Alberta Health Services

Alberta Health Services
Annual Report | 2020-21

Approved June 28, 2021
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The 2020-21 Alberta Health Services Annual Report was prepared in accordance with the *Fiscal Planning and Transparency Act* and *Regional Health Authorities Act*. The 2020-21 fiscal year spanned from April 1, 2020 to March 31, 2021. All material economic and fiscal implications known as of June 1, 2021 have been considered in preparing the Annual Report.

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

Table of Contents

Message from the Board Chair and President & CEO

The 2020-21 Alberta Health Services (AHS) Annual Report represents the most difficult and demanding 12 months in the organization's history. Throughout this year, our teams and our people were responding to the most deadly global health crisis in a century: the COVID-19 pandemic. And yet, cast against a backdrop of illness, this report captures a year at AHS defined by resilience, courage, innovation, partnership and dedication. In no way do we wish to minimize the terrible toll of the virus on our physical and mental well-being, our healthcare delivery system, our friends and families, and on our society as a whole. Too many lives have been lost. However, AHS can look back at 2020-21 and know we responded quickly, we followed best evidence, we leveraged innovation and integration, and we did everything we could to keep Albertans safe while putting the province — and our healthcare delivery system — on the path toward a brighter post-pandemic future.

AHS has operated as part of a provincewide, fully integrated healthcare delivery system for more than a decade. During the last 12 years, our teams have responded to many emergencies, including the H1N1 pandemic of 2009-10; the Slave Lake and Fort McMurray wildfires of 2011 and 2016, respectively; and the southern Alberta floods of 2013. So when the first case of COVID-19 was confirmed in Alberta three weeks before the end of the 2019-20 fiscal year, AHS teams knew what they had to do. AHS established its Emergency Coordination Centre the following day, with Zone Emergency Operation Centres established shortly after, and we moved resources to areas of highest need, strategically and promptly.

For example, in the early months of the pandemic, we knew COVID-19 testing and contact tracing would be the best tools to slow the spread of the virus until vaccines became available. At the start of the pandemic, AHS was performing 35 COVID-19 tests per day; by the end of the 2020-21 fiscal year, AHS was performing more than 15,000 tests per day. Similarly, we had 50 contact tracers to start but, by redeploying human and financial resources, our contact tracing team expanded 50-fold to exceed 2,500 people capable of investigating up to 2,000 cases per day.

The first COVID-19 vaccines arrived in the province in December 2020, with the first member of the public — a resident at a long-term care centre in Medicine Hat — getting their immunization on December 30. An online booking tool for COVID-19 immunization was developed and launched; Albertans could also book through Health Link at 811 and through participating pharmacies. By the end of the 2020-21 fiscal year, more than 568,900 Albertans had received at least one of two required doses of vaccine; of those vaccinated, more than 322,500 had received both required doses.

Meanwhile, to maintain continuity of care during a time of physical distancing, AHS teams found new ways to serve Albertans and meet their physical and mental health needs. In-person chronic disease management classes were moved online, as were many addiction and mental health services, including group counselling. Virtual clinical visits replaced many in-person clinical visits due to public health measures. And AHS' two main 'home hospital' projects — Virtual Hospital in Edmonton and Complex Care Hub in Calgary — accepted even more patients, keeping them safe and healthy in home rather than in a hospital unit. Both projects use digital patient monitoring to collect patient data that informs clinical decision-making, and leverage existing supports in the community, such as home care teams and specially trained community paramedics who can perform treatments and diagnostics that were previously performed in a hospital environment. All of this enables patients with complex health conditions and those recovering from surgery to receive high-quality acute care from a multidisciplinary team at home rather than in hospital. Both programs cared for a total of 530 patients this past fiscal year compared to 296 the previous year, representing nearly an 80 per cent increase.

AHS ended the 2020-21 fiscal year proud of our pandemic response under stressful and ever-changing circumstances, knowing there was still much work ahead. But despite the focus on COVID-19, AHS also pushed forward on other crucial work:

- Wave 2 of Connect Care launched on October 24, 2020, and involved acute and long-term care sites in suburban Edmonton; interim dialysis and renal care programs on the Walter C. Mackenzie Campus in Edmonton; and pharmacy, diagnostic imaging and Alberta Precision Labs sites in suburban Edmonton. This fiscal year also involved planning for the Wave 3 launch at select AHS North Zone sites less than two weeks after the end of the 2020-21 fiscal year.

- Due to the pandemic, both Accreditation Canada spring and fall surveys took place from September 27 to October 2, 2020. This involved 22 Accreditation Canada surveyors interviewing more than 900 staff, physicians, patients and families. The surveyors assessed rural hospitals in the South Zone for all clinical standards as well as the foundational standards of medication management, infection prevention and control, reprocessing of reusable medical devices and service excellence. Surveyors also assessed Correctional Health Services, Emergency Medical Services (EMS), Organ & Tissue Donation and Transplant and some clinical standards in urban hospitals, including emergency departments, perioperative services and invasive procedures, and inpatient services. The survey results highlighted the excellent work being done with the COVID-19 response, as well as recognized the strategic rollout and implementation of Connect Care. AHS was seen as accreditation-ready, meaning that we live up to accreditation standards each and every day, beyond the time surveyors are present.

Approximately 60 initiatives identified in the implementation plan of the Alberta Health Services Performance Review were progressed, working in partnership with our employees and physicians, the communities we serve, and Albertans. This included consolidation of EMS dispatch, improved alignment between AHS and Alberta Precision Laboratories, and further reductions in discretionary spending. We progressed work around contracting of services such as Community Lab Services and Linen and Laundry Services.

We are pleased to present this report that highlights our achievements in 2020-21. We are proud of our approximately 130,000 staff, physicians and volunteers who have worked so hard and sacrificed so much to protect the health of all Albertans during a global health emergency. We are also grateful to government and AHS' many partners in healthcare philanthropy, academia, private business and the social sector for working together with us to get us through this pandemic and to start work on a better, more sustainable healthcare delivery system in the future.

[Original Signed By]

David Weyant, QC
Board Chair
Alberta Health Services Board

[Original Signed By]

Dr. Verna Yiu
President & CEO
Alberta Health Services
June 28, 2021

Healthy Albertans.
Healthy Communities.
Together.

