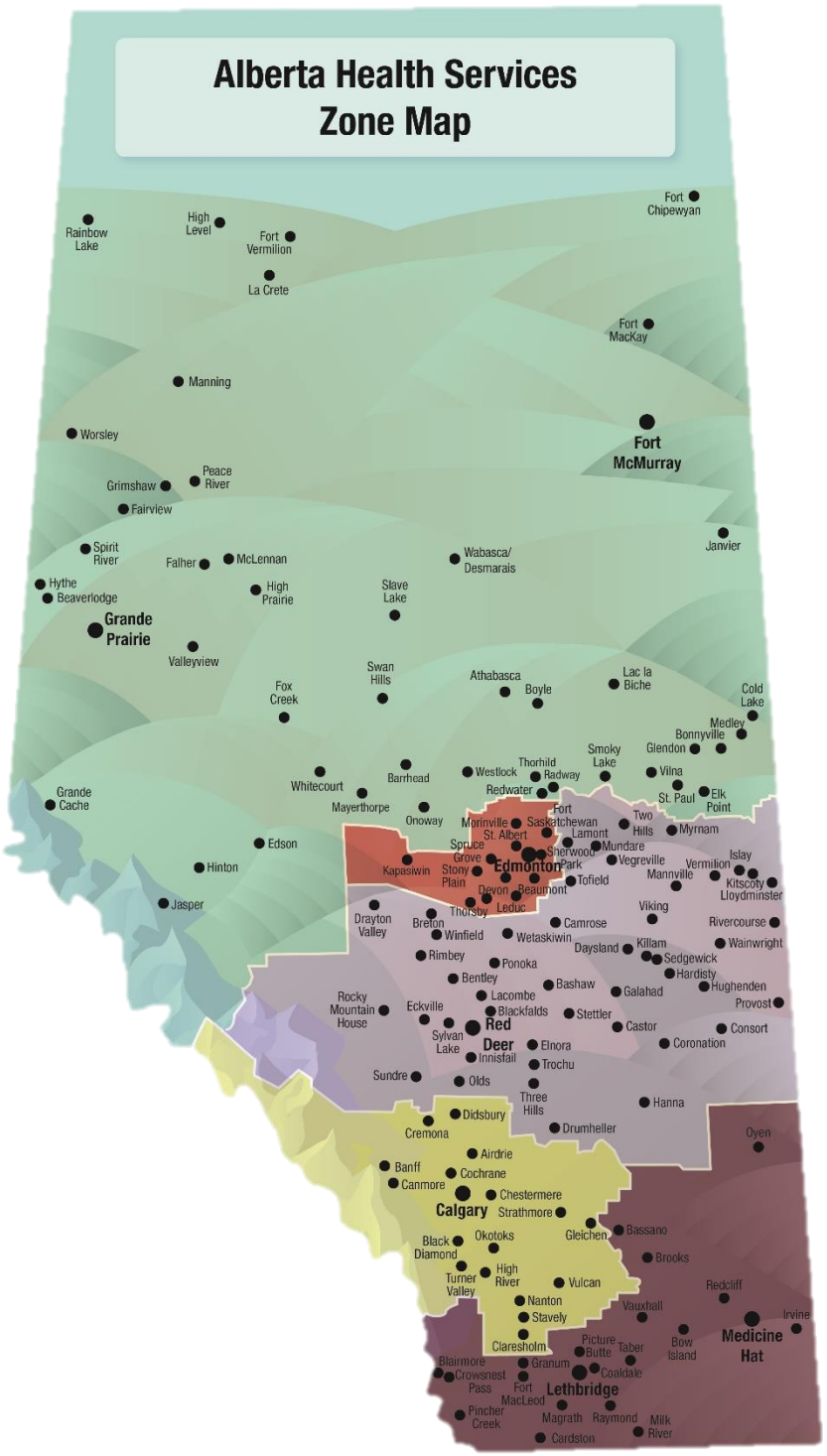
Map

AHS is organized into five geographic zones: South, Calgary, Central, Edmonton and North.

Our zones enable local decision-making as well as listening and responding to local communities, local staff members, and our patients and clients.

Province-wide services—such as ambulance services, population and public health, Indigenous health, diagnostic imaging, and quality and safety—work together with the zones to deliver care.

The next section includes an overview of activity and service delivery changes for each zone.



Quick Facts

The table below provides a snapshot of AHS' activity and demonstrates the change in services provided over the last few years.

Alberta Health Services	2015-16	2016-17	2017-18	2018-19	2019-20
Primary Care / Population Health					
Ambulatory Care Visits	6,421,309	6,569,162	6,638,806	6,578,463	Not avail.
Number of Unique/Individual Home Care Clients	117,491	119,725	121,887	127,150	132,478
Number of People Placed in Continuing Care	7,879	7,963	7,927	8,098	8,521
HealthLink Calls	755,334	744,278	706,280	694,313	891,931*
Poison Information Calls (PADIS)	36,375	39,467	39,270	38,785	39,253
Seasonal Influenza Immunizations**	1,146,569	1,171,825	1,229,350	1,317,659	1,438,866
EMS Events	517,640	512,167	544,744	560,434	589,498
Food Safety Inspections	92,857	82,482	78,311	65,560	48,247
Acute Care					
Emergency Department Visits (all sites)	2,134,945	2,079,688	2,101,629	2,056,631	2,058,370
Urgent Care Visits	189,775	187,519	198,108	197,401	202,683
Hospital Discharges	404,514	403,958	400,909	401,208	399,216
Births	55,283	53,647	51,692	50,793	49,980
Total Hospital Days	2,812,244	2,837,865	2,862,324	2,853,001	2,851,395
Average Length of Stay (in days)	7.0	7.0	7.1	7.1	7.1
Diagnostic / Specific Procedures					
Hip Replacements (scheduled and emergency)	5,564	6,004	6,191	6,278	6,596
Knee Replacements (scheduled and emergency)	6,645	6,692	6,556	6,613	6,231
Cataract Surgery	36,806	38,053	39,340	40,554	43,972
Main Operating Room Activity	286,445	290,802	291,089	291,755	288,393
MRI Exams	195,419	192,375	195,017	204,744	201,118
CT Exams	391,600	405,332	415,755	441,938	427,508
X-rays	1,874,879	1,843,076	1,857,946	1,845,811	1,846,918
Lab Tests	75,512,771	76,282,776	76,974,638	80,237,687	81,366,973
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	616,237	641,856	639,449	668,817	704,191
Unique/Individual Cancer Patients	55,020	57,549	58,409	59,249	62,513
Addiction and Mental Health					
Mental Health Hospital Discharges (acute care sites)	22,646	24,183	24,471	26,111	26,787
Community Treatment Orders (CTOs) Issued	452	462	492	494	399 (Q3YTD)
Addiction Residential Treatment & Detoxification Admissions	10,919	10,591	11,009	10,663	10,724

Notes: Data updated as of May 25, 2020. Definitions can be found at https://www.ahs.ca/about/Page11905.aspx.
- Food safety inspections decreased due to implementation of new software, training, and some inspection work no longer being counted.
- Ambulatory care visit data is lagged and was not available at the time of this report.
** HealthLink call volumes include COVID-19 inquiries.*
*** Source: Alberta Health Influenza Immunization Report 2019-2020.*

Bed Numbers

AHS wants to shift services from a focus on care in hospitals and facilities to the services and resources available in the community. We are committed to providing community-based care options for Albertans, including long-term care, designated supportive living, palliative care, and home care.

In 2019-20, AHS opened 611 net new continuing care beds – this is a decrease from the 2018-19 year (1,267 new beds). Since 2010, AHS has opened 8,074 new beds to support individuals who need community-based healthcare and supports (including palliative). This means that, gradually, people are more efficiently being moved from a hospital setting to a more appropriate (and often more cost-effective) community-based setting.

Additional detail on continuing care bed capacity can be found in the Appendix.

Number of Beds/Spaces	March 31, 2019	March 31, 2020	Difference	% Change
ACUTE CARE				
Acute Care	8,479	8,515	36	0.4%
TOTAL ACUTE CARE	**8,479**	**8,515**	**36**	**0.4%**
ADDICTION AND MENTAL HEALTH				
Psychiatric (stand-alone facilities)	928	928	0	0.0%
Addiction Treatment	970	979	9	0.9%
Community Mental Health	866	878	12	1.4%
TOTAL ADDICTION AND MENTAL HEALTH	**2,764**	**2,785**	**21**	**0.8%**
COMMUNITY-BASED CARE				
Continuing Care – Long-Term Care (LTC)				
Auxiliary Hospital	5,607	5,561	-46	-0.8%
Nursing Home	9,990	10,104	114	1.1%
Sub-Total Long-Term Care (LTC)	**15,597**	**15,665**	**68**	**0.4%**
Continuing Care - Designated Supportive Living (DSL)				
Designated Supportive Living 3	1,534	1,513	-21	-1.4%
Designated Supportive Living 4	6,462	6,840	378	5.8%
Designated Supportive Living 4 - Dementia	3,321	3,500	179	5.4%
Sub-Total Designated Supportive Living (DSL)	**11,317**	**11,853**	**536**	**4.7%**
SUB-TOTAL LONG-TERM CARE & DESIGNATED SUPPORTIVE LIVING	**26,914**	**27,518**	**604**	**2.2%**
Community Palliative and Hospice (out of hospital)	249	256	7	2.8%
TOTAL CONTINUING CARE (includes LTC, DSL and Palliative Care)	**27,163**	**27,774**	**611**	**2.2%**
Sub-acute in Auxiliary Hospitals	472	472	0	0.0%
TOTAL COMMUNITY-BASED CARE (includes LTC, DSL, Palliative Care and Sub-Acute in Auxiliary Hospitals)	**27,635**	**28,246**	**611**	**2.2%**
PROVINCIAL TOTAL	**38,878**	**39,546**	**668**	**1.7%**

Source: AHS Bed Survey as of March 31, 2020.

South Zone Overview

Below are examples of the great work accomplished in South Zone in 2019-20:

- The South Zone Continuing Care Quality Initiative aims to sustain high care quality at 11 of their long-term care sites, with a focus on meeting and exceeding Alberta Health's Continuing Care Health Service Standards (CCHSS), increasing family presence by providing clinical leadership and support, and developing consistency in practice and processes to support informed and dynamic care planning. The results of a five-month pilot saw a 20% improvement in overall compliance with the CCHSS and, specifically, a 23% improvement in care planning and a 52% improvement in case management.

- Work continued on the Four Winds Indigenous Patient Navigation Model which aims to help Indigenous patients and their families navigate complex transitions during their journey through the health system. Working groups have been formed to focus on navigation, connections and communications, and cultural safety. The working groups include members from the Piikani, Kainai, Inuit and Métis communities, service partners such as the Friendship Society and the Town of Cardston, Health Advisory Councils, and AHS staff. The first Indigenous patient navigator will begin in spring 2020.

- The South Zone received a new healing teepee designed by local Piikani and Kainai elders to help all patients in their journeys back to health and well-being. The inclusive space is intended to create strong bridges of understanding and new relations between AHS, local Indigenous peoples, and the broader South Zone community.

The table below provides a snapshot of South Zone's activity and demonstrates the change in services provided over the last few years.

SOUTH ZONE QUICK FACTS	2015-16	2016-17	2017-18	2018-19	2019-20
Population Statistics					
Overall Population	300,372	302,500	305,134	307,033	308,924
Aging Population (over 65)	44,200	45,560	46,988	48,662	50,362
Life Expectancy	80.8	79.7	80.4	80.5	81.1
Median Age	36	37	37	37	38
Primary Care / Population Health					
Ambulatory Care Visits	376,743	406,163	430,483	461,425	Not avail.
Number of Unique/Individual Home Care Clients	12,223	12,597	12,828	13,104	13,494
Number of People Placed in Continuing Care	887	925	905	908	870
HealthLink Calls	34,773	34,061	32,644	30,306	37,182*
Seasonal Influenza Immunizations**	88,172	90,273	92,391	95,240	101,651
Food Safety Inspections	7,866	7,707	6,401	4,926	3,557
Acute Care					
Emergency Department Visits (all sites)	194,257	192,083	193,467	189,864	194,338
Hospital Discharges	30,485	30,521	29,905	29,148	28,692
Births	4,217	3,940	3,865	3,692	3,671
Total Hospital Days	219,218	228,308	222,761	220,260	216,396
Average Length of Stay (in days)	7.2	7.5	7.4	7.6	7.5
Diagnostic / Specific Procedures					
Hip Replacements (scheduled and emergency)	578	591	569	582	619
Knee Replacements (scheduled and emergency)	838	784	778	830	821
Cataract Surgery	2,847	2,955	2,920	3,105	3,080
Main Operating Room Activity	23,209	23,352	22,548	22,134	20,860
MRI Exams	14,288	13,809	13,601	14,513	15,333
CT Exams	26,964	28,926	30,418	31,640	32,976
X-rays	166,251	165,091	162,358	163,170	162,798
Lab Tests	5,263,114	5,195,905	5,200,813	5,473,081	5,617,814
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	32,144	34,055	31,067	32,437	35,948
Unique/Individual Cancer Patients	4,273	4,379	3,733	3,045	3,183
Addiction and Mental Health					
Mental Health Hospital Discharges (acute care sites)	2,052	2,166	2,230	2,316	2,520
Workforce					
AHS Staff	7,280	7,431	7,533	7,308	7,284
AHS Volunteers	1,746	1,632	1,441	1,435	1,663
AHS Physicians	569	578	613	596	556

** HealthLink call volumes exclude COVID-19 inquiries.*
*** Source: Alberta Health Influenza Immunization Report 2019-2020.*

Calgary Zone Overview

Below are examples of the great work accomplished in Calgary Zone in 2019-20:

- The Calgary Zone co-developed and is implementing an Indigenous Health Action Plan in collaboration with Indigenous community members and, in May 2019, over 60 AHS zone leaders, programs, and Indigenous partners and agencies came together at the Blackfoot Crossing, which is a traditional meeting place of the Blackfoot people and a sacred site where Treaty 7 was signed, to officially release the plan. Community partners indicated they saw their voice reflected in the plan's recommendations, felt that relationships with AHS had improved due to this process, and are feeling engaged and optimistic for the future. To celebrate the approval of the plan, the relationships that were developed, and to launch the next stage, a pipe ceremony was held at the South Health Campus in Calgary.

- Patients undergoing knee replacement surgery are recovering faster and going home sooner due to a new protocol for knee replacement surgery in patients with osteoarthritis. Of the 39 patients who underwent the procedure, 36 returned home same-day and the other three within 24 hours. None required hospital readmission and nine of the 39 patients did not require any narcotics at all post-procedure. Before this approach, patients undergoing this surgery would typically remain in hospital for three to five days. About 6,000 knee replacement surgeries are performed each year in Alberta. Over the past 10 years, through care path development, measurement, and ongoing quality improvement initiatives involving acute care surgical teams, the median length of stay for knee replacement in the Calgary Zone has been reduced from 4.2 days to 2.3 days.

The table below provides a snapshot of Calgary Zone's activity and demonstrates the change in services provided over the last few years.

CALGARY ZONE QUICK FACTS	2015-16	2016-17	2017-18	2018-19	2019-20
Population Statistics					
Overall Population	1,587,121	1,616,535	1,641,318	1,669,272	1,696,765
Aging Population (over 65)	171,892	180,787	190,551	200,478	211,374
Life Expectancy	83.3	83.2	82.9	83.1	83.8
Median Age	37	37	37	37	38
Primary Care / Population Health					
Ambulatory Care Visits	2,646,960	2,661,944	2,762,142	2,663,827	Not avail.
Number of Unique/Individual Home Care Clients	34,663	35,797	37,274	39,025	40,367
Number of People Placed in Continuing Care	2,722	2,438	2,632	2,668	2,757
HealthLink Calls	318,422	310,333	292,109	289,203	314,209*
Seasonal Influenza Immunizations**	467,942	491,931	525,652	559,488	630,305
Food Safety Inspections	30,496	27,093	26,494	23,688	16,814
Acute Care					
Emergency Department Visits (all sites)	487,862	475,485	476,013	476,267	485,695
Urgent Care Visits	179,832	176,120	185,718	185,450	189,534
Hospital Discharges	143,063	143,659	144,354	145,427	145,931
Births	19,720	19,394	18,883	18,195	18,116
Total Hospital Days	1,030,612	1,024,174	1,021,481	1,036,176	1,024,279
Average Length of Stay (in days)	7.2	7.1	7.1	7.1	7.0
Diagnostic / Specific Procedures					
Hip Replacements (scheduled and emergency)	2,099	2,184	2,276	2,321	2,283
Knee Replacements (scheduled and emergency)	2,511	2,490	2,353	2,394	2,344
Cataract Surgery	13,577	13,490	14,439	14,425	17,750
Main Operating Room Activity	101,016	101,850	102,776	102,108	101,975
MRI Exams	76,850	77,116	77,502	78,231	78,925
CT Exams	142,863	145,678	151,370	162,445	157,162
X-rays	546,546	537,800	546,543	542,446	543,709
Lab Tests	28,800,108	29,212,266	29,639,947	31,010,367	32,011,102
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	200,599	213,828	214,536	221,104	230,955
Unique/Individual Cancer Patients	22,934	23,792	24,651	25,356	26,094
Addiction and Mental Health					
Mental Health Hospital Discharges (acute care sites)	9,022	9,499	9,668	10,931	11,205
Workforce					
AHS Staff	37,023	36,887	37,022	37,755	38,126
AHS Volunteers	5,100	4,206	4,267	4,298	4,918
AHS Physicians	3,326	3,439	3,497	3,120	3,181

** HealthLink call volumes exclude COVID-19 inquiries.*
*** Source: Alberta Health Influenza Immunization Report 2019-2020.*

Central Zone Overview

Below are examples of the great work accomplished in Central Zone in 2019-20:

- Wetaskiwin-and-area residents have improved access to addiction and mental health services at the Wetaskiwin Hospital and Care Centre. The community crisis response team, comprised of addiction and mental health clinicians, are now on-call during evenings and weekends to consult with physicians and help patients who arrive at the emergency department needing specialized crisis support. The service provides expanded on-call consultation on weeknights, weekends, and holidays. Prior to this initiative, patients would receive crisis support care but often waited until regular business hours to be assessed by an addiction and mental health clinician.

- More local patients with chronic kidney disease are able to access dialysis after the satellite hemodialysis unit expanded its hours to offer additional appointment times. Dialysis is offered an additional four hours per day, three days a week. The expanded hours went into effect in December and have provided space for nine additional patients from the Wetaskiwin area to receive the care they need closer to home.

- The Empower Mothers and Families, Mentorship, Building Healthy Relationships, Respect, Actively Listen and Learn, Collaboration and Engagement (EMBRACE) program was launched at Red Deer Regional Hospital Centre in April 2019. This program teaches new moms, who used opioids during pregnancy, how to care for their newborns. The program teaches moms comfort methods such as skin-to-skin, cuddling and swaddling, and breastfeeding.

The table below provides a snapshot of Central Zone's activity and demonstrates the change in services provided over the last few years.

CENTRAL ZONE QUICK FACTS	2015-16	2016-17	2017-18	2018-19	2019-20
Population Statistics					
Overall Population	474,628	476,106	476,519	479,435	482,349
Aging Population (over 65)	67,755	69,855	72,001	74,503	77,408
Life Expectancy	79.9	80.6	80.2	81.0	81.1
Median Age	37	38	38	38	39
Primary Care / Population Health					
Ambulatory Care Visits	479,723	501,083	481,016	493,336	Not avail.
Number of Unique/Individual Home Care Clients	18,693	18,988	19,226	20,368	21,477
Number of People Placed in Continuing Care	1,060	1,352	1,236	1,312	1,468
HealthLink Calls	68,388	61,431	56,996	56,202	61,687*
Seasonal Influenza Immunizations**	105,872	106,934	112,629	118,796	126,288
Food Safety Inspections	11,390	9,944	9,508	7,511	5,788
Acute Care					
Emergency Department Visits (all sites)	360,966	344,993	347,222	328,256	325,148
Hospital Discharges	45,577	45,265	43,982	42,801	41,703
Births	5,037	4,765	4,433	4,364	4,038
Total Hospital Days	323,983	338,305	328,939	334,361	333,465
Average Length of Stay (in days)	7.1	7.5	7.5	7.8	8.0
Diagnostic / Specific Procedures					
Hip Replacements (scheduled and emergency)	585	632	646	654	683
Knee Replacements (scheduled and emergency)	616	678	621	706	664
Cataract Surgery	3,782	3,859	3,947	4,221	3,808
Main Operating Room Activity	29,999	30,930	28,603	29,573	29,585
MRI Exams	12,406	11,034	12,058	13,089	13,845
CT Exams	37,485	38,679	38,310	42,698	42,457
X-rays	255,147	251,374	251,082	255,168	262,054
Lab Tests	6,374,514	6,426,497	6,385,971	6,707,603	6,850,045
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	32,098	33,366	33,856	34,856	37,857
Unique/Individual Cancer Patients	2,762	2,970	3,038	3,268	3,586
Addiction and Mental Health					
Mental Health Hospital Discharges (acute care sites)	2,497	2,633	2,614	2,611	2,786
Workforce					
AHS Staff	12,772	12,813	12,910	12,848	12,894
AHS Volunteers	3,409	2,852	3,011	2,935	3,118
AHS Physicians	710	725	749	786	783

** HealthLink call volumes exclude COVID-19 inquiries.*
*** Source: Alberta Health Influenza Immunization Report 2019-2020.*

Edmonton Zone Overview

Below are examples of the great work accomplished in Edmonton Zone in 2019-20:

- The Integrated Operations Center is an innovative approach to patient flow management that aims to decrease strain on hospitals and emergency medical services with the purpose of identifying barriers and developing an appropriate zone-level plan. The center is already making a positive impact on patient flow and improving appropriate distribution of patients among acute care sites in the zone.
- The Edmonton Zone Virtual Hospital uses technology and integrated care teams to support and care for patients in their own homes while improving coordination across the healthcare system. The care team interacts by phone and video with patients and their community caregivers to help manage problems before they become serious enough to require an acute care admission or emergency department visit. As a result of this innovation, emergency department visits decreased by more than 50%, acute care admission rates decreased by 86%, length of stay decreased by 49%, and 90% of patients and care providers involved were very satisfied with their care. In support of the AHS COVID-19 response, virtual services were expanded and adapted to assist secondary assessment centers and vulnerable populations.

- Patients and families with addiction and mental health concerns in the Edmonton area can now access services through a single point of contact. Access 24/7 is now open in Anderson Hall across from the Royal Alexandra Hospital Emergency Department. Adult patients can receive in-person assessment; walk-in, phone, and crisis outreach; and stabilization around the clock, every day of the year. Other services include referrals and support for individuals and families to navigate the healthcare system and community services.

The table below provides a snapshot of Edmonton Zone's activity and demonstrates the change in services provided over the last few years.

EDMONTON ZONE QUICK FACTS	2015-16	2016-17	2017-18	2018-19	2019-20
Population Statistics					
Overall Population	1,331,375	1,358,813	1,383,025	1,404,498	1,424,837
Aging Population (over 65)	158,083	165,098	172,297	179,787	188,087
Life Expectancy	81.9	82.0	82.0	82.0	82.4
Median Age	36	36	36	37	37
Primary Care / Population Health					
Ambulatory Care Visits	2,490,807	2,581,917	2,561,790	2,555,649	Not avail.
Number of Unique/Individual Home Care Clients	37,986	38,438	38,266	39,671	41,360
Number of People Placed in Continuing Care	2,506	2,575	2,388	2,525	2,685
HealthLink Calls	269,205	278,755	267,218	263,928	301,610*
Seasonal Influenza Immunizations**	384,723	389,918	406,229	443,574	473,086
Food Safety Inspections	27,788	23,188	20,484	16,673	13,140
Acute Care					
Emergency Department Visits (all sites)	541,451	545,147	552,858	552,341	553,175
Urgent Care Visits	9,943	11,399	12,390	11,951	13,149
Hospital Discharges	141,279	142,584	140,224	143,163	142,905
Births	19,751	19,849	18,758	18,949	18,692
Total Hospital Days	975,054	995,740	1,007,038	998,979	1,003,769
Average Length of Stay (in days)	6.9	7.0	7.2	7.0	7.0
Diagnostic / Specific Procedures					
Hip Replacements (scheduled and emergency)	1,987	2,270	2,345	2,337	2,605
Knee Replacements (scheduled and emergency)	2,166	2,191	2,241	2,199	1,940
Cataract Surgery	14,458	15,751	16,014	16,642	17,840
Main Operating Room Activity	102,463	106,465	108,765	112,350	111,772
MRI Exams	78,254	77,523	79,087	85,649	81,244
CT Exams	149,237	157,225	159,512	168,599	158,734
X-rays	613,135	603,962	609,941	601,553	594,029
Lab Tests	27,781,396	28,233,276	28,672,978	29,879,909	29,701,154
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	337,234	344,170	343,539	363,466	380,991
Unique/Individual Cancer Patients	25,074	26,442	27,150	27,726	28,810
Addiction and Mental Health					
Mental Health Hospital Discharges (acute care sites)	6,195	6,909	6,813	7,314	7,468
Workforce					
AHS Staff	32,921	33,473	33,969	34,050	34,292
AHS Volunteers	2,903	2,771	2,781	2,688	2,904
AHS Physicians	2,714	2,824	2,919	2,852	2,839

** HealthLink call volumes exclude COVID-19 inquiries.*
*** Source: Alberta Health Influenza Immunization Report 2019-2020.*

North Zone Overview

Below are examples of the great work accomplished in North Zone in 2019-20:

- The new heliport at Northern Lights Regional Health Centre in Fort McMurray is now operational. Last year, more than 40 flights carrying patients landed at the Fort McMurray airport. The new heliport is expected to receive the same number of landings per year.
- Two newly renovated palliative care rooms are providing a modernized, comforting space for critically ill patients and their families at the Cold Lake Healthcare Centre. The goal of palliative care is to prevent and relieve suffering and to improve quality of life for patients facing serious, complex illness. These rooms feature updated, homelike furnishings, where patients and families have the ability to video-conference loved ones through the 'smart' TVs in each room. Each year, around 40 patients use the centre's two palliative care beds, which serve Cold Lake and surrounding communities.
- In May 2019, wildfires led to the evacuation of more than 10,000 Albertans, including staff, patients and long-term care residents from the High Level, LaCrete, Fort Vermilion, Wabasca-Desmarais, Bigstone Cree Nation, Peerless Trout First Nation, Paddle Prairie, and Manning areas. The Zone Emergency Operations Centre supported local teams impacted by the disaster and managed AHS' response by working with site staff and leadership to understand capacity and resource requirements. One immediate priority was the need to bring additional AHS staff into the North Zone. For example, nearly 200 Edmonton Zone staff volunteered to take shifts at North Zone evacuation centres.

The table below provides a snapshot of North Zone's activity and demonstrates the change in services provided over the last few years.

NORTH ZONE QUICK FACTS	2015-16	2016-17	2017-18	2018-19	2019-20
Population Statistics					
Overall Population	483,904	482,275	480,002	482,179	484,941
Aging Population (over 65)	45,024	46,417	48,126	50,045	52,197
Life Expectancy	79.0	79.8	79.7	80.0	79.8
Median Age	34	34	34	35	35
Primary Care / Population Health					
Ambulatory Care Visits	427,076	418,055	403,375	404,226	Not avail.
Number of Unique/Individual Home Care Clients	13,926	13,905	14,293	14,982	15,780
Number of People Placed in Continuing Care	704	673	766	685	741
HealthLink Calls	64,546	59,698	57,313	54,674	60,829*
Seasonal Influenza Immunizations**	99,860	92,672	92,449	100,382	107,352
Food Safety Inspections	15,317	14,550	15,424	12,762	8,948
Acute Care					
Emergency Department Visits (all sites)	550,409	521,980	532,069	509,903	500,014
Hospital Discharges	44,110	41,929	42,444	40,669	39,985
Births	6,558	5,699	5,753	5,593	5,463
Total Hospital Days	263,377	251,338	282,105	263,225	273,486
Average Length of Stay (in days)	6.0	6.0	6.6	6.5	6.8
Diagnostic / Specific Procedures					
Hip Replacements (scheduled and emergency)	315	327	355	384	406
Knee Replacements (scheduled and emergency)	514	549	563	484	462
Cataract Surgery	2,142	1,998	2,020	2,161	1,494
Main Operating Room Activity	29,758	28,205	28,397	25,590	24,201
MRI Exams	13,621	12,893	12,769	13,262	11,771
CT Exams	35,051	34,824	36,145	36,556	36,179
X-rays	293,800	284,849	288,022	283,474	284,328
Lab Tests	5,038,109	4,937,068	4,819,741	4,893,157	4,944,690
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	14,162	16,437	16,451	16,954	18,440
Unique/Individual Cancer Patients	2,318	2,378	2,297	2,314	2,199
Addiction and Mental Health					
Mental Health Hospital Discharges (acute care sites)	2,880	2,976	3,146	2,939	2,808
Workforce					
AHS Staff	10,403	10,574	10,852	10,918	10,911
AHS Volunteers	2,774	1,626	1,648	1,612	1,847
AHS Physicians	607	594	624	645	628

** HealthLink call volumes exclude COVID-19 inquiries.*
*** Source: Alberta Health Influenza Immunization Report 2019-2020.*

AHS Performance

Leading in Health

While AHS is striving to improve and to address challenges in healthcare, the following examples highlight where Alberta excels in the country. According to the latest statistics from the Canadian Institute for Health Information (CIHI), AHS is a national leader in many areas of healthcare, including having administration costs that are among the lowest in the country as a percentage of total spending.

The following indicators were developed by CIHI to measure the health of Canadians and health system performance in Canada. These indicators help inform AHS and Albertans on how we perform nationally.

At the time of this report, CIHI postponed many data releases due to the COVID-19 pandemic. As a result, the most recent wait time data is March 2019 and the most recent cardiac care data is May 2019.

Alberta is first in the country for:

- Least total time spent in emergency department for admitted patients (out of 4 provinces)
- Lowest potentially inappropriate use of antipsychotics in long-term care (out of 5 provinces)
- Best perceived health (out of 10 provinces)
- Highest percentage of hip fracture surgeries within 48 hours (out of 9 provinces)
- Highest percentage of patients receiving radiation therapy within national benchmark of 28 days (tied) (out of 10 provinces)

Alberta is second in the country for:

- Fewest repeat hospital stays for mental illness (out of 10 provinces)
- Fewest hospital deaths following major surgery (tied) (out of 10 provinces)
- Lowest restraint use in long-term care (out of 5 provinces)
- Fewest experiencing pain in long-term care (out of 5 provinces)
- Highest physical activity (age 18 and older) (out of 10 provinces)
- Lowest 30-day in-hospital mortality after percutaneous coronary intervention (out of 8 provinces)

Alberta is third in the country for:

- Lowest obstetric patients readmitted to hospital (out of 10 provinces)
- Fewest self-harm hospitalizations (out of 10 provinces)
- Lowest corporate services expense ratio (previously called administrative expenses) (out of 10 provinces)
- Fewest hospitalized heart attacks (out of 10 provinces)
- Fewest hospitalized strokes (out of 9 provinces)
- Lowest 30-day in-hospital mortality after coronary artery bypass graft and aortic valve replacement (out of 9 provinces)
- Fewest 30-day readmissions after percutaneous coronary intervention (out of 8 provinces)

Sources:
CIHI Your Health System: In Depth Website, May 2020 update.
CIHI Wait Times in Canada, March 2019 update.
CIHI Cardiac Care Quality Indicators, May 2019 update.

Accreditation

Accreditation Canada surveyors conducted approximately 1,800 interviews at 28 locations across Alberta during the 2019 spring and fall surveys.

Accreditation compares AHS' health services with national standards of excellence to help identify what AHS is doing well and how it can improve. Twenty-five Accreditation Canada surveyors assessed AHS on five foundational standards in 2019: Governance, Leadership, Infection Prevention and Control, Medication Management, and Medical Device Reprocessing. Surveyors met with the AHS Board, corporate and zone operational leaders, and provincial department leaders. There was further validation of performance against the foundational standards at AHS urban hospitals. In addition, relevant clinical service standards were assessed at AHS urban hospitals and at rural hospitals in the Calgary, Central, Edmonton, and North Zones.

The surveyors highlighted AHS' caring, compassionate people and the collaboration that occurs at all levels of the organization. They also cited several examples of AHS' patient-centered approach, including the Board's focus on listening to the patient voice and how patient advisors feel their voice is playing an important role in AHS. Surveyors also noted AHS' efforts to engage with community partners to achieve its vision of *Healthy Albertans. Healthy Communities. Together.*

Patient Concerns

AHS has processes in place to review and respond to feedback from patients and families. If a resolution is not possible, a concern will be forwarded to the Patient Concerns Officer (PCO) for review. All reported concerns and commendations are tracked and monitored to identify areas for broader improvement.

The table below summarizes the numbers and types of feedback, and the concerns escalated to the PCO:

Concerns and Commendations	2016-17	2017-18	2018-19	2019-20
Total Number of Commendations*	1,847	1,727	1,696	1,473
Total Number of Concerns	10,596	10,404	10,392	10,773
Total Number of Concerns reviewed by PCO	30	10	3	20
Percent of Actions Arising from Concerns Resolved in 30 Days or Less	62%	69%	71%	72%

Data includes Covenant Health
**Commendations received in March are not captured in the database because of capacity constraints due to COVID-19 response efforts.*

Data note: Due to the nature of concerns data, it is not possible to provide a rate or percentage. There is no meaningful denominator that can be used to calculate a percentage. Members of the public who have not yet accessed AHS services may identify concerns and in other situations multiple people (i.e., patients, friends or families) may identify the same concern. The number of concerns and commendations is provided for information on the volume of feedback received by the Patient Relations Department. Successful management of concerns is being monitored through the percentage closed within our guidelines and the number of concerns escalated.

2019-20 Key Activities and Accomplishments

AHS is working to improve the quality of care we provide to Albertans. Across the province, significant progress is being made toward building a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Prior to the emergence of the COVID-19 pandemic, AHS focused on many actions that align to our organizational goals and strategic objectives. The following section is a sampling of key activities showcasing what AHS achieved, specifically in the first three quarters of 2019-20.

AHS Performance Review

In an effort to find clinical and operational efficiencies and cost savings while continuing to improve the quality and safety of care for patients, the AHS Performance Review was conducted on behalf of Alberta Health by external consultants who have conducted similar reviews in other provinces. AHS worked closely with Alberta Health and the external consultants, and enlisted staff, patients, and families throughout the process.

The AHS Performance Review was completed in February 2020. It recognized the successes AHS has achieved over the last decade while identifying opportunities where more needs to be done. An implementation team is in place to explore the recommendations and opportunities in the report. AHS is already addressing many of the recommendations through ongoing efforts. Careful consideration will be made in moving forward on the proposed recommendations.

Connect Care

After years of planning and preparation, Connect Care launched Wave 1 in November 2019 at several sites in the Edmonton Zone. Connect Care is the provincial clinical information system to manage and share information across the healthcare system and with patients. Albertans are already accessing their health information online through MyAHS Connect, formerly known as MyChart, which enables users to manage appointments, access test results, and communicate directly with their healthcare team.

Prior to the launch, more than 15,000 people attended in-person training sessions and an additional 190,810 Connect Care online learning modules were completed. Supplementary eHealth Competence modules are available to help staff develop and refine their information technology and digital communication skills. AHS has continued to refine content and workflows based on user feedback.

The Auditor General of Alberta conducted a review during the Wave 1 launch of Connect Care. Highlights of the audit include that AHS had excellent processes in place to monitor and assess AHS readiness, confirm staff and physicians were ready, and manage the risks to ensure Connect Care was put in place safely and effectively.

With the onset of the COVID-19 pandemic, preparations for launching future waves were put on hold, and Connect Care teams were refocused to support AHS in its COVID-19 response. Work included enhancing systems with new COVID-19 configurations, developing COVID-19 content and workflows, creating educational resources to support staff and physicians, and augmenting the MyAHS Connect patient portal experience.

Seniors Health and Community Care

To keep pace with population growth and aging, AHS opened 611 net new continuing care beds to support individuals who need community-based care and supports (including palliative) in 2019-20. The 611 new beds are comprised of 68 long-term care, 536 supportive living (including 179 dementia), and seven palliative.

AHS developed an online facility directory to simplify the process of finding a care home in Alberta. The directory contains comprehensive information on all of the province's 355 publicly-funded continuing care facilities. Approximately 8,521 people moved into an AHS continuing care facility in 2019-20.

Enhancing Care in the Community (ECC) refers to AHS' goal of helping people to be as healthy, well, and independent as they can be in their homes and communities. It is the roadmap for improving community-based care and services and reducing over-reliance on acute care services. This work falls under AHS' Health System Integration umbrella, which focuses on working collectively toward broad system integration to ensure that Albertans experience care that is well coordinated and continuous. The following is a summary of the progress made in 2019-20.

Emergency Medical Services (EMS) has implemented two programs that provide Mobile Integrated Healthcare (MIH) to improve access to care in the community and at home. The number of MIH events in 2019-20 (23,780) increased by 27% compared to 2018-19 (18,714).

The expansion of home care and community palliative care services continued in 2019-20 with a focus on case review processes that ensure all patients, even when geographically dispersed, still receive high quality, consistent care. There has been a consistent increase in the number of clients benefiting from home care programs. The number of unique home care clients in 2019-20 (132,478) increased by 4.2% compared to 2018-19 (127,150).

The Enhanced Respite Day Program in the North Zone provides purposeful activities to decrease social isolation, and improve the cognitive and physical well-being of community clients. This program supports clients to continue living at home by optimizing their level of physical, social, and emotional function while also providing increased support for caregivers by providing them with a break from care duties. In 2019-20, the program became fully operational.

The Calgary Rural Palliative In-Home Funding Program is focused on increasing equitable access to palliative home care services for patients who live in rural areas of the Calgary Zone. It provides support for clients and their families wishing to stay at home with additional in-home palliative and end-of-life care. In 2019, the program was recognized as a High Impact Practice that results in better care, outcomes and value by the Canadian Home Care Association. The program is fully operational and is currently being considered for implementation in other communities across Alberta.

Patients who were once provided care in hospitals are being cared for at home through the Virtual Hospital and Complex Care Hub programs in Edmonton and Calgary. These Hospital at Home programs not only allow for avoidance of hospital admission but also facilitate earlier discharge for those who require initial acute care intervention. For clients in these programs, it has resulted in a 54% reduction in ED visits and a 35% reduction in acute care admissions as of year-end 2019-20.

Community Support Teams are multidisciplinary teams that provide early intervention by supporting clients with complex care needs, as well as developing intermediary and follow-up care plans to ensure care can effectively be provided in the clients' current location in the community. Work continued in 2019-20 to place clients with complex care needs from acute care into more appropriate care settings.

Clinical Appropriateness

AHS continues to work on initiatives to improve patient care while driving better value for healthcare dollars. For example, AHS Pharmacy Services seeks opportunities to streamline drug therapy while maintaining or improving optimal patient care and safety. Initiatives include transitioning to more cost-effective suppliers for specific drugs, low-molecular-weight heparin streamlining, use of biosimilars, and roll-out of innovative formulary management strategies such as the Not Reviewed Do Not Provide formulary status which prevents use in AHS facilities of newly marketed drugs prior to completion of a clinical and economic assessment in AHS.

Addictions and Mental Health

In 2019-20, AHS added 12 new community mental health spaces in Calgary and Edmonton Zones to support the placement of vulnerable Albertans.

AHS is reducing the effects of substance use, including expanding programming associated with addiction, improving access to treatment, and increasing public awareness and education. In 2019-20, the number of voluntarily reported overdose reversals, where naloxone was administered to reverse effects of an opioid overdose (6,751), increased by 16% compared to the same period last year (5,810). The number of community-based naloxone kits dispensed by AHS, the Alberta Community Council on HIV agencies, community pharmacies, and other community organizations in 2019-20 (98,557) increased by 18% compared to the same period last year (83,547). In addition, Zone Service Plans have been updated to include opioid response activities.

Cancer Care

CancerControl Alberta expanded resources for underserved and specialized populations with the development of the Guide to Cancer Care in Alberta for Newly Diagnosed Indigenous People, as well as specialized navigators for Indigenous, adolescent, and young adult patients with cancer.

The Alberta Cellular Therapy program supports the coordination of resources across multiple sites to support immunotherapy for treatment of cancer. Over the past year, sites created a provincial approach for the delivery of cellular therapy for blood and marrow cancers. The program takes advantage of efficiencies of scale, builds experience in coordination, provides toxicity management and service delivery, and provides clear lines of accountability. It also builds on best practices that are common to all sites of care delivery.

Capital infrastructure projects continue to progress with the build of the new Calgary Cancer Centre and the Grande Prairie Cancer Centre, and replacement of critical treatment equipment in the Cross Cancer Institute and Tom Baker Cancer Centre.

Emergency Medical Services (EMS)

New ambulances will be safer due to safety design improvements known as Safety-Oriented Design. The design stems from a study conducted by EMS who worked with a manufacturer to improve the interior design of new ambulances. Some changes include improved layout and seat design, putting most-used tools and equipment in easy reach, adding lips to surfaces to prevent falling objects, and adding an additional grab handle for stability.

Community Response Teams aim to support patients in continuing care with patient-centered treatment while avoiding emergency department visits and hospital admissions. In 2019-20, referral pathways were established with community shelters and agencies to support clients with mental health and addiction concerns at risk of an EMS response and emergency department admission.

In 2019-20, EMS implemented the Workforce Support Unit to assess workforce wellness needs during the COVID-19 response, and devise strategies and actions to address issues related to isolation and mental health in order to enhance workforce wellness. The primary goal is to create an environment where EMS staff feel supported and cared for during the course of the pandemic.

Operational Best Practice

Operational Best Practice compares AHS healthcare delivery costs and processes with healthcare systems across Canada to ensure we provide efficient and focused quality care. Comparing the practices of similar healthcare operational areas provincially and nationally helps reduce variation, achieve efficiencies and supports excellent, sustainable patient- and family-centred care for all Albertans.

Ongoing improvements are necessary to ensure health services are sustainable into the future and resources are appropriately directed where they are needed most. Through this process, AHS has identified variations in the cost of delivering services at different sites which provide opportunities for improvement.

Strategic Clinical Networks™ (SCN™)

SCNs™ bring together clinicians, researchers, patients, and policymakers to drive innovation and research, standardize care, share best practices, improve access to services, and improve health system sustainability. SCNs™ have developed and implemented countless initiatives to improve all areas of the healthcare system. A sampling of 2019-20 initiatives is provided below.

AHS implemented GLA:D, an exercise-based management program aimed at people who have osteoarthritis in the knees and hips. Research shows that participants report less pain, use fewer painkillers, and are more physically active. Uptake of the program continues to grow and a program evaluation is underway.

Care pathways promote organized and efficient patient care based on evidence and are proven to reduce variation in clinical practice and improve patient outcomes and satisfaction. For example, the heart failure and chronic obstructive pulmonary disease pathways aim to improve coordination of care between acute, primary, and community care. In 2019-20, these pathways were rolled out across the province and include updated order sets (standard instructions) available through Connect Care. In addition, the diabetic foot care pathway identifies patients with foot problems and refers them for appropriate treatment. The pathway was rolled out across the province in 2019-20 to help improve community access to care while decreasing rates of diabetic foot ulcers and related amputations.

AHS implemented provincial guidelines and developed a website for patients and providers to support safe self-management of insulin pump therapy in hospitals. This initiative allows patients to continue to use their insulin pumps to manage their diabetes in hospital. Improving blood sugar control in hospital has been associated with shorter length of hospital stay and decreased rates of readmission.