Alberta Health Services' Response to COVID-19

Timeline on AHS' Response to COVID-19

EARLY PLANNING & ACTIONS

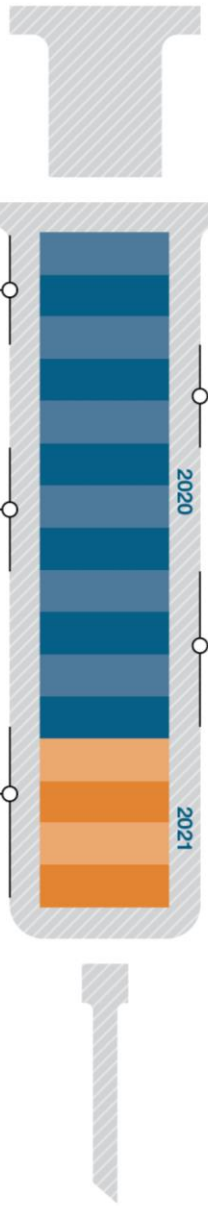
- AHS activates pandemic plans and establishes the Provincial Emergency Command Centre.
- The first case of COVID-19 is identified in Alberta on March 5; testing begins at the first two assessment centres in Calgary and Edmonton.
- AHS Contracting, Procurement & Supply Management (CPSM) secures personal protective equipment (PPE) for front-line staff and community providers.
- AHS' online self-assessment tool goes live and is shared with other provinces and countries.
- Health Link increases capacity to manage influx of COVID-related calls, and receives a record 12,000 calls on March 19.

SUMMER 2020

- More than 70 drive-through and drop-in assessment centres are in operation.
- Family visitation guidelines and tools are developed and shared with continuing care sites.
- The first temporary Pandemic Response Unit is opened at the Peter Lougheed Centre in Calgary.

WINTER 2021

- COVID-19 vaccinations are administered to eligible frontline healthcare workers, continuing care staff and residents, First Nations and Métis people aged 35 and older, and Albertans over age 75.
- Online booking tool is launched for eligible healthcare workers to schedule COVID-19 immunizations.
- Rapid and large-scale expansion of case investigation and contact tracing staff and capacity.
- A Pandemic Response Unit is opened in Edmonton at the Universiade Pavilion (Butterdome).
- AHS planned capacity for 2,250 acute care COVID-19 beds and 425 intensive care COVID-19 beds.
- Temporary satellite COVID-19 immunization clinics are established for emergency department physicians and staff.



SPRING 2020

- Alberta Precision Laboratories (APL) increases testing capacity from 35 tests per day to an average of 15,000 tests per day.
- Text4Hope and other mental health resources are introduced to help Albertans deal with COVID-19-related stressors and anxiety.
- Indigenous communities are supported with culturally appropriate/translated materials, supply and distribution of PPE, and access to testing.
- Virtual care technologies for at-home patient care are expanded to include virtual hospitals in Calgary and Edmonton.
- COVID-19 tests are made available to populations vulnerable to poor outcomes.
- Plans are developed to increase acute care, intensive care and continuing care bed capacity due to rising COVID-19 cases.

FALL 2020

- Health Link receives its one millionth call since the start of the pandemic.
- AHS partners with Togetherall to provide Albertans with free, peer-to-peer online mental health services.
- APL introduces a clinical pilot for Rapid Point of Care testing.
- Plans for immunization roll-out are developed.
- Freezers are secured by CPSM for transportation and storage of COVID-19 vaccine.
- The first Albertans (healthcare workers) receive the COVID-19 vaccine on December 15th.

Alberta Health Services' Response to COVID-19

The COVID-19 pandemic has been the single greatest threat to the health of Albertans and to the healthcare delivery system since the Spanish Influenza in 1918-19 that was responsible for 20-40 million deaths globally. Efforts in 2020-21 have been primarily focused on responding quickly and efficiently to the many emerging and ongoing challenges of managing a pandemic.

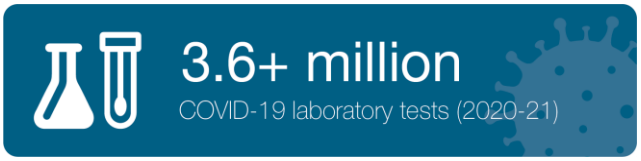
AHS continues to collaborate with Alberta Health (AH) to develop and action a coordinated provincial response to the COVID-19 pandemic. Regular joint meetings occur between AH's Emergency Operations Centre (EOC) leadership and AHS' Emergency Coordination Centre (ECC) leadership, with overarching direction provided by the Chief Medical Officer of Health. Policies and Orders are actioned through multidisciplinary working groups that address various aspects of the pandemic response, including commercial isolation, airport screening, continuing care, Indigenous health, and public health order enforcement, among others. These actions aim to reduce the impact of COVID-19 on Albertans and the healthcare delivery system as a whole.

The COVID-19 pandemic has placed significant demands on Alberta Health Services (AHS) and our workforce that have never been experienced before. The strength of our COVID-19 response has been grounded in our ability to work as part of an integrated provincial team. This structure allowed AHS to take swift, strategic and innovative action. AHS continues to take precautions to reduce the spread within Alberta, while aggressively responding to outbreaks and ongoing pandemic activity.

AHS staff, physicians and community partners have shown their enduring strength and commitment to the delivery of healthcare services. Across Alberta, teams embraced difficult changes to processes, routines, work hours and their personal lives to meet the needs of Albertans during the COVID-19 pandemic. Below are some examples of the incredible work done by AHS teams across the organization in 2020-21. Additional highlights can be found throughout the Annual Report.

Detection and Testing

Since the beginning of the pandemic, AHS has continued to focus on early symptom detection and outbreak management. Thanks to the hard work of **Information Technology** (IT) teams, AHS was the first in Canada to launch an online COVID-19 assessment tool, allowing Albertans to determine their eligibility and book a COVID-19 test. In 2020-21, AHS expanded testing centres to more than 70 active drop-in and drive-through sites across the province. These sites supported improved access for Albertans requiring a COVID-19 test and expanded opportunities to provide guidance on reducing community and facility transmission. AHS regularly modifies the assessment tool to improve and advance Alberta's testing strategy.



On September 3, 2020, **Alberta Precision Laboratories** (APL) reached a big milestone by processing the one-millionth COVID-19 swab in Alberta. In December 2020, APL began piloting point-of-care rapid testing for COVID-19. Rapid testing provides faster, more convenient testing which enables timely identification of positive COVID-19 test results. Individuals who are within the first seven days of exhibiting symptoms are eligible for this type of testing, allowing APL to quickly identify and notify positive cases within hours. In 2020-21, APL completed more than 3.6 million tests on 1.9 million people.

An Albertan receives COVID-19 rapid testing in Calgary. Photo by Leah Hennel/AHS.

Case Investigation and Contact Tracing

Case investigators and contact tracers carry out their functions under the authority and direction of Medical Officers of Health across AHS. These health professionals work to prevent, respond and manage outbreaks to lessen the harmful effects of the COVID-19 pandemic to everyone in Alberta. This happens in accordance with legislation under the *Alberta Public Health Act* and in alignment with policy direction from Alberta Health.