Proton pump inhibitors (PPIs) reduce the production of acid by blocking the enzyme in the wall of the stomach that produces acid. While effective for various indications, there is emerging evidence of adverse events associated with their long-term use. AHS is working to improve appropriateness of prescribing PPIs, including decision support tools for patients, primary care physicians, and community pharmacists. Implementation strategies are being developed for provincial roll-out.

Emergency department (ED) visits related to opioid use disorder and addiction continue to rise in Alberta. These visits can be an opportunity to engage patients in treatment. Buprenorphine/naloxone (Suboxone®) is a medication that reduces cravings and withdrawal symptoms and helps people feel well and use opioids less often and in smaller amounts. AHS implemented a program to screen patients, initiate treatment, and provide rapid follow-up in the community. The program decreases mortality rates and decreases the number of opioid-related ED visits and overdoses.

AHS and Patient & Community Engagement Research (PaCER) are partnering to provide training for Indigenous people to participate in patient engagement research. The purpose of the Indigenous PaCER Internship Program is to build the research capacity of Indigenous community members to help inform culturally-appropriate and safe approaches to cancer prevention and screening for Indigenous Albertans. Over 100 participants attended orientation sessions and returned expressions of interest.

The Reducing the Impact of Financial Strain project aims to collaboratively design local solutions to reduce financial strain as a barrier to health, particularly in the areas of cancer and chronic disease. This collaboration will support primary care screening for financial concerns among patients, strengthen linkages to community services, and build capacity to address gaps. The program is piloting in the North, Edmonton, and Central Zones.

Population and Public Health

During the influenza season, there were over 1.4 million doses of influenza vaccine administered in the province. Immunizations are delivered by AHS public health staff, community pharmacists and physicians, as well as other non-AHS community providers. Approximately 40% of Albertans received the influenza immunization. Immunization coverage increased by 2.8% compared to 2018-19.

People who smoke or vape are at higher risk of virus transmission, developing severe disease, and death. The Tobacco Reduction Program is mitigating these risks as they relate to COVID-19 by providing health professionals with information on caring for nicotine-dependent patients with suspected or confirmed COVID-19. There is increased access to cessation supports, including a virtual group cessation program and free cessation pharmacotherapy to individuals in quarantine or those trying to quit during the pandemic.

The Indigenous Health Strategy was completed in the fall of 2019 and provides AHS with a mandate for the development of processes, accountabilities, and an organizational culture to support the achievement of health equity for Indigenous peoples. Continued planning is underway to implement the strategy and action plan.

The First Nations Cancer Prevention and Screening Practices project provides resources and mentorship to six First Nations communities to use local data to prioritize, plan, and implement comprehensive cancer prevention and screening plans. Communities implemented 35 activities, including training service providers to advocate for screening. One community also co-developed a new care pathway to improve access to Hepatitis C testing and treatment.

Research and Innovation

AHS continues to strengthen health research innovations, new technologies, and new knowledge to apply to clinical settings. Below are examples of research activities in 2019-20.

The Improving Acute Care for Long-Term Care Residents project reduces the number of transfers from long-term care facilities to an emergency department. A referral pathway will be used to identify patients who can be safely treated by a community paramedic directly in the patient's care facility.

The Cirrhosis Care Alberta program improves quality of care and reduces acute care utilization for patients with advanced cirrhosis by using best practice guidelines and tools for care transitions, providing on-demand system and disease management support, and enabling virtual monitoring to support care between scheduled visits.

The Virtual Supervised Consumption project improves patients' and families' experiences and health outcomes by removing barriers such as stigma, geographic distance, and community resistance to supervised consumption services. An operator monitors the client after substance use, dispatches emergency medical services if the client becomes unresponsive, and provides information on resources for safer use and treatment.

The Innovative Models of Acute Pediatric Mental Health and Addiction Care project engages in service redesign to provide support to youth and their families presenting to the emergency department for an acute mental health or addiction concern. This project will implement and evaluate a new model that connects children and families with the resources they need.

The Enhancing Community Health Through Patient Navigation, Advocacy, and Social Support (ENCOMPASS) study improves health outcomes for patients with multiple chronic conditions by linking them to a community health navigator who will assist with system navigation, understanding information, locating community resources, and supporting self-management.

Research at the Stollery Children's Hospital in Edmonton is looking at a smartphone app to assist adolescents with congenital heart disease to take on responsibility for their health and care as they transition into adulthood.

Researchers are partnering with critically ill patients and their families to help them transition from intensive care units to another hospital unit or home. The goal is to educate, empower, and engage them as informed stewards of the care journey.

The NowICU project uses an iPad and virtual technology to connect mothers to their infants when they become separated at birth due to medical issues. The project aims to bridge communication between families, the infant, and medical teams to offer updates about the infant's condition and progress in a secure and confidential manner.

Connect Care has useful tools which provide AHS staff and stakeholders the ability to create and use real-time data about patients, populations, and the health system. This can then be transformed into information that guides evidence-informed decisions in service of continuous clinical improvement. Connect Care also flags patients who are in a study so that records are accurately updated by staff to enable follow-up.

Workforce Engagement and Safety

AHS currently holds four top employer awards: Canada's Top 100 Employers, Alberta's Top 75 Employers, Canada's Best Employers for Young People, and Canada's Best Diversity Employers.

Over 51,000 employees, physicians and volunteers responded to the 2019 Our People Survey, which is the highest participation for any AHS workforce engagement or patient safety culture survey in AHS' 10-year history. AHS observed significant increases in engagement and patient safety culture scores for employees, physicians, and midwives. Results are available for leaders to share with their teams.

AHS continues to recognize its employees through the President's Excellence Awards program. In 2019, AHS received a record 153 nominations with 23 award recipients across seven award categories to recognize staff, physicians, and volunteers who demonstrate innovation, collaboration, and a patient-focus.

The first workforce resource groups were launched for LGBTQ2S+ and Women in EMS Leadership. These voluntary groups bring together members of the workforce who share a common identity and/or background. The primary purpose is to provide groups with a formal structure to support their unique needs as it relates to specific characteristics, including visible and invisible identities or qualities.

The new Respectful Workplaces and the Prevention of Harassment and Violence Policy suite was developed and advances a safe, healthy, and inclusive workplace that supports physical, psychological, and social well-being. Workshops were created on respectful workplaces including resources and supports on conflict resolution, self-awareness, and personal wellness.

In September 2019, AHS transitioned to a new Employee and Family Assistance Program managed by Homewood Health. Services provide the opportunity for AHS staff to focus on proactive and preventative resources while maintaining short-term counselling services. Early feedback has been positive with 89.9% of users agreeing the services were easy to access and 84.5% of users agreeing they would use the services again.

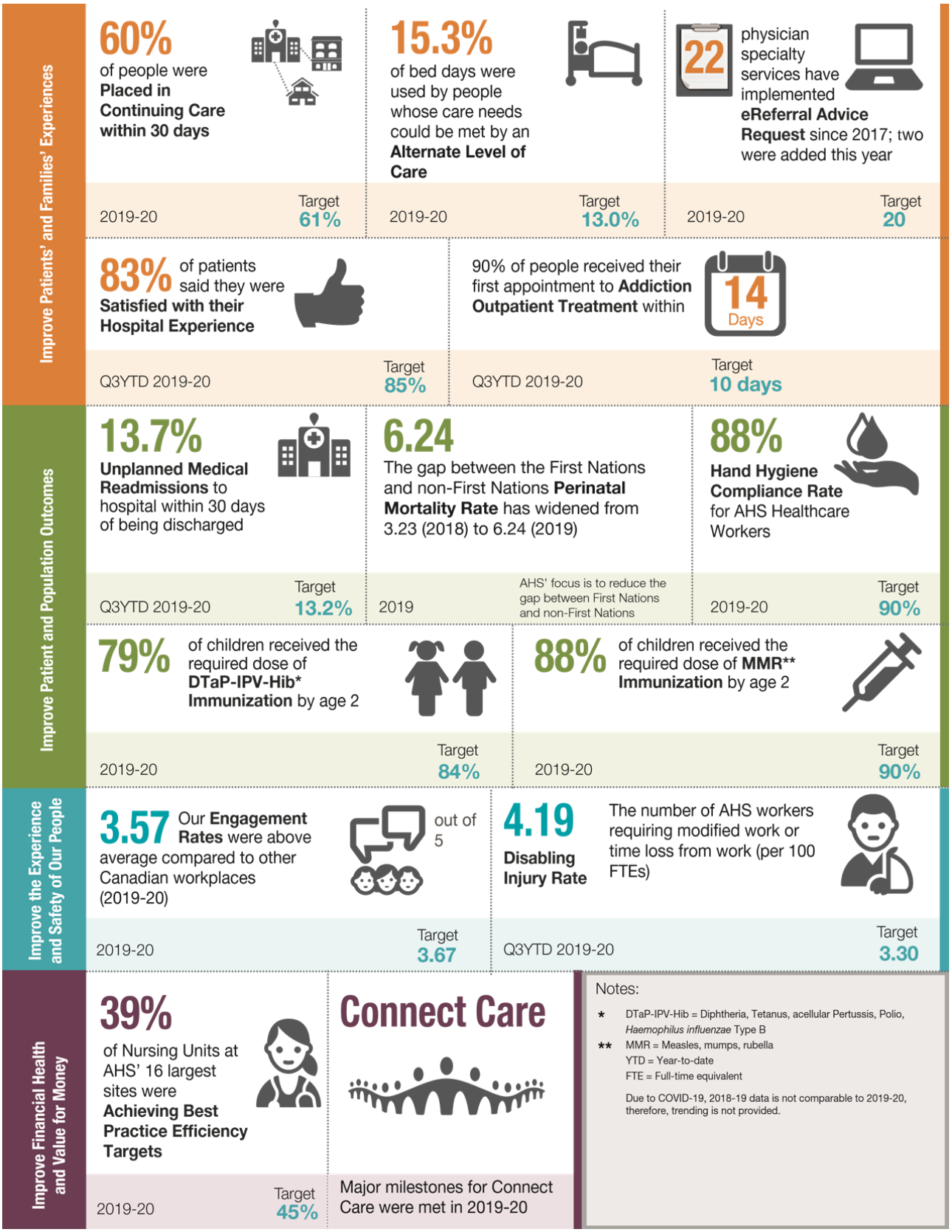
The availability and use of client lifts is a key element in reducing client handling injuries. More than 500 mounted and mobile patient lifts were installed across the province this fiscal year. In Q4, 100% of the planned client lifts installations were complete.

AHS Protective Services continued to enhance its collaboration with clinical care teams across the province to promote integrated care planning in support of the Patient First Strategy and improved staff safety. Results of the Accreditation Canada review recognized these efforts under the "areas of excellence" in raising its profile and commitment to staff safety across AHS.

In response to the COVID-19 pandemic, Protective Services initiated the Safety Ambassadors Program to increase its ability to meet the challenges of the pandemic and ensure a safe and secure environment for all who attend AHS facilities.

Performance Measure Results

The 2019-20 year-end results are summarized below for the 13 performance measures. More detail is provided in the following section.



Performance Measure Results

AHS has performance measures that enable us to evaluate our progress and link our organizational objectives to specific results.

AHS has targets that span across the continuum of healthcare, which are used to track and measure progress in key areas of the healthcare system. These measures help us monitor what is needed to provide the very best care to our patients, clients, and families. Targets were established using historical performance data, benchmarking with peers, and consideration of pressures that exist within zones and sites. This approach resulted in targets that, if achieved, would reflect a performance improvement in the areas of our Health Plan's 12 objectives. Targets were endorsed by AHS and Alberta Health as published in the Year 3 2017-20 Health Plan and 2019-20 Business Plan.

The 2017-20 AHS Health Plan provided a roadmap for how AHS would improve system performance and how we would measure success each year. Over the three-year term of the Health Plan, AHS has shown improvement in many areas across the health system. Now, at the end of our three-year (2017-2020) strategy, we are reflecting back on how we have performed over the longer term. Targets were set based on where we were in 2016-17 and where we wanted to be in 2019-20. Ten measures (77%) have shown improvement or remained stable since 2016-17.

We are proud of the results we have achieved, but AHS acknowledges there is still more work to be done. We will continue to monitor and improve on measures that are showing deterioration.

- While we did not achieve the three-year combined target of 45 specialties, AHS successfully implemented eReferral in 22 specialty areas across the organization. Ongoing work is now focused on the Alberta Surgical Initiative, including alignment with centralized intake processes and Connect Care, where possible.
- The perinatal mortality rate gap between First Nations and non-First Nations groups has shown deterioration over time. AHS is committed to continuing our work with Indigenous communities and partners to better support and improve outcomes.
- AHS' Disabling Injury Rate has shown deterioration year-over-year. Changes to the Workers Compensation Board (WCB) Act in 2018 broadened the scope of injuries that are acceptable and now include incidents of violence and harassment.

The 13 performance measures are reported as follows:

- Nine measures include 2019-20 year-end data.
- Four measures are reported with Q3 year-to-date (Q3YTD) data. Three of the measures rely on patient follow up, generally after they have been discharged from care. One measure (Disabling Injury Rate) is reported one quarter later because data continues to accumulate as individual employee cases are closed.

Improving system performance does not happen overnight. AHS remains committed to collaborating with key stakeholders including Albertans, communities, associations, and organizations, and works in partnership with Alberta Health to progress joint measures and continually improve the care and services available to all Albertans. The following pages provide definitions and detailed zone and site information for the 2019-20 performance measures.

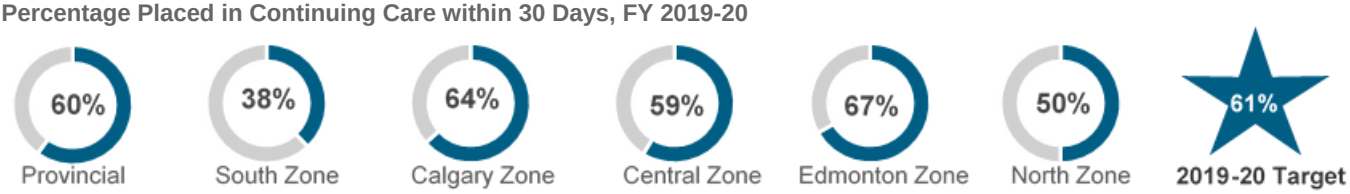
AHS Performance Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2019-20 Target
Improve Patients' and Families Experiences						
Percentage Placed in Continuing Care within 30 Days	60%	56%	52%	58%	60%	61%
Percentage of Alternate Level of Care (ALC) Patient Days	13.5%	15.4%	17.5%	16.5%	15.3%	13.0%
Timely Access To Specialty Care (eReferrals)	0	1	8	12	2	20
Patient Satisfaction with Hospital Experience	82%	82%	82%	83%	83% (Q3YTD)	85%
Addiction Outpatient Treatment Wait Time	13	15	13	14	14 (Q3YTD)	10
Improve Patient and Population Outcomes						
Unplanned Medical Readmissions	13.7%	13.6%	13.6%	13.8%	13.7% (Q3YTD)	13.2%
Perinatal Mortality Rate - First Nations (Gap)	5.38	5.08	2.90	3.23	6.24	Reduce gap between First Nations and non-First Nations
Hand Hygiene Compliance	80%	82%	85%	87%	88%	90%
Childhood Immunization Rate - DTaP-IPV-Hib	78%	78%	78%	78%	79%	84%
Childhood Immunization Rate – MMR	87%	87%	87%	86%	88%	90%
Improve the Experience and Safety of Our People						
AHS Workforce Engagement Rate	No survey	3.46	No survey	No survey	3.57	3.67
Disabling Injury Rate	3.57	3.85	4.11	4.12	4.19 (Q3YTD)	3.30
Improve Financial Health and Value for Money						
Percentage of Nursing Units Achieving Best Practice Targets	20%	28%	38%	32%	39%	45%

PEOPLE PLACED IN CONTINUING CARE WITHIN 30 DAYS

DEFINITION: Percentage of clients admitted to a Continuing Care Living Option (i.e., designated supportive living levels 3, 4, and 4-dementia or long-term care) within 30 days of the assessed-and-approved date the client is placed on the waitlist.

WHY THIS IS IMPORTANT: AHS wants to offer seniors and persons with disabilities more options for quality accommodations that suit their healthcare service needs and lifestyles. This measure monitors the percentage of people who are quickly moved from hospitals and communities into community-based continuing care settings. The higher the percentage the better, as it demonstrates capacity is available for long-term care or designated supportive living.

Percentage Placed in Continuing Care within 30 Days, FY 2019-20



Percentage Placed in Continuing Care within 30 Days

Zone	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2019-20 Target
Provincial	**59.9%**	**59.6%**	**56.1%**	**51.8%**	**57.9%**	**60.0%**	**61%**
South Zone	59.5%	47.6%	45.9%	43.3%	45.9%	38.0%	61%
Calgary Zone	57.1%	58.4%	57.4%	58.7%	59.6%	63.5%	61%
Central Zone	54.6%	61.5%	60.3%	54.6%	53.7%	58.8%	61%
Edmonton Zone	66.2%	64.5%	55.8%	48.7%	65.9%	66.8%	61%
North Zone	58.8%	58.7%	57.5%	43.9%	45.5%	50.1%	61%

Total Clients Placed

Zone	2015-16	2016-17	2017-18	2018-19	2019-20
Provincial	**7,879**	**7,963**	**7,927**	**8,098**	**8,521**
South Zone	887	925	905	908	870
Calgary Zone	2,722	2,438	2,632	2,668	2,757
Central Zone	1,060	1,352	1,236	1,312	1,468
Edmonton Zone	2,506	2,575	2,388	2,525	2,685
North Zone	704	673	766	685	741

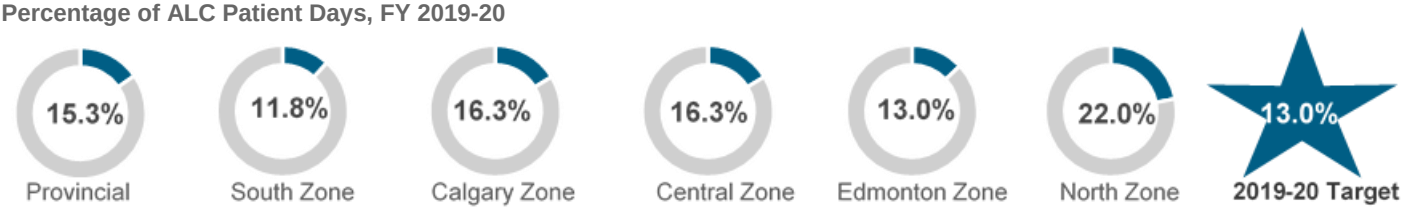
Source: AHS Seniors Health Continuing Care Living Options Report as of May 11, 2020.

PERCENTAGE OF ALTERNATE LEVEL OF CARE PATIENT DAYS

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

WHY THIS IS IMPORTANT: Hospital days are captured in hospitalization data as patients waiting for an alternate level of care. If the percentage of ALC days is high, there may be a need to focus on ensuring timely accessibility to options for ALC patients. Therefore, the lower the percentage the better.

Percentage of ALC Patient Days, FY 2019-20



Percentage of ALC Patient Days

Zone	Site	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2019-20 Target
Provincial	**Provincial**	**12.2%**	**13.5%**	**15.4%**	**17.5%**	**16.5%**	**15.3%**	**13.0%**
South Zone	**South Zone**	**9.0%**	**12.6%**	**13.9%**	**15.7%**	**16.3%**	**11.8%**	**13.0%**
	Chinook Regional Hospital	4.4%	7.8%	8.6%	12.3%	17.3%	10.1%	13.0%
	Medicine Hat Regional Hospital	14.6%	18.9%	18.9%	22.0%	13.4%	14.6%	13.0%
	Other South Hospitals	9.4%	11.5%	17.3%	11.6%	18.1%	11.6%	13.0%
Calgary Zone	**Calgary Zone**	**15.2%**	**16.7%**	**16.9%**	**19.2%**	**18.8%**	**16.3%**	**13.0%**
	Alberta Children's Hospital	0.2%	1.3%	1.2%	2.0%	4.4%	0.9%	13.0%
	Foothills Medical Centre	15.7%	14.7%	15.2%	19.2%	18.8%	16.6%	13.0%
	Peter Lougheed Centre	14.6%	13.6%	16.8%	14.4%	15.6%	13.5%	13.0%
	Rockyview General Hospital	16.2%	21.9%	22.2%	26.0%	23.2%	21.4%	13.0%
	South Health Campus	14.4%	20.4%	17.6%	19.6%	19.5%	14.3%	13.0%
	Other Calgary Hospitals	26.4%	27.2%	21.0%	21.9%	23.6%	21.8%	13.0%
Central Zone	**Central Zone**	**13.1%**	**12.0%**	**15.3%**	**15.9%**	**17.8%**	**16.3%**	**13.0%**
	Red Deer Regional Hospital Centre	11.4%	8.8%	12.4%	12.2%	13.5%	8.0%	13.0%
	Other Central Hospitals	14.4%	14.3%	17.2%	18.3%	20.7%	21.7%	13.0%
Edmonton Zone	**Edmonton Zone**	**9.1%**	**9.5%**	**14.0%**	**15.6%**	**12.7%**	**13.0%**	**13.0%**
	Grey Nuns Community Hospital	10.2%	9.2%	11.1%	10.8%	9.3%	9.3%	13.0%
	Misericordia Community Hospital	10.8%	12.8%	14.7%	17.4%	17.2%	15.2%	13.0%
	Royal Alexandra Hospital	10.6%	11.0%	18.5%	18.7%	14.8%	14.8%	13.0%
	Stollery Children's Hospital	0.0%	1.8%	0.6%	0.2%	0.1%	0.3%	13.0%
	Sturgeon Community Hospital	12.3%	12.3%	18.9%	22.5%	19.2%	15.9%	13.0%
	University of Alberta Hospital	6.0%	6.2%	11.7%	15.2%	10.3%	11.8%	13.0%
	Other Edmonton Hospitals	11.8%	12.1%	12.1%	14.4%	14.9%	19.7%	13.0%
North Zone	**North Zone**	**13.8%**	**18.5%**	**16.4%**	**21.3%**	**20.7%**	**22.0%**	**13.0%**
	Northern Lights Regional Health Centre	7.4%	18.5%	12.0%	8.0%	17.0%	15.1%	13.0%
	Queen Elizabeth II Hospital	14.0%	20.4%	15.2%	26.0%	19.3%	16.3%	13.0%
	Other North Hospitals	14.9%	17.9%	17.5%	21.8%	21.9%	25.1%	13.0%

Total ALC Discharges

Zone	2015-16	2016-17	2017-18	2018-19	2019-20
Provincial	**10,254**	**13,513**	**17,099**	**15,573**	**16,152**
South Zone	624	674	663	746	549
Calgary Zone	4,684	5,027	6,232	6,525	6,783
Central Zone	1,085	1,327	1,418	1,427	1,514
Edmonton Zone	3,046	5,518	7,709	5,947	6,192
North Zone	815	967	1,077	928	1,114

Source: AHS Provincial Discharge Abstract Database (DAD) as of May 1, 2020.
Note: Results may change due to data updates in the source information system or revisions to the measure inclusion and exclusion criteria.

TIMELY ACCESS TO SPECIALTY CARE (eReferrals)

DEFINITION: The number of physician specialty services implemented with eReferral Advice Request.

WHY THIS IS IMPORTANT: When Advice Request is enabled within eReferral, a referring provider can send a request asking for guidance on a non-urgent clinical question. Advice Requests allow the specialty service to reply back to the request within five calendar days. The advice provided may suggest a referral be submitted or provide guidance for ongoing management of the patient's condition. Having more specialists providing advice for non-urgent questions and being able to do so in an electronic format may provide patients with care sooner, prevent them from waiting for an appointment they don't need, and support them better while they are waiting for an appointment.

Over the three-year term of the 2017-2020 Health Plan, AHS successfully implemented eReferral in 22 specialty areas. While we did not achieve the three-year combined target of 45 specialties due to funding constraints and limited stakeholder readiness, ongoing work is now focused on the Alberta Surgical Initiative. This will include alignment with centralized intake processes and Connect Care, where possible.

Number of Specialty Services Added to eReferral Advice Request, FY 2019-20

FY 2019-20 **2019-20 Target**

Zone and/or Provincially Enabled Specialties

Specialty	Prior to 2017-18	2017-18	2018-19	2019-20
Family Medicine - Transgender Care				✓
Psychiatry – Child and Adolescent				✓
Cardiology			✓	
Chronic Pain Medicine			✓	
Community Pediatrics			✓	
General Surgery*			✓	
Infectious Disease			✓	
Neurology			✓	
Obstetrics/Gynecology - Maternal Fetal Medicine			✓	
Ophthalmology – Adult			✓	
Ophthalmology – Pediatrics			✓	
Otolaryngology			✓	
Palliative Care Medicine			✓	
Urology – Pediatrics			✓	
Addiction and Mental Health – Opiate Agonist Therapy		✓		
Endocrinology		✓		
Gastroenterology – Adult		✓		
General Internal Medicine		✓		
Neurosurgery – Spinal		✓		
Obstetrics/Gynecology		✓		
Pulmonary Medicine		✓		
Urology – Adult		✓		
Nephrology	✓			
Oncology – Breast Cancer	✓			
Oncology – Lung Cancer	✓			
Orthopedic Surgery – Hip and Knee Joint Replacement	✓			
Total Enabled	**4**	**8**	**12**	**2**

** In June 2018, General Surgery was added to eReferral Advice Request. Due to the breadth of General Surgery procedures, Advice Requests for General Surgery were specified as breast-only issues (i.e. General Surgery (Breast Health)). In October 2019, six other General Surgery reasons for referral were added to eReferral Advice Request. To avoid unnecessary confusion, Breast Health was removed and now all General Surgery reasons for referral are referred to as General Surgery.*

Number of eReferral Advice Requests Received

	Prior to 2017-18	2017-18	2018-19	2019-20
Total Advice Requests Received	98	4,934	7,013	5,135*

Source: Netcare Repository and Access Improvement as of April 14, 2020.
** The decline in eReferral Advice Requests is largely due to the introduction of eReferral Consult Request for Urology in the Edmonton Zone in June 2018 which received large volumes of inappropriate Advice Requests that are better managed through Consult Request. While Urology's Advice Requests have declined, other specialties are seeing increasing volumes.*

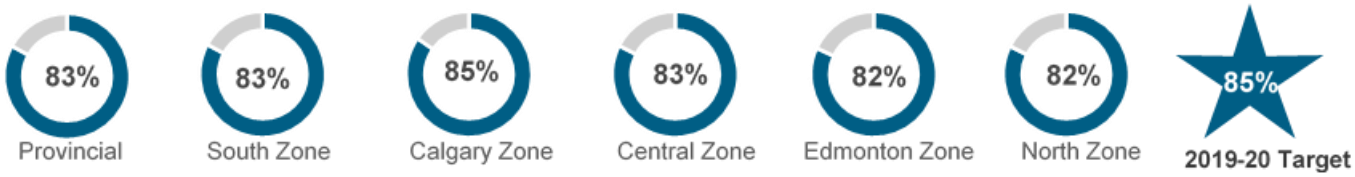
Revised: July 28, 2020.

PATIENT SATISFACTION WITH HOSPITAL EXPERIENCE

DEFINITION: Percentage of patients rating hospital care as 8, 9, or 10 on a scale from 0-10, where 10 is the best possible rating. The survey is conducted by telephone on a sample of adults within six weeks of discharge from acute care facilities.

WHY THIS IS IMPORTANT: Gathering feedback from individuals using hospital services is a critical aspect of measuring progress and improving the health system. This measure reflects patients' overall perceptions associated with the hospital where they received care. The higher the number the better, as it demonstrates more patients are satisfied with their care in the hospital.

Patient Satisfaction with Hospital Experience, Q3YTD 2019-20



Patient Satisfaction with Hospital Experience

Zone	Site	2014-15	2015-16	2016-17	2017-18	2018-19	Q3YTD 2018-19	Q3YTD 2019-20	2019-20 Target
Provincial	**Provincial**	**81.8%**	**81.8%**	**82.4%**	**81.8%**	**82.7%**	**82.7%**	**83.1%**	**85%**
South Zone	**South Zone**	**81.8%**	**80.9%**	**82.2%**	**79.8%**	**82.4%**	**82.2%**	**82.9%**	**85%**
	Chinook Regional Hospital	76.6%	78.2%	82.3%	80.2%	79.5%	79.9%	80.4%	85%
	Medicine Hat Regional Hospital	85.7%	81.3%	81.3%	77.1%	84.0%	83.0%	85.8%	85%
	Other South Hospitals	88.3%	87.2%	85.5%	85.3%	87.4%	87.4%	85.5%	85%
Calgary Zone	**Calgary Zone**	**83.2%**	**82.0%**	**83.0%**	**82.3%**	**83.7%**	**83.7%**	**84.7%**	**85%**
	Foothills Medical Centre	80.8%	80.8%	80.3%	80.2%	82.4%	82.9%	83.4%	85%
	Peter Lougheed Centre	79.9%	77.2%	78.7%	77.7%	78.6%	78.1%	80.8%	85%
	Rockyview General Hospital	85.4%	81.7%	85.1%	83.6%	85.6%	85.4%	85.6%	85%
	South Health Campus	89.7%	90.1%	90.9%	90.1%	89.6%	89.6%	90.8%	85%
	Other Calgary Hospitals	90.3%	92.9%	92.2%	92.9%	91.5%	91.7%	92.9%	85%
Central Zone	**Central Zone**	**84.8%**	**83.4%**	**85.0%**	**83.7%**	**84.1%**	**84.6%**	**82.5%**	**85%**
	Red Deer Regional Hospital Centre	83.0%	82.2%	82.7%	81.5%	81.2%	82.1%	79.7%	85%
	Other Central Hospitals	86.7%	84.8%	87.0%	85.7%	86.7%	86.8%	85.8%	85%
Edmonton Zone	**Edmonton Zone**	**80.3%**	**81.6%**	**80.8%**	**80.7%**	**81.6%**	**81.4%**	**81.9%**	**85%**
	Grey Nuns Community Hospital	87.2%	86.1%	86.4%	85.5%	86.0%	86.2%	85.2%	85%
	Misericordia Community Hospital	75.3%	77.2%	79.8%	75.2%	79.0%	78.1%	81.7%	85%
	Royal Alexandra Hospital	76.5%	77.3%	76.6%	77.8%	78.6%	78.3%	79.0%	85%
	Sturgeon Community Hospital	87.6%	89.8%	88.0%	88.0%	84.7%	83.7%	84.5%	85%
	University of Alberta Hospital	80.2%	83.5%	80.4%	81.8%	82.6%	82.8%	82.3%	85%
	Other Edmonton Hospitals	85.3%	86.3%	85.7%	84.8%	85.5%	86.3%	86.3%	85%
North Zone	**North Zone**	**80.6%**	**81.3%**	**83.2%**	**82.6%**	**81.7%**	**82.1%**	**82.4%**	**85%**
	Northern Lights Regional Health Centre	74.7%	78.6%	82.2%	82.1%	79.8%	78.4%	81.4%	85%
	Queen Elizabeth II Hospital	77.2%	78.6%	80.3%	79.9%	77.1%	79.8%	78.0%	85%
	Other North Hospitals	83.7%	83.5%	84.8%	84.0%	84.3%	84.3%	84.5%	85%

Total Eligible Discharges

Zone	2015-16	2016-17	2017-18	2018-19	Q3YTD 2018-19	Q3YTD 2019-20	Completed Surveys Q3YTD 2019-20	Margin of Error (±) Q3YTD 2019-20
Provincial	**218,546**	**246,917**	**246,227**	**247,279**	**186,100**	**181,839**	**19,270**	**0.53%**
South Zone	19,737	19,840	19,642	19,280	14,489	13,511	1,514	1.90%
Calgary Zone	61,044	83,208	83,397	84,287	63,378	62,892	6,485	0.88%
Central Zone	29,272	29,531	29,238	28,448	21,462	19,494	2,325	1.54%
Edmonton Zone	82,559	89,005	87,951	90,141	67,673	68,278	6,808	0.91%
North Zone	25,934	25,333	25,999	25,123	19,098	17,664	2,138	1.61%

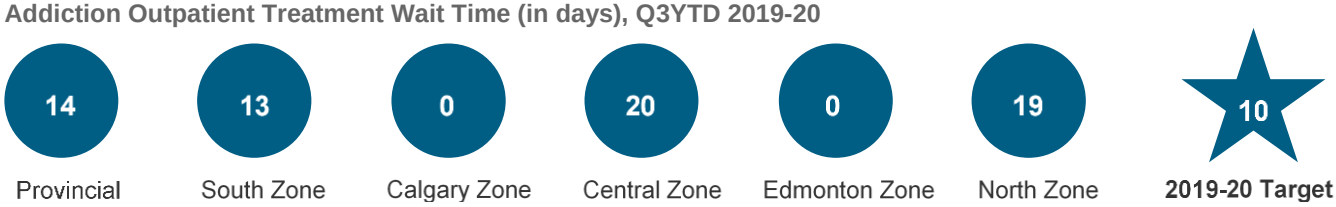
Source: AHS Canadian Hospital Consumer Assessment of Healthcare Providers and Systems (CH-CAHPS) Survey as of April 2, 2020.
Notes:
- The results are reported a quarter later due to requirements to follow-up with patients after end of reporting quarter.
- The margin of errors were calculated using a normal estimated distribution for sample size greater than 10. If the sample size was less than 10, the Plus two & Plus four methods were used.
- Provincial and zone level results presented here are based on weighted data.
- Facility level results and all Other Hospitals results presented here are based on unweighted data.

WAIT TIME FOR ADDICTION OUTPATIENT TREATMENT

DEFINITION: The time it takes to access adult addiction outpatient treatment services, expressed as the number of days that nine out of 10 clients have attended their first appointment since referral or first contact. This measure excludes opioid dependency programs.

WHY THIS IS IMPORTANT: Getting clients the care they need in a timely manner is critical to improving our services. The lower the number the better, as it demonstrates people are waiting for a shorter time to receive adult addiction outpatient services.

Addiction Outpatient Treatment Wait Time (in days), Q3YTD 2019-20



Addiction Outpatient Treatment Wait Time by Zone (90th Percentile, in days)

Wait Time Grouping	Zone Name	2014-15	2015-16	2016-17	2017-18	2018-19	Q3YTD 2018-19	Q3YTD 2019-20	2019-20 Target
Provincial	**Provincial**	**15**	**13**	**15**	**13**	**14**	**14**	**14**	**10**
Urban									
	Calgary Zone	9	5	6	0	0	0	0	10
	Edmonton Zone	14	0	0	0	0	0	0	10
Rural									
	South Zone	20	21	26	21	21	22	13	10
	Central Zone	16	14	15	14	16	16	20	10
	North Zone	16	19	27	24	21	22	19	10

Addiction Outpatient Treatment Wait Time by Zone (Average, in days)

Wait Time Grouping	Zone Name	2014-15	2015-16	2016-17	2017-18	2018-19	Q3YTD 2018-19	Q3YTD 2019-20
Provincial	**Provincial**	**6.5**	**5.7**	**7.3**	**6.2**	**5.6**	**5.8**	**5.8**
Urban								
	Calgary Zone	7.4	7.8	11.4	9.1	6.4	6.9	6.5
	Edmonton Zone	5.1	1.2	0.9	0.4	0.3	0.4	0.0
Rural								
	South Zone	7.8	7.8	8.7	7.5	7.5	8.3	4.7
	Central Zone	6.2	6.0	6.2	5.7	6.9	6.7	7.5
	North Zone	7.3	8.2	11.1	10.5	8.7	9.0	7.9

Total Enrollments

Zone	2015-16	2016-17	2017-18	2018-19	Q3YTD 2018-19	Q3YTD 2019-20
Provincial	**18,330**	**18,034**	**18,028**	**17,548**	**12,934**	**11,872**
South Zone	1,760	1,818	1,742	1,761	1,236	1,450
Calgary Zone	4,617	4,455	4,385	3,942	2,896	2,601
Central Zone	3,467	3,560	3,829	4,145	3,108	3,088
Edmonton Zone	4,957	4,665	4,629	4,195	3,160	1,959
North Zone	3,529	3,536	3,443	3,505	2,534	2,774

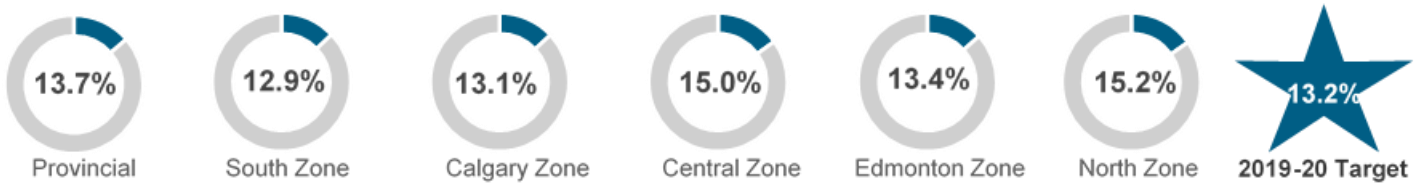
Sources: 1.) Addiction System for Information and Service Tracking (ASIST) Data Research View for Treatment Service, Standard Data Product; 2.) Clinical Activity Reporting Application (CARA) for results since April 1, 2013; 3.) Geriatric Mental Health Information System (GMHIS) for results since April 1, 2013; 4.) eClinician for results since June 22, 2015 (ASE program) and April 20, 2015 (YASE program) as of April 24, 2020.
Notes:
- The results are reported a quarter later due to requirements to follow-up with patients after end of reporting quarter.
- Average wait time is also provided to provide further context for the interpretation of the wait time performance measure.
- Results may change due to data updates in the source information system or revisions to the measure inclusion and exclusion criteria.
- Enrollments have decreased due to higher client acuity and longer program stays resulting in less capacity.
- Edmonton Zone is currently transitioning to a new system. As such, Q3 data was not reported for this zone due to potential inconsistencies in data collection.

UNPLANNED MEDICAL READMISSIONS

DEFINITION: The percentage of medical patients with unplanned readmission to hospital within 30 days of leaving the hospital (excluding admissions for surgery, pregnancy, childbirth, mental health diseases and disorders, palliative care and chemotherapy for cancer).

WHY THIS IS IMPORTANT: High rates of readmission act as a signal to hospitals to look more carefully at their practices, including discharge planning and continuity of services after discharge. Rates may be impacted due to the nature of the population served by a facility (elderly patients and patients with chronic conditions) or due to different models of care and healthcare services accessibility. The lower the percentage the better, as it demonstrates that fewer people are being readmitted shortly after being discharged.

Unplanned Medical Readmissions, Q3YTD 2019-20



Unplanned Medical Readmissions

Zone	Site	2014-15	2015-16	2016-17	2017-18	2018-19	Q3YTD 2018-19	Q3YTD 2019-20	2019-20 Target
Provincial	**Provincial**	**13.6%**	**13.7%**	**13.6%**	**13.6%**	**13.8%**	**13.9%**	**13.7%**	**13.2%**
South Zone	**South Zone**	**13.4%**	**14.2%**	**13.9%**	**13.9%**	**13.0%**	**13.3%**	**12.9%**	**13.2%**
	Chinook Regional Hospital	13.4%	14.0%	13.3%	12.7%	11.6%	11.9%	12.3%	13.2%
	Medicine Hat Regional Hospital	12.4%	14.1%	13.8%	13.9%	13.2%	13.2%	12.8%	13.2%
	Other South Hospitals	14.7%	14.5%	14.9%	15.5%	14.8%	15.3%	13.9%	13.2%
Calgary Zone	**Calgary Zone**	**12.2%**	**12.3%**	**12.3%**	**12.5%**	**12.8%**	**12.9%**	**13.1%**	**13.2%**
	Foothills Medical Centre	12.1%	12.3%	12.3%	12.3%	12.7%	12.7%	13.1%	13.2%
	Peter Lougheed Centre	12.3%	12.8%	13.1%	12.6%	12.6%	12.5%	13.3%	13.2%
	Rockyview General Hospital	11.9%	12.0%	12.1%	12.4%	12.8%	13.1%	12.8%	13.2%
	South Health Campus	12.3%	12.0%	11.4%	12.3%	13.4%	13.7%	12.9%	13.2%
	Other Calgary Hospitals	13.7%	12.5%	13.0%	13.4%	12.9%	12.1%	14.2%	13.2%
Central Zone	**Central Zone**	**14.9%**	**15.0%**	**14.8%**	**14.2%**	**14.9%**	**14.9%**	**15.0%**	**13.2%**
	Red Deer Regional Hospital Centre	13.8%	14.0%	13.0%	13.1%	14.0%	14.0%	13.1%	13.2%
	Other Central Hospitals	15.3%	15.4%	15.6%	14.6%	15.3%	15.3%	15.9%	13.2%
Edmonton Zone	**Edmonton Zone**	**13.8%**	**13.6%**	**13.6%**	**13.9%**	**14.2%**	**14.3%**	**13.4%**	**13.2%**
	Grey Nuns Community Hospital	12.3%	13.2%	12.7%	12.7%	14.2%	14.7%	13.3%	13.2%
	Misericordia Community Hospital	13.7%	13.5%	15.0%	14.2%	15.1%	15.6%	13.7%	13.2%
	Royal Alexandra Hospital	14.0%	13.7%	13.1%	14.2%	13.9%	13.9%	13.3%	13.2%
	Sturgeon Community Hospital	13.7%	13.4%	13.1%	13.8%	14.9%	15.3%	13.5%	13.2%
	University of Alberta Hospital	14.5%	14.2%	14.4%	14.5%	14.5%	14.2%	13.9%	13.2%
	Other Edmonton Hospitals	12.7%	11.9%	12.9%	12.0%	12.4%	12.3%	12.3%	13.2%
North Zone	**North Zone**	**15.3%**	**15.3%**	**15.2%**	**14.8%**	**14.7%**	**15.0%**	**15.2%**	**13.2%**
	Northern Lights Regional Health Centre	12.8%	13.3%	14.2%	15.0%	13.6%	13.7%	14.7%	13.2%
	Queen Elizabeth II Hospital	11.9%	13.3%	13.4%	11.7%	12.3%	11.5%	12.6%	13.2%
	Other North Hospitals	16.1%	15.9%	15.6%	15.3%	15.3%	15.7%	15.8%	13.2%

Total Discharges

Zone	2015-16	2016-17	2017-18	2018-19	Q3YTD 2018-19	Q3YTD 2019-20
Provincial	**114,313**	**114,400**	**114,717**	**114,906**	**86,187**	**87,852**
South Zone	9,688	9,885	9,598	9,322	7,056	6,788
Calgary Zone	35,594	35,712	36,842	36,926	27,564	29,059
Central Zone	16,898	16,811	16,298	15,516	11,739	11,569
Edmonton Zone	37,859	37,853	37,828	39,524	29,445	30,303
North Zone	14,274	14,139	14,151	13,618	10,383	10,133

Source: AHS Provincial Discharge Abstract Database (DAD) as of May 1, 2020.
Notes:
- The results are reported a quarter later due to requirements to follow-up with patients after end of reporting quarter.
- This indicator measures the risk-adjusted rate of urgent readmission to hospital for the medical patient group, which is adapted from the CIHI methodology (2016).

PERINATAL MORTALITY RATE AMONG FIRST NATIONS

DEFINITION: The number of perinatal deaths per 1,000 total births among First Nations. A perinatal death is a fetal death (stillbirth) or an early neonatal death (under 7 days of age).

WHY THIS IS IMPORTANT: AHS' focus is to reduce the health gap between First Nations and non-First Nations. This indicator provides important information on the health status of First Nations pregnant women, new mothers, and newborns. Monitoring this rate helps AHS develop and adapt population health initiatives and services to better meet the health needs of First Nations and Inuit people. The lower the number the better. This measure does not include Métis residents.