Case investigation and contact tracing is a key strategy for preventing further spread of COVID-19 that requires specialized skills to provide epidemiologic intelligence that supports government and healthcare decision-making. Case investigators are responsible for contacting all new positive COVID-19 cases to gather client information, determine exposures, identify contacts, provide isolation and self-monitoring instructions, complete appropriate documentation and send necessary referrals. In 2020-21, AHS spent more than 277,000 hours completing case investigations.

Contact tracing is completed to prevent secondary infections by notifying contacts and informing them of required quarantine protocols. Information is also provided on recommended testing, symptom monitoring and who to contact for more support. Early recognition of outbreaks and appropriate management is required to control the spread of COVID-19. By the end of March 2021, AHS had the capacity to trace up to 2,000 cases per day.

As of March 31, 2021, AHS had approximately 2,500 contact tracers and case investigators who reached out to Albertans upon confirmation of a positive test result. This is 50 times higher than at the same time last year when the pandemic began.

Outbreak Identification and Management

The COVID-19 pandemic has shed light on the complexity and challenges of outbreaks in congregate living settings. Risk factors include building capacity, shared spaces and increased interpersonal interactions. Building age, condition and size also contribute to outbreak severity.

AHS worked with community partners and continuing care operators to ensure quick and effective action to protect residents and staff at continuing care facilities across the province. AHS also implemented daily screening of residents and staff, restrictions on visitation practices and rules to ensure staff only worked at one site to reduce risk.

Seniors Health teams coordinated pandemic response efforts with continuing care sites that were experiencing outbreaks, including supports provided by **Infection Prevention & Control**, **Safe & Healthy Environments**, **Provincial Continuing Care** and Alberta Health audit teams. For example, risk-based screening tools and protocols, including standardized quality-monitoring visits, were developed to assess and recommend remediation for both COVID-19 processes and quality of care issues, with planned follow-up to ensure challenges were fully addressed.

Seniors Health also established a telephone service to provide long-term care, designated supportive living and seniors lodge operators with access to a rapid-response team at the first sign of illness. The service provides facilities with resources and support to ensure all necessary precautions are in place and assists the operator in implementing additional recommended infection prevention and control measures when needed. AHS also established a dedicated COVID-19 e-mail service for all continuing care operators in Alberta, efficiently providing a single source of immediate advice and guidance regarding the management of potential illness.

In partnership with facilities, hospitals and continuing care operators, **Infection Prevention & Control** continues to provide guidance on recognizing symptoms, proper use of PPE, maintaining physical distancing and the importance of site cleaning to promote healthy environments. Early identification of facility outbreaks allows for timely testing and early intervention using outbreak control measures.

Staff put on personal protective equipment (PPE) to care for a patient with COVID-19. Photo by Leah Hennel/AHS.

Cleaning and disinfecting practices at care facilities has played a key role in AHS' pandemic response. **Linen & Environmental Services** teams have been working around the clock to protect staff and patients by keeping sites clean and linens stocked. Environmental Services implemented, and are sustaining, enhanced cleaning practices for high-touch surfaces throughout AHS facilities. Since the

increase in demand for patient room isolation cleaning which is a resource-intensive process that helps break the chain of infection and ensures a safe environment for patients and staff.

Data Modeling and Projections

In 2020-21, AHS worked with experts across the province, the country, and internationally to monitor and predict how COVID-19 will affect Albertans. **Data & Analytics** teams, in collaboration with **Population & Public Health**, developed predictive modeling tools to support evidence-informed planning based on emerging COVID-19 trends. The tool projects how various levels of demand would affect the healthcare delivery system, enabling proactive action to be taken in areas such as capacity planning and PPE supply.

Communication, Coordination and Advisors

AHS **Communications** helps the organization communicate and engage with more than 4.4 million Albertans, including our staff, physicians and volunteers. In 2020-21, in support of the provincial COVID-19 response, countless messages were developed and shared with stakeholder groups across the continuum of care and Albertans across the province to support their understanding of vital healthcare information and inform audiences about recommended actions and available resources. Messages were timely, accurate and clear, and were customized to meet diverse needs, including digital adaptations, language translations and relevant supporting materials to enhance value.

Throughout the pandemic, AHS' **Advisory Councils** have been an invaluable resource that kept the voice of Albertans at the centre of pandemic response efforts. Advisory councils are made up of community volunteers who bring experiences and grassroots advice from their communities to inform AHS decision-making. Council members supported the design, delivery and evaluation of AHS' provincial COVID-19 response.

The Provincial **Critical Care** COVID-19 Response Committee is responsible for coordinating critical care surge capacity plans for 16 adult intensive care units as well as coordinating equipment, staffing and training requirements. The committee facilitated a COVID-19 response that ensured standardized care for critically ill patients across Alberta, including formulating guidelines for patients with known or suspected COVID-19, providing recommendations for life support, coordinating critical care triage tools and providing COVID-19 resources to support patients, families and staff. The Communicable Disease Emergency Response Plan was also developed to ensure provincial sharing of resources in the event of unbalanced stress on the critical care resources of any one zone.

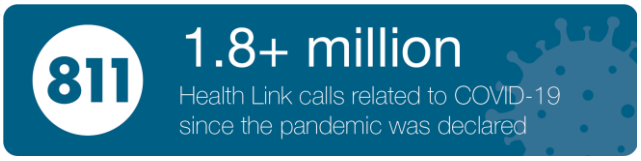
The Scientific Advisory Group provides recommendations to physicians, staff and families based on scientific evidence and international best practices. In 2020-21, COVID-19 management topics included recommendations for PPE guidelines and determining the best strategies for controlling COVID-19 outbreaks in acute and community settings.

AHS' **Emergency Coordination Centre** (ECC) was activated in early 2020 as the central point for all COVID-19 response coordination. ECC leadership provides high-level oversight, mobilizes resources and makes critical decisions to support zones and services involved in the COVID-19 response. **Zone Emergency Operations Centres** (ZEOCs) have also played key roles in operationalizing coordinated efforts across the province. ZEOCs are responsible for zone-level implementation of emergency response strategies.

Environmental Public Health (EPH) works to keep public places safe, inform the public about health risks (e.g., unsafe water or housing) and ensure that the *Public Health Act* is being followed. EPH is a primary source of public health information, creating countless resources for home, businesses and communities to promote wellness across the province. In 2020-21, EPH teams focused efforts on providing guidance to the public on the risks of COVID-19 exposure and transmission.

Community Supports

Health Link, the provincial 24/7 telephone information line, became the first point of contact to access triage, health advice, testing referrals and COVID-19 information. From the time the pandemic was declared in mid-March 2020 to March 31, 2021, Health Link received 3.1 million calls — an average of more than 7,800 calls per day, compared to approximately 2,000 calls pre-COVID-19. Health Link teams also established the Physician Support Line, the 844 Coordinated Early Identification and Response Line, negative test result notification, and collaborated in the implementation of the Rehabilitation Advice Line and the expansion of the Addiction and Mental Health Help Line.