The perinatal mortality rate gap between First Nations and non-First Nations groups widened between 2018 and 2019 and has shown deterioration over time. While both groups experienced a similar decline in birth rate, the First Nations group had a small increase in the number of deaths while the non-First Nations group experienced a small decrease over the same period. While the changes are likely due to normal variation, the effect is magnified by the relatively small number of First Nations births compared to non-First Nations (approximately 16x fewer births). A three year average has also been provided (second table and graph below). This calculation allows for a larger sample size which gives a more accurate representation of change over time. We will continue to work with our Indigenous communities and partners to better support and improve outcomes.

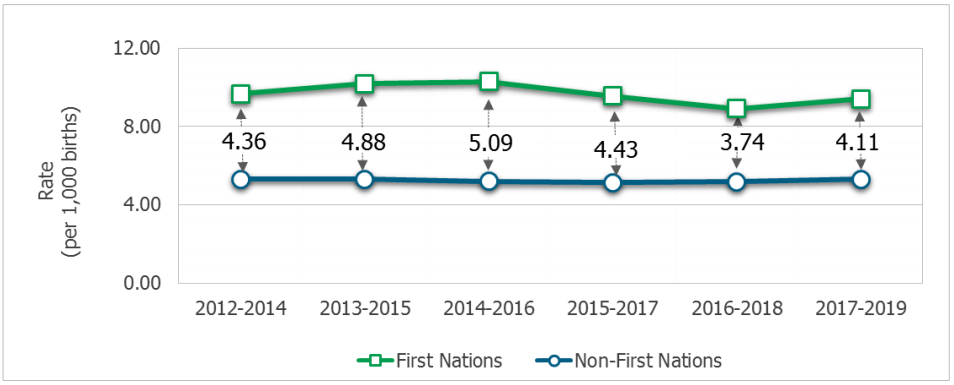
Perinatal Mortality Rate Gap, 2019

Perinatal Mortality Rate by Population (single year)

Population	2014	2015	2016	2017	2018	2019	2018-19 Target
First Nations	10.49	10.66	9.75	8.37	8.62	11.26	AHS' focus is to reduce the gap between First Nations and non-First Nations
Non-First Nations	5.67	5.28	4.67	5.47	5.39	5.02	
Rate Gap	**4.82**	**5.38**	**5.08**	**2.90**	**3.23**	**6.24**	

Perinatal Mortality Rate by Population (three year average)

Population	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2019-20 Target
First Nations	9.65	10.18	10.28	9.56	8.91	9.41	AHS' focus is to reduce the gap between First Nations and non-First Nations
Non-First Nations	5.29	5.30	5.19	5.13	5.17	5.30	
Rate Gap	**4.36**	**4.88**	**5.09**	**4.43**	**3.74**	**4.11**	



Source: Alberta Health as of April 3, 2020.
Note: Perinatal mortality is reported on an annual basis pending the availability of the most recent census data (2017). It is a performance indicator rather than a performance measure and therefore no target is identified.

Revised: July 30, 2020.

HAND HYGIENE COMPLIANCE

DEFINITION: The percentage of opportunities in which healthcare workers clean their hands during the course of patient care.

WHY THIS IS IMPORTANT: Hand hygiene is the single most effective strategy to reduce the transmission of infection in the healthcare setting. Direct observation is recommended to assess hand hygiene compliance rates for healthcare workers. The higher the percentage the better, as it demonstrates more healthcare workers are complying with appropriate hand hygiene practices. Healthcare workers are directly observed by trained personnel to see if they are compliant with routine hand hygiene practices according to the Canadian Patient Safety Institute's "4 Moments of Hand Hygiene" which are: before contact with a patient or patient's environment, before a clean or aseptic procedure, after exposure (or risk of exposure) to blood or body fluids, and after contact with a patient or patient environment.

Hand Hygiene Compliance, FY 2019-20

Hand Hygiene Compliance

Zone	Site	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2019-20 Target
Provincial	**Provincial**	**75%**	**80%**	**82%**	**85%**	**87%**	**88%**	**90%**
South Zone	**South Zone**	**82%**	**82%**	**84%**	**80%**	**87%**	**89%**	**90%**
	Chinook Regional Hospital	85%	82%	83%	78%	87%	87%	90%
	Medicine Hat Regional Hospital	77%	82%	87%	84%	89%	90%	90%
	Other South Hospitals	85%	83%	83%	81%	87%	90%	90%
Calgary Zone	**Calgary Zone**	**71%**	**78%**	**81%**	**84%**	**86%**	**85%**	**90%**
	Alberta Children's Hospital	74%	77%	80%	79%	81%	82%	90%
	Foothills Medical Centre	66%	76%	83%	84%	85%	84%	90%
	Peter Lougheed Centre	77%	85%	79%	80%	85%	88%	90%
	Rockyview General Hospital	68%	74%	84%	88%	91%	90%	90%
	South Health Campus	59%	69%	76%	77%	76%	82%	90%
	Other Calgary Hospitals	77%	80%	79%	85%	88%	89%	90%
Central Zone	**Central Zone**	**74%**	**81%**	**78%**	**87%**	**91%**	**92%**	**90%**
	Red Deer Regional Hospital Centre	69%	78%	78%	85%	88%	89%	90%
	Other Central Hospitals	77%	82%	78%	87%	92%	93%	90%
Edmonton Zone	**Edmonton Zone**	**74%**	**79%**	**83%**	**86%**	**87%**	**88%**	**90%**
	Grey Nuns Community Hospital	75%	73%	83%	89%	92%	92%	90%
	Misericordia Community Hospital	77%	75%	80%	86%	88%	89%	90%
	Royal Alexandra Hospital	75%	81%	84%	86%	85%	87%	90%
	Stollery Children's Hospital	75%	79%	80%	81%	80%	85%	90%
	Sturgeon Community Hospital	81%	84%	86%	88%	83%	85%	90%
	University of Alberta Hospital	70%	74%	85%	88%	89%	87%	90%
	Other Edmonton Hospitals	73%	79%	82%	86%	89%	90%	90%
North Zone	**North Zone**	**81%**	**87%**	**88%**	**88%**	**89%**	**91%**	**90%**
	Northern Lights Regional Health Centre	64%	88%	87%	82%	88%	94%	90%
	Queen Elizabeth II Hospital	91%	96%	91%	88%	81%	86%	90%
	Other North Hospitals	74%	85%	88%	89%	90%	91%	90%

Total Observations *(excludes Covenant sites)*

Zone	2015-16	2016-17	2017-18	2018-19	2019-20
Provincial	**396,941**	**383,982**	**334,396**	**321,717**	**313,833**
South Zone	39,185	38,056	18,277	26,191	28,987
Calgary Zone	182,568	162,014	128,687	114,642	122,216
Central Zone	45,144	35,952	39,162	41,865	38,945
Edmonton Zone	100,965	125,926	118,535	107,935	95,583
North Zone	29,079	22,034	29,735	31,084	28,102

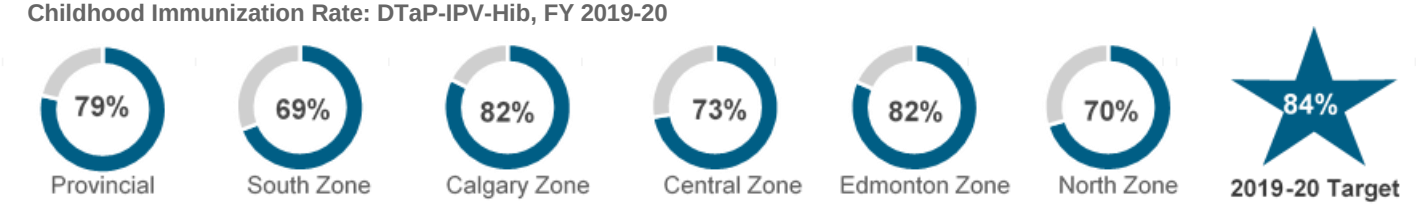
Sources: AHS Infection Prevention and Control Surveillance and Standards as of May 20, 2020; Covenant Health Infection Prevention and Control as of January 15, 2020.
Notes:
- *Covenant Health sites (including Misericordia Community Hospital and Grey Nuns Hospital) use different methodologies for capturing and computing hand hygiene compliance. These are available twice a year in spring (Q1 & Q2) and fall (Q3 & Q4). These are not included in the Edmonton Zone and Provincial totals.*
- *"Other Sites" include any hand hygiene observations collected at an AHS operated program, site, or unit including acute care, continuing care, and ambulatory care settings such as Cancer Control, Corrections, EMS, Hemodialysis, Home Care, and Public Health.*

CHILDHOOD IMMUNIZATION RATE: DTaP-IPV-Hib
DIPHTHERIA, TETANUS, ACELLULAR PERTUSSIS, POLIO, HAEMOPHILUS INFLUENZAE TYPE B

DEFINITION: This measure is defined as the percentage of children who have received the required number of vaccine doses by two years of age.

WHY THIS IS IMPORTANT: Immunizations protect children and adults from a number of vaccine-preventable diseases, some of which can be fatal or produce permanent disabilities. A high rate of immunization for a population reduces the incidence of vaccine-preventable childhood diseases, and controls outbreaks. The higher the percentage the better, as it demonstrates more children are immunized and protected from vaccine-preventable childhood diseases.

Childhood Immunization Rate: DTaP-IPV-Hib, FY 2019-20



Childhood Immunization Rate: DTaP-IPV-Hib

Zone	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2019-20 Target
Provincial	**78.3%**	**78.0%**	**78.3%**	**77.7%**	**77.7%**	**78.6%**	**84%**
South Zone	67.9%	65.7%	67.8%	70.0%	69.8%	69.2%	84%
Calgary Zone	82.6%	81.5%	81.4%	79.8%	81.0%	82.3%	84%
Central Zone	71.1%	70.9%	70.6%	70.7%	71.9%	72.5%	84%
Edmonton Zone	84.0%	84.6%	84.0%	82.9%	80.5%	81.7%	84%
North Zone	66.6%	66.5%	67.7%	68.9%	69.6%	70.4%	84%

Total Eligible Population

Zone	2015-16	2016-17	2017-18	2018-19	2019-20
Provincial	**54,267**	**55,138**	**56,208**	**54,550**	**52,715**
South Zone	4,104	4,157	4,271	4,061	3,972
Calgary Zone	19,602	20,424	20,862	20,349	19,676
Central Zone	6,240	5,833	5,661	5,361	5,180
Edmonton Zone	16,870	17,578	18,114	17,869	17,146
North Zone	7,451	7,146	7,300	6,910	6,741

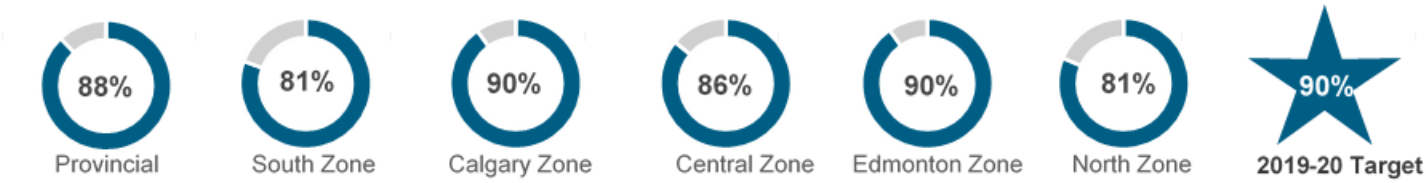
Source: Province-wide Immunization Program, Communicable Disease Control as of April 30, 2020.
Notes:
- The target represents AHS' 2019-20 organizational target. Alberta Health uses the national target (set by CIHI) for DTaP-IPV-Hib vaccine by two years of age.
- 2018-19 rates are not comparable to previous years due to changes in the reporting system. Going forward, the new system will provide a more accurate reflection of the rate.

CHILDHOOD IMMUNIZATION RATE: MMR
MEASLES, MUMPS, RUBELLA

DEFINITION: This measure is defined as the percentage of children who have received the required number of vaccine doses by two years of age.

WHY THIS IS IMPORTANT: Immunizations protect children and adults from a number of vaccine-preventable diseases, some of which can be fatal or produce permanent disabilities. A high rate of immunization for a population reduces the incidence of vaccine-preventable childhood diseases, and controls outbreaks. The higher the percentage the better, as it demonstrates more children are immunized and protected from vaccine-preventable childhood diseases.

Childhood Immunization Rate: MMR, FY 2019-20



Childhood Immunization Rate: MMR

Zone	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2019-20 Target
Provincial	**87.6%**	**86.9%**	**87.4%**	**86.9%**	**86.5%**	**87.9%**	**90%**
South Zone	83.9%	78.8%	81.0%	82.1%	82.0%	80.5%	90%
Calgary Zone	89.6%	89.2%	89.6%	87.9%	88.6%	90.0%	90%
Central Zone	80.8%	81.1%	82.3%	84.2%	83.8%	86.0%	90%
Edmonton Zone	92.2%	91.9%	91.8%	90.5%	88.7%	90.3%	90%
North Zone	80.3%	78.5%	77.8%	79.6%	79.3%	81.4%	90%

Total Eligible Population

Zone	2015-16	2016-17	2017-18	2018-19	2019-20
Provincial	**54,267**	**55,138**	**56,208**	**54,550**	**52,715**
South Zone	4,104	4,157	4,271	4,061	3,972
Calgary Zone	19,602	20,424	20,862	20,349	19,676
Central Zone	6,240	5,833	5,661	5,361	5,180
Edmonton Zone	16,870	17,578	18,114	17,869	17,146
North Zone	7,451	7,146	7,300	6,910	6,741

Source: Provincewide Immunization Program, Communicable Disease Control as of April 30, 2020.
Notes:
- The target represents AHS' 2019-20 organizational target. Alberta Health uses the national target (set by CIHI) for DTaP-IPV-Hib vaccine by two years of age.
- 2018-19 rates are not comparable to previous years due to changes in the reporting system. Going forward, the new system will provide a more accurate reflection of the rate.

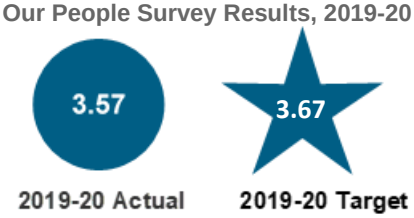
AHS WORKFORCE ENGAGEMENT

DEFINITION: This measure is defined as the mean score of the responses to the AHS' 'Our People Survey' which utilized a five-point scale, with one being 'strongly disagree' and five being 'strongly agree'.

WHY THIS IS IMPORTANT: The higher the rate the better, as it demonstrates that more employees feel positive about their work and are more engaged. More than 51,000 individuals – including nurses, emergency medical services, support staff, midwives, physicians and volunteers – participated in the 'Our People Survey' in 2019-20.

Engagement refers to how committed an employee is to the organization, their role, their manager, and co-workers. High engagement correlates with higher productivity, safe patient care and willingness to give discretionary effort at work. AHS has the opportunity both to create a satisfying workplace and to deliver services in a sustainable manner.

Our People Survey Results, 2019-20



Our People Survey Results, 2019-20

Portfolio or Departments	2016-17	2019-20	2019-20 Target
Provincial	3.46	3.57	**3.67**

Source: AHS People portfolio
Note: The reported engagement rate includes AHS Employees only; the rate excludes responses from physicians, volunteers, and midwives.

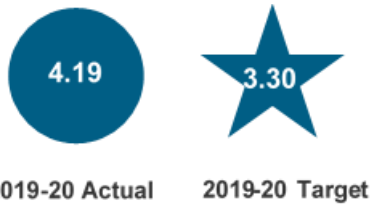
DISABLING INJURIES IN AHS WORKFORCE

DEFINITION: The number of AHS workers requiring modified work or time loss from work per 200,000 paid hours (approximately 100 full-time equivalent workers).

WHY THIS IS IMPORTANT: Our disabling injury rate enables us to identify Workplace Health & Safety (WHS) programs that provide AHS employees, volunteers and physicians with a safe and healthy work environment and keeps them free from injury. The lower the rate, the fewer disabling injuries are occurring at work.

AHS' Disabling Injury Rate has shown deterioration year-over-year and, while the number of reported injuries has been increasing overall, the rate of increase has slowed. Changes to the Workers Compensation Board (WCB) Act in 2018 has broadened the scope of injuries that are acceptable by the WCB. This includes harassment and violence incidents as well as presumptive coverage of psychological injuries.

Disabling Injury Rate, Q3YTD 2019-20



Disabling Injury Rates

Level of Portfolio	Portfolio or Departments	2015-16	2016-17	2017-18	2018-19	Q3YTD 2018-19	Q3YTD 2019-20	2019-20 Target
Province	**Provincial**	**3.57**	**3.85**	**4.11**	**4.12**	**3.90**	**4.19**	**3.30**
Zone	South Zone Clinical Operations	3.57	3.50	3.75	4.23	3.87	4.22	3.30
	Calgary Zone Clinical Operations	3.56	3.88	4.89	4.88	4.66	4.50	3.30
	Central Zone Clinical Operations	3.88	4.12	4.91	4.37	3.93	5.68	3.30
	Edmonton Zone Clinical Operations	3.48	3.73	4.11	4.11	4.06	3.79	3.30
	North Zone Clinical Operations	4.35	3.75	4.08	4.40	4.19	5.61	3.30
Provincial Portfolios	CancerControl Alberta	1.68	1.47	1.03	1.54	1.30	2.27	3.30
	Capital Management	2.15	2.74	2.24	2.47	2.20	2.89	3.30
	Chief Information Officer	0.26	0.17	0.21	0.10	0.13	0.12	3.30
	Clinical Workforce Strategy & Services	n/a	n/a	10.23	10.48	10.43	11.50	3.30
	Community Engagement & Communications	0.00	0.00	0.00	0.00	0.00	1.15	3.30
	Contracting, Procurement & Supply Chain Management	2.61	3.85	3.24	4.59	3.34	4.08	3.30
	Diagnostic Imaging Services	1.85	2.86	3.57	3.79	3.70	3.03	3.30
	Emergency Medical Services	12.94	15.09	15.02	12.80	12.69	13.05	3.30
	Finance	0.16	0.33	0.56	0.38	0.50	0.77	3.30
	HR, Legal & Privacy, WHS	n/a	n/a	0.50	0.34	0.11	0.86	3.30
	Internal Audit & Enterprise Risk Management	0.00	0.00	0.00	0.00	0.00	2.86	3.30
	Nutrition, Food, Linen & Environment	6.95	6.89	6.35	6.50	6.19	6.76	3.30
	Office of CMO & Medical Affairs	0.70	1.18	0.88	0.81	0.70	0.75	3.30
	Pharmacy Services	1.05	1.69	1.22	1.14	1.01	1.45	3.30
	Protective Services	n/a	n/a	8.54	11.13	9.60	11.06	3.30
	System Innovations and Programs	0.27	0.25	0.61	0.70	0.58	0.41	3.30

Sources: WCB Alberta and e-Manager Payroll Analytics (EPA). EPA 2017-20 YTD data as of March 2020. WCB data April-December 2019 as of March 2020. Data retrieved April 13, 2020.
Notes:
- This measure is reported one quarter later as data continues to accumulate as individual employee cases are closed.
- Reporting of "0.00" is accurate and reflects these portfolios having no disabling injuries.
- As of Q3 2019-20, Clinical Workforce Strategies and Services is reported separately from the previous Health Professionals & Practice Portfolio.
- Accurate mapping of historical data is not possible as a number of functional centres were disabled in March 2019. As a result, some employees were not mapped to any portfolio for historical data up to 2016/17.

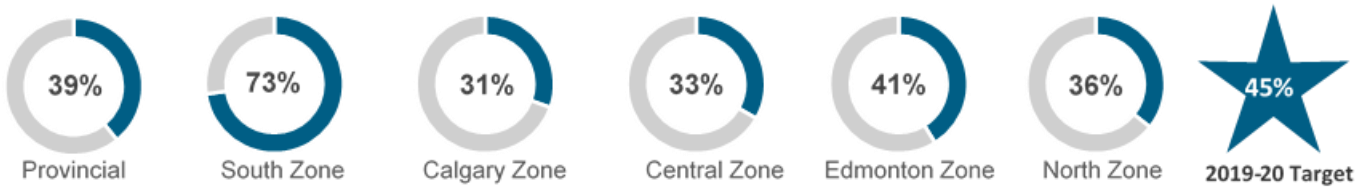
Revised: July 30, 2020.

NURSING UNITS ACHIEVING BEST PRACTICE EFFICIENCY TARGETS

DEFINITION: The percentage of nursing units at the 16 busiest sites meeting Operational Best Practice (OBP) labour efficiency targets.

WHY THIS IS IMPORTANT: Operational best practice is one of the ways we can reduce costs while maintaining or improving care to ensure a sustainable future. Using comparative data from across the county, AHS has developed OBP targets for nursing inpatient units. These targets are designed to achieve more equitable service delivery across the province and reduce variations in the cost of delivering high-quality services at AHS sites. A higher percentage means more efficiencies have been achieved across AHS.

Percentage of Nursing Units Achieving Best Practice Efficiency Targets, FY 2019-20



Percentage of Nursing Units Achieving Best Practice Efficiency Targets

Zone	2015-16	2016-17	2017-18	2018-19	2019-20	2019-20 Target
	Prior methodology was utilized.					
Provincial	**20%**	**28%**	**38%**	**32%**	**39%**	**45%**
South Zone	63%	58%	61%	68%	73%	45%
Calgary Zone	15%	20%	25%	25%	31%	45%
Central Zone	7%	14%	47%	27%	33%	45%
Edmonton Zone	14%	29%	42%	35%	41%	45%
North Zone	33%	33%	36%	7%	36%	45%

Source: AHS General Ledger (no allocations); Worked Hours - Finance consolidated trial balance, Patient Days – Adult & Child - Finance statistical General Ledger as of April 29, 2020.
Notes:
- A change in the methodology used to calculate results in 2018-19 and 2019-20 makes prior data (2015-16 to 2017-18) not comparable. The performance measure target (45%) is calculated using the percentage of nursing units achieving individualized unit-level best practice targets. Previously, nursing unit-level targets were automatically adjusted quarterly based on the data set. Nursing unit-level targets are now set for two years to allow enough time to make changes in staffing levels to achieve targets. Unit-level targets, which are utilized to calculate the performance measure target (45%), will be re-evaluated every two years. This change in methodology does not impact the current performance measure target (45%) as outlined in the Health Plan.
- The COVID-19 outbreak had a significant impact on this measure. If March 2020 data is excluded, more nursing units met target.

Financial Summary

Financial Statement Discussion and Analysis
For the year ended March 31, 2020

This Financial Statement Discussion and Analysis (FSD&A) provides a financial overview of the results of Alberta Health Services' (AHS) operations and financial position for the year ended March 31, 2020. The FSD&A reports to stakeholders how financial resources are being utilized to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans. It serves as an opportunity to communicate with stakeholders about AHS' 2019-20 financial performance, as well as cost drivers, strategies, and plans to address financial risk and sustainability.

This FSD&A has been prepared by and is the responsibility of management and should be read in conjunction with the March 31, 2020 audited consolidated financial statements, notes, and schedules.

Additional information about AHS is available on the AHS website at **www.albertahealthservices.ca**

Highlights

On March 11, 2020, the World Health Organization officially declared a pandemic related to the outbreak of the novel coronavirus disease, COVID-19. A state of public health emergency was declared in Alberta on March 17, 2020. In response, AHS, with the help of its employees, leaders, physicians, contracted health service providers, and the Government of Alberta quickly shifted its efforts and resources to respond to the pandemic. AHS acted swiftly to increase COVID-19 testing and contact tracing, and created additional acute and intensive care bed capacity across the province in preparation for the peak of the outbreak. AHS also ramped up the procurement of additional personal protective equipment (PPE) and other supplies, which it started to stockpile in January 2020 in anticipation of an outbreak. Subsequent to March 31, 2020, the Government of Alberta announced additional funding directed to Alberta Health to be used in the continued response to the pandemic, including significant purchase commitments, the operation of assessment and treatment centres, advanced laboratory testing, and deposits to secure more essential supplies and equipment. AHS continues to closely monitor the COVID-19 pandemic and has identified potential financial implications arising from delays or deferrals of certain non-essential services, future declines in the value of marketable securities held by AHS, and the temporary suspension of parking fees at all sites across the province. As the response is ongoing and an ending to the pandemic is indeterminable, the future financial and operational impact of COVID-19 cannot be estimated at this time.

During fiscal 2019-20, AHS advanced many key initiatives and priorities as outlined in the third and final year of AHS' current 2017-2020 Health Plan and 2019-20 Business Plan. The successful launch of the first wave of Connect Care in November 2019 was a significant milestone in the development of a provincial clinical information system. Connect Care will have a transformative impact on the quality and safety of health services in Alberta through the replacement of over 400 outdated records systems, the creation of common clinical standards and processes, and the ability to share information across the continuum of health care. In 2019-20, capital expenditures were $200 million ($359 million cumulative since 2017-18) and operating expenses were $98 million ($151 million cumulative since 2017-18).

AHS' first comprehensive performance review since its formation in 2009 was conducted in 2019-20. The AHS Performance Review was performed on behalf of Alberta Health by external consultants with experience conducting similar reviews in other provinces. The review recognized the significant achievements AHS has made over the past decade as the largest integrated health system in Canada, including the wide range of ongoing efforts underway to improve the efficiency and quality of the health system. The report also made recommendations for continued improvement and identified opportunities for further efficiencies. AHS has implemented a number of the recommendations while others are closely aligned with AHS' current savings initiatives, such as Operational Best Practices (OBP). Implementation of the AHS Performance Review recommendations will continue to be a priority moving forward.

Several other important initiatives from the prior fiscal year continued in 2019-20. Most notably, AHS focused on addressing wait times for surgeries and diagnostic services in the province, and transitioning patients from acute care settings to community settings where appropriate. These initiatives remain long-term priorities for AHS, however, the COVID-19 pandemic has required AHS to redeploy a significant amount of its human, material, and financial resources to combat the spread of the virus.

Financial Results

AHS continues to respond to rising rates of chronic diseases and demand on health care services at a time when limited financial resources are available as a result of the economic climate in Alberta.

AHS finished the year with a $146 million annual operating deficit, representing less than one per cent of budgeted expenses. Acute care and home care services, in particular, were two key areas that exceeded the budget due to higher demand resulting in higher staffing levels, overtime, and contracted health service provider costs. Delays in achieving savings through OBP initiatives, partially as a result of using an attrition-based approach, further contributed to the deficit. A high number of vacancies across AHS, coupled with cost containment strategies, such as reduced or deferred discretionary spending, strategic deferral of certain maintenance projects, and enhanced vacancy management partially offset the deficit.

Key Trending

SELECT ANNUAL FINANCIAL INFORMATION
FOR THE YEAR ENDED MARCH 31
(in millions)

	2020	2019	2018	2017	2016
Revenue	15,468	15,274	14,856	14,470	13,955
Expenses	15,614	15,313	14,765	14,403	14,100
Annual operating surplus (deficit)	**$(146)**	**$ (39)**	**$ 91**	**$ 67**	**$(145)**
Accumulated Surplus	1,132	1,278	1,317	1,226	1,159

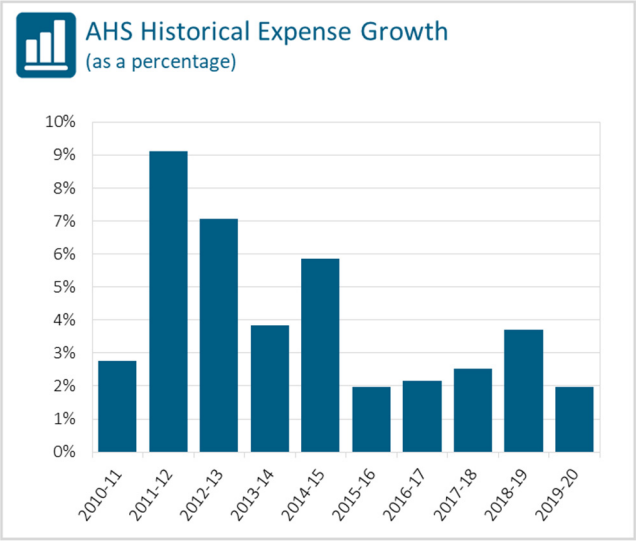
ANNUAL OPERATING SURPLUS (DEFICIT)

AHS is expected to operate within the budget approved by the AHS Board and the Minister of Health. Since 2015-16, AHS' annual operating surpluses and deficits have averaged less than one per cent of total budgeted expenses.

EXPENSE GROWTH

AHS continues to enhance and improve health services for Alberta's growing and aging population, while maintaining strong fiscal stewardship of public resources.

Alberta's population growth has continued to exceed the national average, resulting in increased demand on the province's healthcare system and frontline services. Between 2014 and 2019 Alberta's population grew by 8.2%, while all other provinces grew an average of 4.4% during the same period[1]. Although Alberta has one of the youngest populations in Canada, by 2046, the average age is predicted to increase from 38 years in 2018 to 41 years, and almost one in five Albertans is projected to be age 65 or older[2].



Total expenses grew by 2.0% from the prior year which was lower than the 2018-19 growth rate of 3.7%.

Expenses directly funded by revenue received from Alberta Health or other sources which were restricted for specific purposes grew 7.1% (2018-19 – 4.7%). This was mainly due to the following externally funded initiatives:

- utilization of high cost cancer drugs which were provided at no cost to AHS by suppliers through compassionate drug access programs,
- newly approved cancer drugs funded through the Outpatient Cancer Drug Benefit Program,
- new psychiatry and medical genetics programs as part of the Academic Medicine and Health Services Program[3] (AMHSP) (North and South Sectors),
- supporting indigenous communities with programming for youth suicide prevention, mental wellness, and healthy lifestyle promotion,
- the completion of additional cataract surgeries to address wait times,
- emergency funding related to the Northern Alberta Wildfires, and
- COVID-19 pandemic response funding, which includes operating assessment centres throughout the province, additional laboratory tests and equipment, and the increased use of PPE.

Expenses not directly funded by restricted revenues grew by 1.4% (2018-19 – 3.6%). This was a result of increased home and continuing care services as part of the Continuing Care Capacity Plan (CCCP) and Enhancing Care in the Community (ECC)[4]. These initiatives are part of AHS' strategy to transition patients from more costly acute care settings to community and home based settings when it is appropriate and safe to do so. Expenses also increased due to Connect Care, the impact of the leap year in 2020, and the write-down of certain capital assets, including the Edmonton Lab Hub.

Cost Containment and Savings

Through OBP and other various organization-wide and local initiatives, AHS has been able to slow the rate of spending growth. Expenses have increased by an average of 2.5% per year since 2015-16, while historically, expenses were growing an average of 5.7% per year.

OBP is a key initiative for improving the financial health and value for money at AHS. This initiative ensures AHS is efficient and focused on quality care and helps achieve more equitable service delivery across the province, while delivering safe, quality healthcare to Albertans. OBP compares healthcare delivery costs within Alberta, and with healthcare systems across Canada. Since 2016-17, the first full year of OBP, AHS has cumulatively saved approximately $218 million. The implementation of OBP operates under the principles of adherence to collective agreements and the commitment to quality and continuous improvement in the healthcare system. However, in some areas an attrition-based strategy has resulted in delays in the realization of savings in 2019-20.

Other savings initiatives that were implemented in 2019-20 included the strategic deferral of certain maintenance projects, reduction of discretionary spending, such as travel and minor equipment, and various enhanced vacancy management practices.

The savings initiatives mentioned above, align with many of the recommendations identified in the AHS Performance Review report issued in February 2020. These recommendations identified potential opportunities to further reduce costs and improve overall system performance. AHS' implementation of the recommendations will continue to be a priority moving forward.

[1] Statistics Canada. (2020, April 28). Table 17-10-0005-01. Retrieved from Population estimates on July 1st, by age and sex: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000501

[2] Alberta Treasury Board. (2019, July 3). Population Projection Highlights. Retrieved from Alberta.ca: https://open.alberta.ca/dataset/90a09f08-c52c-43bd-b48a-fda5187273b9/resource/53f133fc-db57-421d-a7fb-92b8d2326274/download/2019-2046-alberta-population-projections-highlights.pdf

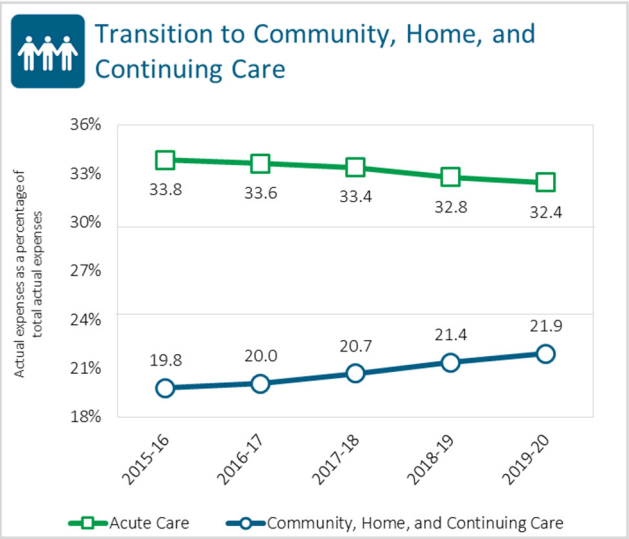
[3] The AMHSP, which is provided to universities, ensures physicians ae compensated for services non-billable under the fee-for-service model by providing clinical and non-clinical funding, including support for research, education, and administrative functions.

[4] ECC falls under AHS' Health System Integration umbrella which focuses on working collectively toward broad system integration to ensure that Albertans experience care that is well coordinated and continuous.

COMMUNITY, HOME, AND CONTINUING CARE

Enhancing community care options for Albertans continued to be a key priority for AHS in 2019-20. Through ECC, CCCP, and other key initiatives, AHS has been working toward providing more community, home, and continuing care options to ease pressures on hospitals so resources can be directed to areas that will better support the long-term health and wellness of Albertans.

The transition from hospital to community continues to be a priority and a corresponding shift of trained healthcare professionals is required. AHS continued to use an attrition-based approach to achieve this objective in 2019-20.



Over the past few years, AHS' acute care expense growth has slowed, increasing by approximately 6% since 2015-16 while spending related to community, home and continuing care services has increased by approximately 23% during the same period. As of March 31, 2020, 410 patients were waiting for a continuing care placement in an acute care setting, a decrease of 218 since 2015-16. The average wait time in an acute care setting was 36 days in 2019-20 compared to 44 days in 2015-16.

With a shift towards enhancing care in the community, AHS' community, home, and continuing care expenses increased $149 million from the prior year, and represented 21.9% of total expenses in 2019-20. Although acute care expenses increased $47 million from the prior year, the proportion of acute care expenses to total expenses continued to decline, representing 32.4% of total expenses, a decrease of 0.4%.

WORKFORCE

AHS reports calculated Full Time Equivalents (FTEs) on Schedule 2 in its consolidated financial statements which is determined by actual hours earned divided by 2,030.50 annual base hours. Annual base hours were higher than the prior year due to the extra leap year day in 2020.

CALCULATED FTEs				
	2019-20	2018-19	Increase (Decrease)	
			FTE	%
Clinical staff[5]	52,180	51,201	979	1.9
Other staff[6]	27,672	27,252	420	1.5
Management – includes both clinical and other management	3,191	3,103	88	2.8
Total FTEs	**83,042**	**81,556**	**1,486**	**1.8**

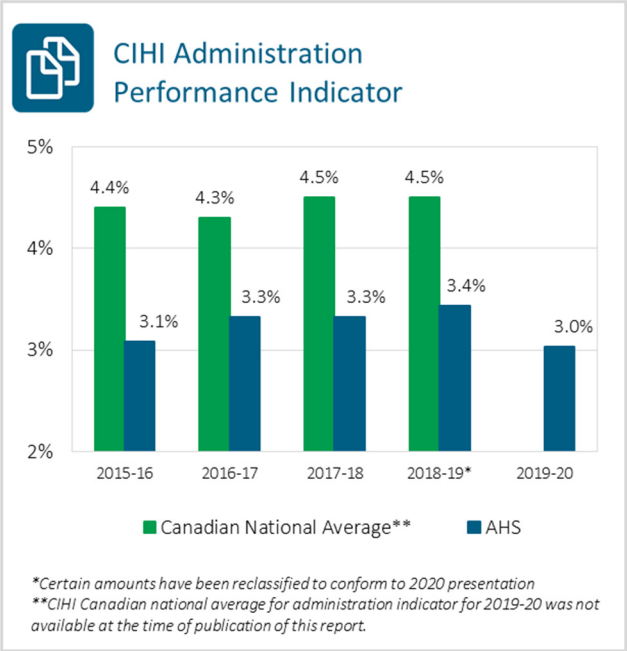
The increase in FTEs was primarily due to increased worked and training hours related to AHS' priority initiatives, including Connect Care, ECC, and CCCP, as a result of higher current year activity and annualized FTEs for staff who were hired during the prior year to support these initiatives. Overtime incurred during the COVID-19 pandemic response in March 2020 further impacted FTEs across all the categories, however, total 2019-20 overtime hours were lower than in the prior year due to AHS' ongoing efforts to reduce overtime.

Wages increased slightly in 2019-20 as a result of the wage reopener arbitration between AHS and the Alberta Union of Provincial Employees (AUPE) General Support Services (GSS), which resulted in a 1.0% increase for members in the 2019-20 fiscal year. Increases related to collective agreement step movements also contributed to the increase. There continues to be an ongoing wage freeze for management and non-union employees which has been in place since 2013 and will continue to March 31, 2021.

[5] Clinical staff are comprised of AHS' medical doctors, regulated nurses, health technical and professional staff, and unregulated health service providers.
[6] Other staff includes support services employees such as food services, facilities and maintenance, clerical, and administrative support staff.

ADMINISTRATION EXPENSE

Administration expense is comprised of human resources, finance, senior leaders' compensation and benefits, insurance, and other functions, such as infection control, quality assurance, public relations, telecommunications, mail services, utilization management, internal audit and enterprise risk management, legal, and planning and development.



The Canadian Institute of Health Information (CIHI) reports corporate services expense ratio as a financial performance indicator calculated based on administration expense and total expenses[7]. For 2019-20 AHS' indicator was 3.0% (2018-19 – 3.4%). The current year decrease in this indicator was mainly the result of lower liability insurance costs than the previous year.

AHS has continued to improve healthcare system efficiency through local and site-based decision-making. Over the past decade, AHS has reduced the number of senior leadership roles by nearly half, and their compensation has remained in the low to mid-range when compared to other national healthcare systems and the rest of the Alberta public sector. Additionally, the consolidation of many administrative systems, including payroll, information technology systems, and contracting, procurement, and supply chain management has led to significant cost savings for the province since the formation of AHS. While AHS continues to strive to be more efficient, further reductions will have to be balanced with the potential impact on managing quality and costs across the organization.

[7] Canadian Institute for Health Information. (n.d.). Your Health System. Retrieved from Interactive Map: Corporate Services Expense Ratio (Percentage), 2018-19: https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en&_ga=2.14406708.221575360.1556214366-662852099.1551116985#/indicator/041/2/C20018/

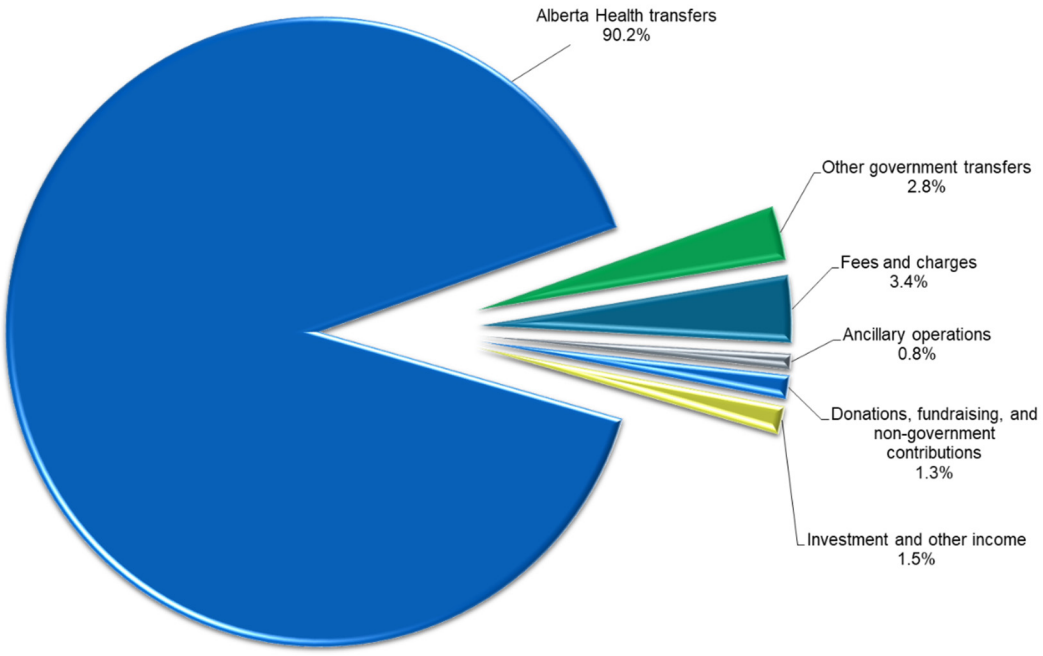
Financial Analysis

AHS discloses its results from operations in its consolidated financial statements by function on the Statement of Operations and by object on Schedule 1. Actual financial results for 2019-20 operations are analyzed in comparison to the budget and the prior year in this report. A glossary of financial statement line definitions can be found at the end of this FSD&A. An analysis of AHS' financial position compared to prior year is also discussed in this section.

Certain prior year amounts have been reclassified to conform to 2020 presentation.

Operations – Comparison to the budget and the prior year

Revenues



2019-20 actual revenue sources as a per cent of total 2019-20 actual revenue
A glossary of financial statement line definitions can be found at the end of this FSD&A

The overall distribution of revenues remained consistent with the prior year. Alberta Health transfers accounted for 90.2% of AHS' total revenues (2018-19 – 90.2%). AHS' total revenues amounted to $15,468 million, which was $103 million or 0.7% higher than the budget of $15,365 million.

REVENUES (in millions)					
	2019-20 Budget	2019-20 Actual	Variance $	2018-19 Actual	Change $
Alberta Health transfers	13,955	13,950	(5)	13,773	177
Other government transfers	427	434	7	430	4
Fees and charges	508	532	24	539	(7)
Ancillary operations	136	129	(7)	133	(4)
Donations, fundraising and non-government contributions	154	196	42	181	15
Investment and other income	185	227	42	218	9
Total revenues	**$ 15,365**	**$ 15,468**	**$ 103**	**$ 15,274**	**$ 194**

Significant variances are explained as follows:

COMPARISON TO BUDGET

Fees and charges was $24 million or 4.7% higher than the budget mainly due to an increased number of patients, including those who reside outside Alberta and were provided care that is billable to other Canadian jurisdictions, the Workers' Compensation Board (WCB) and other responsible parties.