Advancing the use of virtual care technology is an important aspect of helping Albertans manage the immediate and long-term effects of COVID-19. In addition to improving access to services for vulnerable and remote populations, virtual care initiatives in 2020-21 focused on ambulatory and acute care services to ensure patients received safe care while limiting the risk of virus exposure and transmission. Initiatives, including virtual hospitals and acute specialist

virtual consultations, reduced ambulatory and emergency department visits and hospitalizations.

Vincent Facullo tearfully speaks with his wife and children via tablet after being intubated due to complications from COVID-19. Photo by Leah Hennel/AHS.

Working together with communities and government departments, AHS provided COVID-19 supports for populations vulnerable to poor health outcomes, including persons experiencing homelessness, newcomers and those with physical and developmental disabilities. Supports included translated health-related information, system navigation, drop-in rapid testing, temporary isolation sites and at-home testing via the Community Paramedic program.

In partnership with Indigenous communities, the AHS Indigenous Task Force was established to support local COVID-19 response efforts. Consultation and guidance from the Wisdom Council, which includes representation from Elders and Indigenous communities across Alberta, ensured that pandemic supports met the unique needs of Indigenous Peoples in Alberta. AHS developed and distributed culturally-appropriate and translated materials, assisted with supply and distribution of personal protective equipment, and provided enhanced access to testing throughout the pandemic.

Keith Weasel Head was happy to receive a traditional Indigenous medicine pouch during his stay at Chinook Regional Hospital in Lethbridge. Photo by Leah Hennel/AHS.

To further protect the mental health and well-being of Albertans, AHS worked with academic institutions and community agencies to offer enhanced information and supports such as Togetherall mental health supports and Text4Hope. Other key online resources include free virtual stress management workshops and videos covering topics such as stress management and speaking to kids about COVID-19.

Care Delivery and Innovation

A patient's family (as determined by the patient) is an integral part of patient safety, comfort and quality of life. As the pandemic evolved, in-person visitation across AHS sites was restricted to mitigate the risk of the pandemic to the system. In 2020-21, designated support persons were identified and recognized as an essential partner in care for patients, and welcomed back to AHS sites and services, guided by mandatory processes for enhanced screening and personal protective equipment. Visitors provide social benefits to patients and residents, but are distinguished from designated support persons. Two brochures, *Know Your Role* and *Know Your Risk,* help designated support persons understand their role in protecting themselves, their loved ones and care staff in reducing the spread of COVID-19.

AHS collaborated with industry, post-secondary and foundation partners to create temporary Pandemic Response Units (PRUs) in Calgary and Edmonton to meet increasing service demand. PRUs allow lower-acuity patients to be treated in spaces separate from those with COVID-19, thereby limiting the potential for transmission.

As case numbers and hospital admissions rose, AHS increased acute care and intensive care capacity to treat patients with COVID-19. Strategies that helped increase capacity included timely transfer of patients who no longer required care in a hospital into an appropriate post-discharge setting, repurposing decommissioned spaces, opening temporary and previously closed units, using community facilities and purpose-built facilities, and reducing some health services, such as ambulatory care and elective surgeries, to reduce bed and staffing demand unrelated to COVID-19.

In Wave 1 of the pandemic, AHS planned surge capacity for 2,250 acute care COVID-19 patients and 425 intensive care unit (ICU) COVID-19 patients. At the height of Wave 2, 767 acute care beds and 151 ICU beds were occupied by COVID-19 patients. At the time of this report, AHS was responding to Wave 3 of the pandemic.

Safe Practices and Environments

Contracting, Procurement & Supply Management (CPSM) teams established procurement and supply chain processes to secure large quantities of PPE to help manage demand and flow to frontline staff, as well as to community providers and sites. PPE supplies includes gloves, masks, isolation gowns, N95 respirators, goggles and face shields.

AHS also created a PPE Task Force to consolidate best practice guidelines which enabled ongoing improvements to best meet the needs of healthcare providers. In collaboration with **Infection Prevention & Control**, the Task Force developed information and supports related to the safe and appropriate use of PPE in clinical settings, including guidelines for donning and doffing PPE, continuous masking and eye protection, and a checklist for droplet and contact precautions.

The safety of our patients, staff, physicians and volunteers remains a top priority and AHS is taking every possible step to ensure safe environments for all. AHS established an Acute Care Outbreak Prevention and Management Task Force to develop resources and recommendations to support ongoing investigation and management of COVID-19 outbreaks in AHS and Covenant Health acute care facilities. The task force includes representation from **Infection Prevention & Control**, **Workplace Health & Safety** and **Population & Public Health**.

AHS' **Protective Services** teams (including AHS community peace officers, contracted security guards and safety ambassadors) support a culture and environment of safety. Throughout the pandemic, these teams have been responsible for keeping sites secure and assessing risk through facility entrance screening and enforcement of public health guidelines.

Supporting Our Workforce

The AHS workforce is the backbone of Alberta's healthcare delivery system. More than 108,600 Albertans make up the AHS workforce, and an additional 35,750 Albertans support the delivery of healthcare services in AHS as physicians, midwives, subsidiary staff and volunteers.

Provincial Staffing Services (PSS) was instrumental in redeploying and hiring staff to essential roles and assigning relief employees quickly and efficiently. Planning for COVID-19 staffing was facilitated through emergency surge capacity modelling and sought out alternative staffing sources including students, new graduates and private sector pharmacists.

PSS teams were able to integrate new innovations and technology, such as the Automated Shift Callout app, to overcome some of the pandemic's scheduling challenges. AHS' non-clinical staff were encouraged to work remotely when possible and, with the assistance of IT services, were given required technology and access to support working from home.

Resources to address stress and anxiety as well as support psychological safety, mental health and wellness have been developed by AHS and the Employee and Family Assistance Program. Pandemic-specific sessions were designed to offer support, emotional first-aid and self-care strategies to employees.

COVID-19 Immunization

With the launch of Alberta's COVID-19 Immunization Program in December 2020, Alberta Health established a phased approach to vaccine eligibility that was aligned with anticipated vaccine supply and considered populations at the highest risk for severe illness. AHS' provincial and zone **Population & Public Health** teams provided insight and expertise to help identify key populations to be included in the early stages of the province's phased immunization program.

Monique Prud'homme was the first Albertan to receive the Covishield AstraZeneca vaccine. Photo by Leah Hennel/AHS.

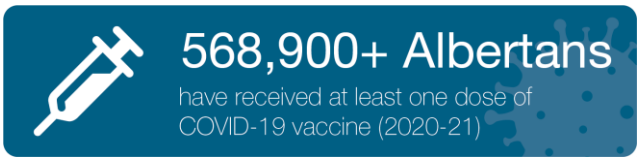
Populations most at risk of negative outcomes from the COVID-19 virus were considered first priority and included healthcare workers in critical care and emergency care environments, seniors living in congregate settings and Indigenous Persons living on-reserve and on-Métis

Settlement. The uncertainty of vaccine supply in Alberta prompted AHS to implement a Vaccine Waste Mitigation Strategy to ensure as many doses of vaccine as possible were available to Albertans interested in receiving the vaccine.

In addition to public health immunizers, AHS recruited other healthcare providers, retirees, undergraduate nurses and community pharmacists to provide immunizations across the province. This collective effort enabled rapid response to demand and continues to support Alberta's fight against COVID-19 transmission.

AHS' **IT** and **Digital Solutions** teams worked tirelessly to launch the online immunization booking tool which increased system capacity to respond to expanding eligibility criteria. By adding queueing software and other enhancements, the team improved user experience and access. The booking tool has helped speed up the immunization process and contributes to the goal of getting Albertans immunized as quickly as possible. AHS also added capacity to Health Link phone lines and additional staff to support growing demand.

To be immunized against COVID-19, two doses of vaccine are required (except Johnson and Johnson). As of March 31, 2021, more than 568,900 people in Alberta had received a first dose of vaccine, and 322,500 had received both doses. **Population & Public Health** worked closely with Alberta Health to provide first and second dose vaccinations to as many Albertans as possible. AHS staff involved in the COVID-19 immunization rollout worked long hours and demonstrated their commitment to protecting staff, patients and the public against this deadly virus.



COVID-19 Variants

Variants describe viruses that have changed or mutated over time. COVID-19 Variants of Concern were first identified in the United Kingdom, South Africa and Brazil. These strains have since been detected in Alberta and in countries around the world. Variants of Concern can spread quickly and cause more serious illness that could result in increased hospitalizations and deaths as they spread throughout the community.

The first variant case in Alberta was reported in December 2020. Initially, variant cases were linked to travel outside of Canada but quickly began spreading through community transmission. AHS continues to monitor and track cases daily.

AHS has been tested by the day-to-day demands of COVID-19. But with the incredible effort and determination of staff, physicians, facility operators, community partners and volunteers, AHS has built a strong front to fight this unpredictable virus. While the pandemic response is rapidly evolving to meet the demands of the virus, AHS is committed to providing safe, quality care to all Albertans virtually and in-person.

COVID-19 testing at ProvLab in Calgary. Photo by Leah Hennel/AHS.

AHS is incredibly grateful to everyone for rising to the challenges of COVID-19. Our workforce has demonstrated incredible resilience and continues to provide exceptional care to Albertans.

THANK-YOU!

About Alberta Health Services

Who We Are

Alberta Health Services (AHS) is proud to be part of Canada's first and largest provincewide, fully integrated health system. As Alberta's regional health authority, AHS plays a significant role in delivering a broad range of health services to more than 4.4 million people living in Alberta. AHS is one of three entities within the Ministry of Health, delivering a broad range of health care on behalf of government, in accordance with the mandate set by government.

AHS and its many health service delivery partners, including Covenant Health, physicians practicing in community, allied health professionals, pharmacies, local governments and Indigenous communities, work together to deliver high-quality healthcare across the province as well as to some residents of Saskatchewan, British Columbia and the Northwest Territories.

In 2020-21, AHS was recognized for the fourth consecutive year as one of Canada's Top 100 Employers, Canada's Top Employers for Young People and Alberta's Top Employers. AHS was also recognized as one of Canada's Best Diversity Employers for the third consecutive year. This success can be attributed to the dedication, collaboration and hard work of our staff and volunteers. AHS is proud to be recognized for supporting our people and creating workplaces where everyone feels safe, healthy, valued and included, and able to reach their full potential.

Some 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, nearly 400,000 virtual connections provided improved access to services for Albertans across the province, including those in urban centres, smaller communities and remote locations.

AHS has more than 108,600 direct AHS employees (excluding Covenant Health and other contracted health service providers), nearly 150 midwives, and more than 12,500 staff working in AHS' wholly-owned subsidiaries, such as Carewest, CapitalCare Group and Alberta Precision Laboratories.

AHS is also supported by more than 10,900 licensed practising physicians, approximately 9,000 of whom are members of the AHS medical staff (including active, temporary and community appointments).

Volunteers play an integral role in fostering environments that support patient- and family-centred care. AHS' 12,200 volunteers contributed more than 330,000 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, assume wayfinding roles and tend retail shops to raise funds.

AHS programs and services are offered at more than 900 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 relevant legislation.

As of March 31, 2021 there were 106 acute care hospitals; five standalone psychiatric facilities; 8,513 acute care beds; 477 sub-acute care beds; 27,973 continuing care beds/spaces (15,800 long-term care beds, 11,916 designated supportive living beds and 257 community palliative and hospice beds/spaces); and 2,840 addiction and mental health beds/spaces. This is a total of 39,803 AHS-operated and contracted beds in service.

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. AHS' provincial Student Placement Team helps coordinate and facilitate clinical student placements and ensures positive student experiences by using a collaborative model where students can apply their skills as part of an integrated team.

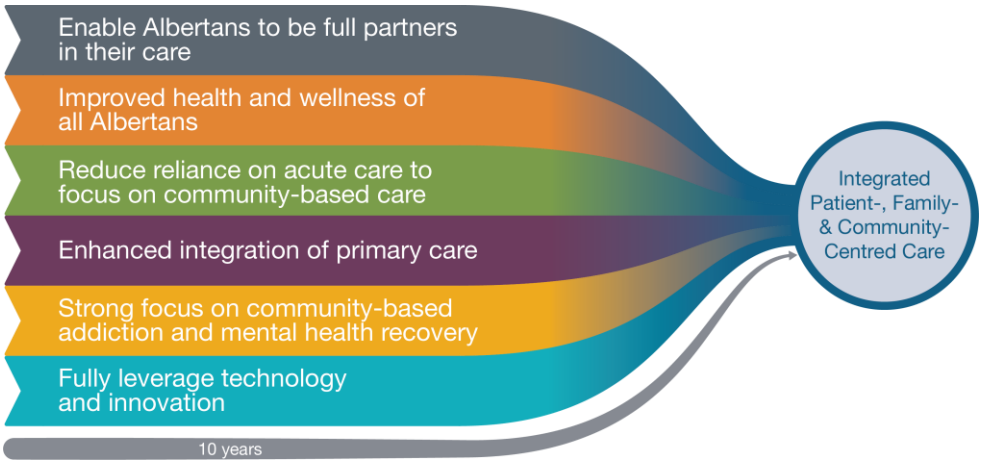
Strategic Direction

AHS' 10-year Vision

Since its inception in 2009, AHS has evolved by advancing healthcare service access and patient-care improvements, preventing disease and promoting health, streamlining governance and accountability, driving standardization, and strengthening leadership and culture. Over the next 10 years, AHS will need to find new and innovative ways to provide high-quality care in a way that makes healthcare sustainable and accessible for all Albertans. This will help AHS become an organization that is modern, agile and capable of navigating future challenges.