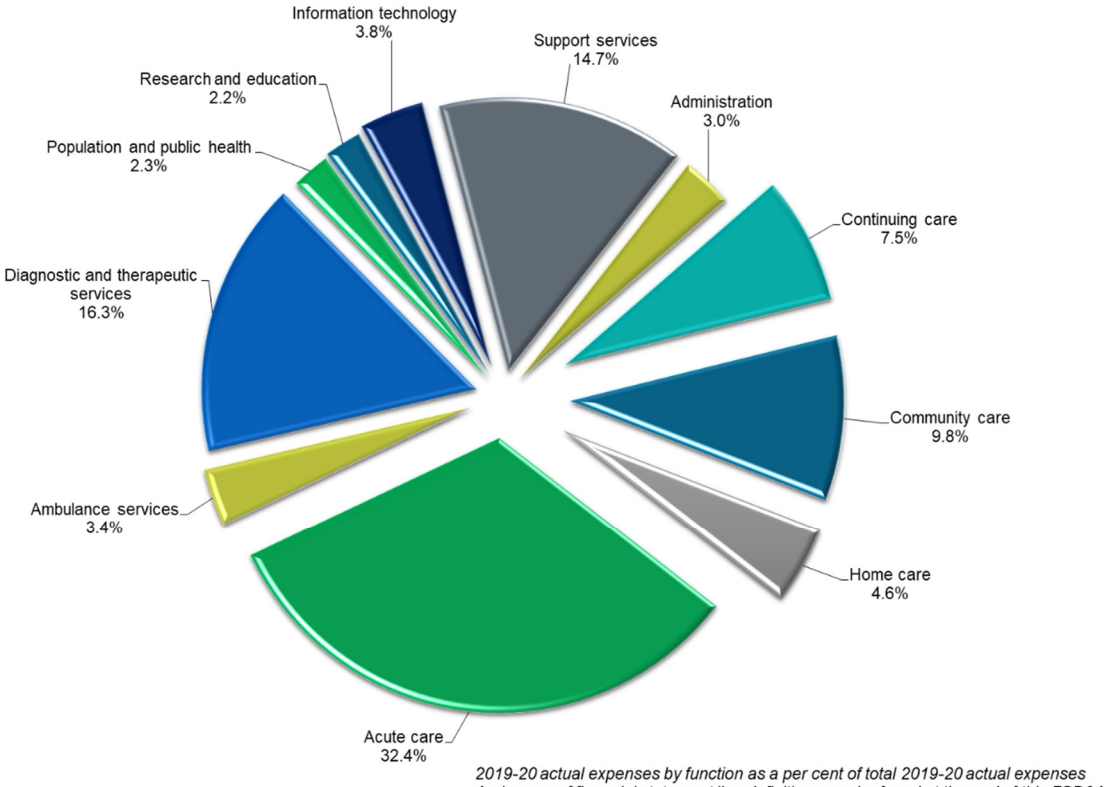
Donations, fundraising and non-government contributions was $42 million or 27.3% higher than the budget mainly due to the accounting for unbudgeted high cost cancer drugs which are received at no cost from suppliers and subsequently provided at no cost to patients as part of compassionate drug access programs and higher than anticipated donations throughout the year.

Investment and other income was $42 million or 22.7% higher than the budget mainly due to higher than anticipated recoveries from external entities, such as the WCB. Higher than budgeted interest revenue on funds held in AHS' bank accounts and higher than budgeted realized gains resulting from investment portfolios with a strong fixed income base further contributed to the variance.

COMPARISON TO PRIOR YEAR

Alberta Health transfers was $177 million or 1.3% higher than the prior year mainly due to a base operating funding increase of $82 million. New and increased restricted funding related to the COVID-19 response, physician services programs, addiction and mental health programs, cataract surgeries, Primary Care Networks, and the Outpatient Cancer Drug Benefit Program further contributed to the increase.

Expenses by Function



2019-20 actual expenses by function as a per cent of total 2019-20 actual expenses
A glossary of financial statement line definitions can be found at the end of this FSD&A

Expenses by function represent AHS' major distinguishable activities and services. The overall distribution of expenses by function changed slightly from the prior year, consistent with AHS' efforts, with community, home, and continuing care making up 21.9% of total expenses (2018-19 – 21.4%). Acute care continued to be the largest function, making up 32.4% of total expenses (2018-19 – 32.8%). Total expenses amounted to $15,614 million, which was $249 million or 1.6% higher than the budget of $15,365 million.

EXPENSES BY FUNCTION (in millions)					
	2019-20 Budget	2019-20 Actual	Variance $	2018-19 Actual	Change $
Continuing care	1,157	1,176	(19)	1,137	39
Community care	1,521	1,526	(5)	1,445	81
Home care	689	717	(28)	688	29
Acute care	4,940	5,066	(126)	5,019	47
Ambulance services	517	531	(14)	528	3
Diagnostic and therapeutic services	2,495	2,539	(44)	2,505	34
Population and public health	361	357	4	350	7
Research and education	319	345	(26)	347	(2)
Information technology	588	597	(9)	508	89
Support services	2,265	2,287	(22)	2,260	27
Administration	513	473	40	526	(53)
Total expenses by function	**$ 15,365**	**$ 15,614**	**$ (249)**	**$ 15,313**	**$ 301**

Significant variances are explained as follows:

COMPARISON TO BUDGET

Home care was $28 million or 4.1% higher than the budget mainly due to responding to the increasing demand for home care services through self-managed or contracted providers.

Acute care was $126 million or 2.6% higher than the budget partially due to the demand for health care services, which included providing care to a higher number of hemodialysis and urban emergency room patients than budgeted. Higher than budgeted acute care costs are also partially affected by the availability of long-term care beds that can result in patients waiting in acute care settings. This overall demand contributed to higher staffing levels and overtime costs.

The use of an attrition-based approach for OBP initiatives resulted in delays in achieving some savings. This was partially offset by other cost containment strategies, such as reducing discretionary expenses and enhanced vacancy management.

Further contributing to the variance was the fair-value accounting for unbudgeted high cost cancer drugs received at no cost from suppliers and provided at no cost to patients as part of compassionate drug access programs. During March 2020, the COVID-19 pandemic response resulted in additional unplanned staffing and medical supply expenses in acute care settings across the Province.

Total number of births

49,980 (2019-20)

50,793 (2018-19)

Partially offsetting the overall negative variance was lower demand for other health care services, including obstetric services as a result of lower birth rates. There was also a lower number of surgeries performed than budgeted as a result of the deferral of elective surgeries to expand capacity in anticipation of the peak of the COVID-19 outbreak. Physician vacancies, lower than budgeted benefit expenses, and a budget misalignment with Research and education of $21 million related to the AMHSP North Sector further offset the variance.

Diagnostic and therapeutic services was $44 million or 1.8% higher than the budget mainly due to lower than planned achieved savings. Increased access for Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scans to address wait-times, staffing costs associated with the Wave 1 launch of Connect Care, and unbudgeted laboratory testing during the COVID-19 pandemic response also contributed to the variance. Vacancies and savings related to third party contract settlements partially offset the overall variance.

Research and education was $26 million or 8.2% higher than the budget mainly due the previously mentioned budget misalignment relating to academic support for the AMHSP North Sector of $21 million. Excluding this misalignment, Research and education was $5 million higher than budget mainly due to slightly higher than budgeted expenses related to the AMHSP North and South Sectors.

Support services was $22 million or 1.0% higher than the budget mainly due to the write-down of the cancelled Edmonton Lab Hub. Further contributing to the variance was increased protective services, higher staffing costs related to the impact of the leap year and the AUPE union settlement, support related to the COVID-19 pandemic response, and inflation related to utilities and other contracts. The overall increase was partially offset by cost containment measures including the strategic deferral of certain maintenance projects, lower minor equipment purchases, and lower staff travel.

Administration was $40 million or 7.8% lower than the budget mainly due to vacancies and a reduction in other expenses as a result of discretionary spending reduction strategies, such as reduced spending on travel, non-clinical education, and minor equipment purchases.

COMPARISON TO PRIOR YEAR

Continuing care was $39 million or 3.4% higher than the prior year mainly due to higher contracted health service provider costs related to the annualized cost of the operation of beds that opened part way through the prior year and the opening of new beds in 2019-20, related to CCCP. In the last two years, there were 1,878 net new continuing care beds opened[8].

Community care was $81 million or 5.6% higher than the prior year mainly due to higher costs resulting from the full implementation of initiatives related to CCCP and ECC which started part-way through the prior year. Higher costs related to Primary Care Networks and a higher number of urgent care visits compared to the prior year also contributed to the increase.

Home care was $29 million or 4.2% higher than the prior year mainly due to increased demand for home care services and the full implementation of initiatives started part way through the prior year related to ECC.

Total number of home care clients served

132,478 (2019-20)

127,150 (2018-19)

Acute care was $47 million or 0.9% higher than the prior year mainly due to increased utilization of high cost cancer drugs and newly approved cancer drugs, which were either received at no cost from suppliers or funded directly through the Outpatient Cancer Drug Benefit Program. The COVID-19 pandemic response and the impact of the leap year also resulted in additional expenses. The achievement of various OBP initiatives and enhanced vacancy management offset a portion of the increase.

Diagnostic and therapeutic services was $34 million or 1.4% higher than the prior year mainly due to a full year of ECC initiatives that started part way through the prior year, Allied Health community programs[9], the implementation of Wave 1 of Connect Care, and laboratory costs related to the COVID-19 pandemic response. The increase was partially offset by achieved savings related to third party contract negotiations.

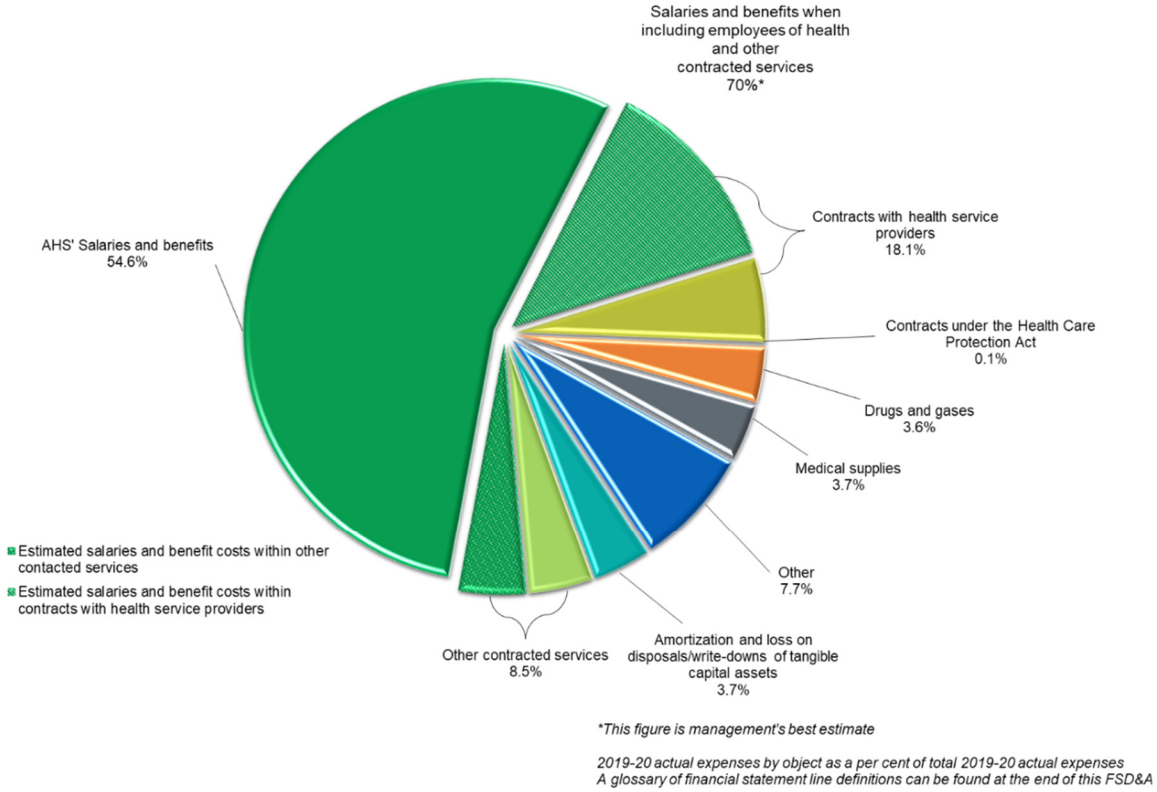
Information technology was $89 million or 17.5% higher than the prior year mainly due to costs related to the continued development and implementation of Connect Care, including the Wave 1 launch in November. The write-down of out-of-date information technology operating systems further contributed to the increase.

Support services was $27 million or 1.2% higher than the prior year mainly due to the write-down of the cancelled Edmonton Lab Hub. Increased protective services, and support for clinical initiatives, the impact of the leap year, the AUPE union settlement, and support related to the COVID-19 pandemic response further contributed to the increase. The overall increase was partially offset by cost containment measures, including the strategic deferral of certain maintenance projects, lower minor equipment purchases, and lower staff travel.

Administration was $53 million or 10.1% lower than prior year mainly due to lower costs of liability insurance.

[8] Expenses related continuing care beds may be recorded in continuing care or community care in AHS' consolidated financial statements based on the national standards from the Canadian Institute for Health Information (CIHI) and in accordance with the financial directives issued by Alberta Health.
[9] Allied Heath community programs cover a continuum from health promotion to acute care involving: audiology, exercise therapy, occupational therapy, physiotherapy, recreational therapy, speech language pathology, social work, and respiratory therapy services

Expenses by Object



**This figure is management's best estimate*

2019-20 actual expenses by object as a per cent of total 2019-20 actual expenses
A glossary of financial statement line definitions can be found at the end of this FSD&A

The overall distribution of expenses by object remained consistent with prior years with salaries and benefits making up 54.6% of total expenses (2018-19 – 54.3%). When including the employees of AHS' contracted health service providers and other contracted services the percentage increases to approximately 70%.

EXPENSES BY OBJECT (in millions)					
	2019-20 Budget	2019-20 Actual	Variance $	2018-19 Actual	Change $
Salaries and benefits	8,327	8,530	(203)	8,322	208
Contracts with health service providers	2,781	2,824	(43)	2,750	74
Contracts under the Health Care Protection Act	20	20	-	17	3
Drugs and gases	501	561	(60)	506	55
Medical supplies	588	581	7	593	(12)
Other contracted services	1,378	1,320	58	1,323	(3)
Other	1,216	1,196	20	1,273	(77)
Amortization and loss on disposals/ write-downs of tangible capital assets	554	582	(28)	529	53
Total expenses by object	**$ 15,365**	**$ 15,614**	**$ (249)**	**$ 15,313**	**$ 301**

Significant variances are explained as follows:

COMPARISON TO BUDGET

Salaries and benefits was $203 million or 2.4% higher than the budget mainly due to higher than budgeted demand for acute care services, which resulted in higher staffing levels and overtime. The use of an attrition-based approach for OBP initiatives also resulted in delays in achieving some savings. Further contributing to the variance was the impact of the AUPE union settlement and additional staff required for the COVID-19 pandemic response. A high number of planned vacancies partially offset the variance.

Contracts with health service providers was $43 million or 1.5% higher than the budget mainly due to providing increased funding to meet demand for home care, acute care, and diagnostic and therapeutic services.

Drugs and gases was $60 million or 12.0% higher than the budget mainly due to the fair-value accounting for unbudgeted high cost cancer drugs received at no cost from suppliers and provided at no cost to patients as part of compassionate drug access programs. Higher utilization of newly approved cancer drugs funded through the Outpatient Cancer Drug Benefit Program further contributed to the variance.

Other contracted services was $58 million or 4.2% lower than the budget mainly due to physician vacancies and savings related to third party contract settlements. Partially offsetting the variance was higher than budgeted MRI and CT scans to address wait-times, higher demand for contracted security services, contract inflation related to technology services, and lower than planned achieved savings.

Other was $20 million or 1.6% lower than the budget mainly due to cost containment measures including the strategic deferral of certain maintenance projects, lower minor equipment purchases, reducing or delaying non-essential purchases, and lower staff travel. Increased information technology expenses as a result of required computer replacements and higher utilities as a result of market price inflation partially offset the variance.

Amortization was $28 million or 5.1% higher than the budget mainly due to the write-down of the cancelled Edmonton Lab Hub and out-of-date information technology operating systems.

COMPARISON TO PRIOR YEAR

Salaries and benefits was $208 million or 2.5% higher than the prior year mainly due to increased staffing costs to support the continued implementation and operation of priority initiatives, including Connect Care, ECC, and CCCP. The extra day due to the leap year, the COVID-19 pandemic response, and the AUPE union settlement further contributed to the increase.

Contracts with health service providers was $74 million or 2.7% higher than the prior year mainly due to increased contracted provider funding to support the continued implementation of priority initiatives, including Connect Care, ECC, and CCCP, as well as responding to the increasing demand for home care services in order to avoid having patients waiting for home care in acute or continuing care settings.

Drugs and gases was $55 million or 10.9% higher than the prior year mainly due to increased drug costs as a result of increased utilization of high cost cancer drugs and newly approved cancer drugs, which were either received at no cost from suppliers through compassionate drug access programs or funded directly through the Outpatient Cancer Drug Benefit Program.

Total number of cancer patients cared for

62,513 (2019-20)

59,249 (2018-19)

Other was $77 million or 6.0% lower than the prior year due to decreased costs of liability insurance and cost containment measures including the strategic deferral of certain maintenance projects, lower minor equipment purchases, reducing or delaying non-essential purchases, and lower staff travel.

Amortization and loss on disposals/write-downs of tangible capital assets was $53 million or 10.0% higher than the prior year mainly due to increased amortization of capital assets related to Connect Care, the write-down of the cancelled Edmonton Lab Hub and out-of-date information technology operating systems.

Financial Position - Comparison to Prior Year

AHS prepares its consolidated financial statements using the net debt presentation which emphasizes financial vs. non-financial assets on the Consolidated Statement of Financial Position. Net debt represents the extent to which sufficient financial assets exist to discharge liabilities.

FINANCIAL POSITION (in millions)			
	2019-20	2018-19	Change $
Financial assets	2,633	2,706	(73)
Liabilities	(3,332)	(3,123)	(209)
Net debt	**$ (699)**	**$ (417)**	**$ (282)**
Non-financial assets	9,195	8,655	540
Expended deferred capital revenue	(7,360)	(6,925)	(435)
Net assets	**$ 1,136**	**$ 1,313**	**$ (177)**

Net assets represent the extent to which total assets exceed total liabilities, including expended deferred capital revenue. AHS ended the year with an overall positive net asset position of $1,136 million reflecting a 13.5% decrease over the prior year. AHS' net assets are comprised of its unrestricted surplus, investment in capital assets, endowments, internally restricted surplus for insurance equity requirements and AHS' controlled foundations.

AHS saw its net debt ratio of liabilities to financial assets increase slightly to 1.26 (2018-19 – 1.15). The increase was mainly due to an increase in liabilities related to the timing of payroll and remittance liabilities, new obligations under capital leases, and the net decrease in financial assets as a result of investment liquidations driven by operational cash requirements during the year. The net asset ratio of total assets to total liabilities remained positive and stable at 1.10 (2018-19 – 1.13).

Financial Assets

Financial assets are the financial resources available to AHS to settle its liabilities or to finance future activities.

CASH

Cash is comprised of cash on hand. Cash on hand is held for the purpose of meeting short-term commitments. At year-end, AHS' consolidated cash balances were $539 million compared to $61 million at March 31, 2019. AHS preserved higher cash balances in response to the COVID-19 pandemic for the purpose of procuring significant volumes of PPE and for other short-term cash requirements. As a result AHS' year-end cash balance was higher than in previous years.

PORTFOLIO INVESTMENTS

In accordance with AHS' Investment Policy and Investment Bylaw, AHS' investment portfolio strategy invests mainly in high quality instruments, such as government and corporate bonds and lower volatility equities. The portfolio is sufficiently liquid in nature to enable AHS to respond to cash flow requirements quickly and efficiently.

AHS' portfolio is designed to ensure that funds are invested to promote short and long-term sustainability of AHS' operations. The investment philosophy assures preservation of capital by minimizing exposure to undue risk of loss, while maintaining a reasonable expectation of fair return or appreciation and offsetting the effects of inflation. This strategy protects the original investment value while providing reasonable returns with a conservative exposure to equity markets.

Investments decreased during the year by $796 million, or 34.9% to $1,483 million. This decrease was due to required investment liquidations driven by operational cash requirements, the timing of cash inflows and outflows at year-end, and the need to maintain higher cash balances in anticipation of the ramp-up of COVID-19 related procurement needs. Investments are used to fund AHS' liabilities, both short and medium term, including accounts payable, accrued liabilities, employee future benefits, and debt.

AHS' investment portfolio generated a return of 3.9% during 2019-20 (2018-19 - 2.8%), the result of strong market performances throughout the year. The market declines in March 2020 as a result of the global pandemic dampened year-end investment valuations, but were less impactful on AHS' overall returns in the year as a whole. AHS' investment portfolio is low risk in nature with more funds invested in fixed income than equities, and as a result has outperformed the performance benchmarks in the AHS Investment Policy during this period of volatility.

ACCOUNTS RECEIVABLE

AHS' accounts receivable include amounts related to patient receivables, such as uninsured services, services provided to non-residents, Emergency Medical Services (EMS), WCB, and GST receivables. Amounts owed to AHS by Alberta Health, Alberta Infrastructure, and other government organizations are also included in this category.

Accounts receivable increased by 66.9% to $611 million during the year, mainly due to an increase in receivables related to restricted funding from Alberta Health. This was partly offset by Alberta Infrastructure capital funding received during 2019-20.

Liabilities

Liabilities are existing financial obligations of AHS as at the date of the consolidated financial statements.

ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

Accounts payable and accrued liabilities includes payroll and remittance liabilities, trade accounts payable, and other obligations, including obligations under capital leases.

Accounts payable and accrued liabilities increased by $122 million to $1,628 million mainly as a result of increased payroll accruals due to the timing of pay periods, which included additional costs related to the COVID-19 response. New obligations under capital lease also contributed to the increase from the prior year.

DEBT

AHS' debt is primarily comprised of debentures issued to Alberta Capital Financing Authority (ACFA) to finance the construction of parking facilities.

AHS parking operations is an ancillary operation, and under the Alberta Regional Health Authorities regulation must be self-sustaining and able to generate sufficient cash flows to repay these loans. AHS pledges the revenue derived from all parking facilities as security for the debentures.

During the year, AHS received $157 million in loan proceeds for the construction of the Calgary Cancer Centre parkade which increased AHS' debt balance to $482 million as at March 31, 2020 (2018-19-$348 million). Total repayments during the year on all other outstanding debt amounted to $23 million.

AHS also has access to a $220 million revolving demand loan facility with a Canadian chartered bank, which may be used for operating purposes. This facility was not utilized during the year. AHS also has access to a $33 million revolving demand letter of credit facility, of which $4 million in letters of credit were outstanding at March 31, 2020 (2018-19 - $4 million).

OTHER LIABILITIES

Employee future benefits includes vacation benefits payable and accumulated non-vesting sick leave. Unexpended deferred operating revenue and unexpended deferred capital revenue are comprised of unspent operating and capital funds that have been received by AHS for which spending restrictions, imposed by a funder or donor, exist. Other liabilities saw minimal changes from the prior year.

EXPENDED DEFERRED CAPITAL REVENUE

Expended deferred capital revenue represents external resources spent on the acquisition of capital assets, stipulated for use in the provision of services over their useful lives. These balances are recognized as revenue over the useful lives of the related assets acquired. The assets include hospitals and other facilities, equipment, and information technology systems. Funding from the Government of Alberta represented $6,679 million, or 90.7% of the $7,360 million total balance (2018-19 – 92.3%).

Non-Financial Assets

Non-financial assets are assets that are not intended to be monetized for settling AHS' liabilities. While capital assets are AHS' most significant non-financial assets, other non-financial assets including inventories and prepaid expenses are also included.

TANGIBLE CAPITAL ASSETS

To effectively provide quality health care services to Albertans, AHS maintains and invests in capital assets, including facilities and improvements, equipment, information technology systems, building service equipment, and land.

TANGIBLE CAPITAL ASSETS
(in millions)

	Actual 2019-20	Actual 2018-19	Increase (Decrease)
Cost	17,159	16,234	925
Accumulated amortization	8,303	7,853	450
Net book value	**$ 8,856**	**$ 8,381**	**$ 475**

In the current year, capital assets increased by $475 million. This increase is mainly within work in progress (WIP), which represents assets acquired but not yet ready for use, and equipment additions.

Several capital projects totaling $764 million were brought into service during 2019-20, including Connect Care (Wave 1), the installation of building service equipment, facility renovations, and the Foothills Medical Centre parkade.

The remaining WIP of $1,745 million includes facilities, improvements, and information technology capital expenditures that support the following initiatives:

- Grande Prairie Regional Hospital Development
- Connect Care Wireless Program
- Calgary Cancer Centre (including the parkade)
- Norwood Care Centre
- Fort McMurray Care Centre

Capital equipment additions in 2019-20 included equipment acquired for diagnostic services, EMS, the Grande Prairie Regional Hospital, leased vehicles, and beds.

While certain capital assets are internally funded from net assets, AHS receives significant external funding for capital expenditures, primarily from Alberta Government ministries. In 2019-20, capital asset additions amounted to $1,057 million, of which 85.7% were externally funded (2018-19 – 72.4%).

OTHER NON-FINANCIAL ASSETS

Prepaid expenses increased $45 million from the prior year mainly as a result of deposits paid for the future procurement of PPE for the COVID-19 pandemic response. The remaining non-financial assets saw minimal increases from the prior year.

Net Assets

AHS is in an overall positive net asset position, reflecting the amount by which assets exceed liabilities. This measure that represents the net economic position of the organization from all years of operations.

AHS' net assets, decreased in 2019-20 mainly due to AHS' current year operating deficit. AHS' net assets are comprised of accumulated surplus and accumulated remeasurement gains and losses.

NET ASSETS (in millions)			
	Actual 2019-20	Actual 2018-19	Increase (Decrease)
Unrestricted Surplus	35	42	(7)
Invested in tangible capital assets	940	940	-
Endowments	75	75	-
Internally restricted surplus for future purposes	-	153	(153)
Internally restricted surplus for insurance equity requirements and foundations	82	68	14
Accumulated Surplus	**$ 1,132**	**$ 1,278**	**$ (146)**
Accumulated Remeasurement Gains	4	35	(31)
Total Net Assets	**$ 1,136**	**$ 1,313**	**$ (177)**

The unrestricted surplus of $35 million at March 31, 2020 does not have any restrictions attached to its future use and may be used at AHS' discretion for operating or capital purposes. The decrease in the current year is related to the annual operating deficit and the purchase of capital assets with internal funds. As a result of AHS' annual operating deficit, internal restrictions on surpluses for future purposes were released, resulting in the transfer of $129 million to unrestricted surplus.

The invested in capital assets balance at March 31, 2020 of $940 million represents the net book value of capital assets that have previously been purchased with AHS' unrestricted surplus. AHS' internally funded capital assets support the objectives of the Health Plan and the delivery of effective programs and services.

The internally restricted surplus for future purposes represents surpluses which have been approved by the Board to be restricted for various requirements, including the need to address funding of expenses for certain initiatives spanning multiple fiscal years. As a result of AHS' annual operating deficit, internal restrictions were released and $129 million was transferred to unrestricted surplus and $24 million was invested in the capital assets.

The endowments of $75 million are comprised of donations received by AHS and its controlled foundations where the principal amount is maintained in perpetuity and investment income earned on the principal is available for use as stipulated by the endowment donors.

Internally restricted surplus for insurance equity requirements of $28 million (2018-19 - $16 million) represents the equity of the Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP) relating to legislative requirements of the Insurance Act. The balance of donations received in the name of AHS' controlled foundations without external restrictions was $54 million (2018-19 - $52 million).

Accumulated remeasurement gains represent accumulated unrealized gains on portfolio investments excluding restricted transfers or donations. The decrease of $31 million from the prior year relates to decreases in the fair value of AHS' portfolio investments due to the decline in stock markets towards the end of the year.

Financial Reporting, Control and Accountability

The AHS consolidated financial statements have been prepared in accordance with Canadian Public Sector Accounting Standards and the financial directives issued by Alberta Health. The chart of accounts that AHS uses to report expenses by function and by object is based on the national standards from the Canadian Institute for Health Information (CIHI). Detailed site-based results are submitted to CIHI annually for analysis and reporting on Canada's health system and the health of Canadians. AHS' annual reports are available at **www.albertahealthservices.ca** under "Publications and Transparency".

AHS performance measures correspond with the AHS 2017-20 Health Plan's 12 Objectives built on the four areas of focus in AHS' Quadruple Aim (patient experience, patient and population outcomes, our people, and financial health and value for money).

An effective and integrated governance model is an essential component in support of improving:

- the delivery of care and services to Albertans;
- support for people who deliver care and services; and
- the way the organization operates.

The Board provides oversight and carries out its risk management mandate primarily through sub committees, which include the Audit & Risk Committee, Finance Committee, Quality & Safety Committee, Governance Committee, Human Resources Committee, and Community Engagement Committee.

The Audit & Risk Committee assists the Board in fulfilling their oversight responsibilities with respect to enterprise risk management and compliance, external financial reporting, internal controls over financial reporting, internal audit, and the external audit. The Finance Committee assists the Board in fulfilling their financial oversight responsibilities including those pertaining to the Health Plan and Business Plan, the budget, and the investment portfolio.

AHS has established an Internal Audit function with the mandate of providing independent advisory and assurance services to management and the Board on AHS operations. The scope of Internal Audit's work includes a risk-based approach to evaluate and improve the effectiveness of AHS' governance, risk management, financial and management controls, and operations. The Chief Audit Executive is also responsible for coordinating AHS' Enterprise Risk Management function, including the development and implementation of policies and processes for identifying, monitoring, and reporting on risks within the organization.

As a component of the Internal Audit function, AHS has an Internal Controls over Financial Reporting (ICOFR) team, which is tasked with ensuring the financial reporting environment has a sustainable framework of internal controls that mitigates the risk of material misstatements. In fulfilling its mandate, ICOFR provides assurance on the design and operating effectiveness of the financial reporting controls.

The Auditor General of Alberta is the appointed external auditor of AHS. In addition to expressing an audit opinion on the AHS annual consolidated financial statements, the Auditor General of Alberta also reports recommendations related to AHS to the legislature. The Auditor General of Alberta's reports are available at www.oag.ab.ca under "Our Reports".

Forward-Looking Statements Disclosure

The FSD&A includes forward-looking statements and information about AHS' outlook, direction, operations, and future financial results that are subject to risks, uncertainties, and assumptions. As a consequence, actual results in the future may differ materially from any conclusion, forecast, or projection in such forward looking statements. Forward looking statements should be considered carefully and undue reliance should not be placed on them.

Outlook

AHS continues to enhance and improve health services and strive to operate within the budget approved by AHS' Board of Directors and the Minister of Health. These objectives have not changed as a result of the COVID-19 pandemic.

Over the next several years, AHS will improve wait times for surgeries and continue to enhance care in the community by adding new continuing care spaces. Implementation of Connect Care will continue and, in time, will give health care providers immediate access to tools for decision-making and will give patients access to their own health information. Efficiencies will be achieved through ongoing implementation of operational and clinical best practices. AHS, in conjunction with Alberta Health and Alberta Infrastructure, will continue to support facilities, equipment, and other infrastructure needed to deliver quality health services.

Almost all work on the strategic priorities noted above was paused due to the global COVID-19 pandemic. Efforts will be gradually restarted, but implementation plans and timelines will need to be revisited. Some action and progress in the 2020-21 fiscal year is expected but clinical, operational, and financial objectives for 2020-21 that were established before the pandemic will not be achievable. Dialogue with Alberta Health and the Minister is required to set realistic outcomes for 2020-21 recognizing the delays in implementation that have already resulted and the risk of additional delays due to future waves or local outbreaks of COVID-19.

Risks

AHS has an Enterprise Risk Management (ERM) program which supports AHS leadership and management in identifying, analyzing, and monitoring risks that may impact the achievement of its strategic objectives. Priority strategic risks for AHS for future years are updated annually and risk mitigation strategies are developed.

The following are key risks and mitigation strategies for the outlook:

COVID-19

Restrictions as a result of public health measures will be carefully and gradually lifted when Alberta begins its relaunch strategy. AHS will enhance COVID-19 testing and contact tracing to identify and notify people at risk and will ensure strong protections for those most at risk, including those in continuing care settings. The COVID-19 pandemic response will remain AHS' top priority and this creates risk for other priority initiatives such as Connect Care and the Alberta Surgical Initiative. Clinical, operational, and financial benefits from these initiatives could be significantly delayed for lower than previously anticipated.

Although the COVID-19 pandemic will also impact AHS' risks related to population and demand, financial sustainability, engagement, and infrastructure, the risks described below are additional risks to AHS.

POPULATION AND DEMAND

The population of Alberta continues to increase and is aging and living longer. On average, AHS is providing more health care per person compared to previous generations. These factors are driving increased demand and costs in many areas of the health care system. AHS will work with Alberta Health to increase Albertan's understanding of the health system and to reallocate funding to support the transformation toward a more sustainable system. By enhancing care in the community, AHS expects to increase quality of life and independence for patients and manage demand on our hospitals.

FINANCIAL

To manage the risks to AHS' long-term financial sustainability, there will be a strong focus on achieving savings, managing cost growth, and improving quality.

The AHS Performance Review was completed in February 2020 and identified savings opportunities to improve the quality and long-term sustainability of health services. AHS has been engaging staff and clinical leaders to develop a long-term implementation plan and will submit an initial plan to the Minister of Health in August 2020.

Salaries and benefits expenses represent the largest cost for AHS so managing cost growth in these areas is critical. Collective bargaining agreements with the United Nurses of Alberta (UNA), Health Sciences Association of Alberta (HSAA) and Alberta Union of Provincial Employees (AUPE) (Auxiliary Nursing, General Support Services) expired on March 31, 2020 and further negotiations on new agreements have been postponed until later this year. This delay will impact AHS' ability to move forward on workforce related changes identified in the AHS Performance Review.

AHS will continue to focus on improving quality, which saves the health system money through fewer complications, fewer hospital readmissions, shorter hospital lengths of stay, and enabling more seniors to remain safe and independent in their homes.

ENGAGEMENT

Enhancing care and managing cost growth requires engagement from multiple stakeholders, including advisory councils, AHS' employees, physicians, contracted health care providers, and the Government of Alberta. AHS will work with all key stakeholders to plan for and implement strategies and initiatives that will manage cost growth and maximize the value of each dollar spent.

INFRASTRUCTURE

Facilities, equipment, and information technology systems are vital to the delivery of health care services. Aging infrastructure and the need for expanded infrastructure in priority areas will create funding pressures. Strategic investments are being made in new infrastructure, such as Connect Care, the Grande Prairie Regional Hospital, the Calgary Cancer Centre, new continuing care facilities, and renewal of the Red Deer Regional Hospital Centre. Investments in facilities maintenance and the replacement of clinical and information technology equipment are also ongoing. AHS will work closely with Alberta Health and Alberta Infrastructure to develop multi-year capital plans.

Glossary of Financial Statement Line Definitions

These definitions are based on the national standards from the Canadian Institute for Health Information (CIHI) and are in accordance with the financial directives issued by Alberta Health.

REVENUES

Alberta Health transfers are comprised of all funding received from Alberta Health; unrestricted, restricted operating, and capital. Unrestricted Alberta Health transfers are the main source of operating funding to provide health-care services to the population of Alberta. Restricted operating and capital funding can only be used for specific purposes and are recognized when the related expenses are incurred.

Other government transfers are comprised of funding from federal, provincial (other than Alberta Health), and municipal governments that can be unrestricted or restricted for operating or capital purposes. Restricted amounts received are recognized as revenue when the related stipulations are met.

Fees and charges consist of patient revenue from medically necessary health services provided to patients, and collected by AHS from individuals, Workers' Compensation Board (WCB), federal and provincial governments, and other parties, such as Alberta Blue Cross and other insurance companies.

Ancillary operations consist of revenue from the sale of goods and services that are unrelated to the direct provision of health services, and include parking, non-patient food services, and rental operations.

Donations, fundraising, and non-government contributions are comprised of revenue that can be unrestricted or restricted for operating or capital purposes. Restricted amounts received are recognized as revenue when the related stipulations are met.

Investment and other income is comprised of interest income, dividends, net realized gains and losses on disposal of investments, recoveries from external sources other than ancillary operations, and miscellaneous revenues that cannot be classified elsewhere.

EXPENSES BY FUNCTION

Continuing care is comprised of long-term care including chronic and psychiatric care in facilities operated by AHS and contracted providers.

Community care includes supportive living, palliative and hospice care, and community programs including Primary Care Networks, Family Care Clinics, urgent care centres, and community mental health. This segment excludes community-based dialysis, oncology, and surgical services.

Home care is comprised of home nursing and support.

Acute care is comprised predominantly of patient care units such as medical, surgical, intensive care, obstetrics, pediatrics, mental health, emergency, day/night care, clinics, day surgery, and contracted surgical services. This category also includes operating and recovery rooms.

Ambulance services is comprised of ground ambulance, air ambulance, patient transport, and Emergency Medical Services (EMS) central dispatch. AHS also supports community paramedic programs, as well as other programs that support the learning, development, quality and safety of EMS professionals.

Diagnostic and therapeutic services support and provide care for patients through clinical laboratories (both in the community and acute settings), diagnostic imaging, pharmacy, acute and therapeutic services such as physiotherapy, occupational therapy, respiratory therapy, and speech language pathology.

Population and public health is comprised primarily of health promotion, disease and injury prevention, and health protection.

Research and education is comprised primarily of costs pertaining to health research and graduate medical education, primarily funded by donations, and third party contributions.

Information technology is comprised of costs pertaining to the provision of services to design, develop, implement, and maintain effective and efficient management support systems in the areas of data processing, systems engineering, technical support, and systems research and development.

Support services is comprised of building maintenance operations (including utilities), materials management (including purchasing, central warehousing, distribution and sterilization), housekeeping, patient registration, health records, food services, and emergency preparedness.

Administration is comprised of human resources, finance, communications and general administration, as well as a share of administration of certain contracted health service providers. General administration includes senior executives and many functions such as planning and development, infection control, quality assurance, patient safety, insurance, privacy, public relations, risk management, internal audit, and legal.

EXPENSES BY OBJECT

Salaries and benefits is comprised of compensation for hours worked, vacation and sick leave, other cash benefits (which includes overtime), employer benefit contributions made on behalf of employees, and severance.

Contracts with health service providers include voluntary and private health service providers with whom AHS contracts for health services, such as long-term care facilities, acute care providers, home care providers, and lab service providers. These health service providers incur expenses similar to AHS, such as salaries and benefits, clinical supplies and other expenses.

Contracts under the Health Care Protection Act relates to contracts with surgical facilities pursuant to the Health Care Protection Act which ensures quality while promoting the delivery of publicly funded services by allowing contracting out to profit-orientated surgical facilities.

Drugs and gases include all drugs used by AHS, including medicines, certain chemicals, anaesthetic gas, oxygen, and other medical gases used for patient treatment. Drugs used for purposes other than patient treatment such as diagnostic reagents, are not included in this category, and are reported in other expenses.

Medical supplies include prostheses, instruments used in surgical procedures and in treating and examining patients, sutures, and other supplies.

Other contracted services are payments to those under contract that are not considered to be employees. This category includes payments to physicians for referred-out services and purchased services, as well as home support contracts and various self-managed care contracts.

Other expenses relate to those expenses not classified elsewhere.

Amortization and losses on disposals/write-downs of tangible capital assets relates to the periodic charges to expenses representing the estimated portion of the cost of the respective tangible capital asset that expired through use and age during the period. A loss on disposal/write-down of capital assets occurs when the net book value (defined as historical cost less accumulated amortization) exceeds the proceeds/fair value from the disposal/write-down.

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2020

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the year ended March 31, 2020 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Public Sector Accounting Standards and the financial directives issued by Alberta Health, and of necessity include some amounts based on estimates and judgment.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains systems of financial management and internal control which give consideration to costs, benefits and risks that are designed to:

- provide reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations, and properly recorded so as to maintain accountability of public money;
- safeguard the assets and properties of the "Province of Alberta" under Alberta Health Services' administration

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit & Risk Committee (the Committee). The Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to the Alberta Health Services Board for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Committee.

The Auditor General of Alberta provides an independent audit of the consolidated financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures which allow him to report on the fairness of the consolidated financial statements prepared by management.

[original signed by]

Dr. Verna Yiu, MD, FRCPC
President and Chief Executive Officer
Alberta Health Services

[original signed by]

Robert Hawes, CPA, CA, ICD.D
Interim Vice President Corporate Services and Chief Financial Officer
Alberta Health Services

June 24, 2020

Auditor General
OF ALBERTA

Independent Auditor's Report

To the Members of the Alberta Health Services Board and the Minister of Health

Report on the Consolidated Financial Statements

Opinion

I have audited the consolidated financial statements of Alberta Health Services (the Group), which comprise the consolidated statement of financial position as at March 31, 2020, and the consolidated statements of operations, change in net debt, remeasurement gains and losses, and cash flows for the year then ended and notes to the consolidated financial statements, including a summary of significant accounting policies.

In my opinion, the accompanying consolidated financial statements present fairly, in all material respects, the consolidated financial position of the Group as at March 31, 2020, and the results of its operations, its remeasurement gains and losses, its changes in net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for opinion

I conducted my audit in accordance with Canadian generally accepted auditing standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Consolidated Financial Statements* section of my report. I am independent of the Group in accordance with the ethical requirements that are relevant to my audit of the consolidated financial statements in Canada, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Other information

Management is responsible for the other information. The other information comprises the information included in the *Annual Report*, but does not include the consolidated financial statements and my auditor's report thereon. The *Annual Report* is expected to be made available to me after the date of this auditor's report.

My opinion on the consolidated financial statements does not cover the other information and I do not express any form of assurance conclusion thereon.

In connection with my audit of the consolidated financial statements, my responsibility is to read the other information identified above and, in doing so, consider whether the other information is materially inconsistent with the consolidated financial statements or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

If, based on the work I will perform on this other information, I conclude that there is a material misstatement of this other information, I am required to communicate the matter to those charged with governance.

Responsibilities of management and those charged with governance for the consolidated financial statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of the consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is responsible for assessing the Group's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless an intention exists to liquidate or to cease operations, or there is no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Group's financial reporting process.

Auditor's responsibilities for the audit of the consolidated financial statements

My objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these consolidated financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, I exercise professional judgment and maintain professional skepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Group's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Group's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the consolidated financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the Group to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the consolidated financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

- Obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the Group to express an opinion on the consolidated financial statements. I am responsible for the direction, supervision and performance of the group audit. I remain solely responsible for my audit opinion.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

[Original signed by W. Doug Wylie FCPA, FCMA, ICD.D]
Auditor General

June 24, 2020
Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS YEAR ENDED MARCH 31			
	2020		2019
	Budget (Note 3)	Actual	Actual
Revenues:			
Alberta Health transfers			
Base operating	$ 12,600,000	$ 12,598,000	$ 12,485,595
One-time base operating	-	-	29,558
Other operating	1,294,000	1,290,302	1,192,862
Recognition of expended deferred capital revenue	61,000	61,354	65,104
Other government transfers (Note 4)	427,000	434,768	429,665
Fees and charges	508,000	532,250	538,721
Ancillary operations	136,000	129,129	133,513
Donations, fundraising, and non-government contributions (Note 5)	154,000	195,980	181,319
Investment and other income (Note 6)	185,000	226,752	218,367
TOTAL REVENUE	**15,365,000**	**15,468,535**	**15,274,704**
Expenses:			
Continuing care	1,157,000	1,176,468	1,137,363
Community care	1,521,000	1,525,789	1,445,283
Home care	689,000	716,561	688,295
Acute care	4,940,000	5,065,807	5,018,467
Ambulance services	517,000	530,662	528,045
Diagnostic and therapeutic services	2,495,000	2,539,566	2,505,618
Population and public health	361,000	357,117	349,669
Research and education	319,000	344,634	347,239
Information technology	588,000	597,005	507,326
Support services (Note 7)	2,265,000	2,287,205	2,260,421
Administration (Note 8)	513,000	473,544	525,609
TOTAL EXPENSES (Schedules 1 and 3)	**15,365,000**	**15,614,358**	**15,313,335**
ANNUAL OPERATING DEFICIT	**-**	**(145,823)**	**(38,631)**
Accumulated surplus, beginning of year	1,278,000	1,278,424	1,317,055
Accumulated surplus, end of year (Note 19)	**$ 1,278,000**	**$ 1,132,601**	**$ 1,278,424**

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31		
	2020 Actual	2019 Actual (Note 26)
Financial Assets:		
Cash	$ 538,778	$ 60,610
Portfolio investments (Note 10)	1,483,341	2,279,068
Accounts receivable (Note 11)	610,571	366,722
	2,632,690	2,706,400
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,627,584	1,505,873
Employee future benefits (Note 13)	707,471	688,496
Unexpended deferred operating revenue (Note 14)	405,951	453,219
Unexpended deferred capital revenue (Note 15)	108,823	128,394
Debt (Note 17)	481,551	347,642
	3,331,380	3,123,624
NET DEBT	**(698,690)**	**(417,224)**
Non-Financial Assets:		
Tangible capital assets (Note 18)	8,855,960	8,381,004
Inventories for consumption	127,298	106,509
Prepaid expenses, deposits, and other non-financial assets	211,480	167,722
	9,194,738	8,655,235
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	8,496,048	8,238,011
Expended deferred capital revenue (Note 16)	7,359,615	6,925,118
NET ASSETS	**1,136,433**	**1,312,893**
Net Assets is comprised of:		
Accumulated surplus (Note 19)	1,132,601	1,278,424
Accumulated remeasurement gains	3,832	34,469
	$ 1,136,433	**$ 1,312,893**

Contractual Obligations and Contingent Liabilities (Note 20)
Impact of COVID-19 (Note 25)

The accompanying notes and schedules are part of these consolidated financial statements.