AHS Health Plan & Business Plan

The AHS 2020-22 Health Plan & 2021-22 Business Plan is a legislated public accountability document that describes, at a strategic level, the actions AHS will take in carrying out its legislated responsibilities with a focus on the delivery of quality healthcare services. The AHS Health Plan & Business Plan reflects direction from Alberta Health and is aligned to the Ministry of Health's 2021-24 Business Plan, the Blue Ribbon Panel on Alberta's Finances report released in 2019 and the AHS Performance Review released in February 2020.



Mission, Vision & Values

Our mission, vision and values are core statements describing the overall purpose of our organization, how we operate and what keeps us moving forward. It clarifies what we do, who we do it for and why we do it.

Our Mission: To provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Our Vision: Healthy Albertans.
Healthy Communities.
Together.

Our Values:

AHS cares

Compassion
Accountability
Respect
Excellence
Safety

Foundational Strategies

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

Patient First puts patients and families at the centre of all healthcare activities, decisions, and teams. It helps us work towards patient-experience excellence.

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

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 improve decision-making.

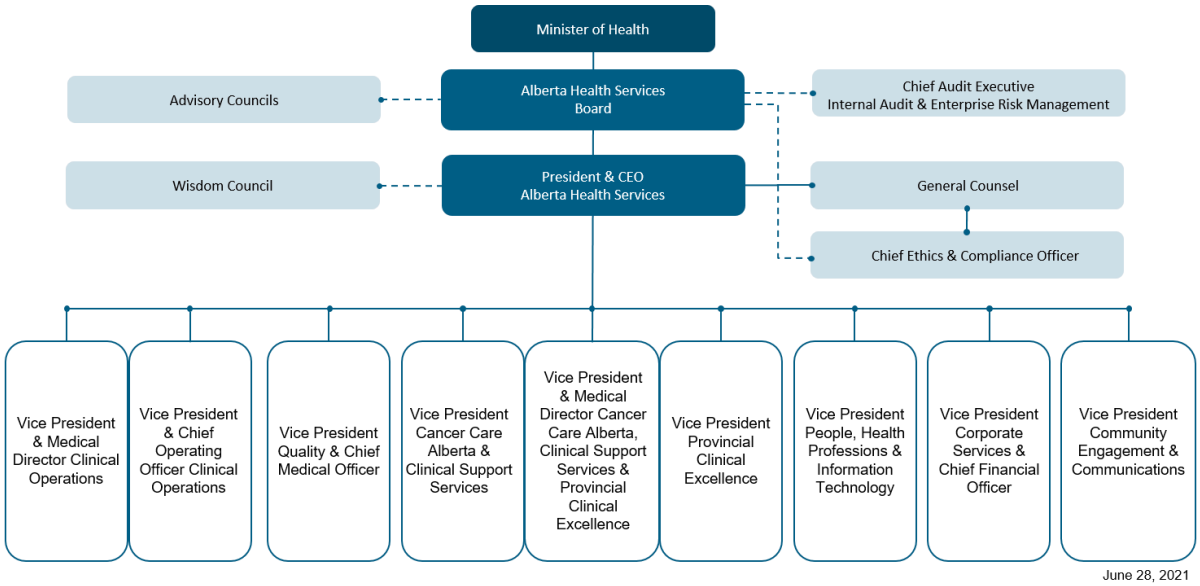
Board Governance

The AHS Board is responsible for the governance of AHS to ensure all Albertans have access to high-quality health services across the province. Led by the Board Chair, David Weyant, QC, the AHS Board 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.

Organizational Structure

Reporting directly to the Board, Dr. Verna Yiu is President & Chief Executive Officer (CEO) of AHS and leads more than 108,600 caring and dedicated individuals who make up the AHS workforce. Along with leaders and staff in the organization, AHS is proud to have a culture that exemplifies its values, takes a provincial perspective on issue 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.



Advisory Councils

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

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

- True North – La Crete, High Level & Area
- Peace – Peace River, Grande Prairie & Area
- Lesser Slave Lake – Slave Lake, High Prairie & Area
- Wood Buffalo – Fort McMurray & Area
- Lakeland Communities – Lac La Biche, Redwater, Cold Lake & Area
- Tamarack – Hinton, Edson, Whitecourt & Area
- Oldman River – Lethbridge & Area
- Greater Edmonton – Edmonton & Area
- Yellowhead East – Camrose, Lloydminster & Area
- David Thompson – Red Deer & Area
- Prairie Mountain – Calgary & Area
- Palliser Triangle – Medicine Hat & Area

Each HAC 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. In 2020-21, HACs enhanced their efforts to engage with the public and shifted to online events during the pandemic. As a result, public participation at meetings and events increased by 380 per cent compared to last year.

Wisdom Council

The Wisdom Council provides guidance and recommendations on the development and implementation of culturally-appropriate and innovative health service delivery for Indigenous Peoples. It is made up of Indigenous Peoples with wide-ranging backgrounds, including traditional knowledge-holders, youth, nursing professionals and health consultants. The council recognizes knowledge keepers as distinct members within the Wisdom Council Elders Circle. Elders can opt to continue to serve after their membership term ends. In 2020-21, the council was asked to name the newly amalgamated Indigenous Health Program and Indigenous Health Strategic Clinical Network™. The Provincial Indigenous Wellness Core offers a 'home' for Indigenous health which enables AHS to advance the important work identified in the Indigenous Health Strategy.

Alberta Clinician Professional Practice Council

The Alberta Clinician Professional Practice Council is a forum for clinicians to share knowledge and experience 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. Despite the pandemic, council members provided feedback on six organizational priorities in 2020-21, including Connect Care, Our People and the Allied Health Workforce Plan.

Provincial Advisory Councils

The **Addiction and Mental Health Provincial Advisory Council** works in partnership with the AHS Provincial Addiction & Mental Health team on provincewide programs and services. The council provides recommendations that seek to improve system access, quality of service and patient satisfaction. In 2020-21, members collaborated with national partners to address topics including community-based supports for alcohol use disorder during a pandemic and the impact of COVID-19 on people who live with long-term conditions or disabilities, among others.

The **Cancer Provincial Advisory Council** provides advice related to priorities for cancer services, including screening and prevention, diagnosis, treatment and care, and research. Members are experts in cancer-related fields, have a loved one touched by cancer or are cancer survivors. In 2020-21, council members provided input on several initiatives, including the Cancer Care Alberta virtual care initiative and the Cancer Treatment Prioritization Framework.