Approved by the Alberta Health Services Board:

[original signed by]

David Weyant, Q.C.
Board Chair

[original signed by]

David Carpenter, FCPA, FCA
Audit & Risk Committee Chair

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT YEAR ENDED MARCH 31			
	2020		2019
	Budget (Note 3)	Actual	Actual
Annual operating deficit	$ -	$ (145,823)	$ (38,631)
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets (Note 18):			
Purchased tangible capital assets	(542,000)	(533,483)	(593,957)
Contributed tangible capital assets	(496,000)	(523,196)	(285,368)
Amortization and loss on disposals/write-downs of tangible capital assets (Note 18)	554,000	581,723	529,628
Effect of other changes:			
Net increase in expended deferred capital revenue	448,000	434,497	189,664
Net decrease (increase) in inventories for consumption	22,000	(20,789)	(9,936)
Net decrease (increase) in prepaid expenses and other non-financial assets	1,000	(43,758)	(2,001)
Net remeasurement gains (losses) for the year	22,000	(30,637)	13,634
Decrease (increase) in net debt for the year	**9,000**	**(281,466)**	**(196,967)**
Net debt, beginning of year	(417,000)	(417,224)	(220,257)
Net debt, end of year	**$ (408,000)**	**$ (698,690)**	**$ (417,224)**

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31			
	2020		2019
	Budget (Note 3)	Actual	Actual
Unrestricted unrealized gains (losses) attributable to:			
Derivatives	$ -	$ 539	$ 253
Portfolio investments	30,000	(5,933)	17,751
Amounts reclassified to the Consolidated Statement of Operations:			
Portfolio investments	(8,000)	(25,243)	(4,370)
Net remeasurement gains (losses) for the year	**22,000**	**(30,637)**	**13,634**
Accumulated remeasurement gains, beginning of year	35,000	34,469	20,835
Accumulated remeasurement gains, end of year (Note 10)	**$ 57,000**	**$ 3,832**	**$ 34,469**

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS YEAR ENDED MARCH 31		
	2020 Actual	2019 Actual (Note 26)
Operating transactions:		
Annual operating deficit	$ (145,823)	$ (38,631)
Non-cash items:		
Amortization and loss on disposals/write-downs of tangible capital assets	581,723	529,628
Recognition of expended deferred capital revenue	(404,405)	(383,405)
Decrease (increase) in:		
Accounts receivable related to operating transactions	(254,073)	48,304
Inventories for consumption	(20,789)	(9,936)
Prepaid expenses and other non-financial assets	(43,758)	(2,001)
Increase (decrease) in:		
Accounts payable and accrued liabilities related to operating transactions	100,838	76,173
Employee future benefits	18,975	15,360
Unexpended deferred operating revenue	(60,847)	(31,957)
Cash (applied to) provided by operating transactions	(228,159)	203,535
Capital transactions:		
Purchased tangible capital assets	(533,483)	(593,957)
Increase in accounts payable and accrued liabilities related to capital transactions	44,406	37,368
Cash applied to capital transactions	(489,077)	(556,589)
Investing transactions:		
Purchase of portfolio investments	(2,683,128)	(3,161,266)
Proceeds on disposals of portfolio investments	3,429,544	3,220,278
Cash provided by investing transactions	746,416	59,012
Financing transactions:		
Restricted capital contributions received	343,010	331,363
Unexpended deferred capital revenue returned	(4,398)	(250)
Proceeds from debt	157,000	-
Principal payments on debt	(23,091)	(22,133)
Payments on obligations under capital leases	(23,814)	(19,985)
Net receipt (repayment) of life lease deposits	281	(596)
Cash provided by financing transactions	448,988	288,399
Increase (decrease) in cash	**478,168**	**(5,643)**
Cash, beginning of year	60,610	66,253
Cash, end of year	**$ 538,778**	**$ 60,610**

The accompanying notes and schedules are part of these consolidated financial statements.

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS FOR THE YEAR ENDED MARCH 31, 2020

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established under the *Regional Health Authorities Act* (Alberta), effective April 1, 2009, as a result of the merger of 12 formerly separate health entities in Alberta.

Pursuant to Section 5 of the *Regional Health Authorities Act* (Alberta), AHS is responsible in Alberta to:

- promote and protect the health of the population and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the population;
- determine priorities in the provision of health services and allocate resources accordingly;
- ensure that reasonable access to quality health services is provided and;
- promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities.

Additionally, AHS is accountable to the Minister of Health (the Minister) for the delivery and operation of the public health system.

The AHS consolidated financial statements include the revenue and expenses associated with its responsibilities. These consolidated financial statements do not reflect the complete costs of provincial health care. For a complete picture of the costs of provincial health care, readers should consult the consolidated financial statements of the Government of Alberta (GOA).

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

These consolidated financial statements have been prepared in accordance with Canadian Public Sector Accounting Standards and the financial directives issued by Alberta Health (AH).

These consolidated financial statements reflect the assets, liabilities, revenues, and expenses of the reporting entity, which is comprised of the organizations controlled by AHS as noted below:

(i) Controlled Entities

AHS controls the following three entities:

- Alberta Precision Laboratories Ltd. (APL) (formerly Alberta Public Laboratories Ltd.) - provides medical diagnostic services throughout Alberta. AHS owns 100% of the Class A voting shares.
- CapitalCare Group Inc. (CCGI) - manages continuing care programs and facilities in the Edmonton area. AHS owns 100% of the Class A voting shares.
- Carewest - manages continuing care programs and facilities in the Calgary area. AHS owns 99% of the Class A voting shares and 1% of the Class A voting shares are held in trust for the benefit of AHS by the Chair of the Board of Directors.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS has majority representation on, or the right to appoint, the governance boards indicating control of the following entities:

- Foundations:

Airdrie Health Foundation
Alberta Cancer Foundation
American Friends of the Calgary Health Trust Foundation (*inactive)*
Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Calgary Health Trust
Canmore and Area Health Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Trust (*inactive)*
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation
Grimshaw/Berwyn and District Hospital Foundation
Jasper Health Care Foundation
Lac La Biche Regional Health Foundation
Lacombe Health Trust
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Peace River and District Health Foundation
Ponoka and District Health Foundation
Rocky Mountain House & Area Health Services Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Two Hills Health Centre Foundation
Vermillion and Region Health and Wellness Foundation (*inactive)*
Viking Health Foundation
Vulcan County Health and Wellness Foundation
Windy Slopes Health Foundation

- Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP)

  LPIP's main purpose is to share the risks of general and professional liability to lessen the impact on any one subscriber. Effective April 1, 2020, LPIP ceased providing new liability coverage and continues in operation for the limited purpose of winding up its affairs.

- Queen Elizabeth II Hospital Child Care Centre

All inter-entity accounts and transactions between these organizations and AHS are eliminated upon consolidation.

(ii) Government Partnerships

AHS proportionately consolidates its 50% interests in Primary Care Network (PCN) partnerships with physician groups, its 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta, and its 33.33% interest in the Institute for Reconstructive Sciences in Medicine (iRSM) partnership with the University of Alberta and Covenant Health (Note 22).

AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services to achieve the PCN plan objectives, and to contract and hold property interests required in the delivery of PCN services.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

The following PCNs are included in these consolidated financial statements on a proportionate basis:

Alberta Heartland Primary Care Network
Aspen Primary Care Network
Big Country Primary Care Network
Bighorn Primary Care Network
Bonnyville Primary Care Network
Bow Valley Primary Care Network
Calgary Foothills Primary Care Network
Calgary Rural Primary Care Network
Calgary West Central Primary Care Network
Camrose Primary Care Network
Chinook Primary Care Network
Cold Lake Primary Care Network
Drayton Valley Primary Care Network
Edmonton North Primary Care Network
Edmonton Oliver Primary Care Network
Edmonton Southside Primary Care Network
Edmonton West Primary Care Network
Grande Prairie Primary Care Network
Highland Primary Care Network
Kalyna Country Primary Care Network
Lakeland Primary Care Network
Leduc Beaumont Devon Primary Care Network
Lloydminster Primary Care Network
McLeod River Primary Care Network
Mosaic Primary Care Network
Northwest Primary Care Network
Palliser Primary Care Network
Peace Region Primary Care Network
Peaks to Prairies Primary Care Network
Provost Primary Care Network
Red Deer Primary Care Network
Rocky Mountain House Primary Care Network
Saddle Hills Primary Care Network (formerly Sexsmith / Spirit River Primary Care Network and West Peace Region Primary Care Network)
Sherwood Park/Strathcona County Primary Care Network
South Calgary Primary Care Network
St. Albert & Sturgeon Primary Care Network
Wainwright Primary Care Network
WestView Primary Care Network
Wetaskiwin and Area Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

All inter-entity accounts and transactions between these organizations and AHS are eliminated upon consolidation.

(iii) Trusts under Administration

These consolidated financial statements do not include trusts administered on behalf of others (Note 23). AHS provides services to certain entities not included in these consolidated financial statements.

(iv) Other

AHS is responsible for the delivery and operation of the public health system in Alberta (Note 1), and contracts with various voluntary and private health service providers to provide health services throughout Alberta. The largest of these service providers is Covenant Health, a denominational health care organization, providing a full spectrum of care. Covenant Health is an independent, separate legal entity with a separate Board of Directors and accordingly, these consolidated financial statements do not include their assets, liabilities or results of operations. However, the payments for contracts with health service providers such as Covenant Health are recorded as expenses in the Consolidated Statement of Operations.

(b) Revenue Recognition

Revenue is recognized in the year in which the transactions or events that give rise to the revenue as described below occur. All revenue is recorded on an accrual basis, except when the accrual cannot be determined within a reasonable degree of certainty or when estimation is impracticable.

(i) Government Transfers

Transfers from AH, other GOA ministries and agencies, and other government entities are referred to as government transfers.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Government transfers and the associated externally restricted investment income are recorded as deferred revenue if the eligibility criteria for the use of the transfer, or the stipulations together with AHS' actions and communications as to the use of the transfer, create a liability. These transfers are recognized as revenue as the stipulations are met and, when applicable, AHS complies with the communicated use of the transfer.

All other government transfers, without stipulations for the use of the transfer, are recorded as revenue when the transfer is authorized and AHS meets the eligibility criteria.

Deferred revenue consists of unexpended deferred operating revenue, unexpended deferred capital revenue, and expended deferred capital revenue. The term deferred revenue in these consolidated financial statements refers to the components of deferred revenue as described.

Unallocated costs comprising of materials and services contributed by related parties in support of AHS' operations, are not recognized in these consolidated financial statements.

(ii) Donations, Fundraising, and Non-Government Contributions

Donations, fundraising, and non-government contributions are received from individuals, corporations, and other not-for-profit organizations. Donations, fundraising, and non-government contributions may be unrestricted or externally restricted for operating or capital purposes.

Unrestricted donations, fundraising, and non-government contributions are recorded as revenue in the year received or in the year the funds are committed to AHS if the amount can be reasonably estimated and collection is reasonably assured.

Externally restricted donations, fundraising, non-government contributions, and the associated externally restricted investment income are recorded as deferred revenue if the terms for their use, or the terms along with AHS' actions and communications as to their use create a liability. These resources are recognized as revenue as the terms are met and, when applicable, AHS complies with the communicated use.

In-kind donations of services and materials from non-related parties are recorded at fair value when such value can reasonably be determined. While volunteers contribute a significant amount of time each year to assist AHS, the value of their services is not recognized as revenue and expenses in the consolidated financial statements because fair value cannot be reasonably determined.

(iii) Transfers and Donations related to Land

Transfers and donations for the purchase of land are recognized as deferred revenue when received and as revenue when the land is purchased.

(iv) Fees and Charges, Ancillary Operations, and Other Income

Fees and charges, ancillary operations, and other income are recognized in the year that goods are delivered or services are provided by AHS. Amounts received for which goods or services have not been provided by year end are recorded as deferred revenue.

(v) Investment Income

Investment income includes dividend income, interest income, and realized gains or losses on the sale of portfolio investments. Unrealized gains and losses on portfolio investments exclusive of restricted transfers or donations are recognized in the Consolidated Statement of Remeasurement Gains and Losses until the related portfolio investments are sold. When realized, these gains or losses are recognized in the Consolidated Statement of Operations. Investment income and unrealized gains and losses from restricted transfers or donations are allocated to their respective balances according to the provisions within the individual funding agreements.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(c) Expenses

Expenses are reported on an accrual basis. The cost of all goods consumed and services received during the year are expensed. Interest expense includes debt servicing costs.

Expenses include grants and transfers under shared cost agreements. Grants and transfers are recorded as expenses when the transfer is authorized and eligibility criteria have been met by the recipient.

(d) Financial Instruments

Financial instruments comprise financial assets and liabilities. Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations. Liabilities are present obligations of AHS to others arising from past transactions or events occurring before the year end, the settlement of which is expected to result in the future sacrifice of economic benefits.

All of AHS' financial assets and liabilities are initially recorded at their fair value. The following table identifies AHS' financial assets and liabilities and identifies how they are subsequently measured:

Financial Assets and Liabilities	Subsequent Measurement and Recognition
Portfolio investments	Measured at fair value with unrealized changes in fair values recognized in the Consolidated Statement of Remeasurement Gains and Losses or deferred revenue until realized, at which time the cumulative changes in fair value are recognized in the Consolidated Statement of Operations.
Accounts receivable, accrued vacation pay, accounts payable and accrued liabilities and debt	Measured at amortized cost.

AHS records equity investments quoted in an active market to be recorded under the fair value category and AHS may choose to record other financial assets under the fair value category if there is an investment strategy to evaluate the performance of a group of these financial assets on a fair value basis. AHS has elected to record all portfolio investments at fair value. The three levels of information that may be used to measure fair value are:

- Level 1 – Unadjusted quoted market prices in active markets for identical assets or liabilities;
- Level 2 – Observable or corroborated inputs, other than level 1, such as quoted prices for similar assets or liabilities in inactive markets or market data for substantially the full term of the assets or liabilities; and
- Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets and liabilities.

AHS measures and recognizes embedded derivatives separately from the host contract when the economic characteristics and risk of the embedded derivative are not closely related to those of the host contract, when it meets the definition of a derivative and, when the entire contract is not measured at fair value.

Derivatives are recorded at fair value in the Consolidated Statement of Financial Position. Derivatives with a positive or negative fair value are recognized as increases or decreases to portfolio investments. Unrealized gains and losses from changes in the fair value of derivatives are recognized in the Consolidated Statement of Remeasurement Gains and Losses.

All financial assets are assessed for impairment on an annual basis. When a decline is determined to be other than temporary, the amount of the loss is reported as a realized loss on the Consolidated Statement of Operations.

Transaction costs associated with the acquisition and disposal of portfolio investments are expensed as incurred. Investment management fees are expensed as incurred. The purchase and sale of portfolio investments are accounted for using trade date accounting.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(e) Cash

Cash is comprised of cash on hand. Cash on hand includes amounts in interest bearing accounts held for the purpose of meeting short-term commitments rather than for investment purposes.

(f) Inventories For Consumption

Inventories for consumption are valued at lower of cost (defined as moving average cost) and replacement cost.

(g) Tangible Capital Assets

Tangible capital assets and work in progress are recorded at cost, which includes amounts that are directly related to the acquisition, design, construction, development, improvement, or betterment of the assets. Cost includes overhead directly attributable to construction and development as well as interest costs that are directly attributable to the acquisition or construction of the asset. Costs incurred by Alberta Infrastructure (AI) to build tangible capital assets on behalf of AHS are recorded by AHS as work in progress as AI incurs costs.

Contributed tangible capital assets from non-related entities are recognized at their fair value at the date of the contribution when fair value can be reasonably determined. When AHS cannot determine the fair value, it records such contributions at nominal value.

The costs less residual values of tangible capital assets, excluding land, are amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Facilities and improvements	10-40 years
Equipment	3-20 years
Information systems	3-15 years
Building service equipment	5-40 years
Land improvements	5-40 years

Work in progress, which includes facility and improvement projects and development of information systems, is not amortized until after a project is substantially complete and the tangible capital assets are available for or in use.

Leases transferring substantially all benefits and risks of tangible capital asset ownership are classified as capital leases and reported as tangible capital assets. Capital leases and leasehold improvements are amortized over the term of the lease. Capital lease obligations associated with these capital leases are recorded at the present value of the minimum lease payments excluding executory costs (e.g. insurance, maintenance costs, etc.) and reported as obligations under capital leases. The discount rate used to determine the present value of the lease payments is the lower of AHS' rate for incremental borrowing and the interest rate implicit in the lease.

Tangible capital assets are written down to their net recoverable amounts when conditions indicate that they no longer contribute to AHS' ability to provide goods and services or when the value of future economic benefits associated with the tangible capital assets are less than their net book value. Net write-downs are accounted for as expenses in the Consolidated Statement of Operations.

Works of art, historical treasures, and collections are not recognized as tangible capital assets.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(h) Employee Future Benefits

(i) Defined Benefit Pension Plans

Local Authorities Pension Plan (LAPP) and Management Employees Pension Plan (MEPP)

AHS participates in LAPP and MEPP which are registered defined benefit pension plans. These multi-employer public sector defined benefit plans provide pensions for participants for each year of pensionable service based on the average salary of the highest five consecutive years, up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE), over the same five consecutive year period. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). Prior to March 1, 2019, the President of Alberta Treasury Board and Minister of Finance was the legal trustee and administrator for LAPP and MEPP. Although there has been no change in MEPP governance, effective March 1, 2019, LAPP Corporation became the legislated administrator and trustee of LAPP. As a participating government organization, AHS accounts for these plans on a defined contribution basis. Accordingly, the pension expense recorded for these plans in these consolidated financial statements is comprised of the employer contributions that AHS is required to pay for its employees during the fiscal year, which are calculated based on actuarially pre-determined amounts that are expected to provide the plan's future benefits.

Supplemental Executive Retirement Plan (SERP)

The SERP covers certain employees and supplements the benefits under AHS' registered plans that are limited by the *Income Tax Act* (Canada). The SERP has been closed to new entrants since April 1, 2009. The SERP provides future pension benefits to participants based on years of service and earnings.

As required under the *Income Tax Act* (Canada), approximately half of the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SERP are invested in a combination of Canadian equities and Canadian fixed income securities.

(ii) Defined Contribution Pension Plans

Group Registered Retirement Savings Plans (GRRSPs)

AHS sponsors GRRSPs for certain employee groups. Under the GRRSPs, AHS matches a certain percentage of any contribution made by plan participants up to certain limits. AHS also sponsors a defined contribution pension plan for certain employee groups where the employee and employer each contribute specified percentages of pensionable earnings.

Supplemental Pension Plan (SPP)

Subsequent to April 1, 2009, staff that would have otherwise been eligible for SERP have been enrolled in a defined contribution SPP. The SPP supplements the benefits under AHS registered plans that are limited by the *Income Tax Act* (Canada). AHS contributes a percentage of an eligible employee's pensionable earnings, in excess of the limits of the *Income Tax Act* (Canada). The SPP provides participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(iii) Other Benefit Plans

Accumulating Non-Vesting Sick Leave

Sick leave benefits accumulate with employees' service and are provided by AHS to certain employee groups of AHS, as defined by employment agreements, to cover illness related absences that are outside of short-term and long-term disability coverage. Benefit amounts are determined and accumulate with reference to employees' final earnings at the time they are paid out. The cost of the accumulating non-vesting sick leave benefits is expensed as the benefits are earned.

AHS recognizes a liability and expense for accumulating non-vesting sick leave benefits using an actuarial cost method as the employees render services to earn the benefits. The liability and expense is determined using the projected benefit method pro-rated for service and management's best estimates of expected discount rate, inflation, rate of compensation increase, termination and retirement dates, and mortality. Actuarial gains and losses are amortized on a straight-line basis over the expected average remaining service life of the related employee groups.

AHS does not record a liability for sick leave benefits that do not accumulate beyond the current reporting year as these are renewed annually.

Other Benefits

AHS provides its employees with basic life, accidental death and dismemberment, short-term disability, long-term disability, extended health, dental, and vision benefits through benefits carriers. AHS fully accrues its obligations for employee non-pension future benefits.

(i) Liability for Contaminated Sites

Contaminated sites are a result of contamination being introduced into air, soil, water, or sediment of a chemical, organic or radioactive material or live organism that exceeds an environmental standard. A liability for remediation of contaminated sites is recognized when all of the following criteria are met:

(i) an environmental standard exists;
(ii) contamination exceeds the environmental standard;
(iii) AHS is directly responsible or accepts responsibility;
(iv) it is expected that future economic benefits will be given up; and
(v) a reasonable estimate of the amount can be made.

(j) Foreign Currency Translation

Transaction amounts denominated in foreign currencies are translated into their Canadian dollar equivalents at exchange rates prevailing at the transaction dates. Carrying values of monetary assets and liabilities and non-monetary items included in the fair value category reflect the exchange rates at the Consolidated Statement of Financial Position date. Unrealized foreign exchange gains and losses are recognized in the Consolidated Statement of Remeasurement Gains and Losses.

In the year of settlement, foreign exchange gains and losses are reclassified to the Consolidated Statement of Operations, and the cumulative amount of remeasurement gains and losses are reversed in the Consolidated Statement of Remeasurement Gains and Losses.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(k) Reserves

Certain amounts, as approved by the AHS Board, may be set aside in accumulated surplus for use by AHS for future purposes. Transfers to, or from, are recorded to the respective reserve account when approved. Reserves include Invested in Tangible Capital Assets, Internally Restricted Surplus for Future Purposes, and Internally Restricted Surplus for Insurance Equity Requirements and Foundations.

(l) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a difference between the recognized or disclosed amount and another reasonably possible amount. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences could require adjustment in subsequent reporting years. Significant estimates include: amortization of tangible capital assets, recognition of expended deferred capital revenue, employee future benefits, provision for unpaid claims, accrued liabilities and allowance for doubtful accounts.

(m) Future Accounting Changes

The following accounting standards are applicable in future years:

- **PS 3280 – Asset Retirement Obligations (effective April 1, 2021)**
  PS 3280 provides guidance on how to account for and report a liability for retirement of a tangible capital asset. AHS has completed an initial review of the standard and conducted a preliminary assessment of tangible capital assets impacted. Based on the scoping work performed to date, AHS has identified the asset categories of Facilities and Equipment as the assets primarily impacted by this standard. In-depth discussions continue as AHS considers the nature and related cost estimates of, the applicable retirement obligations for these assets. The overall impact of adopting this standard on the future consolidated financial statements continues to be assessed.

- **PS 3400 – Revenue (effective April 1, 2022)**
  PS 3400 provides guidance on how to account for and report revenue, and specifically, it differentiates between revenue arising from exchange and non-exchange transactions. AHS is currently assessing what the impact of this standard will have on future consolidated financial statements.

Note 3 Budget

The AHS Health Plan and Business Plan, which included the 2019-20 annual budget, was approved by the AHS Board on December 11, 2019 for submission to the Minister who approved it on January 28, 2020.

Note 4 Other Government Transfers

	Budget	2020	2019
Unrestricted operating	$ 32,000	$ 34,035	$ 32,790
Restricted operating (Note 14)	113,000	92,152	114,269
Recognition of expended deferred capital revenue (Note 16)	282,000	308,581	282,606
	$ 427,000	**$ 434,768**	**$ 429,665**

Other government transfers include $425,845 (2019 – $420,622) transferred from the GOA, $8,923 (2019 – $9,043) from government entities outside the GOA, and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

Note 5 Donations, Fundraising, and Non-Government Contributions

	Budget	2020	2019
Unrestricted operating	$ 3,000	$ 3,940	$ 4,073
Restricted operating (Note 14)	124,000	157,289	141,088
Recognition of expended deferred capital revenue (Note 16)	27,000	34,470	35,695
Endowment contributions	-	281	463
	$ 154,000	**$ 195,980**	**$ 181,319**

Note 6 Investment and Other Income

	Budget	2020	2019
Investment income	$ 65,000	$ 80,243	$ 68,521
Other income:			
GOA (Note 21)	34,000	28,077	30,847
AH	-	12,562	12,698
Other	86,000	105,870	106,301
	$ 185,000	**$ 226,752**	**$ 218,367**

The Other balance of $105,870 (2019 - $106,301) mainly relates to recoveries for services provided to third parties.

Note 7 Support Services

	Budget	2020	2019
Facilities operations	$ 913,000	$ 905,659	$ 893,599
Patient: health records, food services, and transportation	439,000	436,326	424,288
Housekeeping, laundry, and linen	224,000	220,500	217,296
Materials management	177,000	177,684	174,916
Support services expense of full-spectrum contracted health service providers	157,000	152,542	154,714
Ancillary operations	108,000	97,099	103,122
Fundraising expenses and grants awarded	48,000	48,635	45,689
Emergency preparedness services	6,000	5,847	5,255
Other	193,000	242,913	241,542
	$ 2,265,000	**$ 2,287,205**	**$ 2,260,421**

Note 8 Administration

	Budget	2020	2019
General administration	$ 258,000	$ 220,679	$ 272,241
Human resources	116,000	114,865	115,901
Finance	74,000	74,969	73,075
Communications	27,000	24,771	24,415
Administration expense of full-spectrum contracted health service providers	38,000	38,260	39,977
	$ 513,000	**$ 473,544**	**$ 525,609**

Note 9 Financial Risk Management

AHS is exposed to a variety of financial risks associated with its financial instruments. These financial risks include market risk, credit risk, and liquidity risk.

(a) Market Risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in market prices. Market risk is comprised of three types of risk: price risk, interest rate risk, and foreign currency risk.

In order to earn financial returns at an acceptable level of market risk, the consolidated investment portfolio is governed by investment bylaws and policies with clearly established target asset mixes. The target assets range between 0% and 100% for cash and money market securities, 0% to 80% for fixed income securities and 0% to 70% for equity holdings.

Risk is reduced through asset class diversification, diversification within each asset class, and portfolio quality constraints governing the quality of portfolio holdings.

AHS assesses the sensitivity of its portfolio to market risk based on historical volatility of equity and fixed income markets. Volatility is determined using a ten year average based on fixed income and equity market fluctuations and is applied to the total portfolio. Based on the volatility average of 3.24% (2019 – 2.26%) increase or decrease, with all other variables held constant, the portfolio could expect an increase or decrease in accumulated remeasurement gains and losses and unrealized net gains and losses attributable to unexpended deferred operating revenue of $28,877 (2019 – $38,130).

(i) Price Risk

Price risk relates to the possibility that equity portfolio investments will change in fair value due to future fluctuations in market prices caused by factors specific to an individual equity investment or other factors affecting all equities traded in the market. AHS is exposed to price risk associated with the underlying equity portfolio investments held in pooled funds. If equity market indices (S&P/TSX, S&P1500 and MSCI ACWI and their sectors) declined by 10%, and all other variables are held constant, the potential loss in fair value to AHS would be approximately $42,045 or 2.84% of total portfolio investments (March 31, 2019 – $50,535 or 2.22%).

In March 2020, the COVID-19 global pandemic resulted in an overall reduction of market prices for equities traded in the market at year-end. AHS is invested primarily in interest bearing securities (money market and fixed income securities) and this diversification served to mitigate price risk for AHS. As a result of this diversification, AHS did not realize significant losses in March 2020.

(ii) Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument might be adversely affected by a change in market interest rates. AHS manages the interest rate risk exposure of its fixed income securities by management of average duration and laddered maturity dates.

AHS is exposed to interest rate risk through its investments in fixed income securities with both fixed and floating interest rates. AHS has fixed interest rate loans for all debt, thereby mitigating interest rate risk from rate fluctuations over the term of the outstanding debt. The fair value of fixed rate debt fluctuates with changes in market interest rates but the related future cash flows will not change.

In general, investment returns for fixed income securities are sensitive to changes in the level of interest rates, with longer term interest bearing securities being more sensitive to interest rate changes than shorter term bonds.

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $53,634 (March 31, 2019 – $78,148).

Note 9 Financial Risk Management (continued)

Fixed income securities have the following average maturity structure:

	2020	2019
0 – 5 years	56%	77%
6 – 10 years	20%	8%
Over 10 years	24%	15%

	Average Effective Market Yield	
Asset Class	**2020**	**2019**
Fixed income securities	1.98%	2.47%

(iii) Foreign Currency Risk

Foreign currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates. The fair value of cash and portfolio investments denominated in foreign currencies is translated into Canadian dollars on a daily basis using the reporting date exchange rate. Both the realized gain/loss and remeasurement gain/loss comprise actual gains or losses on the underlying instrument as well as changes in foreign exchange rates at the time of the valuation. AHS is exposed to foreign exchange fluctuations on its cash denominated in foreign currencies. AHS is also exposed to changes in the valuation on its global equity funds attributable to fluctuations in foreign currency.

Foreign currency risk is managed by the investment policies which limit non-Canadian equities to a maximum of 10% to 45% of the total investment portfolio, depending on the policy. At March 31, 2020, investments in non-Canadian equities represented 18.4% (March 31, 2019 – 14.5%) of total portfolio investments.

Foreign exchange fluctuations on cash balances are mitigated by derivatives and holding minimal foreign currency cash balances. At March 31, 2020, AHS held US dollar forward contracts with ATB Financial to manage currency fluctuations relating to its US dollar accounts payable requirements. As at March 31, 2020, AHS held derivatives in the form of forward contracts for future settlement of $12,000 (2019 – $18,000). The fair value of these forward contracts as at March 31, 2020 was $1,253 (2019 – $714) and is included in portfolio investments (Note 10).

(b) Credit Risk

Credit risk is the risk of loss arising from the failure of a counterparty to fully honour its contractual obligations. The credit quality of financial assets is generally assessed by reference to external credit ratings. Credit risk can also lead to losses when issuers and debtors are downgraded by credit rating agencies. The investment policies restrict the types and proportions of eligible investments, thus mitigating AHS' exposure to credit risk.

Accounts receivable primarily consists of amounts receivable from AH, other Alberta government reporting entities, patients, other provinces and territories, and the federal government. AHS periodically reviews the collectability of its accounts receivable and establishes an allowance based on its best estimate of potentially uncollectible amounts.

Under the investment bylaw and policies governing the consolidated investment portfolio, money market securities are limited to a rating of R1 or equivalent or higher, and no more than 10% may be invested in any one issuer unless guaranteed by the Government of Canada or a Canadian province. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total fixed income securities. Investments in debt and equity of any one issuer are limited to 5% of the issuer's total debt and equity. AHS holds unrated mortgage fund investments which are classified as part of AHS' fixed income securities. Short selling is not permitted.

Note 9 Financial Risk Management (continued)

The following table summarizes AHS' investment in debt securities by counterparty credit rating at March 31, 2020. The unrated securities consist of low volatility pooled mortgages that are not rated on an active market.

Credit Rating	2020	2019
Investment Grade (AAA to BBB)	89%	87%
Unrated	11%	13%
	100%	**100%**

(c) Liquidity Risk

Liquidity risk is the risk that AHS will encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivery of cash or another financial asset. Liquidity requirements of AHS are met through funding provided in advance by AH, income generated from portfolio investments, and by investing in liquid assets, such as money market securities, fixed income securities and equities traded in an active market that are easily sold and converted to cash. Short term borrowing to meet financial obligations would be available through established credit facilities as described in Note 17(b).

Note 10 Portfolio Investments

	2020		2019	
	Fair Value	Cost	Fair Value	Cost
Cash held for investing purposes	**$ 112,072**	**$ 112,072**	**$ 110,887**	**$ 110,887**
Interest bearing securities:				
Money market securities	38,076	38,076	177,199	177,199
Fixed income securities	902,690	888,059	1,485,637	1,467,856
	940,766	**926,135**	**1,662,836**	**1,645,055**
Equities:				
Canadian equity investments	44,554	47,368	45,866	38,488
Canadian equity funds	66,937	73,807	129,525	119,364
Global equity funds	278,175	256,183	329,954	288,454
	389,666	**377,358**	**505,345**	**446,306**
Real estate pooled funds	**40,837**	**40,267**	**-**	**-**
	$ 1,483,341	**$ 1,455,832**	**$ 2,279,068**	**$ 2,202,248**

	2020	2019
Items at Fair Value		
Portfolio investments designated to the fair value category	$ 1,437,534	$ 2,232,488
Portfolio investments in equity instruments that are quoted in an active market	44,554	45,866
Derivatives	1,253	714
	$ 1,483,341	**$ 2,279,068**

Included in portfolio investments is $233,282 (March 31, 2019 – $212,323) that is restricted for use as per the requirements in Sections 99 and 100 of the *Insurance Act* of Alberta. Endowment principal included in portfolio investments amounts to $75,438 (March 31, 2019 – $75,157).

Note 10 Portfolio Investments (continued)

The following are the total net remeasurement gains on portfolio investments:

	2020	2019
Accumulated remeasurement gains	$ 3,832	$ 34,469
Restricted unrealized net gains attributable to unexpended deferred operating revenue (Note 14(b))	23,677	42,351
	$ 27,509	**$ 76,820**

Fair Value Hierarchy

	2020			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ 112,072	$ -	$ -	$ 112,072
Interest bearing securities:				
Money market securities	-	38,076	-	38,076
Fixed income securities	-	827,477	75,213	902,690
Equities:				
Canadian equity investments	44,554	66,937	-	111,491
Global equity funds	-	278,175	-	278,175
Real estate pooled funds	-	-	40,837	40,837
	$ 156,626	**$ 1,210,665**	**$ 116,050**	**$ 1,483,341**
Percent of total	10%	82%	8%	100%

	2019			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ 110,887	$ -	$ -	$ 110,887
Interest bearing securities:				
Money market securities	-	177,199	-	177,199
Fixed income securities	-	1,320,899	164,738	1,485,637
Equities:				
Canadian equity investments	45,866	129,525	-	175,391
Global equity funds	-	329,954	-	329,954
	$ 156,753	**$ 1,957,577**	**$ 164,738**	**$ 2,279,068**
Percent of total	7%	86%	7%	100%

Reconciliation of Investments classified as level 3.

	2020		
	Fixed income securities	Real estate pooled funds	Total
Balance at beginning of year	$ 164,738	$ -	$ 164,738
Purchases	4,763	40,268	45,031
Sales	(94,716)	-	(94,716)
Gain (loss) included in the Consolidated Statement of Remeasurement Gains and Losses	447	569	1,016
Transfers in (out)	(19)	-	(19)
Balance at end of year	**$ 75,213**	**$ 40,837**	**$ 116,050**

Note 10 Portfolio Investments (continued)

	2019		
	Fixed income securities	Real estate pooled funds	Total
Balance at beginning of year	$ 147,014	$ -	$ 147,014
Purchases	13,861	-	13,861
Sales	-	-	-
Gain (loss) included in the Consolidated Statement of Remeasurement Gains and Losses	1,044	-	1,044
Transfers in (out)	2,819	-	2,819
Balance at end of year	**$ 164,738**	**$ -**	**$ 164,738**

Note 11 Accounts Receivable

	2020			2019
	Gross	Allowance for Doubtful Accounts	Net	Net (Note 26)
Patient accounts receivable	$ 134,190	$ 34,214	$ 99,976	$ 106,526
AH operating transfers receivable	268,119	-	268,119	36,768
AH capital transfers receivable	40,707	-	40,707	34,356
Other operating transfers receivable	21,667	-	21,667	14,824
Other capital transfers receivable	62,716	-	62,716	79,291
Other accounts receivable	118,188	802	117,386	94,957
	$ 645,587	**$ 35,016**	**$ 610,571**	**$ 366,722**

Accounts receivable are unsecured and non-interest bearing. At March 31, 2019, the total allowance for doubtful accounts was $28,966.

Note 12 Accounts Payable and Accrued Liabilities

	2020	2019
Payroll remittances payable and related accrued liabilities	$ 611,513	$ 543,427
Trade accounts payable and accrued liabilities	636,041	608,740
Provision for unpaid claims[(a)]	208,830	202,511
Obligations under capital leases[(b)]	103,990	97,053
Other liabilities	67,210	54,142
	$ 1,627,584	**$ 1,505,873**

Accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $305,843 (2019 – $284,970). Of these amounts, $13,002 (2019 – $ 12,721) comprise life lease deposits received from tenants of certain AHS' long term care facilities and amounts payable to the Ministry of Infrastructure of $109,150 (2019 – $65,000) related to a project funded by debt.

(a) Provision for Unpaid Claims is an estimate of liability claims against AHS. It is influenced by factors such as historical trends involving claim payment patterns, pending levels of unpaid claims, claims severity and claim frequency patterns.

The provision has been estimated using the discounted value of claim liabilities using a discount rate of 2.25% (2019 – 2.45%) plus a provision for adverse deviation, based on actuarial estimates. –deviation, based on actuarial estimates.

Note 12 Accounts Payable and Accrued Liabilities (continued)

(b) Obligations under capital leases include a site lease with the University of Calgary, vehicle leases, obligations related to a clinical information system and site leases for ambulance services.

The obligations will be settled between 2020 and 2036 and have an implicit interest rate payable ranging from 1.93% to 5.07% (2019 – 2.37% to 7.04%).

AHS is committed to making payments for obligations under capital leases as follows:

Year ended March 31	Minimum Contract Payments
2021	$ 29,041
2022	27,427
2023	14,536
2024	4,738
2025	4,364
Thereafter	40,328
	120,434
Less: interest	(16,444)
	$ 103,990

(c) Liability for Contaminated Sites

At March 31, 2020, AHS has not identified or accepted any liability for contaminated sites (2019 – $nil).

Note 13 Employee Future Benefits

	2020	2019
Accrued vacation pay	$ 582,819	$ 566,415
Accumulating non-vesting sick leave[a]	124,652	122,081
Registered defined benefit pension plans[b] [c]	-	-
	$ 707,471	**$ 688,496**

(a) Accumulating Non-Vesting Sick Leave

Sick leave benefits are paid by AHS; there are no employee contributions and no assets set aside to support the obligation.

	2020	2019
Funded status – deficit	$ 153,419	$ 103,857
Unamortized net actuarial (loss) gain	(28,767)	18,224
Accrued benefit liability	**$ 124,652**	**$ 122,081**

Key assumptions used in the determination of the accumulating non-vesting sick leave liability are:

	2020	2019
Estimated average remaining service life	13 years	13 years
Draw down rate of accumulated non-vesting sick leave bank	18.30%	16.50%
Discount rate – beginning of year	3.51%	3.38%
Discount rate – end of year	2.14%	3.51%
Rate of compensation increase per year	2019-20	2018-19
	0.75%	0.75%
	2020-21	2019-20
	0.75%	0.75%
	Thereafter	Thereafter
	2.75%	2.75%

Note 13 Employee Future Benefits (continued)

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP. AHS' employees comprise approximately 46% (2019-46%) of the total membership in LAPP. AHS is not responsible for future funding of the plan deficit other than through contribution increases. As AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

The LAPP provides for a pension of 1.4% for each year of pensionable service based on the average salary of the highest five consecutive years up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE), over the same five consecutive year period and 2.0% on the excess, subject to the maximum pension benefit limit allowed under the Income Tax Act (Canada). The maximum pensionable service allowable under the plan is 35 years.

(ii) LAPP Surplus

LAPP carried out an actuarial valuation as at December 31, 2018 and these results were then extrapolated to December 31, 2019. The LAPP's December 31, 2019 net assets available for benefits divided by the LAPP's pension obligation shows that the LAPP is 119% (2018 – 108%) funded.

	December 31, 2019	December 31, 2018
LAPP net assets available for benefits	$ 50,520,461	$ 44,468,547
LAPP pension obligation	42,607,200	40,999,200
LAPP surplus	**$ 7,913,261**	**$ 3,469,347**

The LAPP net assets available for benefits are subject to significant market volatility due to the economic crisis stemming from the global COVID-19 pandemic. To the extent that the pension plans may not recover market-losses during the remainder of 2020, the funded status of the plans would experience a correlated decline. The financial market impact of the outbreak has been rapidly evolving, which precludes a reasonable estimate of the impact.

The 2020 and 2019 LAPP contribution rates are as follows:

Calendar 2020		Calendar 2019	
Employer	**Employees**	**Employer**	**Employees**
9.39% of pensionable earnings up to the YMPE and 13.84% of the excess	8.39% of pensionable earnings up to the YMPE and 12.84% of the excess	9.39% of pensionable earnings up to the YMPE and 13.84% of the excess	8.39% of pensionable earnings up to the YMPE and 12.84% of the excess

(c) Pension Expense

	2020	2019
Local Authorities Pension Plan	$ 547,168	$ 556,609
Defined contribution pension plans and group RRSPs	45,029	48,408
Supplemental Pension Plan	2,095	2,265
Management Employees Pension Plan	378	378
	$ 594,670	**$ 607,660**

Note 14 Unexpended Deferred Operating Revenue

(a) Changes in the unexpended deferred operating revenue balance are as follows:

	2020				2019
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 155,302	$ 29,579	$ 268,338	$ 453,219	$ 420,245
Received or receivable during the year, net of repayments	1,262,036	59,538	171,893	1,493,467	1,417,630
Unexpended deferred operating revenue returned	(13,061)	(60)	(1,013)	(14,134)	(2,496)
Restricted investment income	1,179	1,718	10,231	13,128	9,465
Transferred from unexpended deferred capital revenue[(ii)]	2,265	28,227	1,761	32,253	57,237
Recognized as revenue	(1,290,302)	(92,152)	(157,289)	(1,539,743)	(1,434,092)
Miscellaneous other revenue recognized	(1,333)	(2,384)	(9,848)	(13,565)	(22,463)
	116,086	**24,466**	**284,073**	**424,625**	**445,526**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	(1,025)	553	(18,202)	(18,674)	7,693
Balance, end of year	**$ 115,061**	**$ 25,019**	**$ 265,871**	**$ 405,951**	**$ 453,219**

[(i)] The balance at March 31, 2020 for other government includes $1,007 of unexpended deferred operating revenue received from government entities outside the GOA (March 31, 2019 – $506). The remaining balance in other government all relates to the GOA, see Note 21.
[(ii)] The transfer is mainly comprised of restricted capital funding that was used for approved expenditures that did not meet the definition of a tangible capital asset

(b) The unexpended deferred operating revenue balance at the end of the year is externally restricted for the following purposes:

	2020				2019
	AH	Other Government	Donors and Non-Government	Total	Total
Research and education	$ 8,811	$ 2,505	$ 165,575	$ 176,891	$ 182,763
Physician revenue and alternate relationship plans	36,375	309	-	36,684	37,070
Primary Care Networks	24,778	-	-	24,778	24,354
Long term care partnerships	-	15,093	-	15,093	18,329
Promotion, prevention and community	2,405	1,179	345	3,929	15,777
Addiction and mental health	32,951	226	1,950	35,127	31,668
Support services	945	481	61,196	62,622	58,265
Others less than $10,000	8,705	1,688	16,757	27,150	42,642
Unrealized net gain attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 10)	91	3,538	20,048	23,677	42,351
	$ 115,061	**$ 25,019**	**$ 265,871**	**$ 405,951**	**$ 453,219**

Note 15 Unexpended Deferred Capital Revenue

(a) Changes in the unexpended deferred capital revenue balance are as follows:

	2020				2019 (Note 26)
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 53,862	$ 6,173	$ 68,359	$ 128,394	$ 124,289
Received or receivable during the year	170,756	118,764	43,266	332,786	349,293
Unexpended deferred capital revenue returned	(4,343)	-	(55)	(4,398)	(250)
Transfer to expended deferred capital revenue	(180,340)	(92,073)	(43,293)	(315,706)	(287,701)
Transferred to unexpended deferred operating revenue[(ii)]	(2,265)	(28,227)	(1,761)	(32,253)	(57,237)
Balance, end of year	**$ 37,670**	**$ 4,637**	**$ 66,516**	**$ 108,823**	**$ 128,394**

[(i)] The balance at March 31, 2020 for other government all relates to the GOA, see Note 21.
[(ii)] The transfer is mainly comprised of restricted capital funding that was used for approved expenditures that did not meet the definition of a tangible capital asset

(b) The unexpended deferred capital revenue balance at the end of the year is externally restricted for the following purposes:

	2020	2019
AH		
Information systems	$ 11,118	$ 16,712
Medical Equipment Replacement Upgrade Program	1,457	2
Diagnostic equipment	18,189	19,585
Other equipment	6,906	17,563
Total AH	**37,670**	**53,862**
Other government		
Facilities and improvements	4,637	6,173
Total other government	**4,637**	**6,173**
Donors and non-government		
Equipment	59,809	59,849
Facilities and improvements	6,707	8,510
Total donors and non-government	**66,516**	**68,359**
	$ 108,823	**$ 128,394**

Note 16 Expended Deferred Capital Revenue

Changes in the expended deferred capital revenue balance are as follows:

	2020				2019
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 340,429	$ 6,392,303	$ 192,386	$ 6,925,118	$ 6,735,454
Transferred from unexpended deferred capital revenue	180,340	92,073	43,293	315,706	287,701
Contributed tangible capital assets	-	523,196	-	523,196	285,368
Less: amounts recognized as revenue	(61,354)	(308,581)	(34,470)	(404,405)	(383,405)
Balance, end of year	**$ 459,415**	**$ 6,698,991**	**$ 201,209**	**$ 7,359,615**	**$ 6,925,118**

[(i)] The balance at March 31, 2020 for other government includes $20 of expended deferred capital revenue received from government entities outside the GOA (March 31, 2019 – $36). The remaining balance in other government all relates to the GOA, see Note 21.

Note 17 Debt

	2020	2019
Debentures payable[(a)]:		
Parkade loan #1	$ 23,447	$ 26,500
Parkade loan #2	22,984	25,522
Parkade loan #3	31,338	34,048
Parkade loan #4	124,680	132,577
Parkade loan #5	30,388	32,200
Parkade loan #6	21,576	22,557
Parkade loan #7	47,479	49,516
Parkade loan #8	157,000	-
Energy savings initiative loan	22,336	24,089
Other	323	633
	$ 481,551	**$ 347,642**

(a) AHS issued debentures to Alberta Capital Financing Authority (ACFA), a related party, to finance the construction of parkades. AHS has pledged revenue derived directly or indirectly from the operations of all parking facilities being built, renovated, owned, and operated by AHS as security for these debentures.

AHS issued a debenture to ACFA relating to an energy savings initiative. AHS has pledged the mortgage on the Royal Alexandra hospital Lands and Alberta Hospital Lands as security for this debenture.

AHS is in compliance with all performance requirements of its debenture loans as at March 31, 2020.

Note 17 Debt (continued)

The maturity dates and interest rates for the debentures are as follows:

	Maturity Date	Fixed Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Parkade loan #6	December 2035	3.6090%
Parkade loan #7	March 2038	2.6400%
Parkade loan #8	December 2059	3.6010%
Energy savings initiative loan	December 2030	2.4160%
Other	March 2021	4.6000%

(b) As at March 31, 2020, AHS holds a $220,000 (March 31, 2019 - $220,000) revolving demand facility with a Canadian chartered bank which may be used for operating purposes. Draws on the facility bear interest at the bank's prime rate less 0.50% per annum. As at March 31, 2020, AHS has $nil (March 31, 2019 - $nil) draws against this facility.

AHS also has access to a $33,000 (March 31, 2019 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2020, AHS has $4,687 (March 31, 2019 – $4,419) in a letter of credit outstanding against this facility. AHS is in compliance with the terms of the agreement relating to the letter of credit, therefore no liability has been recorded.

(c) AHS is committed to making payments as follows:

Year Ended March 31	Principal Payments	Interest Payments	Total
2021	$ 25,893	$ 18,974	$ 44,867
2022	26,666	17,866	44,532
2023	27,811	16,721	44,532
2024	29,008	15,524	44,532
2025	30,258	14,274	44,532
Thereafter	341,915	144,874	486,789
	$ 481,551	**$ 228,233**	**$ 709,784**

During the year, the total interest related to debt was $15,864 (2019 – $15,199).

Note 18 Tangible Capital Assets

Cost	2019	Additions[a]	Transfers	Disposals/write-downs[b]	2020
Facilities and improvements	$ 9,401,390	$ 1,867	$ 244,882	$ (2,839)	$ 9,645,300
Work in progress	1,625,941	909,759	(763,719)	(27,293)	1,744,688
Equipment[c]	2,561,156	106,152	3,591	(47,283)	2,623,616
Information systems	1,474,803	17,073	389,281	(53,358)	1,827,799
Building service equipment	729,544	-	110,662	(84)	840,122
Land[d]	116,823	133	-	(30)	116,926
Leased facilities and improvements	229,874	21,695	3,830	(6)	255,393
Land improvements	94,188	-	11,473	(80)	105,581
	$ 16,233,719	**$ 1,056,679**	**$ -**	**$ (130,973)**	**$ 17,159,425**

Accumulated Amortization	2019	Amortization Expense	Effect of Transfers	Disposals/write-downs[b]	2020
Facilities and improvements	$ 3,915,175	$ 263,455	$ -	$ (2,729)	$ 4,175,901
Work in progress	-	-	-	-	-
Equipment[c]	1,933,533	147,466	-	(46,288)	2,034,711
Information systems	1,320,894	77,772	-	(41,877)	1,356,789
Building service equipment	434,531	42,533	-	(84)	476,980
Land[d]	-	-	-	-	-
Leased facilities and improvements	179,731	7,308	-	(6)	187,033
Land improvements	68,851	3,280	-	(80)	72,051
	$ 7,852,715	**$ 541,814**	**$ -**	**$ (91,064)**	**$ 8,303,465**

	Net Book Value	
	2020	2019
Facilities and improvements	$ 5,469,399	$ 5,486,215
Work in progress	1,744,688	1,625,941
Equipment[c]	588,905	627,623
Information systems	471,010	153,909
Building service equipment	363,142	295,013
Land[d]	116,926	116,823
Leased facilities and improvements	68,360	50,143
Land improvements	33,530	25,337
	$ 8,855,960	**$ 8,381,004**

Note 18 Tangible Capital Assets (continued)

Cost	2018	Additions[a]	Transfers	Disposals/write-downs[b]	2019
Facilities and improvements	$ 9,300,463	$ -	$ 108,258	$ (7,331)	$ 9,401,390
Work in progress	1,179,069	692,879	(246,007)	-	1,625,941
Equipment[c]	2,512,888	164,704	(923)	(115,513)	2,561,156
Information systems	1,438,547	21,742	46,064	(31,550)	1,474,803
Building service equipment	648,352	-	81,747	(555)	729,544
Land[d]	116,875	-	-	(52)	116,823
Leased facilities and improvements	229,065	-	809	-	229,874
Land improvements	84,197	-	10,052	(61)	94,188
	$ 15,509,456	**$ 879,325**	**$ -**	**$ (155,062)**	**$ 16,233,719**

Accumulated Amortization	2018	Amortization Expense	Effect of Transfers	Disposals/write-downs	2019
Facilities and improvements	$ 3,666,479	$ 255,001	$ -	$ (6,305)	$ 3,915,175
Work in progress	-	-	-	-	-
Equipment[c]	1,898,695	148,701	-	(113,863)	1,933,533
Information systems	1,277,120	75,320	-	(31,546)	1,320,894
Building service equipment	398,200	36,884	-	(553)	434,531
Land[d]	-	-	-	-	-
Leased facilities and improvements	172,370	7,361	-	-	179,731
Land improvements	65,285	3,627	-	(61)	68,851
	$ 7,478,149	**$ 526,894**	**$ -**	**$ (152,328)**	**$ 7,852,715**

	Net Book Value	
	2019	2018
Facilities and improvements	$ 5,486,215	$ 5,633,984
Work in progress	1,625,941	1,179,069
Equipment[c]	627,623	614,193
Information systems	153,909	161,427
Building service equipment	295,013	250,152
Land[d]	116,823	116,875
Leased facilities and improvements	50,143	56,695
Land improvements	25,337	18,912
	$ 8,381,004	**$ 8,031,307**

(a) Contributed Tangible Capital Assets

Additions include total contributed tangible capital assets of $523,196 (2019 – $285,368) consisting of $523,196 from AI (2019 – $285,322) and $nil from other sources (2019 – $46).

(b) Write-Downs

Write-downs include work in progress of $22,615 (2019 - $ nil) related to the cancelled Edmonton Lab Hub project.

Note 18 Tangible Capital Assets (continued)

(c) Leased Equipment

Equipment includes tangible capital assets acquired through capital leases at a cost of $22,884 (2019 – $17,240) with accumulated amortization of $12,152 (March 31, 2019 – $12,119). For the year ended March 31, 2020, leased equipment included a net increase of $6,707 related to vehicles under capital leases (2019 – net increase of $4,363).

(d) Leased Land

Land at the following sites has been leased to AHS at nominal values:

Site	Leased from	Lease Expiry
Evansburg Community Health Centre	Yellowhead County	April 2031
Jasper Healthcare Centre	Parks Canada	January 2034
Bethany Care Centre	Red Deer College	April 2034
Myrnam Land	Eagle Hill Foundation	May 2038
Two Hills Helipad	Stella Stefiuk	August 2041
McConnell Place North	City of Edmonton	September 2044
Northeast Community Health Centre	City of Edmonton	February 2047
Foothills Medical Centre Parkade	University of Calgary	July 2054
Alberta Children's Hospital	University of Calgary	December 2103
Kaye Edmonton Clinic (Parcel H)	The University of Alberta	February 2109

Note 19 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2020						2019
	Unrestricted Surplus	Invested in Tangible Capital Assets[a]	Endowments[b]	Internally Restricted Surplus for Future Purposes[c]	Internally Restricted Surplus for Insurance Equity Requirements and Foundations[d]	Total	Total
Balance, beginning of year	$ 42,108	$ 940,283	$ 75,157	$ 152,842	$ 68,034	$ 1,278,424	$ 1,317,055
Annual operating deficit	(145,823)	-	-	-	-	(145,823)	(38,631)
Tangible capital assets acquired with internal funds	(127,589)	151,391	-	(23,802)	-	-	-
Amortization of internally funded tangible capital assets	177,318	(177,318)	-	-	-	-	-
Principal payments on debt	(23,091)	23,091	-	-	-	-	-
Payments on obligations under capital leases	(3,204)	3,204	-	-	-	-	-
Net receipt of life lease deposits	281	(281)	-	-	-	-	-
Transfer of internally restricted surplus	129,040	-	-	(129,040)	-	-	-
Transfer of insurance equity requirements and foundations surpluses	(14,342)	-	-	-	14,342	-	-
Transfer of endowment contributions	(281)	-	281	-	-	-	-
Balance, end of year	**$ 34,417**	**$ 940,370**	**$ 75,438**	**$ -**	**$ 82,376**	**$ 1,132,601**	**$ 1,278,424**

Note 19 Accumulated Surplus (continued)

(a) Invested in Tangible Capital Assets

The accumulated surplus invested in tangible capital assets represents the net book value of tangible capital assets that have previously been purchased with AHS' unrestricted surplus.

Reconciliation of invested in tangible capital assets:

	2020	2019
Tangible Capital Assets (Note 18)	$ 8,855,960	$ 8,381,004
Less funded by:		
Expended Deferred Capital Revenue (Note 16)	(7,359,615)	(6,925,118)
Debt (Note 17)	(481,551)	(347,642)
Unexpended Debt	42,568	6,813
Other funding [(i)]	-	(65,000)
Obligations under capital leases (Note 12b)	(103,990)	(97,053)
Life lease deposits (Note 12)	(13,002)	(12,721)
	$ 940,370	**$ 940,283**

(i) Other funding comprises in substance, tangible capital assets financing provided to AHS by the Ministry of Infrastructure as accounts payable of $109,150 (2019 - $65,000) (Note 12), offset by unexpended debt proceeds of $109,150 (2019 - $nil) earmarked to settle the liability.

(b) Endowments

Endowments represent the portion of accumulated surplus that is restricted and must be maintained in perpetuity. Transfers of endowment contributions from unrestricted surplus include $281 (2019 - $463) of contributions received in the year (Note 5).

(c) Internally Restricted Surplus for Future Purposes

The restriction of accumulated surplus for AHS' future operating and capital purposes is as follows:

(i) Ancillary services surplus of $nil (2019 - $112,508) comprising ancillary operation surpluses from parking, retail food services, and controlled entities. Transfers in the year include $23,802 to invested in tangible capital assets representing tangible capital assets acquired with the funds and $88,706 to unrestricted surplus to close the account.

(ii) Other surplus of $nil (2019 - $40,334) comprising surpluses set aside to address funding of expenses for certain initiatives spanning multiple fiscal years. Transfers in the year include $40,334 to unrestricted surplus to close the account.

(d) Internally Restricted Surplus for Insurance Equity Requirements and Foundations

Insurance equity requirements comprise surpluses of $28,237 (2019 - $15,725) related to equity of the LPIP mainly relating to legislative requirements per the Insurance Act. Foundations comprise surpluses amounting to $54,139 (2019 - $52,309) related to donations received by AHS' Controlled Foundations without external restrictions attached.

Note 20 Contractual Obligations and Contingent Liabilities

(a) Contractual Obligations

Contractual obligations are AHS' obligations to others that will become liabilities in the future when the terms of those contracts or agreements are met.

The estimated aggregate amount payable for the unexpired terms of these contractual obligations are as follows:

Year ended March 31	Services[(i)]	Other[(ii)]	Operating Lease Payments	Capital Projects	Total[(iii)]
2021	$ 2,698,884	$ 505,868	$ 58,184	$ 181,085	$ 3,444,021
2022	1,449,315	273,261	54,595	30,407	1,807,578
2023	1,085,695	161,159	47,375	-	1,294,229
2024	927,396	91,475	38,270	-	1,057,141
2025	704,878	50,599	28,935	-	784,412
Thereafter	7,296,428	85,456	70,499	-	7,452,383
	$ 14,162,596	**$ 1,167,818**	**$ 297,858**	**$ 211,492**	**$ 15,839,764**

(i) Service obligations mainly relate to contracts entered into with third parties for the provision of long-term care and home care services.
(ii) Other obligations mainly relate to contracts entered into with third parties for maintenance, information technology services, software, equipment, acquisitions, and procurement of medical supplies and food.
(iii) In 2019-20, AHS reassessed for disclosure, contractual obligations related to services, other obligations and capital projects. These amounts were not previously reported.

(b) Contingent Liabilities

AHS is subject to legal claims during its normal course of business. AHS records a liability when the assessment of a claim indicates that a future event is likely to confirm that an asset had been impaired or a liability incurred at the date of the financial statements and the amount of the contingent loss can be reasonably estimated.

Accruals have been made in specific instances where it is likely that losses will be incurred based on a reasonable estimate. As at March 31, 2020, accruals have been recorded as part of the provision for unpaid claims and other liabilities (Note 12). Included in this accrual are claims in which AHS has been jointly named with the Minister. The accrual provided for these claims under the provision for unpaid claims represents AHS' portion of the liability.

AHS has been named in 262 legal claims (2019 – 225 claims) related to conditions in existence at March 31, 2020 where the likelihood of the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 222 claims have $498,678 in specified amounts and 40 have no specified amounts (2019 – 205 claims with $415,883 of specified claims and 20 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that is different than the claimed amount.

Note 21 Related Parties

Transactions with related parties are included within these consolidated financial statements, unless otherwise stated.

The Minister appoints all members of the AHS Board. The viability of AHS' operations depends on transfers from AH. Transactions between AHS and AH are reported and disclosed in the Consolidated Statement of Operations, the Consolidated Statement of Financial Position, and the Notes to the Consolidated Financial Statements, and are therefore excluded from the tables below.

Related parties also include key management personnel of AHS. AHS has defined key management personnel to include those disclosed in Sub-Schedule 2A & 2B of these consolidated financial statements. Related party transactions with key management personnel primarily consist of compensation related payments and are considered to be undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length.

AHS is considered to be a related party with those entities consolidated or included on a modified equity basis in the GOA consolidated financial statements. Entities consolidated or included on a modified equity basis have been grouped with their respective ministry and transactions between AHS and the other ministries are recorded at their exchange amount as follows:

	Revenues[a]		Expenses	
	2020	2019	2020	2019
Ministry of Advanced Education[b]	$ 56,092	$ 57,266	$ 191,053	$ 184,812
Ministry of Infrastructure[c]	343,065	340,892	222	1
Other ministries[d]	58,326	55,399	29,794	31,064
Total for the year	**$ 457,483**	**$ 453,557**	**$ 221,069**	**$ 215,877**

	Receivable from		Payable to	
	2020	2019	2020	2019
Ministry of Advanced Education[b]	$ 6,545	$ 7,692	$ 33,967	$ 35,618
Ministry of Infrastructure[c]	25,477	50,566	109,150	65,000
Other ministries[d]	12,128	8,483	488,080	349,886
Balance, end of year	**$ 44,150**	**$ 66,741**	**$ 631,197**	**$ 450,504**

(a) Revenues with GOA ministries include other government transfers of $425,845 (2019 – $420,622), (Note 4), other income of $28,077 (2019 – $30,847), (Note 6), and fees and charges of $3,561 (2019 – $2,088).

(b) Most of AHS transactions with the Ministry of Advanced Education relate to initiatives with the University of Alberta and the University of Calgary. These initiatives include teaching, research, and program delivery. A number of physicians are employed by either AHS or the universities but perform services for both. Due to proximity of locations, some initiatives result in sharing physical space and support services. The revenue and expense transactions are a result of funding provided from one to the other and recoveries of shared costs.

(c) The transactions with the Ministry of Infrastructure (AI) relate to the construction and funding of tangible capital assets. These transactions include operating transfers of $35,271 (2019 – $58,957) and recognition of expended deferred capital revenue of $307,794 (2019 – $281,935) relating to tangible capital assets with stipulations or external restrictions to utilize over their remaining useful lives. Not included in the table above but included in total amounts disclosed in Note 18(a) is the transfer of land and other tangible capital assets from AI of $523,196 (2019 – $285,322).

Note 21 Related Parties (continued)

(d) The payable transactions with other ministries include the debt payable to ACFA (Note 17(a)).

At March 31, 2020, AHS has recorded deferred revenue from other ministries within the GOA, excluding AH, of $24,012 (March 31, 2019 – $29,073) related to unexpended deferred operating revenue (Note 14), $4,637 (March 31, 2019 – $6,173) related to unexpended deferred capital revenue (Note 15) and $6,698,971 (March 31, 2019 – $6,392,267) related to expended deferred capital revenue (Note 16).

Contingent liabilities in which AHS has been jointly named with other government entities within the GOA are disclosed in Note 20.

Note 22 Government Partnerships

AHS has proportionately consolidated 50% of the results of the PCNs and NACTRC and 33.33% of the results in iRSM. The following is 100% of the financial position and results of operations for AHS' government partnerships.

	2020	2019
Financial assets (portfolio investments, accounts receivable, other assets)	$ 74,273	$ 72,548
Liabilities (trade accounts payable, unexpended deferred operating revenue)	74,273	72,548
Accumulated surplus	$ -	$ -
Total revenues	$ 260,975	$ 248,538
Total expenses	260,975	248,538
Annual surplus	**$ -**	**$ -**

Note 23 Trusts under Administration

(a) Health Benefit Trust of Alberta (HBTA)

AHS is one of more than 30 participants in the HBTA and has a majority of representation on the HBTA governance board. The HBTA is a formal health and welfare trust established under a Trust Agreement effective January 1, 2000. The HBTA provides health and other related employee benefits pursuant to the authorizing Trust Agreement.

HBTA's balances as at March 31 are as follows:

	2020	2019
Financial assets	$ 128,181	$ 155,705
Liabilities	17,486	16,401
Net financial assets	$ 110,695	$ 139,304
Non-financial assets	4	3
Net assets	**$ 110,699**	**$ 139,307**

AHS has included in prepaid expenses $74,828 (2019 – $93,784) representing in substance a prepayment of future premiums to HBTA. For the fiscal year ended March 31, 2020, AHS paid premiums of $407,512 (2019 – $391,734) which is approximately 98% (2019 – 98%) of the total premiums received by HBTA.

Note 23 Trusts under Administration (continued)

(b) Other Trust Funds

AHS receives funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to appropriate the funds or to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2020, the balance of funds held in trust by AHS for research and development is $100 (March 31, 2019 – $100).

AHS receives funds in trust from continuing care residents for personal expenses. As at March 31, 2020, the balance of these funds is $1,390 (March 31, 2019 – $1,452). These amounts are not included in the consolidated financial statements.

AHS and a third party trustee administer the SERP in accordance with a retirement compensation arrangement trust agreement. As at March 31, 2020, there are $29,181 in plan assets (March 31, 2019 - $32,674). These amounts are not included in the consolidated financial statements

Note 24 Segment Disclosure

The Consolidated Schedule of Segment Disclosures – Schedule 3 is intended to enable users to better understand the reporting entity and identify the resources allocated to the major activities of AHS.

AHS' revenues, as reported on the Consolidated Statement of Operations, are most informatively presented by source and are not reasonably assignable to the reportable segments. For each reported segment, the expenses are directly or reasonably attributable to the segment.

The segments have been selected based on the presentation that is adopted for the financial reporting, planning and budget processes, and represent the major distinguishable activities of AHS.

Segments include:

(a) Continuing care

Continuing care is comprised of long-term care including chronic and psychiatric care in facilities operated by AHS and contracted providers.

(b) Community care

Community care includes supportive living, palliative and hospice care, and community programs including Primary Care Networks, Family Care Clinics, urgent care centres, and community mental health. This segment excludes community-based dialysis, oncology, and surgical services.

(c) Home care

Home care is comprised of home nursing and support.

(d) Acute care

Acute care is comprised predominantly of patient care units such as medical, surgical, intensive care, obstetrics, pediatrics, mental health, emergency, day/night care, clinics, day surgery, and contracted surgical services. This segment also includes operating and recovery rooms.

(e) Ambulance services

Ambulance services is comprised of ground ambulance, air ambulance, patient transport, and Emergency Medical Services (EMS) central dispatch. AHS also supports community paramedic programs, as well as other programs that support the learning, development, quality and safety of EMS professionals.

Note 24 Segment Disclosure (continued)

(f) Diagnostic and therapeutic services

Diagnostic and therapeutic services support and provide care for patients through clinical lab (both in the community and acute settings), diagnostic imaging, pharmacy, acute and therapeutic services such as physiotherapy, occupational therapy, respiratory therapy, and speech language pathology.

(g) Population and public health

Population and public health is comprised primarily of health promotion, disease and injury prevention, and health protection.

(h) Research and education

Research and education is comprised primarily of costs pertaining to formally organized health research and graduate medical education, primarily funded by donations, and third party contributions.

(i) Information technology

Information technology is comprised of costs pertaining to the provision of services to design, develop, implement, and maintain effective and efficient management support systems in the areas of data processing, systems engineering, technical support, and systems research and development.

(j) Support services

Support services is comprised of building maintenance operations (including utilities), materials management (including purchasing, central warehousing, distribution and sterilization), housekeeping, patient registration, health records, food services, and emergency preparedness.

(k) Administration

Administration is comprised of human resources, finance, communications and general administration, as well as a share of administration of certain contracted health service providers. General administration includes senior executives and many functions such as planning and development, infection control, quality assurance, patient safety, insurance, privacy, risk management, internal audit, and legal.

Note 25 Impact of COVID-19

The World Health Organization assessed the novel strain of coronavirus, COVID-19, a global pandemic and recommended containment measures worldwide. On March 17, 2020, a state of public health emergency was declared in Alberta.

In response to the global pandemic, AH provided AHS with $23,317 in funding up to March 31, 2020. These funds were used for incremental expenditures arising from testing, surveillance and treatment of patients. Assessment and treatment centers were also set up to assist with the anticipated demand of COVID-19 related healthcare services. Expenditures were also incurred for hospital supplies and equipment, including personal protective equipment.

Subsequent to March 31, 2020, AHS has received additional funding from AH to assist in the continued response to COVID-19. To date, the following impacts of the pandemic have been identified:

- Additional measures relating to the provision of personal protective equipment for the overall safety of Albertans. This has entailed the entering into of significant purchase commitments, including payment of deposits to secure essential supplies and equipment for both AHS and third party health service providers within Alberta. At the direction of the Minister, AHS also acquired personal protective equipment to provide to other provinces.
- Delays or deferrals of certain health care related services
- Increases in funding provided to third party service providers, especially long term care providers which have been significantly impacted by COVID-19
- Operation of assessment and treatment centers as well as increased laboratory testing relating to COVID-19

Note 25 Impact of COVID-19 (continued)

- Redeployment of parts of the AHS workforce as the organization responds to measures such as contact tracing and testing, remote solutions such as virtual health and health link support.
- Delays in the implementation of certain information systems initiatives
- Delays in negotiations and settlement of open contracts relating to the AHS labor workforce
- Potential declines in the value of marketable securities held by AHS as described in Note 9
- Increased uncertainty relating to recoverability of outstanding accounts receivable balances
- Temporary suspension of parking fees
- Receipt of donated ventilators, supplies and personal protective equipment as Albertans come together to assist in the response to COVID-19

As Alberta progresses through the first wave of COVID-19, AHS continues to closely monitor the COVID-19 developments. Overall, as the response is ongoing and an end to the pandemic is indeterminable, the related financial and operational impacts of the pandemic cannot be reliably estimated at this time.

Note 26 Corresponding Amounts

In the current year, AHS determined that certain immaterial donor contributions related to the purchase of equipment had been recorded before the contributions were authorized by the donor. As a result, AHS has retrospectively adjusted certain consolidated financial statement accounts as at and for the year ended March 31, 2019 including accounts receivable and unexpended deferred capital revenue which have been reduced by $78,485 to more appropriately reflect the timing of the donor authorizations.

Certain other corresponding amounts have been reclassified to conform to the 2020 consolidated financial statement presentation.

Note 27 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on June 24, 2020.

SCHEDULE 1 – CONSOLIDATED SCHEDULE OF EXPENSES BY OBJECT FOR THE YEAR ENDED MARCH 31

	2020		2019
	Budget (Note 3)	Actual	Actual
Salaries and benefits (Schedule 2)	$ 8,327,000	$ 8,530,683	$ 8,321,637
Contracts with health service providers	2,781,000	2,823,741	2,749,686
Contracts under the Health Care Protection Act	20,000	20,041	17,186
Drugs and gases	501,000	560,661	506,662
Medical supplies	588,000	581,490	592,517
Other contracted services	1,378,000	1,319,640	1,322,806
Other[a]	1,216,000	1,196,379	1,273,213
Amortization and loss on disposals/write-downs of tangible capital assets (Note 18)	554,000	581,723	529,628
	$ 15,365,000	**$ 15,614,358**	**$ 15,313,335**
(a) Significant amounts included in Other are:			
Equipment expense	$ 203,000	$ 223,174	$ 212,312
Building rent	121,000	126,387	112,921
Utilities	109,000	115,577	118,372
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies	88,000	86,877	90,608
Building and ground expenses	126,000	85,683	118,206
Food and dietary supplies	81,000	80,855	80,827
Office supplies	53,000	60,311	63,279
Fundraising and grants awarded	54,000	52,298	51,336
Minor equipment purchases	56,000	51,922	59,246
Insurance and liability claims	46,000	42,439	90,867
Telecommunications	39,000	39,983	38,917
Travel	54,000	39,809	45,423
Licenses, fees and memberships	18,000	21,650	17,211
Education	18,000	11,893	12,428
Other	150,000	157,521	161,260
	$ 1,216,000	**$ 1,196,379**	**$ 1,273,213**

SCHEDULE 2 - CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2020

	2020								2019	
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]		Total	FTE [a]	Total
						Number of Individuals	Amount			
Total Board (Sub-Schedule 2A)	10.87	$ -	$ 336	$ -	$ 336	-	$ -	$ 336	10.82	$ 334
Total Executive (Sub-Schedule 2B)	13.95	5,234	58	843	6,135	1	557	6,692	14.00	6,028
Management Reporting to CEO Direct Reports	56.46	13,452	345	2,420	16,217	-	-	16,217	56.86	15,797
Other Management	3,120.38	372,487	5,207	81,279	458,973	30	3,504	462,477	3,031.59	452,716
Medical Doctors not included above[f]	115.97	36,690	472	3,382	40,544	-	-	40,544	141.84	49,934
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	19,930.49	1,906,924	272,159	415,656	2,594,739	7	542	2,595,281	19,566.39	2,544,809
LPNs	5,432.11	358,937	46,374	79,747	485,058	2	86	485,144	5,233.39	464,883
Other health technical and professional	16,557.82	1,530,576	89,423	342,227	1,962,226	11	413	1,962,639	16,948.48	1,963,001
Unregulated health service providers	10,142.83	524,456	61,394	126,612	712,462	5	59	712,521	9,310.80	638,452
Other staff	27,672.17	1,758,794	104,964	382,326	2,246,084	70	3,187	2,249,271	27,251.74	2,186,104
Sub-total	**83,053.05**	**6,507,550**	**580,732**	**1,434,492**	**8,522,774**	**126**	**8,348**	**8,531,122**	**81,565.91**	**8,322,058**
Less amounts included in Other contracted services		(360)	(2)	(77)	(439)	-	-	(439)		(421)
Total		**$ 6,507,190**	**$ 580,730**	**$ 1,434,415**	**$ 8,522,335**	**126**	**$ 8,348**	**$ 8,530,683**		**$ 8,321,637**

This schedule does not include $29,799 in capitalized salaries and benefits (2019 - $27,393).

The accompanying footnotes and sub-schedules are part of this schedule.

SUB-SCHEDULE 2A – BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2020

	Term	2020 Committees	2020 Remuneration	2019 Remuneration
Board Chairs[g]				
Linda Hughes	Nov 27, 2015 to Aug 19, 2019	ARC, CEC, FC, GC, HRC, QSC	$ 26	$ 69
David Weyant	Since Aug 20, 2019	ARC, CEC, FC, GC, HRC, QSC	43	-
Board Members				
Dr. Brenda Hemmelgarn (Vice Chair)	Since Nov 27, 2015	CEC (Chair), HRC, QSC	49	49
David Carpenter	Since Nov 27, 2015	ARC (Chair), FC (Chair), HRC	34	35
Heather Crowshoe	Nov 3, 2016 to Nov 2, 2019	CEC, GC	17	30
Richard Dicerni	Since Nov 27, 2015	CEC, FC, HRC (Chair)	28	27
Robb Foote	Apr 12, 2018 to Feb 1, 2019	-	-	24
Linda Hughes	Aug 20, 2019 to Sep 30, 2019	-	1	-
Stephen Mandel	Since Sep 25, 2019	CEC, FC, QSC	16	-
Heidi Overguard	Since Sep 25, 2019	CEC, FC, GC, HRC	17	-
Hugh Sommerville	Since Nov 27, 2015	ARC, GC (Chair)	32	31
Marliss Taylor	Nov 27, 2015 to Oct 24, 2019	GC, HRC (Chair), QSC	18	34
Brian Vaasjo	Since Aug 20, 2019	ARC, FC, GC	19	-
Glenda Yeates	Since Nov 27, 2015	ARC, FC, QSC (Chair)	32	31
Board Committee Participants[h]				
Dr. Brian Postl	Since Jan 1, 2018	QSC	2	2
Gord Winkel	Since Nov 27, 2015	QSC	2	2
Total Board			**$ 336**	**$ 334**

Board members were remunerated with monthly honoraria. In addition, they received remuneration for attendance at Board and committee meetings.

Board committees were established by the Board to assist in governing AHS and overseeing the management of AHS' business and affairs. Board committee participants are eligible to receive remuneration for meetings attended, and in addition Board committee chairs also receive a monthly honorarium.

Committee legend: ARC = Audit and Risk Committee, CEC = Community Engagement Committee, FC = Finance Committee, GC = Governance Committee, HRC = Human Resources Committee, QSC = Quality and Safety Committee

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2020

	2020						
For the Current Fiscal Year	**FTE [a]**	**Base Salary [b,i]**	**Other Cash Benefits [c]**	**Other Non-Cash Benefits [d]**	**Subtotal**	**Severance [e]**	**Total**
Board Direct Reports							
Andrea Beckwith-Ferraton – Chief Ethics and Compliance Officer[q]	1.00	$ 212	$ 3	$ 37	$ 252	$ -	$ 252
Ronda White – Chief Audit Executive[q]	1.00	278	1	56	335	-	335
Dr. Verna Yiu – President and Chief Executive Officer[j,r]	1.00	576	-	78	654	-	654
CEO Direct Reports							
Dr. Francois Belanger – VP, Quality and Chief Medical Officer[q]	1.00	465	-	88	553	-	553
Dr. Ted Braun – VP and Medical Director, Clinical Operations[q]	1.00	399	-	61	460	-	460
Mauro Chies – VP, CancerControl Alberta and Clinical Support Services[q]	1.00	331	-	55	386	-	386
Sean Chilton – VP, Health Professions and Practice and Information Technology[k,q]	1.00	331	-	64	395	-	395
Todd Gilchrist – VP, People[l,q]	1.00	452	1	72	525	-	525
Deb Gordon – VP and Chief Operations Officer, Clinical Operations[q]	1.00	372	-	65	437	-	437
Robert Hawes – Interim VP, Corporate Services and Chief Financial Officer[m,s]	0.08	34	3	2	39	-	39
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta[n]	0.95	353	-	57	410	-	410
Dr. Mark Joffe – VP and Medical Director, CancerControl Alberta, Clinical Support Services and Provincial Clinical Excellence[o,t]	1.00	451	34	42	527	-	527
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer[p,u]	0.92	357	1	51	409	557	966
Dr. Kathryn Todd – VP, Provincial Clinical Excellence[o,t]	1.00	291	15	45	351	-	351
Colleen Turner – VP, Community Engagement and Communications[q]	1.00	332	-	70	402	-	402
Total Executive	**13.95**	**$ 5,234**	**$ 58**	**$ 843**	**$ 6,135**	**$ 557**	**$ 6,692**

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2020 (CONTINUED)

	2019						
For the Prior Fiscal Year	**FTE [a]**	**Base Salary [b,i]**	**Other Cash Benefits [c]**	**Other Non-Cash Benefits [d]**	**Subtotal**	**Severance [e]**	**Total**
Board Direct Reports							
Andrea Beckwith-Ferraton – Chief Ethics and Compliance Officer	1.00	$ 211	$ 3	$ 34	$ 248	$ -	$ 248
Ronda White – Chief Audit Executive	1.00	276	2	43	321	-	321
Dr. Verna Yiu – President and Chief Executive Officer	1.00	572	-	84	656	-	656
CEO Direct Reports							
Dr. Francois Belanger – VP, Quality and Chief Medical Officer	1.00	462	-	62	524	-	524
Dr. Ted Braun – VP and Medical Director, Central and Southern Alberta	1.00	395	-	71	466	-	466
Mauro Chies – VP, CancerControl Alberta and Clinical Support Services	0.52	171	-	28	199	-	199
Sean Chilton – VP, Health Professions and Practice	1.00	329	-	55	384	-	384
Todd Gilchrist – VP, People, Legal and Privacy	1.00	448	1	62	511	-	511
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta	1.00	369	-	83	452	-	452
Karen Horon – Interim VP, Clinical Support Services	0.48	110	-	19	129	-	129
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta	1.00	369	-	62	431	-	431
Dr. Mark Joffe – VP and Medical Director, Northern Alberta	1.00	447	35	41	523	-	523
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer	1.00	388	1	54	443	-	443
Dr. Kathryn Todd – VP, System Innovations and Programs	1.00	289	15	43	347	-	347
Colleen Turner – VP, Community Engagement and Communications	1.00	329	-	65	394	-	394
Total Executive	**14.00**	**$ 5,165**	**$ 57**	**$ 806**	**$ 6,028**	**$ -**	**$ 6,028**

SUB-SCHEDULE 2C - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

Certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service. The Supplemental Pension Plan (SPP) is a defined contribution plan and the Supplemental Executive Retirement Plan (SERP) is a defined benefit plan. The SERP is disclosed in Note 2(h)(i). The amounts in this table represent the total SPP and SERP benefits earned by the individual during the fiscal year. The current period benefit costs for SPP and the other costs for SERP included in other non-cash benefits disclosed in Sub-Schedule 2B are prorated for the period of time the individual was in their position directly reporting to the Board or directly reporting to the President and Chief Executive Officer. Only individuals holding a position directly reporting to the Board or President and Chief Executive Officer during the current fiscal year are disclosed.

	2020			2019			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2019	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2020
Andrea Beckwith-Ferraton - Chief Ethics and Compliance Officer	$ 6	$ -	$ 6	$ 6	$ 17	$ 8	$ 25
Dr. Francois Belanger - VP, Quality and Chief Medical Officer	36	-	36	36	239	87	326
Dr. Ted Braun - VP and Medical Director, Clinical Operations							
SERP	-	-	-	5	220	(14)	206
SPP	28	-	28	28	140	49	189
Mauro Chies - VP, CancerControl Alberta and Clinical Support Services	20	-	20	18	102	36	138
Sean Chilton - VP, Health Professions and Practice and Information Technology	20	-	20	20	156	42	198
Todd Gilchrist - VP, People	34	-	34	34	132	59	191
Deb Gordon - VP and Chief Operations Officer, Clinical Operations							
SERP	-	(1)	(1)	15	683	(41)	642
SPP	25	-	25	25	165	54	219
Robert Hawes - Interim VP, Corporate Services and Chief Financial Officer	-	-	-	-	-	-	-
Brenda Huband - VP and Chief Health Operations Officer, Central and Southern Alberta							
SERP	-	(1)	(1)	9	400	(33)	367
SPP	25	-	25	25	174	52	226
Dr. Mark Joffe - VP and Medical Director, CancerControl Alberta, Clinical Support Services and Provincial Clinical Excellence[(o)]	-	-	-	-	-	-	-
Deborah Rhodes - VP, Corporate Services and Chief Financial Officer[(u)]	25	-	25	27	229	(229)	-
Dr. Kathryn Todd - VP, Provincial Clinical Excellence[(o)]	-	-	-	-	-	-	-
Colleen Turner - VP, Community Engagement and Communications	20	-	20	20	108	42	150
Ronda White - Chief Audit Executive	13	-	13	14	90	28	118
Dr. Verna Yiu - President and Chief Executive Officer	49	-	49	49	137	66	203

(1) The SPP current period benefit costs are AHS contributions earned in the period.
(2) Other SERP costs include retirement benefits, interest expense on the obligations, and amortization of actuarial gains and losses, offset by the expected return on the plans' assets. AHS uses the straight line method to amortize actuarial gains and losses over the expected average remaining service life of the plan members.
(3) The account balance represents the total cumulative earned contributions to the SPP as well as cumulative investment gains or losses on the contributions.
(4) Changes in the accrued benefit obligation include current period benefit cost, interest accruing on the obligations and the amortization of any actuarial gains or losses in the period. Changes in the account balance include the current benefit costs and investment gains or losses related to the account.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2020

Definitions

a. For this schedule, full time equivalents (FTE) are determined by actual hours earned divided by 2,030.50 annual base hours. FTE for the Board and Board committee members are prorated using the number of days in the fiscal year between either the date of appointment and the end of the year, the date of appointment and the termination date, or the beginning of the year and the termination date.

b. Base salary is regular salary and includes all payments earned related to actual hours earned other than those reported as other cash benefits.

   Vacation accruals are included in base salary except for direct reports of the Board or President and Chief Executive Officer whose vacation accruals are included in other non-cash benefits.

c. Other cash benefits include, as applicable, honoraria, overtime, acting pay, membership fees, travel and automobile allowances, lump sum payments and an allowance for professional development. Relocation expenses are excluded from compensation disclosure as they are considered to be recruiting costs to AHS and not part of compensation unless related to severance. Expense reimbursements are also excluded from compensation disclosure except where the expenses meet the definition of the other cash benefits listed above.

d. Other non-cash benefits include:
   - Employer's current period benefit costs and other costs of supplemental pension plan and supplemental executive retirement plans as defined in Sub-Schedule 2C
   - Employer's share of employee benefit contributions and payments made on behalf of employees including pension, health care, dental and vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, and long and short-term disability plans
   - Vacation accruals for direct reports of the Board or President and Chief Executive Officer, and
   - Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

e. Severance includes direct or indirect payments to individuals upon termination which are not included in other cash benefits or other non-cash benefits.

f. Compensation provided by AHS for medical doctors included in salaries and benefits expense includes medical doctors paid through AHS payroll. The compensation provided by AHS for the remaining medical doctors is included in other contracted services.

Board and Board Committee Participants

g. The Board Chair is an Ex-Officio member on all committees.

h. These individuals were participants of Board committees, but are not Board members or AHS employees.