The **Seniors and Continuing Care Provincial Advisory Council** works in partnership with the AHS Provincial Seniors Health & Continuing Care team to improve the delivery of AHS services to seniors and Albertans receiving continuing care services and supports. In 2020-21, council members participated in COVID-19 planning activities related to visitation restrictions and guidance for essential visitors in licensed supportive living and long-term care facilities.

The **Sexual Orientation, Gender Identity and Expression Provincial Advisory Council** aims to create a safer, more inclusive and welcoming healthcare environment for sexual and gender minority (lesbian, gay, bisexual, transgender, queer, and 2 Spirit or LGBTQ2S+) patients and their families. In 2020-21, the council hosted a virtual information webinar to build awareness of the new council and encourage members of the public to attend regular council meetings.

Patient and Family Advisory Group

The Patient and Family Advisory Group is a council 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 voice of patients and families is included in the design and planning of policies and services within AHS to enhance the principles of patient- and family-centred care.

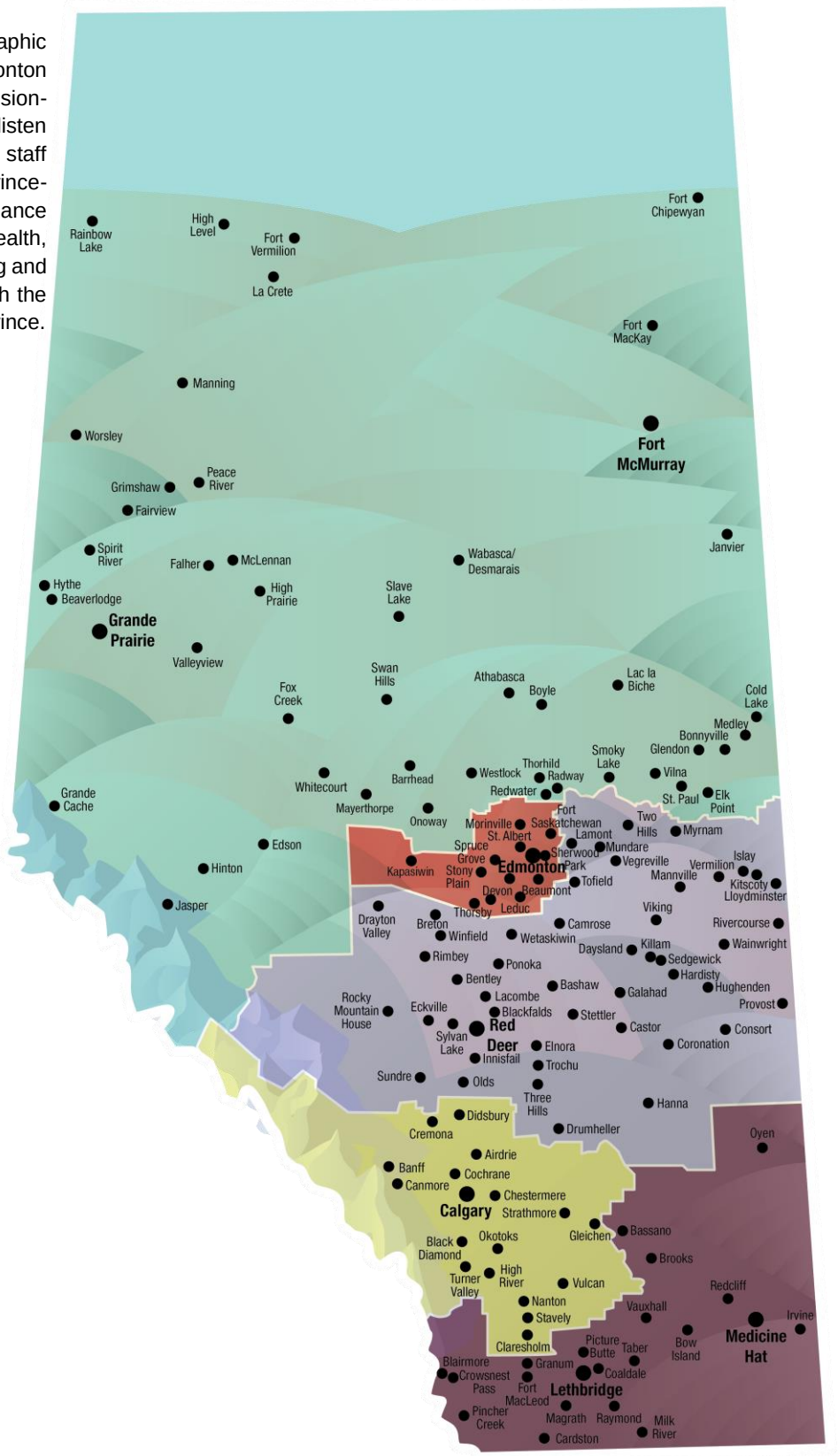
In 2020-21, members contributed approximately 1,700 volunteer hours and participated in more than 80 consultations related to COVID-19, including addressing visitor restrictions, surgical service continuity and patient experience. Their advice and feedback brought valuable lived experience and perspective to planning efforts throughout the pandemic.

Alberta Map by Zone

AHS is organized into five geographic zones: South, Calgary, Central, Edmonton and North. Zones enable local decision-making and enhance our ability to listen and respond to local communities, staff members, 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 across the province.

Population (2020)	
Alberta	4,421,887
North Zone	480,924
Edmonton Zone	1,442,009
Central Zone	476,674
Calgary Zone	1,710,560
South Zone	311,514

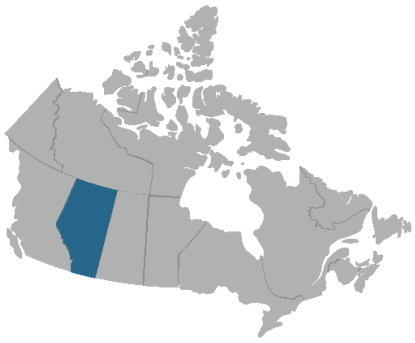
Note: The provincial total includes residents not attached to a local geographic area; zones may not sum to Alberta total.