Executive

i. Base salary reported for executives are the actual payments earned during the year, and is therefore contingent on the number of AHS' work days in the year. For the year ended March 31, 2020, the number of work days at AHS is 262 (2019 – 260 work days).

j. The incumbent is engaged in an employment agreement with AHS while on leave of absence from the University of Alberta. The contract term ends June 2, 2021.

k. The incumbent received a vacation payout of $16 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

l. The incumbent received a vacation payout of $9 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

m. The incumbent was appointed to the temporary position effective March 2, 2020. The term ends July 8, 2020.

n. As a result of restructuring, the incumbent ceased to be a direct report to the President and Chief Executive Officer effective March 16, 2020.

o. The incumbent is on secondment from the University of Alberta. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Alberta, and AHS reimburses the University for the incumbent's base salary and benefits. In lieu of enrollment into the AHS SPP, the incumbent will receive an annual lump sum supplemental payment equivalent to the amount the incumbent would have received as a member of the SPP and payable from AHS. The lump sum has been included in Other Cash Benefits.

p. The incumbent held the position until February 28, 2020 at which time the incumbent left AHS. The incumbent received salary and other accrued entitlements to the date of departure. The reported severance included 65 weeks base salary at the rate in effect at the date of departure, and 15% of the severance in lieu of benefits. AHS will also make payments for the incumbent to attend an outplacement program for a maximum of five months. In addition, the incumbent received a vacation payout of $46 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

Termination Obligations

q. The incumbent's termination benefits have not been predetermined.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2020 (CONTINUED)

r. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to one month base salary for each completed month of service during the first year of the term or, after completion of one year of service of the term, 12 months base salary.

s. There is no severance associated with the temporary position.

t. There is no severance associated with the secondment agreement. Upon termination of the secondment agreement, the incumbent would return to the incumbent's regular position at the University of Alberta.

u. Based on the provision of the applicable SPP, the following outlines the benefits received by individuals who terminated employment with AHS within the 2019-20 fiscal period. As a result of retirement or termination, the incumbents are entitled to the benefits accrued to them up to the date of retirement or termination. For participants of SPP, the benefit includes the account balances as at March 31, 2019 and the current period benefit costs and investment gains or losses related to the account that were incurred during the current year. The AHS obligations are paid through either a lump sum payment or regular instalments:

Position	Supplemental Plan Commencement Date	Benefit (not in thousands)	Frequency	Payment Terms
VP, Corporate Services and Chief Financial Officer	June 1, 2010	$288,935	Once	June 2020

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF SEGMENT DISCLOSURES FOR THE YEAR ENDED MARCH 31

	2020								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Care Protection Act	Drugs and gases	Medical supplies	Other contracted services	Other	Amortization and loss on disposals/ write-downs of tangible capital assets	Total
Continuing care	$ 321,315	$ 806,123	$ -	$ 7,881	$ 4,533	$ 5,802	$ 28,489	$ 2,324	$ 1,176,467
Community care	698,728	698,918	-	4,445	3,451	52,003	67,693	551	1,525,789
Home care	338,742	257,699	-	187	9,308	88,298	22,244	84	716,562
Acute care	3,022,568	388,383	20,041	511,365	356,465	562,803	148,107	56,075	5,065,807
Ambulance services	305,282	173,494	-	2,018	3,945	1,472	27,322	17,129	530,662
Diagnostic and therapeutic services	1,595,207	289,472	-	24,473	188,168	286,529	106,626	49,091	2,539,566
Population and public health	305,676	14,620	-	7,704	4,809	10,225	13,825	258	357,117
Research and education	189,530	3,495	-	103	1,364	124,776	25,217	149	344,634
Information technology	298,101	735	-	-	29	40,667	166,852	90,621	597,005
Support services	1,102,401	152,542	-	2,481	9,167	115,228	541,106	364,280	2,287,205
Administration	353,133	38,260	-	4	251	31,837	48,898	1,161	473,544
Total	**$ 8,530,683**	**$ 2,823,741**	**$ 20,041**	**$ 560,661**	**$ 581,490**	**$ 1,319,640**	**$ 1,196,379**	**$ 581,723**	**$ 15,614,358**

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF SEGMENT DISCLOSURES (CONTINUED) FOR THE YEAR ENDED MARCH 31

	2019								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Care Protection Act	Drugs and gases	Medical supplies	Other contracted services	Other	Amortization and loss on disposals/ write-downs of tangible capital assets	Total
Continuing care	$ 317,473	$ 775,491	$ -	$ 7,600	$ 4,664	$ 5,278	$ 24,705	$ 2,152	$ 1,137,363
Community care	682,532	657,092		3,562	4,556	31,951	65,218	372	1,445,283
Home care	327,974	246,052	-	179	7,910	83,441	22,591	148	688,295
Acute care	2,994,658	394,435	17,186	461,210	366,996	569,378	149,794	64,810	5,018,467
Ambulance services	299,635	174,932	-	1,953	4,094	1,572	28,690	17,169	528,045
Diagnostic and therapeutic services	1,563,230	293,708	-	22,738	187,983	291,808	101,463	44,688	2,505,618
Population and public health	301,511	9,860	-	6,840	4,403	14,836	11,904	315	349,669
Research and education	186,172	2,911	-	15	1,171	129,589	27,216	165	347,239
Information technology	240,922	514	-	-	32	37,156	152,109	76,593	507,326
Support services	1,070,420	154,714	-	2,560	10,237	112,198	587,269	323,023	2,260,421
Administration	337,110	39,977	-	5	471	45,599	102,254	193	525,609
Total	**$ 8,321,637**	**$ 2,749,686**	**$ 17,186**	**$ 506,662**	**$ 592,517**	**$ 1,322,806**	**$ 1,273,213**	**$ 529,628**	**$ 15,313,335**

COMPENSATION ANALYSIS AND DISCUSSION

Compensation Analysis and Discussion – (Non-Union Exempt Employees)

A total compensation strategy is the blueprint for an organization's total compensation program. It includes a mix of direct and indirect compensation provided to employees. This mix, and the means through which it is provided, works to support an organization's goals. It is important that total compensation in a publicly-funded organization such as AHS has a governance-approved strategy or a "blueprint" that is properly aligned with its direction, goals, and values.

Total Compensation Philosophy

AHS reinforces outstanding patient care for all Albertans by attracting, retaining, and engaging talented and committed employees. We do this with total compensation that is competitive and fair and that motivates and rewards performance while demonstrating sound fiscal management and sustainability. Principles set out in the total compensation policy guided by AHS' total compensation philosophy reflect competitive market positioning, internal equity, performance orientation, affordability, individual flexibility, and shared employee/employer responsibility.

Total Compensation Strategy

AHS ensures the process used to set total compensation, establish and maintain good governance, and incorporate best practices is transparent. AHS Non-Union Exempt Employees are currently under a salary freeze that applies to all government agencies, boards, and commissions until March 31, 2021. The job rates for executive, senior leadership, and other non-union exempt salary ranges are intended to be representative of the median of the national healthcare and Alberta public sector markets. Outside of the salary freeze environment, to ensure total compensation remains market competitive, AHS monitors its market positioning on a regular basis. Due to the current salary freeze, AHS has not adjusted its pay bands since the 2013-14 fiscal year. AHS' total compensation programs and practices encourage behaviours that will promote a patient-focused, quality health system that is sustainable and accessible for all Albertans.

Total Compensation Plan Structure

AHS is committed to providing a comprehensive total compensation package including salary, benefits, pension, and other programs and services that support attracting, retaining, and engaging talented and committed employees. AHS' total compensation is comprised of direct and indirect compensation. Elements within direct and indirect compensation fit the overall total compensation strategy by driving accountability and performance, demonstrating sound fiscal management, and promoting a sense of integrity and equity.

Direct Compensation includes pay received as wages and salaries. AHS has no incentive, variable pay, or pay at risk of any kind. Base salary ranges were designed to be competitive at median (50th percentile) of the national healthcare market and the Alberta public sector market. An employee's individual base salary is set based on their skills, education, experience, and internal equity.

Indirect Compensation includes benefits (life insurance, long-term disability, dental and various health and wellness options) terms and conditions, and employee appreciation initiatives that support the health and well-being of employees.

All AHS employees are eligible to participate in the Local Authorities Pension Plan (LAPP). LAPP is a defined benefit plan where enrollment is mandatory for anyone working in a regular position of 30 hours or more per week. Benefits under this plan are capped at the maximum pension benefit limit allowed under the federal *Income Tax Act*, a salary of $168,498 in 2019. All employees over the salary cap are eligible for a Supplemental Pension Plan (SPP) benefit. Unlike the LAPP, the SPP is a defined contribution plan that provides annual notional contributions that are allocated to, and invested as directed, by each member. The SPP helps AHS to compete in its market at lower cost and minimizes risk to the organization. AHS does not provide car allowances or perquisite allowances to its executives or employees.

Total Compensation Governance

The Human Resources Committee of the Board monitors, oversees, and advises the AHS Board on total compensation matters related to AHS including:

- Determining the overall strategic approach to compensation.
- Reviewing substantive changes to total compensation programs to ensure they support the organization's mission, strategic directions, and values.
- Reviewing the compensation of the President & Chief Executive Officer (CEO) and Vice Presidents.
- Reviewing the compensation philosophy recommended by the President & CEO for non-executive staff of AHS.

Total Compensation Reporting

The Schedule 2 – Consolidated Schedule of Salaries and Benefits in the annual audited consolidated financial statements for the year ended March 31, 2020 provides complete disclosure of salary, benefits, and all other compensation earned by the direct reports to the Board and the direct reports to the President & CEO for years ended March 31, 2019, and March 31, 2020. The Board's compensation is also disclosed in Schedule 2 – Consolidated Schedule of Salaries and Benefits in the annual audited consolidated financial statements for the year ended March 31, 2020. The Schedule 2 information on total compensation philosophy and practices can be found on the AHS website.

Total Compensation 2019-20 Information Updates

The *Public Service Compensation Transparency Act* requires compensation disclosure from Alberta agencies, boards, and commissions, including AHS. As required, AHS disclosed the names and compensation of employees whose annual earnings were over $129,809 in the 2018 calendar year on AHS' external website and the Alberta Government compensation disclosure database by June 30, 2019. AHS will continue this process by disclosing the names and compensation of employees whose earnings are over $132,924 for the 2019 calendar year.

Effective April 1, 2018, the Government of Alberta also enacted a new Salary Restraint Regulation which formalizes the current salary restraint measures for the agencies covered by *Alberta Public Agencies Governance Act* (APAGA). This regulation outlines key provisions regarding the salary restraint and defines terms of the freeze. The regulation also includes a section of permitted adjustments that allow for base salary increases in select circumstances and in accordance with the public agency's existing policies. In March 2020, the Government of Alberta extended the salary freeze without interruption and with the same key provisions for the salary restraint up to March 31, 2021.

Compensation regulation under the *Reform of Agencies, Boards, and Commissions Compensation Act* (RABCCA) established total compensation, including salary and benefits, for Chief Executive Officers or equivalent in 27 designated public agencies that are part of the APAGA. This regulation came into effect on March 16, 2017, and applied to 27 designated public agencies identified in *APAGA*. AHS is exempt from this regulation and the executive compensation structure developed by the Government of Alberta. Although exempt, AHS has submitted an executive compensation plan to government. This compensation plan will be completed and submitted annually to demonstrate how AHS aligns to the key compensation principles outlined in *RABCCA* and help ensure scrutiny of its compensation practices. Transparency will continue through mandated salary disclosure.

Appendix

Monitoring Measures

There are a number of measures AHS monitors to help inform other areas of the health system. These monitoring measures do not have targets; however they are familiar and of interest to Albertans. They include a broad range of indicators that span the continuum of care, such as population and public health; primary care; continuing care; mental health; cancer care; emergency department; and surgery. AHS continues to monitor these measures to help support priority-setting and local decision-making. These additional measures are tactical as they inform the performance of an operational area or reflect the performance of key drivers of strategies not captured in the Health Plan.

Data was updated as of May 20, 2020 and definitions can be found online at https://www.albertahealthservices.ca/about/Page12640.aspx.

LIFE EXPECTANCY	2015	2016	2017	2018	2019
The number of years a person would be expected to live, starting at birth, on the basis of mortality statistics.					
Provincial	81.7	81.8	81.7	81.9	82.3
Females	84.0	84.1	84.0	84.3	84.5
Males	79.5	79.7	79.5	79.6	80.2
First Nations	69.7	70.8	70.6	70.4	69.8
Non-First Nations	82.2	82.2	82.1	82.4	82.8

POTENTIAL YEARS OF LIFE LOST	2015	2016	2017	2018	2019
The total number of years not lived (per 1,000 population) by an individual who died before their 75th birthday.					
Both	50.7	49.8	51.0	50.7	46.9
Females	38.3	38.0	38.3	37.1	35.3
Males	62.6	61.1	63.2	63.8	58.1

CANCER SCREENING	2015-16	2016-17	2017-18	2018-19	2019-20
Breast Cancer Participating Rate	63.6%	64.2%	64.4%	64.9%	Not avail.
Colorectal Cancer Participating Rate*	55.1%	55.0%	55.6%	55.7%	Not avail.
Cervical Cancer Participating Rate	65.7% (2014-16)	65.1% (2015-17)	64.3% (2016-18)	63.6% (2017-19)	Not avail.
Early Detection of Cancers	69.8% (2015)	69.7% (2016)	71.2% (2017)	69.5% (2018)	Not avail.

Note: Cancer screening rate measures are lagged and data was not available at the time of this report
** Historical data was updated due to methodology updates to capture both FIT tests and sigmoidoscopy/colonoscopy procedures.*

INFLUENZA IMMUNIZATION	2015-16	2016-17	2017-18	2018-19	2019-20
Seasonal Influenza Immunizations	1,146,569	1,171,728	1,229,350	1,317,659	1,438,866
Adults 65+ years	62.7%	60.2%	60.1%	61.2%	61.4%
Children 6 to 23 months	35.9%	35.3%	34.6%	40.7%	43.2%
AHS healthcare workers	60.9%	62.5%	66.0%	67.6%	67.2%

Source: Alberta Health Influenza Immunization Report 2019-2020.

PRIMARY HEALTH CARE	2015-16	2016-17	2017-18	2018-19	2019-20
Albertans enrolled in a Primary Care Network	79%	80%	82%	82%	81%
Ambulatory care sensitive conditions: rate of hospital admissions for health conditions that may be prevented or managed by appropriate primary healthcare (per 100,000 people)	342	329	320	311	303
Family practice sensitive conditions: percentage of emergency department or urgent care visits for health conditions that may be appropriately managed at a family physician's office	23.2%	22.3%	21.4%	20.5%	20.6%
Number of HealthLink calls	755,334	744,278	706,280	694,313	891,931*
Percentage of HealthLink calls answered within two minutes	76%	74%	73%	74%	60%

** HealthLink call volumes include COVID-19 inquiries.*

CHILDREN'S MENTAL HEALTH SERVICES	2015-16	2016-17	2017-18	2018-19	2019-20
Percentage of children aged 0 to 17 years *offered* scheduled mental health treatment*	85%	81%	74%	82%	Not avail.
Percentage of children aged 0 to 17 years *receiving* scheduled mental health treatment	73%	73%	67%	72%	75% (Q3YTD)

** Data is no longer available due to clinical information system upgrades.*

Monitoring Measures (Cont'd)

EMERGENCY DEPARTMENT (ED)	2015-16	2016-17	2017-18	2018-19	2019-20
Total number of ED visits (all sites)	2,134,945	2,079,688	2,101,629	2,056,631	2,058,370
Percentage of patients treated and admitted to hospital within 8 hours (all sites)	46.9%	46.1%	43.9%	45.4%	42.9%
Percentage of patients treated and admitted to hospital within 8 hours (busiest sites)	37.9%	37.3%	35.5%	37.9%	35.9%
Percentage of patients treated and discharged within 4 hours (all sites)	78.3%	77.8%	76.0%	74.4%	72.2%
Percentage of patients treated and discharged within 4 hours (busiest sites)	62.9%	62.6%	60.1%	58.7%	55.1%
ED time to Physician Initial Assessment (median in hours at busiest sites)	1.3	1.3	1.4	1.4	1.6
Percentage of patients left without being seen and against medical advice	3.9%	3.9%	4.3%	4.5%	5.1%

ACUTE CARE	2015-16	2016-17	2017-18	2018-19	2019-20
Hospital Discharges	404,514	403,958	400,909	401,208	399,216
Acute Care Occupancy: Percentage of patient days in hospital compared to available bed days in the reporting period for top 16 AHS sites	96.1%	97.0%	98.0%	96.2%	95.4%
Acute Length of Stay to Expected Length of Stay Ratio	1.05	1.03	1.02	1.02	1.02
Hospital-Acquired *Clostridium difficile* Infection Rate (per 10,000 patient days)	3.5	3.3	3.0	2.5	2.6
Hospital Standardized Mortality Ratio (HSMR)*	102	102	102	97	98
Mental Health Readmissions within 30 days (risk adjusted)	8.6%	8.8%	8.8%	9.8%	10.4% (Q3YTD)
Surgical Readmissions within 30 days (risk adjusted)	6.5%	6.7%	6.5%	6.6%	6.6% (Q3YTD)
Heart Attack in Hospital Mortality within 30 days (risk adjusted)	6.1%	5.5%	5.4%	5.7%	6.2% (Q3YTD)
Stroke in Hospital Mortality within 30 days (risk adjusted)	14.0%	12.5%	12.8%	12.4%	12.1% (Q3YTD)

** Historical data was updated due to methodology updates that align with national indicators.*

CANCER CARE in weeks, 90th percentile	2015-16	2016-17	2017-18	2018-19	2019-20
Radiation oncology access: referral to first consult (from referral to the time of their first appointment with a radiation oncologist)	4.9	5.0	5.0	6.7	7.0
Medical oncology access: referral to first consult (from referral to the time of their first appointment with a medical oncologist)	5.4	5.0	5.6	6.1	7.0
Radiation therapy access: ready to treat to first therapy	2.9	2.7	2.7	2.7	2.9

SURGERY WAIT TIMES in weeks		2015-16	2016-17	2017-18	2018-19	2019-20
Coronary Artery Bypass Graft (CABG) Ready To Treat (RTT) Urgency III – Scheduled	Average (Median)	4.4	5.1	6.6	7.0	7.7
	90th Percentile	12.1	10.7	22.2	19.4	15.2
	Volume	1,487	1,460	1,453	1,636	1,599
Cataract Surgery RTT	Average (Median)	13.0	13.9	14.9	16.9	18.4
	90th Percentile	33.0	34.0	38.6	48.0	49.1
	Volume	36,806	38,053	39,340	40,554	43,972
Hip Replacement RTT	Average (Median)	13.7	14.6	18.1	18.9	19.3
	90th Percentile	31.4	32.9	36.7	38.0	39.9
	Volume	5,564	6,004	6,191	6,278	6,596
Knee Replacement RTT	Average (Median)	15.9	16.3	20.7	19.1	21.1
	90th Percentile	34.7	36.9	40.7	43.7	46.9
	Volume	6,645	6,692	6,556	6,613	6,231
Hip Fracture Repair: Percentage within 48 hours		90.1%	91.8%	92.8%	94.1%	92.4%

Notes:
- March 2020 surgery volumes were affected by the COVID-19 pandemic.
- Volumes include all procedures, whereas RTT wait times only include scheduled/elective procedures.

Monitoring Measures (Cont'd)

CONTINUING CARE	2015-16	2016-17	2017-18	2018-19	2019-20
Total number of people placed into continuing care	7,879	7,963	7,927	8,098	8,521
Number of patients placed from acute / subacute hospital bed into continuing care	5,405	5,395	5,218	5,005	5,113
Number of clients placed from community (at home) into continuing care	2,474	2,568	2,709	3,093	3,408
Average wait time for continuing care placement (in days)	53	59	62	61	54
Average wait time in acute/subacute care hospital bed for continuing care placement (in days)	44	46	51	46	36
Average wait time for long-term care placement (in days)	37	38	46	39	35
Average wait time for supportive living placement (in days)	79	91	86	95	80
Total number waiting for continuing care placement	1,411	1,873	1,937	1,508	1,412
Number of persons waiting in acute/subacute hospital bed for continuing care placement	628	846	676	474	410
Number of persons waiting in community (at home) for continuing care placement	783	1,027	1,261	1,034	1,002
Number of unique home care clients	117,491	119,725	121,887	127,150	132,478

Public Interest Disclosure (Whistleblower Protection) Act (PIDA)

The *Public Interest Disclosure (Whistleblower Protection) Act* (PIDA) protects employees when disclosing certain kinds of wrongdoing they observe in the AHS workplace.

Its purpose is to:

- Facilitate the disclosure and investigation of significant and serious matters at AHS that may be unlawful, dangerous to the public, or injurious to the public interest.
- Protect those who make a disclosure from reprisal.
- Implement recommendations arising from investigations.
- Provide for the determination of appropriate remedies arising from reprisals.
- Promote confidence in the public sector.

Over the past year, AHS has:

- Updated resources for managers and staff about PIDA and the internal disclosure process.
- Updated the AHS Whistleblower Policy to align with PIDA.

The AHS Designated Officer co-ordinates all PIDA disclosures pertaining to AHS, including those that may originate externally via the Alberta Public Interest Commissioner.

In compliance with legislated reporting requirements from April 1, 2019 to March 31, 2020, AHS reports that seven disclosures were received by or referred to AHS' Designated Officer:

- Seven disclosures acted on by the Designated Officer.
- No disclosures not acted on by the Designated Officer.
- No investigations commenced by the Designated Officer.
- Not applicable - for any investigation that results in a finding of wrongdoing, a description of wrongdoing, recommendations made or corrective measures taken, and if no corrective action has been taken, the reasons for that.

Chartered Surgical Facility Contracts under the Health Care Protection Act (Alberta)

AHS contracts services with multiple chartered surgical facilities (formerly non-hospital surgical facilities (NHSF)) to provide insured surgical services for dermatology, ophthalmology, oral maxillofacial, otolaryngology, plastic surgery, pregnancy terminations, and podiatry. The use of chartered surgical facilities enables AHS to obtain quality services to enhance surgical access and alleviate capacity pressures within AHS main operating rooms.

AHS works with Alberta Health and the College of Physicians and Surgeons of Alberta to coordinate activities addressing quality, safety, and compliance with the *Health Care Protection Act* and regulations.

Contracts with chartered surgical facilities provide increased choice of service provider for patients and supplement the resources available in hospitals while providing good value for public dollars. There was an 8.6% increase in the total numbers of procedures performed in 2019-20 (43,798) compared to 2018-19 (40,344). This increase is largely attributable to an increase in the number of ophthalmology procedures performed.

The table below summarizes chartered surgical facility contracts by service area for 2019-20:

2019-20 CHARTERED SURGICAL FACILITIES ACTIVITY

Contracted Service Area	# of Contracted Operators	# of Contracted Procedures Performed
Dermatology – Edmonton Zone	1	69
Ophthalmology – Calgary Zone*	5	21,458
Ophthalmology – Edmonton Zone	6	4,431
Oral and Maxillofacial Surgery – Calgary Zone*	8	499**
Oral and Maxillofacial Surgery – Edmonton Zone	10	3,316
Otolaryngology (ENT) – Edmonton Zone	2	246
Plastic Surgery – Edmonton Zone	3	304
Pregnancy Termination – Calgary	1	5,318
Pregnancy Termination – Edmonton	1	5,774
Restorative Dental – South Zone	5	299
Restorative Dental – Calgary*	1	362
Dermatology (Non-HCPA) - Edmonton Zone	2	231
Dermatology (Non-HCPA) - Calgary Zone	2	221
Restorative Dental – Edmonton	3	409
Podiatry Contract Surgical Service – Calgary*	2	861

Note: There are no surgical contracts with CSFs in the Central and North Zones that fall under the Health Care Protection Act (HCPA).
** Based on activity generated May 8, 2020.*
*** Calgary Zone Oral and Maxillofacial Surgery 2019-20 data now excludes unfunded cases, causing a decrease in reported cases.*

Facilities and Beds

AHS Facilities

Facility Definitions

Facility	Definition
Addiction	Addiction treatment facilities with beds and mats for clients with substance use and gambling problems. These include detoxification, nursing care, assessment, counselling, and treatment through direct services provided by AHS as well as funded and contracted services. This also includes beds for Protection of Children Abusing Drugs (PChAD) program clients and residential beds funded through the Safe Communities Initiative.
Comm. MH	Community Mental Health (CMH) supports home programs, community beds, and other mental health community beds/spaces that deliver both transitional and permanent/long-term services to clients with varying mental health issues. In addition, CMH treats the clients' behavioral, social, physical, and medical needs.
Standalone Psych	Standalone psychiatric facilities: Claresholm Centre for Mental Health and Addictions, Southern Alberta Forensic Psychiatric Centre (Calgary), Centennial Centre for Mental Health and Brain Injury (CCMHBI) (Ponoka), Alberta Hospital Edmonton, and Villa Caritas (Edmonton).
Hospital	Acute Care Hospitals are where active treatment is provided. They include medical, surgery, obstetrics, pediatrics, acute care psychiatric, NICU (neonatal intensive care levels II and III), ICU (includes intensive care unit, coronary care unit, special care unit, etc.), sub-acute, restorative, and palliative beds located in the hospital. ***Urban*** hospitals are located in large, densely populated cities and may provide access to tertiary and secondary level care. Some examples of tertiary level care include head and neck oncology, high risk perinatology and neonatology, organ transplantation, trauma surgery, high dose (cancer) radiation and chemotherapy, growth and puberty disorders, advanced diagnostics (i.e., MRI, PET, CT, Nuclear Medicine, Interventional Radiology), and tertiary level specialty clinic services. ***Regional*** hospitals provide access to secondary level care medical specialists who do not have first contact with patients (e.g., cardiologists, urologists, and orthopedic surgeons). In addition to providing general surgery services, these facilities provide specialist surgical services (e.g. orthopedics, otolaryngology, plastic surgery, gynecology) and advanced diagnostics (i.e., MRI, CT). ***Community*** hospitals provide access to rural clinical services – ambulatory, emergency, inpatient medicine, obstetrics and surgery (includes endoscopy). ***Standalone Emergency Departments (ED)*** reflect facilities with an ED and access to lab, diagnostic imaging, and outpatient specialty clinics. They do not have acute care beds or inpatient services. ***Ambulatory Endoscopy / Surgical Centre Hospitals (OP)*** reflect facilities providing ambulatory services including endoscopy and outpatient specialty clinics.
Sub-Acute Care (SAC)	Sub-acute care is provided in an auxiliary hospital for the purpose of receiving convalescent and/or rehabilitation services where it is anticipated that the patient will achieve functional potential to enable them to improve their health status and to successfully return to the community.
Palliative (PEOLC)	Palliative and End-of-Life Care (PEOLC) facilities are where a program or bed is designated for the purpose of receiving palliative care services, (including end-of-life and symptom alleviation) but are not located in an acute care facility. This includes community hospice beds.
Long-Term Care (LTC)	Long-term care is provided in nursing homes and auxiliary hospitals. It is reserved for those with unpredictable and complex health needs, usually multiple chronic and/or unstable medical conditions. Long-term care includes health and personal care services such as 24-hour nursing care provided by registered nurses or licensed practical nurses.
Designated Supportive Living (SL)	Designated Supportive Living includes comprehensive services such as the availability of 24-hour nursing care (levels 3 or 4). Designated Supportive Living 4-Dementia and Designated Supportive Living Mental Health is also available for those individuals living with moderate to severe dementia or cognitive impairment. Albertans accessing supportive living services generally reside in lodges, retirement communities, or designated supportive living centres.
Cancer (Ca)	Cancer Care Services include assessments and examinations, supportive care, pain management, prescription of cancer-related medications, education, resource and support counselling, and referrals to other cancer centres.
Ambulatory	***Urgent Care Centre (UCC)*** is a community-based service delivery site (non-hospital setting) where higher level assessment, diagnostic and treatment services are provided for unscheduled clients who require immediate medical attention for injuries/illnesses that require more intensive human and technical resources than what is available in a physician's office or AACC unit. ***Advanced Ambulatory Care Services (AACS)*** is a community-based service delivery site (non-hospital setting) where assessment, diagnostic and treatment services are provided for unscheduled patients seeking immediate medical attention for non-life threatening illnesses, typically patients of lower acuity than those treated in a UCC or ED. ***Community Ambulatory Care Centre (CACC)*** is a community-based service delivery site (non-hospital setting) primarily engaged in the provision of ambulatory care diagnostic and treatment services. This includes typically scheduled primary care for clients who do not require hospital outpatient emergency care or inpatient treatment. ***Public Health Centres*** include community health centres, community health clinics, district offices, public health, and public health centres. They provide services that are offered by public health nurses, including immunization, health education/counselling/support for parents, health assessment and screening to identify health concerns, and referral to appropriate healthcare providers such as physicians, and community resources.

Facilities by Zone

This section contains an overview of facilities that support healthcare throughout the province, including beds or spaces within these facilities. A provincial and zone breakdown is provided.

Number of Facilities	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
Community Ambulatory Care						
Urgent Care Centres		5		1		**6**
Ambulatory Care Centres	2	2	2	1	3	**10**
Primary Care Networks	2	7	12	9	11	**41**
Public Health Centres	17	23	34	21	45	**140**
Addiction and Mental Health						
Addiction	6	11	5	10	6	**38**
Community Mental Health	6	15	2	26	1	**50**
** The number of facilities for Community Mental Health does not include contracted sites with multiple locations. These facilities are noted in Zone Beds by Facility.*		3		2		
Standalone Psychiatric		2	1	2		**5**
Hospital Acute Care						
Urban		5		5		**10**
Regional	2		1		2	**5**
Community	9	8	29	7	31	**84**
Standalone Emergency Departments	2			2	1	**5**
Ambulatory Endoscopy or Surgical Centre Hospital	1	1				**2**
TOTAL DESIGNATED HOSPITALS	**14**	**14**	**30**	**14**	**34**	**106**
Cancer Care						
Cancer Centres	2	3	5	1	6	**17**
Community-Based Care						
Long-Term Care & Designated Supportive Living (3, 4, Dementia, Mental Health and Restorative Care)	51	74	79	92	59	**355**
Additional contracted care sites not included in above number reflect the number of personal care, special care and family care homes		53		55		**108**
Community Hospice, Palliative & End-of-Life Care	2	8	2	6	4	**22**

Source: AHS Bi-Annual Bed Survey as of March 31, 2020.
Note: Family Care Clinics were a pilot project with the following facilities: East Calgary Health Centre, East Edmonton Health Centre, Slave Lake Family Care Clinic. These sites are now being counted as Ambulatory Care Centres.

Provincial Overview of Community-Based Capacity

Continued growth in community and home care capacity is the key to efficient system flow in emergency departments, acute care and community; it also allows patients to receive the most appropriate care in the most appropriate setting by the most appropriate care provider. Since March 2010, 8,074 net new continuing care beds have been added to the system.

As of…	Long-Term Care (LTC)	Designated Supportive Living (DSL)	Total Continuing Care	Net New LTC & DSL Beds	Net New Palliative Beds	Total Net New Continuing Care Beds
March 2010	14,429	5,089	19,518			
March 2011	14,569	6,104	20,673	1,155		**1,155**
March 2012	14,734	6,941	21,675	1,002		**1,002**
March 2013	14,553	7,979	22,532	857	20	**877**
March 2014	14,370	8,497	22,867	335		**335**
March 2015	14,523	9,218	23,741	874	6	**880**
March 2016	14,768	9,937	24,705	964	35	**999**
March 2017	14,745	10,336	25,081	376		**376**
March 2018	14,846	10,807	25,653	572		**572**
March 2019	15,597	11,317	26,914	1,261	6	**1,267**
March 2020	15,665	11,853	27,518	604	7	**611**
Total Net New Beds Since 2010	**1,236**	**6,764**	**8,000**	**8,000**	**74**	**8,074**

Source: AHS Bi-Annual Bed Survey as of March 31, 2020.
Notes:
- Historical bed numbers have been updated with revised data.
- The number of beds above reflects AHS new capacity which has been staffed and in operation (patient placed into beds) during 2019-20. AHS is working with Alberta Health on a number of projects for additional capacity that did not open in 2019-20 but are planned to open in 2020-21. AHS does not include future capacity in any bed reporting.

Continuing Care – New Facilities

In 2019-20, new continuing care capacity was added at existing facilities in all zones including new facilities. All new capacity was built to accommodate clients needing long-term care and dementia care. The table below reflects where clients were placed from the AHS waitlists into the new facilities that opened.

New Facilities Opened in 2019-20	Zone	Location	Date Opened	Long-Term Care	Designated Supportive Living 4-Dementia	Designated Supportive Living 4	Designated Supportive Living 3	Total
The Manor Village at Fish Creek Park	Calgary	Calgary	April 29, 2019		38	38		**76**
Shepherd's Gardens Heritage Eden House	Edmonton	Edmonton	May 9, 2019	53				**53**
Lifestyle Options Schonsee	Edmonton	Edmonton	May 27, 2019		40	34		**74**
Prominence Way Retirement Community	Calgary	Calgary	July 2, 2019		19	36		**55**
Points West Living Cochrane	Calgary	Cochrane	July 15, 2019		26	96		**122**
Generations	Calgary	Calgary	September 3, 2019	62		58		**120**
South Valley Residential Living	North	Valleyview	October 21, 2019		8	15		**23**
Chartwell Emerald Hills	Edmonton	Sherwood Park	December 16, 2019		36	36		**72**
Village at Westmount	Edmonton	Edmonton	January 1, 2020			25		**25**
TOTAL				**115**	**167**	**338**	**0**	**620**

Source: AHS Bi-Annual Bed Survey as of March 31, 2020.
Note: Data does not reflect closures or beds opened in existing facilities.

Continuing Care Facilities by Provider

As of March 31, 2020, there were 27,518 Designated Long-Term Care (LTC) and Designated Supportive Living (DSL) spaces staffed and in operation in the province in over 300 facilities. These facilities encompass AHS, AHS subsidiaries (Carewest and CapitalCare), private (Extendicare, AgeCare, etc.), not-for-profit/non-profit (non-profit includes Covenant, Good Samaritan, etc.) and Saskatchewan Health Authority (Lloydminster) ownership. AHS will continue to improve the system and access to care and supports in the community. Collaboration with our valued service providers is integral to this effort.

Continuing Care Facilities by Operator	Number of Facilities as of March 31, 2020								
	LTC (Facilities)	LTC (Spaces)	DSL (Facilities)	DSL (Spaces)	Campus of Care (Facilities)	Campus of Care (LTC Spaces)	Campus of Care (SL Spaces)	Total Facilities	Total Spaces
AHS Operated	**80**	**4,246**	**18**	**620**	**5**	**351**	**135**	**103**	**5,352**
South	12	243	1	10				13	253
Calgary	6	239	1	38				7	277
Calgary Subsidiary (CareWest)	8	878	1	10	1	175	30	10	1,093
Central	23	1,058	2	32	2	111	27	27	1,228
Edmonton	2	54	1	72				3	126
Edmonton Subsidiary (CapitalCare)	6	994	5	208				11	1,202
North	23	780	7	250	2	65	78	32	1,173
Private	**37**	**4,720**	**75**	**5,165**	**14**	**1,039**	**1,214**	**126**	**12,138**
South	3	288	9	563	3	130	91	15	1,072
Calgary	14	2,379	17	1,217	6	477	858	37	4,931
Central	2	133	20	1,191	1	220	60	23	1,604
Edmonton	14	1,694	23	1,987	1	80	15	38	3,776
North	4	226	6	207	3	132	190	13	755
Non-Profit	**35**	**4,260**	**76**	**4,020**	**13**	**939**	**699**	**124**	**9,918**
South	2	35	18	1,101	3	276	144	23	1,556
Calgary	10	1,603	7	810	3	253	213	20	2,879
Central	8	474	14	405	5	215	225	27	1,319
Edmonton	14	2,118	24	1,420	2	195	117	40	3,850
North	1	30	13	284				14	314
Saskatchewan Health Authority - Lloydminster	**2**	**110**						**2**	**110**
Total	**154**	**13,336**	**169**	**9,805**	**32**	**2,329**	**2,048**	**355**	**27,518**

Source: AHS Bi-Annual Bed Survey as of March 31, 2020.
Note: The number of facilities does not include the over 100 Personal Care Homes which are considered Private Supportive Living. The bed number for these facilities are included in the spaces total. The table also does not include beds in standalone palliative/hospice facilities.

Addiction and Mental Health

The Addiction and Mental Health (AMH) portfolio co-ordinates, plans, delivers and evaluates a province-wide network of AHS programs and contracted services. AMH works with a common purpose: to promote understanding and compassion, to encourage healthy behaviour and attitudes, and to help all Albertans achieve well-being throughout their lives. The tables below reflect the AHS addiction and mental health bed provincial capacity by zone and care stream. These represent AHS contracted facilities and do not include privately-funded facilities.

AHS-Operated and Contracted Addiction and Mental Health beds, as of March 31, 2020

Zone	Addiction			Community Mental Health			Standalone Psychiatric			Acute Care Psychiatric (included in Acute Care)			Mental Health SL 3	Mental Health SL 4	Total Beds
	< 18	≥ 18	Total	< 18	≥ 18	Total	< 18	≥ 18	Total	< 18	≥ 18	Total	(included in Supportive Living)		
South	8	74	**82**	5	37	**42**	0	0	**0**	0	72	**72**	0	0	**196**
Calgary	15	276	**291**	22	434	**456**	0	153	**153**	49	238	**287**	0	0	**1,187**
Central	8	81	**89**	0	31	**31**	0	330	**330**	8	42	**50**	0	0	**500**
Edmonton	21	378	**399**	20	324	**344**	18	427	**445**	54	182	**236**	370	50	**1,844**
North	4	114	**118**	0	5	**5**	0	0	**0**	0	40	**40**	0	0	**163**
Provincial Total	**56**	**923**	**979**	**47**	**831**	**878**	**18**	**910**	**928**	**111**	**574**	**685**	**370**	**50**	**3,890**

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

AHS Addiction Beds

Pertains to beds and mats for clients with substance use and gambling problems. Includes detoxification, shelter mats, residential (short- and long-term), problem gambling, and transitional beds. Also includes beds for Protection of Children Abusing Drugs (PChAD) program clients and residential beds funded through the Safe Communities Initiative (Safe Comm). Direct services provided by AHS as well as funded and contracted services. Excludes beds that are not funded by AHS (privately-funded beds).

PChAD offers 28 residential detoxification and stabilization beds for high risk youth throughout the province. The 28 PChAD beds are included in the 232 publicly-funded child and youth mental health and addictions beds across the province (Calgary-9, Red Deer-8, Edmonton-9, Grande Prairie-2).

AHS-Operated and Contracted Community Addiction Beds, as of March 31, 2020	2015/16	2016/17	2017/18	2018/19	2019/20	Net Change Since 2016
South Zone	64	74	74	82	82	18
Calgary Zone	293	296	301	301	291	-2
Central Zone	66	66	66	70	89	23
Edmonton Zone	379	379	399	399	399	20
North Zone	143	143	131	118	118	-25
Provincial Total	**945**	**958**	**971**	**970**	**979**	**34**

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

AHS Community Health Beds

Community Mental Health (CMH) supports home programs, community beds and other mental health community beds/spaces that deliver both transitional and permanent/long-term services to clients with varying mental health issues. In addition, CMH treats the clients' behavioral, social, physical and medical needs.

AHS-Operated and Contracted Community Mental Health Beds, as of March 31, 2020	2015/16	2016/17	2017/18	2018/19	2019/20	Net Change Since 2016
South Zone	42	42	42	42	42	0
Calgary Zone	352	418	423	459	456	104
Central Zone	31	31	31	31	31	0
Edmonton Zone	200	245	296	329	344	144
North Zone	5	5	5	5	5	0
Provincial Total	**630**	**741**	**797**	**866**	**878**	**248**

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Zone Overview of Bed Numbers

Summary of Bed Numbers by Zone and Detailed Facility Listing

Number of Beds/Spaces as of March 31, 2020	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
Hospital Acute & Sub-Acute Care						
Hospital Acute Care	513	2,189	928	2,419	862	**6,911**
Neonatal Intensive Care (NICU Levels II and III)	23	126	17	136	10	**312**
Special Care (includes ICU, SCU, CCU, CVICU and PICU)	24	136	18	201	12	**391**
Palliative beds in Acute Care	0	29	51	20	21	**121**
Sub-acute in Acute Care	9	32	32	22	0	**95**
Psychiatric in Acute Care	72	287	50	236	40	**685**
Total Hospital Acute & Sub-Acute Care	**641**	**2,799**	**1,096**	**3,034**	**945**	**8,515**
ADDICTION AND MENTAL HEALTH						
Psychiatric (standalone facilities)	0	153	330	445	0	**928**
Addiction Treatment	82	291	89	399	118	**979**
Community Mental Health	42	456	31	344	5	**878**
TOTAL ADDICTION AND MENTAL HEALTH	**124**	**900**	**450**	**1,188**	**123**	**2,785**
COMMUNITY-BASED CARE						
Continuing Care – Long-Term Care (LTC)						
Auxiliary Hospital	286	1,042	1,370	2,206	657	**5,561**
Nursing Home	686	4,962	951	2,929	576	**10,104**
Sub-Total Long-Term Care (LTC)	**972**	**6,004**	**2,321**	**5,135**	**1,233**	**15,665**
Continuing Care – Designated Supportive Living (DSL)						
Designated Supportive Living Level 3	315	233	361	395	209	**1,513**
Designated Supportive Living Level 4	1,046	2,064	1,010	2,199	521	**6,840**
Designated Supportive Living Level 4 - Dementia	548	879	569	1,225	279	**3,500**
Sub-Total Designated Supportive Living (DSL)	**1,909**	**3,176**	**1,940**	**3,819**	**1,009**	**11,853**
SUB-TOTAL LTC & DSL	**2,881**	**9,180**	**4,261**	**8,954**	**2,242**	**27,518**
Community Palliative and Hospice (out of hospital) PEOLC	20	121	17	85	13	**256**
TOTAL CONTINUING CARE (includes LTC, DSL and Palliative Care)	**2,901**	**9,301**	**4,278**	**9,039**	**2,255**	**27,774**
Sub-acute in Auxiliary Hospital (includes transition, rehab, community support beds, etc.)*	24	280	0	168	0	**472**
TOTAL COMMUNITY-BASED CARE (includes LTC, DSL, Palliative Care and Sub-Acute in Auxiliary Hospital)	**2,925**	**9,581**	**4,278**	**9,207**	**2,255**	**28,246**
Alberta Total	**3,690**	**13,280**	**5,824**	**13,429**	**3,323**	**39,546**

Source: AHS Bi-Annual Bed Survey as of March 31, 2020.
** This includes restorative beds located in long-term care. Restorative beds are reported where they are located (auxiliary hospital, nursing home, and supportive living).*

Consolidated Schedule of Facilities and Sites

South Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Bassano Health Centre	X	Bassano				4			8		12		
Crowsnest Pass Health Centre	X	Blairmore				16			58		74		
York Creek Lodge		Blairmore								20	20		
Bow Island Health Centre	X	Bow Island				10			20		30		
Pleasant View Lodge		Bow Island								20	20		
AgeCare Orchard Manor		Brooks								25	25		
AgeCare Sunrise Manor		Brooks								84	84		
Brooks Health Centre	X	Brooks				37			15		52		
Cardston Health Centre	X	Cardston				19			14		33		
Chinook Lodge		Cardston								20	20		
Good Samaritan Lee Crest		Cardston								95	95		
Coaldale Health Centre	X	Coaldale				OP			44		44		
Sunny South Lodge		Coaldale								70	70		
Extendicare Fort Macleod		Fort Macleod							50		50		
Foothills Detox Centre		Fort Macleod	14								14		
Fort MacLeod Health Centre	X	Fort Macleod				ED			10		10		
Pioneer Lodge		Fort Macleod								10	10		
Chinook Regional Hospital	X	Lethbridge	8	5		288					301		
Jack Ady Cancer Centre	X	Lethbridge	Co-located on same campus as Chinook Regional Hospital									CA	
CMHA Crisis Beds		Lethbridge		5							5		
CMHA Laura House		Lethbridge		7							7		
Columbia Care Centre		Lethbridge								50	50		
Edith Cavell Care Centre		Lethbridge							120	-	120		
Extendicare Fairmont Park		Lethbridge								140	140		
Golden Acres Lodge		Lethbridge								45	45		
Good Samaritan Park Meadows Village		Lethbridge								121	121		
Good Samaritan West Highlands		Lethbridge								100	100		
Legacy Lodge		Lethbridge								104	104		
SASHA Group Home #1		Lethbridge		9							9		
SASHA Group Home #2		Lethbridge		8							8		
SASHA Group Home #3		Lethbridge		8							8		
South Country Treatment Centre		Lethbridge	21								21		
Southern Alcare Manor		Lethbridge	13								13		
St. Michael's Health Centre		Lethbridge					24	10	96	72	202		
St. Therese Villa		Lethbridge								200	200		
Youth Residential Services	X	Lethbridge	8								8		
Good Samaritan Garden Vista		Magrath								35	35		
Magrath Health Centre	X	Magrath											CACC
AgeCare Valleyview		Medicine Hat							30	5	35		
Cypress View		Medicine Hat								45	45		
Good Samaritan South Ridge Village		Medicine Hat							80	48	128		
Leisure Way		Medicine Hat								16	16		
Masterpiece Southland Meadows		Medicine Hat							50	50	100		

South Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Meadow Ridge Seniors Village		Medicine Hat								84	84		
Meadowlands Retirement Residence		Medicine Hat								10	10		
Medicine Hat Recovery Centre	X	Medicine Hat	18								18		
Medicine Hat Regional Hospital	X	Medicine Hat				210					210		
Margery E. Yuill Cancer Centre	X	Medicine Hat	Co-located same campus as Medicine Hat Regional Hospital									CA	
River Ridge Seniors Village		Medicine Hat							50	36	86		
Riverview Care Centre		Medicine Hat							118		118		
St. Joseph's Home		Medicine Hat						10	10		20		
Sunnyside Care Centre		Medicine Hat							100	24	124		
The Wellington Retirement Residence		Medicine Hat								50	50		
Milk River Health Centre	X	Milk River				ED			26		26		
Prairie Rose Lodge	X	Milk River								10	10		
Big Country Hospital	X	Oyen				10			30		40		
Piyami Health Centre	X	Picture Butte											CACC
Piyami Lodge		Picture Butte								20	20		
Piyami Place		Picture Butte								15	15		
Good Samaritan Vista Village		Pincher Creek								75	75		
Pincher Creek Health Centre	X	Pincher Creek				16			3		19		
Good Samaritan Prairie Ridge		Raymond								85	85		
Raymond Health Centre	X	Raymond				12			5		17		
Kainai Continuing Care Centre		Stand Off							25		25		
Clearview Lodge		Taber								20	20		
Good Samaritan Linden View		Taber								105	105		
Taber Health Centre	X	Taber				19			10		29		
Total South Zone			**82**	**42**	**0**	**641**	**24**	**20**	**972**	**1,909**	**3,690**		

Calgary Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Airdrie Regional Community Health Centre	X	Airdrie											UCC
Bethany Airdrie		Airdrie							74		74		
Mineral Springs Hospital		Banff				22			25		47		
Oilfields General Hospital	X	Black Diamond				15			30		45		
Agape Hospice		Calgary						20			20		
AgeCare Glenmore		Calgary							208		208		
AgeCare Midnapore		Calgary							270		270		
AgeCare Seton		Calgary							59	252	311		
AgeCare SkyPointe		Calgary							192	160	352		
AgeCare Walden Heights		Calgary							58	238	296		
Alberta Children's Hospital	X	Calgary				141					141		
Alcove Addictions Recovery for Women		Calgary	1								1		
Alpha House		Calgary	48								48		
Approved Homes - Mental Health		Calgary		112							112		
Aspen Family and Community Network		Calgary		3							3		
Aventa Addiction Treatment for Women		Calgary	48								48		
Bethany Calgary		Calgary							416		416		
Bethany Harvest Hills		Calgary							60		60		
Bethany Riverview		Calgary							210		210		
Bow Crest Care Centre		Calgary							150		150		
Bow View Manor		Calgary							231		231		
Calgary Community Rehabilitation Program (Lighthouse NCR Group Home)	X	Calgary		6							6		
Calgary Homeless Foundation - Bridgeland	X	Calgary		10							10		
Calgary Homeless Foundation - Ophelia	X	Calgary		16							16		
Canadian Mental Health Association		Calgary		123							123		
Canadian Mental Health Association - Glamorgan Building		Calgary		23							23		
Canadian Mental Health Association - Hamilton House		Calgary		9							9		
Canadian Mental Health Association - Robert's House		Calgary		9							9		
Carewest Colonel Belcher	X	Calgary							175	30	205		
Carewest Dr. Vernon Fanning Centre	X	Calgary					98		191		289		
Carewest Garrison Green	X	Calgary							200		200		
Carewest George Boyack	X	Calgary							221		221		
Carewest Glenmore Park	X	Calgary					147				147		
Carewest Nickle House	X	Calgary								10	10		
Carewest Rouleau Manor	X	Calgary							77		77		
Carewest Royal Park	X	Calgary							50		50		
Carewest Sarcee	X	Calgary					35	15	85		135		
Carewest Signal Pointe	X	Calgary							54		54		
Centre of Hope - Salvation Army		Calgary	30								30		

Calgary Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Clifton Manor		Calgary							250		250		
CBI- Complex Needs Client		Calgary		1							1		
Community Living Alternatives for the Mentally Disabled Association (Community LAMDA)- LAMA Kilarney		Calgary		34							34		
Community Living Alternatives for the Mentally Disabled Association (Community LAMDA) - LAMDA Mission		Calgary		28							28		
Community Living Alternative Services Ltd (CLAS)		Calgary		2							2		
East Calgary Health Centre	X	Calgary											CACC
Eau Claire Retirement Residence		Calgary								73	73		
Edgemont Retirement Residence		Calgary								31	31		
Evanston Grand Village		Calgary								102	102		
Extendicare Cedars Villa		Calgary							248		248		
Extendicare Hillcrest		Calgary							112		112		
Father Lacombe Care Centre		Calgary							114		114		
Foothills Medical Centre	X	Calgary				1,081					1,081		
Fresh Start Recovery Centre		Calgary	1								1		
Generations		Calgary							62	58	120		
Glamorgan Care Centre		Calgary							52		52		
Holy Cross Manor		Calgary								100	100		
Hull Homes Detox/PChaD		Calgary	15								15		
Intercare Brentwood Care Centre		Calgary							390		390		
Intercare Chinook Care Centre		Calgary						14	169		183		
Intercare Southwood Care Centre		Calgary						24	222		246		
Kingsland Terrace		Calgary								24	24		
Mayfair Care Centre		Calgary							142		142		
McKenzie Towne Continuing Care Centre		Calgary							150		150		
McKenzie Towne Retirement Residence		Calgary								42	42		
Millrise Place		Calgary							51	40	91		
Monterey Place		Calgary								107	107		
Mount Royal Care Centre		Calgary							93		93		
Newport Harbour Care Centre		Calgary							127		127		
Oxford House		Calgary	23								23		
Personal Care Homes - Continuing Care		Calgary								223	223		
Peter Lougheed Centre	X	Calgary				542					542		
Prince of Peace Harbour		Calgary								32	32		
Prince of Peace Manor		Calgary								30	30		
Prominence Way Retirement Community		Calgary								55	55		
Providence Care Centre		Calgary							94	56	150		
Recovery Acres		Calgary	13								13		
Renfrew Recovery Centre	X	Calgary	40								40		
Richmond Road Diagnostic & Treatment Centre	X	Calgary				OP							

Calgary Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Rocky Ridge Retirement Community		Calgary								29	29		
Rockyview General Hospital	X	Calgary				615					615		
Rosedale Hospice		Calgary						7			7		
Rotary Flames House	X	Calgary						7			7		
Sage Hill Retirement Residence		Calgary								72	72		
Scenic Acres Retirement Residence		Calgary								26	26		
SCOPE Hunterview House		Calgary		2							2		
Secura Bright Harbour I	X	Calgary		4							4		
Sheldon M. Chumir Health Centre	X	Calgary											UCC
South Calgary Health Centre	X	Calgary											UCC
South Health Campus	X	Calgary				272					272		
Southern Alberta Forensic Psychiatric Centre	X	Calgary			33						33		
St. Marguerite Manor		Calgary						26		102	128		
St. Teresa Place		Calgary								250	250		
Sunridge Medical Gallery	X	Calgary											CACC
Sunrise Native Addiction Services Society		Calgary	24								24		
Swan Evergreen Village		Calgary								48	48		
The Manor Village at Fish Creek Park		Calgary								76	76		
Thorncliff - Home Space Partnership		Calgary		22							22		
Tom Baker Cancer Centre	X	Calgary										CA	
Trinity Foundation		Calgary		30							30		
Wentworth Manor/The Residence and The Court		Calgary							79	62	141		
Whitehorn Village Retirement Community		Calgary								53	53		
Wing Kei Care Centre		Calgary							145		145		
Wing Kei Greenview		Calgary							80	95	175		
Woods Homes		Calgary		22							22		
Bow Valley Community Cancer Centre	X	Canmore	Co-located on same campus as Canmore General Hospital									CA	
Canmore General Hospital	X	Canmore				21			23		44		
Claresholm Centre for Mental Health and Addictions	X	Claresholm			120						120		
Claresholm General Hospital	X	Claresholm				16					16		
Lander Treatment Centre	X	Claresholm	48								48		
Willow Creek Continuing Care Centre	X	Claresholm							100		100		
Bethany Cochrane		Cochrane							78		78		
Cochrane Community Health Centre	X	Cochrane											UCC
Points West Living Cochrane		Cochrane								122	122		
Aspen Ridge Lodge		Didsbury								30	30		
Bethany Didsbury		Didsbury								100	100		
Didsbury District Health Services	X	Didsbury				16			21		37		
High River Community Cancer Centre	X	High River	Co-located on same campus as High River General Hospital									CA	
High River General Hospital	X	High River				27			50		77		

Calgary Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Seasons High River		High River								108	108		
Silver Willow Lodge	X	Nanton								38	38		
Foothills Country Hospice		Okotoks						8			8		
Okotoks Health and Wellness Centre	X	Okotoks											UCC
Revera Heartland		Okotoks								40	40		
Strafford Foundation Tudor Manor		Okotoks								152	152		
Agecare Sagewood		Strathmore							55	110	165		
Strathmore District Health Services	X	Strathmore				23					23		
Extendicare Vulcan		Vulcan							46		46		
Vulcan Community Health Centre	X	Vulcan				8			15		23		
Total Calgary Zone			**291**	**456**	**153**	**2,799**	**280**	**121**	**6,004**	**3,176**	**13,280**		

Central Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Bashaw Care Centre	X	Bashaw											CACC
Bashaw Meadows		Bashaw								30	30		
Bentley Care Centre	X	Bentley							16		16		
Slim Thorpe Recovery Centre		Blackfoot	26								26		
Breton Health Centre	X	Breton							23		23		
Bethany Meadows		Camrose							65	30	95		
Camrose Community Cancer Centre		Camrose	Co-located on same campus as St. Mary's Hospital									CA	
Faith House		Camrose								20	20		
Louise Jensen Care Centre		Camrose							65		65		
Memory Lane		Camrose								25	25		
Rosehaven Care Centre		Camrose							75		75		
St Mary's Hospital		Camrose				76					76		
Seasons Camrose		Camrose								82	82		
Viewpoint		Camrose								20	20		
Our Lady of the Rosary Hospital		Castor				5			22		27		
Consort Hospital and Care Centre	X	Consort				5			15		20		
Coronation Hospital and Care Centre	X	Coronation				10			23	19	52		
Daysland Health Centre	X	Daysland				26					26		
Providence Place		Daysland								16	16		
Drayton Valley Community Cancer Centre	X	Drayton Valley	Co-located on same campus as Drayton Valley Hospital and Care Centre									CA	
Drayton Valley Hospital and Care Centre	X	Drayton Valley				32			50		82		
Serenity House	X	Drayton Valley								12	12		
Seasons Drayton Valley		Drayton Valley								16	16		
Drumheller Community Cancer Centre	X	Drumheller	Co-located on same campus as Drumheller Health Centre									CA	
Drumheller Health Centre		Drumheller				37			88	8	133		
Grace House		Drumheller	5								5		
Hillview Lodge		Drumheller								36	36		
Eckville Manor House		Eckville								15	15		
Galahad Care Centre	X	Galahad							20		20		
Hanna Health Centre	X	Hanna				17			61		78		
Hardisty Health Centre	X	Hardisty				5			15		20		
Innisfail Health Centre	X	Innisfail				28			78		106		
Sunset Manor		Innisfail								102	102		
Islay Assisted Living	X	Islay								20	20		
Killam Health Care Centre		Killam				5			10	30	45		
Lacombe Hospital and Care Centre	X	Lacombe				35			75		110		
Royal Oak Manor		Lacombe								109	109		
Lamont Health Care Centre		Lamont				15			105		120		
Westview Care Community		Linden							37		37		
Dr Cooke Extended Care Centre		Lloydminster							50		50		
Lloydminster Community Cancer Centre		Lloydminster										CA	
Lloydminster Continuing Care Centre		Lloydminster							60		60		
Lloydminster Hospital		Lloydminster				37					37		

Central Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Pioneer House		Lloydminster								44	44		
Points West Living Lloydminster		Lloydminster								60	60		
Mannville Care Centre	X	Mannville							23		23		
Mary Immaculate Care Centre		Mundare							30		30		
Eagle View Lodge		Myrnam								9	9		
Enviros Wilderness School (Shunda Creek)		Nordegg	10								10		
Olds Hospital and Care Centre	X	Olds				33			50		83		
Seasons Encore Olds		Olds								60	60		
Seasons Olds		Olds								20	20		
Centennial Centre for Mental Health and Brain Injury	X	Ponoka			330						330		
Northcott Care Centre		Ponoka							73		73		
Ponoka Hospital and Care Centre	X	Ponoka				29			28		57		
Seasons Ponoka		Ponoka								20	20		
Provost Health Centre	X	Provost				15			47		62		
Addiction Counselling & Prevention Services	X	Red Deer	8								8		
Bethany CollegeSide		Red Deer							112		112		
Central Alberta Cancer Centre	X	Red Deer	Co-located on same campus as Red Deer Regional Hospital									CA	
Extendicare Michener Hill		Red Deer							220	60	280		
Kentwood Place	X	Red Deer		25							25		
Points West Living Red Deer		Red Deer								114	114		
Red Deer Hospice		Red Deer						16			16		
Red Deer Regional Hospital Centre	X	Red Deer				370					370		
Safe Harbour Society		Red Deer	40								40		
The Hamlets at Red Deer		Red Deer								126	126		
Timberstone Mews		Red Deer								60	60		
Villa Marie		Red Deer							60	106	166		
West Park Lodge		Red Deer								36	36		
Rimbey Hospital and Care Centre	X	Rimbey				23			84		107		
Clearwater Centre		Rocky Mtn House						1	40	38	79		
Park Avenue at Creekside		Rocky Mtn House								40	40		
Rocky Mountain House Health Centre	X	Rocky Mtn House				31					31		
Points West Living Stettler		Stettler								88	88		
Stettler Hospital and Care Centre	X	Stettler				26			50		76		
Sundre Hospital and Care Centre	X	Sundre				14			9		23		
Sundre Seniors Supportive Living		Sundre								40	40		
Bethany Sylvan Lake		Sylvan Lake							40	21	61		
Sylvan Lake Community Health Centre	X	Sylvan Lake											AACS
Chateau Three Hills		Three Hills								15	15		
Three Hills Health Centre	X	Three Hills				21			24		45		
Tofield Health Centre	X	Tofield				16			50		66		
St. Mary's Health Care Centre		Trochu							28		28		

Central Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Two Hills Health Centre	X	Two Hills				27			56		83		
Century Park		Vegreville								40	40		
Heritage House		Vegreville								42	42		
St Joseph's General Hospital		Vegreville				23					23		
Vegreville Care Centre	X	Vegreville							60		60		
Vegreville Manor		Vegreville								15	15		
Vermilion Health Centre	X	Vermilion				25			48		73		
Vermilion Valley Lodge		Vermilion								40	40		
Extendicare Viking		Viking							60		60		
Viking Health Centre	X	Viking				16					16		
Points West Living Wainwright		Wainwright								59	59		
Wainwright Health Centre	X	Wainwright				25			69		94		
Good Samaritan Good Shepherd Lutheran Home		Wetaskiwin								69	69		
Points West Living Wetaskiwin		Wetaskiwin								82	82		
Seasons Wetaskiwin		Wetaskiwin								20	20		
Wetaskiwin Hospital and Care Centre	X	Wetaskiwin				69			107		176		
Wetaskiwin Meadows		Wetaskiwin								26	26		
Wetaskiwin Serenity House (Bosco)		Wetaskiwin		6							6		
Total Central Zone			**89**	**31**	**330**	**1,096**	**0**	**17**	**2,321**	**1,940**	**5,824**		

Edmonton Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Kipohtakawmik Elders Lodge		Alexander Reserve								17	17		
Chateau Vitaline		Beaumont								46	46		
Devon General Hospital	X	Devon				10			14		24		
Addiction Recovery Centre	X	Edmonton	42								42		
Alberta Hospital Edmonton	X	Edmonton			295						295		
Allen Gray Continuing Care Centre		Edmonton							156		156		
Allendale House (House Next Door #4)		Edmonton		10							10		
Ambrose Place		Edmonton		42							42		
Anderson Hall	X	Edmonton		14							14		
Approved Mental Health Care Homes		Edmonton		20						`	20		
Aspire Homes - Newton	X	Edmonton		5							5		
Aspire Homes - Mount Rose	X	Edmonton		5							5		
Aspire Homes - Elmwood Park	X	Edmonton		5							5		
Balwin Place		Edmonton		25							25		
Balwin Villa		Edmonton								104	104		
Benevolence Care Centre		Edmonton							102		102		
CapitalCare Dickinsfield	X	Edmonton							275		275		
CapitalCare Adult Duplexes (Dickinsfield)	X	Edmonton								14	14		
CapitalCare Grandview	X	Edmonton					34		144		178		
CapitalCare Laurier House Lynnwood	X	Edmonton								80	80		
CapitalCare Lynnwood	X	Edmonton							276		276		
CapitalCare McConnell Place North	X	Edmonton								36	36		
CapitalCare McConnell Place West	X	Edmonton								36	36		
CapitalCare Norwood	X	Edmonton					114	23	68		205		
Chartwell Griesbach		Edmonton								131	131		
Chartwell Heritage Valley		Edmonton								52	52		
Chartwell Wild Rose Retirement Residence		Edmonton								27	27		
Churchill Retirement Community		Edmonton								35	35		
Cross Cancer Institute	X	Edmonton				55					55	CA	
Devonshire Care Centre		Edmonton							132		132		
Devonshire Manor		Edmonton								59	59		
Diverse City Housing		Edmonton		15							15		
Donnelly House		Edmonton		8							8		
E4C Eagle Nest (Emerging Adults Transition Housing)		Edmonton		7							7		
E4C Inner Ways - Bear Den		Edmonton		5							5		
E4C Inner Ways - Beaver Den		Edmonton		5							5		
E4C Inner Ways - Buffalo I (Female Harm Reduction Transitional House)		Edmonton		6							6		
E4C Inner Ways - Buffalo II (Complex Health Women's Housing)		Edmonton		2							2		
E4C Meadows Place		Edmonton		16							16		
E4C Our Place		Edmonton		10							10		

Edmonton Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
East Edmonton Health Centre	X	Edmonton											CACC /UCC
Edmonton Chinatown Care Centre		Edmonton							80	15	95		
Edmonton General Continuing Care Centre		Edmonton					20	26	449		495		
Edmonton People in Need #2 (SCH)		Edmonton		12						34	46		
Edmonton People In Need - Bridgeway 2		Edmonton								97	97		
Elizabeth House Harm Reduction Lodge Living		Edmonton		20							20		
Emmanuel Home		Edmonton								15	15		
Extendicare Eaux Claires		Edmonton							204		204		
Extendicare Holyrood		Edmonton							74		74		
Family Care Homes		Edmonton								2	2		
Garneau Hall		Edmonton								37	37		
George Spady Centre Society		Edmonton	73								73		
George's House		Edmonton		5							5		
Glastonbury Village		Edmonton								49	49		
Glenrose Rehabilitation Hospital	X	Edmonton				244					244		
Good Samaritan Dr. Gerald Zetter Care Centre		Edmonton							200		200		
Good Samaritan Millwoods Care Centre		Edmonton							60		60		
Good Samaritan Southgate Care Centre		Edmonton							226		226		
Good Samaritan Wedman House		Edmonton								30	30		
Grand Manor		Edmonton								102	102		
Grey Nuns Community Hospital		Edmonton				363					363		
Hardisty Care Centre		Edmonton							172		172		
Henwood Treatment Centre	X	Edmonton	72								72		
House Next Door #1		Edmonton		8							8		
House Next Door #2		Edmonton		8							8		
House Next Door #3		Edmonton		8							8		
House Next Door Eating Disorders - Enhancing Community Treatment Capacity for Eating Disorders		Edmonton		6							6		
Jasper Place Continuing Care Centre		Edmonton							100		100		
Jellinek House		Edmonton	15								15		
Journey Home (Edmonton John Howard Society)		Edmonton		6							6		
Jubilee Lodge Nursing Home		Edmonton							154		154		
Laurel Heights Retirement Residence		Edmonton								70	70		
Lewis Estates Retirement Residence		Edmonton								87	87		
Lifestyle Options Riverbend		Edmonton								12	12		
Lifestyle Options Schonsee		Edmonton								74	74		
Lifestyle Options Terra Losa		Edmonton								77	77		
Lifestyle Options Whitemud		Edmonton								80	80		
McDougall House		Edmonton	11								11		
Miller Crossing Care Centre		Edmonton							155		155		

Edmonton Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Misericordia Community Hospital		Edmonton				312					312		
Northeast Community Health Centre	X	Edmonton				ED					-		
Ottewell Lodge		Edmonton		38							38		
Our House		Edmonton	60								60		
Our Parents' Home		Edmonton								50	50		
Personal Care Homes (Wellness Integrated Support Homes (Mental Health)		Edmonton								254	254		
Recovery Acres Edmonton		Edmonton	34								34		
Recovery Acres Satellite Housing Program		Edmonton	20								20		
Riverbend Retirement Residence		Edmonton								38	38		
Rosedale Estates		Edmonton								48	48		
Royal Alexandra Hospital	X	Edmonton				894					894		
Rutherford Heights Retirement Residence		Edmonton								89	89		
Saint Thomas Assisted Living Centre		Edmonton								141	141		
Salvation Army Grace Manor		Edmonton								87	87		
Salvation Army Stepping Stone Supportive Residence		Edmonton								50	50		
Shepherd's Care Greenfield		Edmonton								30	30		
Shepherd's Care Kensington		Edmonton							69	87	156		
Shepherd's Care Millwoods		Edmonton							147		147		
Shepherd's Care Vanguard		Edmonton								92	92		
Shepherd's Garden		Edmonton								45	45		
Shepherd's Garden Heritage Eden House		Edmonton							53		53		
South Terrace Continuing Care Centre		Edmonton							107	-	107		
Sprucewood Place		Edmonton							-	93	93		
St. Joseph's Auxiliary Hospital		Edmonton						14	188		202		
St. Michael's Long Term Care Centre		Edmonton							153		153		
Stollery Children's Hospital	X	Edmonton				163			-		163		
The Dianne and Irving Kipnes Centre for Veterans	X	Edmonton							120		120		
Touchmark at Wedgewood		Edmonton							64		64		
Tuoi Hac - Golden Age Manor		Edmonton							-	91	91		
University of Alberta Hospital	X	Edmonton				693			-		693		
Venta Care Centre		Edmonton							148		148		
Villa Caritas		Edmonton			150						150		
Villa Marguerite		Edmonton								239	239		
Village at Westmount		Edmonton								25	25		
Wedman Village Homes		Edmonton								30	30		
Youth Stabilization and Residential Services	X	Edmonton	21								21		
Good Samaritan Pembina Village		Evansburg							40		40		

Edmonton Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Fort Saskatchewan Community Hospital	X	Fort Saskatchewan				36					36		
Rivercrest Care Centre		Fort Saskatchewan						6	74		80		
Extendicare Leduc		Leduc							79		79		
Leduc Community Hospital	X	Leduc				74					74		
Lifestyle Options Leduc		Leduc								74	74		
Salem Manor Nursing Home		Leduc							102		102		
Chartwell Aspen House	X	Morinville								72	72		
CapitalCare Laurier House Strathcona	X	Sherwood Park								42	42		
CapitalCare Strathcona	X	Sherwood Park							111		111		
CASA House		Sherwood Park		20							20		
Chartwell Country Cottage Retirement Residence		Sherwood Park								26	26		
Chartwell Emerald Hills										72	72		
Sherwood Care		Sherwood Park							100		100		
Strathcona Community Hospital	X	Sherwood Park				ED							
Summerwood Village Retirement Residence		Sherwood Park								79	79		
Copper Sky Lodge		Spruce Grove								130	130		
Good Samaritan Spruce Grove Centre		Spruce Grove								30	30		
Chartwell St Albert		St. Albert								70	70		
Citadel Care Centre		St. Albert							129		129		
Citadel Mews West		St. Albert								42	42		
Foyer Lacombe		St. Albert						10	12		22		
Poundmaker's Lodge Treatment Center - Youth Addiction (Safe-Com)		St. Albert	51								51		
St. Albert Retirement Residence		St. Albert								92	92		
Sturgeon Community Hospital	X	St. Albert				167					167		
Youville Home		St. Albert							232		232		
Good Samaritan George Hennig Place		Stony Plain								30	30		
Good Samaritan Stony Plain Care Centre		Stony Plain							126	30	156		
WestView Health Centre - Stony Plain	X	Stony Plain				23		6	40		69		
Special Care Homes		Various								91	91		
West Country Hearth		Villeneuve								32	32		
Cloverleaf Manor		Warburg		13							13		
Total Edmonton Zone			**399**	**344**	**445**	**3,034**	**168**	**85**	**5,135**	**3,819**	**13,429**		

North Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Athabasca Healthcare Centre	X	Athabasca				27			23		50		
Extendicare Athabasca		Athabasca							50		50		
Barrhead Community Cancer Centre	X	Barrhead	Co-located on same campus as Barrhead Healthcare Centre									CA	
Barrhead Healthcare Centre	X	Barrhead				34					34		
Dr. W.R. Keir - Barrhead Continuing Care Centre	X	Barrhead							100		100		
Shepherd's Care Barrhead		Barrhead								42	42		
Beaverlodge Municipal Hospital	X	Beaverlodge				18					18		
Bonnyville Community Cancer Centre		Bonnyville	Co-located same campus as Bonnyville Healthcare Centre									CA	
Bonnyville Healthcare Centre		Bonnyville				33			30		63		
Bonnyville Indian Metis Rehabilitation Centre		Bonnyville	20								20		
Extendicare Bonnyville		Bonnyville							50		50		
Boyle Healthcare Centre	X	Boyle				20					20		
Wild Rose Assisted Living	X	Boyle								22	22		
Cold Lake Healthcare Centre	X	Cold Lake				24			31		55		
Points West Living Cold Lake		Cold Lake								42	42		
Ridgevalley Seniors Home		Crooked Creek								15	15		
Wabasca/Desmarais Healthcare Centre	X	Desmarais				10					10		
Edson Healthcare Centre	X	Edson				24			38	38	100		
Parkland Lodge		Edson								10	10		
Elk Point Healthcare Centre	X	Elk Point				12			30		42		
Elk Point Heritage Lodge	X	Elk Point								10	10		
Fairview Health Complex	X	Fairview				25		1	66		92		
Kahkiyow Keykanow Elders Care Home		Fort Chipewyan								11	11		
Fort McMurray Community Cancer Centre	X	Fort McMurray	Co-located same campus as Northern Lights Regional Health Centre									CA	
Fort McMurray Recovery Centre	X	Fort McMurray	16								16		
Northern Lights Regional Health Centre	X	Fort McMurray				107			41		148		
Pastew Place Detox Centre		Fort McMurray	11								11		
St. Theresa General Hospital	X	Fort Vermilion				26			8		34		
Fox Creek Healthcare Centre	X	Fox Creek				4					4		
Grande Cache Community Health Complex	X	Grande Cache				12					12		
Whispering Pines Seniors Lodge		Grande Cache								15	15		
Grande Prairie Cancer Centre	X	Grande Prairie	Co-located same campus as QEII Hospital									CA	
Grande Prairie Care Centre		Grande Prairie							60	60	120		
Northern Addiction Centre	X	Grande Prairie	51								51		
Prairie Lake Seniors Community		Grande Prairie						10	50	95	155		
Queen Elizabeth II Hospital	X	Grande Prairie				181				71	252		
Emerald Gardens Retirement Residence		Grande Prairie								15	15		
Youth Detoxification Services	X	Grande Prairie	4								4		

North Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Grimshaw/Berwyn and District Community Health Centre	X	Grimshaw				ED		1	19		20		
Stone Brook		Grimshaw								56	56		
Northwest Health Centre	X	High Level				21			11		32		
High Prairie Health Complex	X	High Prairie				30					30		
J.B. Wood Continuing Care Centre	X	High Prairie							27	40	67		
Metis Indian Town Alcohol Association (MITAA Centre)		High Prairie	16								16		
Hinton Community Cancer Centre	X	Hinton	Colocated same campus as Hinton Healthcare Centre									CA	
Hinton Continuing Care Centre	X	Hinton								52	52		
Hinton Healthcare Centre	X	Hinton				23					23		
Hythe Continuing Care Centre	X	Hythe							31		31		
Alpine Summit Seniors Lodge		Jasper								18	18		
Seton - Jasper Healthcare Centre	X	Jasper				11					11		
Heimstaed Lodge		La Crete								54	54		
La Crete Continuing Care Centre	X	La Crete						1	22		23		
La Crete Health Centre	X	La Crete											AACS
Points West Living Lac La Biche		Lac La Biche								40	40		
William J. Cadzow - Lac La Biche Healthcare Centre	X	Lac La Biche				23			41		64		
Manning Community Health Centre	X	Manning				11			16		27		
Extendicare Mayerthorpe		Mayerthorpe							50		50		
Mayerthorpe Healthcare Centre	X	Mayerthorpe				20			30		50		
Pleasant View Lodge		Mayerthorpe								15	15		
Manoir du Lac		McLennan							22	35	57		
Sacred Heart Community Health Centre	X	McLennan				20					20		
Chateau Lac St. Anne		Onoway								15	15		
Peace River Community Cancer Centre	X	Peace River	Colocated same campus as Peace River Comm. Health Centre									CA	
Peace River Community Health Centre	X	Peace River				31			40		71		
Points West Living Peace River		Peace River								42	42		
Radway Continuing Care Centre	X	Radway							30		30		
Rainbow Lake Health Centre		Rainbow Lake											CACC
Redwater Health Centre	X	Redwater				14			7		21		
Points West Living Slave Lake		Slave Lake								45	45		
Slave Lake Family Care Clinic	X	Slave Lake											CACC
Slave Lake Healthcare Centre	X	Slave Lake				24			20		44		
Vanderwell Heritage Place	X	Slave Lake								8	8		
Bar V Nook Supportive Living	X	Smoky Lake								41	41		
George McDougall - Smoky Lake Healthcare Centre	X	Smoky Lake				12			23		35		
Central Peace Health Complex	X	Spirit River				12			16		28		
Aspen House		St. Paul								6	6		
Extendicare St. Paul		St Paul							76		76		
St. Pauls Abilities Network - White Oaks		St. Paul		5							5		

North Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
St. Therese - St. Paul Healthcare Centre	X	St Paul				42			30		72		
Swan Hills Healthcare Centre	X	Swan Hills				6					6		
South Valley Residence Living	X	Valleyview								23	23		
Valleyview Health Centre	X	Valleyview				20			25		45		
Vilna Lodge		Vilna								12	12		
Smithfield Lodge	X	Westlock								46	46		
Westlock Healthcare Centre	X	Westlock				46			120		166		
Spruce View Lodge		Whitecourt								15	15		
Whitecourt Healthcare Centre	X	Whitecourt				22					22		
Total North Zone			**118**	**5**	**0**	**945**	**0**	**13**	**1,233**	**1,009**	**3,323**		

Change in Bed Numbers by Zone from 2018-19 to 2019-20

Reported Beds Staffed & In Operation Summary as of March 31, 2020:

ZONE	ACUTE CARE	ADDICTION AND MENTAL HEALTH			COMMUNITY-BASED CARE									TOTAL CONTINUING CARE (LTC + DSL)	TOTAL COMMUNITY-BASED CARE (includes PEOLC)	TOTAL BEDS
					Sub-Acute in Long-Term Care	CONTINUING CARE										
						Community Palliative & End of Life Care	LONG-TERM CARE (LTC)			DESIGNATED SUPPORTIVE LIVING (DSL)						
	Acute Care	Psychiatric (Standalone	Addiction	Community Mental Health			Auxiliary Hospital	Nursing Home	Long-Term Care Subtotal	Level 3 (includes mental health)	Level 4 (includes mental health)	Level 4-Dementia	DSL Subtotal (DSL 3 + DSL 4 + DSL4-D)			
South Zone	641	0	82	42	24	20	286	686	**972**	315	1,046	548	**1,909**	**2,881**	**2,901**	**3,690**
Calgary Zone	2,799	153	291	456	280	121	1,042	4,962	**6,004**	233	2,064	879	**3,176**	**9,180**	**9,301**	**13,280**
Central Zone	1,096	330	89	31	0	17	1,370	951	**2,321**	361	1,010	569	**1,940**	**4,261**	**4,278**	**5,824**
Edmonton Zone	3,034	445	399	344	168	85	2,206	2,929	**5,135**	395	2,199	1,225	**3,819**	**8,954**	**9,039**	**13,429**
North Zone	945	0	118	5	0	13	657	576	**1,233**	209	521	279	**1,009**	**2,242**	**2,255**	**3,323**
TOTAL	**8,515**	**928**	**979**	**878**	**472**	**256**	**5,561**	**10,104**	**15,665**	**1,513**	**6,840**	**3,500**	**11,853**	**27,518**	**27,774**	**39,546**

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Reported Beds Staffed & In Operation Summary as of March 31, 2019:

ZONE	ACUTE CARE	ADDICTION AND MENTAL HEALTH			COMMUNITY-BASED CARE									TOTAL CONTINUING CARE (LTC + DSL)	TOTAL COMMUNITY-BASED CARE (includes PEOLC)	TOTAL BEDS
					Sub-Acute in Long-Term Care	CONTINUING CARE										
						Community Palliative & End of Life Care	LONG-TERM CARE (LTC)			DESIGNATED SUPPORTIVE LIVING (DSL)						
	Acute Care	Psychiatric (Standalone	Addiction	Community Mental Health			Auxiliary Hospital	Nursing Home	Long-Term Care Subtotal	Level 3 (includes mental health)	Level 4 (includes mental health)	Level 4-Dementia	DSL Subtotal (DSL 3 + DSL 4 + DSL4-D)			
South Zone	645	0	82	42	24	20	286	682	**968**	309	1,035	548	**1,892**	**2,860**	**2,880**	**3,673**
Calgary Zone	2,791	153	301	459	280	121	1,042	4,905	**5,947**	233	1,836	796	**2,865**	**8,812**	**8,933**	**12,917**
Central Zone	1,098	330	70	31	0	10	1,413	951	**2,364**	385	955	557	**1,897**	**4,261**	**4,271**	**5,800**
Edmonton Zone	3,020	445	399	329	168	85	2,209	2,876	**5,085**	398	2,130	1,149	**3,677**	**8,762**	**8,847**	**13,208**
North Zone	925	0	118	5	0	13	657	576	**1,233**	209	506	271	**986**	**2,219**	**2,232**	**3,280**
TOTAL	**8,479**	**928**	**970**	**866**	**472**	**249**	**5,607**	**9,990**	**15,597**	**1,534**	**6,462**	**3,321**	**11,317**	**26,914**	**27,163**	**38,878**

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Change from March 31, 2019 to March 31, 2020:

ZONE	ACUTE CARE	ADDICTION AND MENTAL HEALTH			COMMUNITY-BASED CARE									TOTAL CONTINUING CARE (LTC + DSL)	TOTAL COMMUNITY-BASED CARE (includes PEOLC)	TOTAL BEDS
					Sub-Acute in Long-Term Care	CONTINUING CARE										
						Community Palliative & End of Life Care	LONG-TERM CARE (LTC)			DESIGNATED SUPPORTIVE LIVING (DSL)						
	Acute Care	Psychiatric (Standalone	Addiction	Community Mental Health			Auxiliary Hospital	Nursing Home	Long-Term Care Subtotal	Level 3 (includes mental health)	Level 4 (includes mental health)	Level 4-Dementia	DSL Subtotal (DSL 3 + DSL 4 + DSL4-D)			
South Zone	(4)	-	-	-	-	-	-	4	**4**	6	11	-	**17**	**21**	**21**	**17**
Calgary Zone	8	-	(10)	(3)	-	-	-	57	**57**	-	228	83	**311**	**368**	**368**	**363**
Central Zone	(2)	-	19	-	-	7	(43)	-	**(43)**	(24)	55	12	**43**	**-**	**7**	**24**
Edmonton Zone	14	-	-	15	-	-	(3)	53	**50**	(3)	69	76	**142**	**192**	**192**	**221**
North Zone	20	-	-	-	-	-	-	-	**-**	-	15	8	**23**	**23**	**23**	**43**
TOTAL	**36**	**-**	**9**	**12**	**-**	**7**	**(46)**	**114**	**68**	**(21)**	**378**	**179**	**536**	**604**	**611**	**668**

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Mission
We believe in the transformative power of laboratory medicine to improve health for all Albertans.

Vision
Health informed by world-class integrated laboratory diagnostics.

Background Information

The majority of downstream medical decisions across the continuum of care are based on diagnostic laboratory results, making laboratory medicine a key component of the health-care system. It is a service that impacts all Albertans. Laboratory results impact patients from screening to monitoring and surveillance, and the complexity, scope, and volume of diagnostic testing continues to grow every year.

Alberta Precision Laboratories (APL) employs approximately 5,200 health professionals and is the largest provider of laboratory medicine and pathology services in the province of Alberta. APL is comprised of hospital and community laboratories, mobile collection services, cardiac diagnostic services, on-call services, reference laboratories, public health laboratories, patient service centers, and transportation services.

The establishment of a provincial model of laboratory service delivery in Alberta has allowed for AHS and APL to be more strategic in our efforts. Provincial optimization will result in a multitude of benefits, including equitable access to high-quality services for patients, timely and consistent results for patients and providers, and optimized resources for improved financial health. The role of our public health laboratories in the recent COVID-19 response is just one example of how critical coordinated laboratory testing and reporting is to the health-care system and all Albertans.

To ensure Albertans have access to laboratory testing, there are 150 laboratory testing sites and 191 collection sites (including primary care clinics, physician offices, diagnostic centres, and patient service centres) across the province. Specimens are collected and transported to a laboratory for testing and analysis. Together with our partners, over 80 million tests were completed in Alberta in 2019-20.

Structure and Governance

As a wholly owned subsidiary, APL is accountable to AHS and, subsequently, the Ministry of Health for the provision of all laboratory services in Alberta. In 2018, four legacy laboratory organizations were transitioned into one integrated provincial organization. In 2019, a second restructuring occurred that included changes to the funding framework, infrastructure planning, revisions to the AHS and APL Shared Services roles and responsibilities, a new name, and a newly streamlined governance structure.

The Board that governed APL was dissolved in October 2019 and replaced with a more streamlined and responsive governance structure that included restructuring the APL Executive Leadership Team (ELT) and creating a direct reporting process with the AHS President & CEO via a sole Board Chair. ELT is now a standing committee and is comprised of the senior executive leadership of APL. The purpose of this committee is to set the broad vision, strategic direction, and priorities for the organization, in collaboration with the senior leadership team, the Board Chair, and AHS Executive.

2019-20 at a Glance

In February 2020, the recommendations from the AHS Performance Review were shared provincially. Three specific recommendations were made with regards to the delivery of laboratory services:

1) Explore the closure of underutilized sites
2) Continue to explore the outsourcing of lab services
3) Improve adherence to test appropriateness

APL was already pursuing initiatives that supported the recommendations, including enhancing hours of operation, adjusting service offerings, improving the appropriateness of lab tests, and releasing a Request for Expression of Interest (RFEOI) intended to gauge market interest from private third parties to provide community lab services in Alberta.

Novel coronavirus (COVID-19) emerged in Q4. While the outbreak challenged our capacity and added new layers of complexity to service delivery, it also shone a positive light on the critical role that laboratory services play in the Alberta healthcare system. Testing is a critical component in the diagnosis and monitoring of infections and is key to curbing the spread of COVID-19. From the beginning, Alberta has remained among the leaders in per capita testing volumes in the country. APL teams continue to work tirelessly in these unprecedented times to overcome challenges to ensure we meet the testing needs of Albertans.

2019-20 Notable Accomplishments

APL made notable strides in solidifying the foundation for future delivery of provincial laboratory services. Some important achievements included the wave one implementation of Connect Care, the establishment of an integrated corporate services model, and the completion of multiple research and improvement activities.

Connect Care
The laboratory information system (LIS) is the foundation for laboratory operations and the information highway between ordering physicians, their patients, and other care providers. The first wave of Connect Care launched in multiple sites across the North Sector on November 3, 2019. APL, AHS, and DynaLIFE displayed incredible collaboration and creativity when addressing emerging challenges.

Standardization and Improvement

- A single General Laboratory Requisition form was released to replace the multiple forms that existed in the province.
- A single APL Test Directory is in development to consolidate the existing test directories from AHS Laboratory Services, Genetics & Genomics, Public Health Laboratory, and Calgary Laboratory Services.
- Blood culture practices across the province were aligned to meet international standards, ensuring provincial compliance with international standards that resolved a patient safety concern.
- APL standardized and adopted best practices across the province for fetal Neural Tube Defect Screening and discontinued out-of-date and incorrect maternal prenatal screening requisitions in Alberta.
- Changes to laboratory testing protocols were made to implement Stool Antigen Testing as the main diagnostic test for Helicobacter pylori (H. pylori) infection across all APL sites. This new standard replaces the more invasive Urea Breath Test and reduces patient wait times across the province.
- Commitment to Comfort is an initiative adapted from the Alberta Children's Hospital (ACH) that aims to improve the experience of patients and their families when they come for blood work by reducing pain and distress. Piloted at APL's ACH outpatient collection laboratory last year, the program has now been implemented at all APL Calgary Patient Service Centres, Lacombe Hospital, South Health Campus, and Sundre Hospital with plans to expand to more sites in the future.
- The expanded Newborn Metabolic Screening Program is about health-care providers working together with parents and guardians to screen for treatable conditions like sickle cell disease and cystic fibrosis. Timely screening helps identify conditions early when the treatment can help an infant the most. The laboratory screening panel was updated to include 21 conditions which all Alberta babies will be screened for. Most importantly, implementation of the expanded laboratory testing means early detection of rare diseases, resulting in significantly improved patient outcomes.

Research

Research and development is a foundational underpinning to all laboratory services by supporting vital research that can be used to improve healthcare delivery to patients that need it most. APL researches, develops, tests, and implements new personalized treatments and interventions for patients across the province.

APL continually seeks improvements in the prevention, detection and diagnosis, treatment, and management of medical conditions. Every year, APL has in excess of 1,700 active clinical scientific research protocols underway at various sites in Alberta.

Awards

APL is honored to have received the Clinical and Laboratory Standards Institute (CLSI) 2020 Excellence Award for Membership Organization. The award recognizes volunteers from APL who have participated in CLSI committees to create and revise laboratory standards in areas such as general microbiology, evaluation protocols, molecular methods, and quality management systems. The relevance of the standards have had an impact beyond the borders of Alberta.

Next Steps

In addition to continued transition work, Connect Care implementation, and the ongoing COVID-19 response, APL will continue to work with AHS to identify, design, and validate transformational opportunities for laboratory medicine. These opportunities will drive strategic planning and decision-making in the organization. While instability and opportunities for change still exist for laboratory services in Alberta, Albertans continue to expect the very best from the healthcare system, and APL has the opportunity to demonstrate the transformative power of laboratory medicine in improving the system and the health of Albertans.

APL plays an essential role in providing health services that support and promote positive health outcomes for patients. Test results inform many patient care decisions and are a key component in determining the appropriate course of treatment. Consolidating laboratory services and staff from across the province ensures our patients, providers, and partners receive consistent and efficient access to high quality laboratory services across the province.

Laboratory professionals are making a difference to patient care in Alberta and the teamwork demonstrated by the APL workforce has been remarkable. Teams are dedicated to finding better ways to serve Albertans, and we are pleased to be on this journey together.

The full 2019-20 APL Annual Report can be found online at: www.albertaprecisionlabs.ca/.

Our appreciation and gratitude to all those who contributed to the 2019-20 Annual Report.

Alberta Health Services

The 2019-20 Annual Report was prepared by AHS Planning and Performance.
Financial information in the 2019-20 Annual Report was prepared by AHS Financial Services.