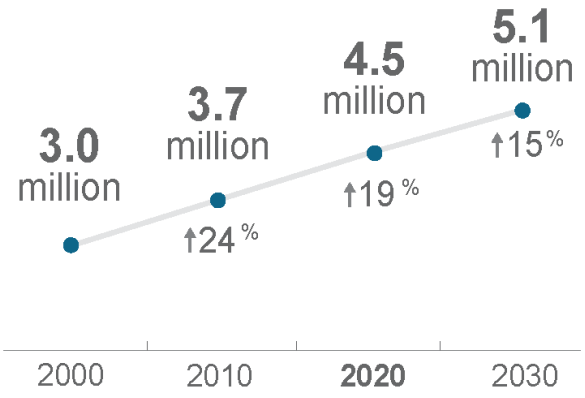
Provincial Demographics

Population

4,421,887 people
lived in Alberta in **2020**



Population Projections

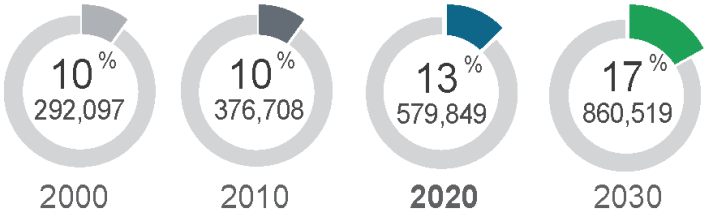


Aging Population

1 in **8**

of the population
were **65+** in **2020**

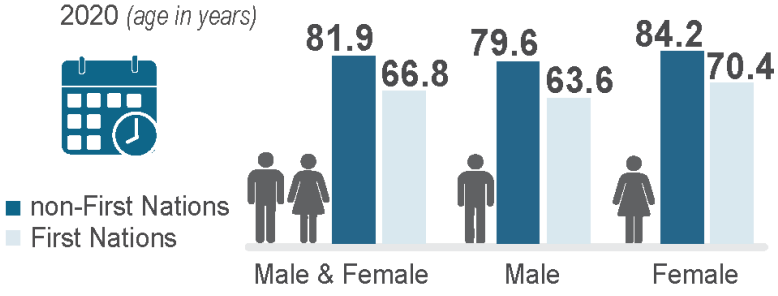
Aging Population Projections



Median Age

Life Expectancy

2020 *(age in years)*



Source: Alberta Health Interactive Health Data Application (IHDA) as of August 27, 2021.

Bed Numbers

AHS continues to shift from a focus on providing care in hospitals and care facilities to providing resources and services 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 2020-21, AHS opened 199 net new continuing care beds. Since 2010, AHS has opened 8,273 new beds to support individuals who need community-based healthcare and supports (including palliative). Increasing community capacity means that people are gradually being moved from hospital settings to a more appropriate (and often more cost-effective) community-based setting.

Additional information on bed capacity can be found in the Appendix.

Number of Beds/Spaces	March 31, 2020	March 31, 2021	Difference	% Change
Acute Care				
Acute Care	8,502	8,513	11	0.1%
Total Acute Care	**8,502**	**8,513**	**11**	**0.1%**
Addiction and Mental Health				
Psychiatric (stand-alone facilities)	928	928	0	0.0%
Addiction Treatment	979	1,037	58	5.9%
Community Mental Health	878	875	-3	-0.3%
Total Addiction and Mental Health	**2,785**	**2,840**	**55**	**2.0%**
Community-Based Care				
Continuing Care – Long-Term Care (LTC)				
Auxiliary Hospital	5,561	5,591	30	0.5%
Nursing Home	10,104	10,209	105	1.0%
Sub-Total Long-Term Care	**15,665**	**15,800**	**135**	**0.9%**
Continuing Care – Designated Supportive Living (DSL)				
Designated Supportive Living 3	1,513	1,513	0	0.0%
Designated Supportive Living 4	6,840	6,924	84	1.2%
Designated Supportive Living 4 - Dementia	3,500	3,479	-21	-0.6%
Sub-Total Designated Supportive Living	**11,853**	**11,916**	**63**	**0.5%**
Sub-Total Long-Term Care & Designated Supportive Living	**27,518**	**27,716**	**198**	**0.7%**
Community Palliative and Hospice (out-of-hospital)	256	257	1	0.4%
Total Continuing Care (includes LTC, DSL and Palliative Care)	**27,774**	**27,973**	**199**	**0.7%**
Sub-acute in Auxiliary Hospitals	472	477	5	1.1%
Total Community-Based Care (includes LTC, DSL, Palliative Care and Sub-Acute in Auxiliary Hospitals)	**28,246**	**28,450**	**204**	**0.7%**
Provincial Total	**39,533**	**39,803**	**270**	**0.7%**

Source: AHS Bed Survey as of March 31, 2021.
Note: Beds may have been restated since previous AHS Annual Reports and AHS Bi-Annual Bed Surveys due to reporting corrections.

Message from South Zone Leadership

South Zone Executive Leadership credits their team's strength, flexibility, resilience and innovation as key elements in the zone's response to the unprecedented and challenging demands of the past year.

The pandemic response in large and small communities, as well as the Kainai and Piikani Nations, demonstrates the commitment to the care and safety of those to whom they have the honour of providing services; particularly during times of unpredictability and constantly changing requirements and expectations.

"We are so proud of our ongoing relationships and linkages with communities as these have served as the foundation for our response to their needs," says Linda Iwasiw, Chief Zone Officer, South Zone. "We also worked closely with our continuing care and addiction and mental health partners across the zone to best care for resident and client needs."

Dr. Bilal Mir in the ED at Chinook Regional Hospital in Lethbridge. Photo by Leah Hennel/AHS.

South Zone teams continue to partner with health officials on the Kainai and Piikani reserves to support their response as needed, including off-reserve vaccine clinics for Indigenous Peoples.

They also acknowledge the unprecedented response of Public Health teams across the zone. Another critical component of their COVID-19 response has been staff and visitor screening at all facilities, work that is especially important at rural sites, where even a small outbreak among staff could quickly limit available resources.

The ability and willingness to go above-and-beyond for the safety of those who require services and for fellow staff and physicians in these uncertain times has been remarkable, and cannot be overstated.

"We have the honour every day of providing health services to southern Albertans," says Dr. Aaron Low, Zone Medical Director, South Zone. "We rely on and work with our colleagues, and our internal and external partners throughout the province each and every day. We want our staff and physicians to know how much their work means to everyone. We are so grateful to those who don't always receive the recognition they should. We want to say thank-you to everyone for the sacrifices you have made and continue to make."

Linda Iwasiw
Chief Zone Officer, South Zone

Dr. Aaron Low
Zone Medical Director, South Zone

Message from Calgary Zone Leadership

Calgary Zone Executive Leadership feels particularly proud of the strong support and collaboration demonstrated by their leaders, staff and physicians while continually providing patient- and family-centred care in communities and hospitals.

They also recognize the importance and significant value of their strong relationships with Primary Care Networks, and their continuously developing partnerships with non-profit organizations that work to care for vulnerable or marginalized populations.

Calgary Zone's swift and effective pandemic response has been greatly supported by clinical and non-clinical areas such as contracting, procurement and supply management, IT, communications and environmental services, and also through community partners working collectively to protect the public and healthcare workers.

AHS nurse clinician Jill Paulsen (left) and artist Tracy Franks (right) at Hope Hallway on the Adolescent Mental Health Unit at Foothills Medical Centre. Photo by Paul Rotzinger/AHS.

An unprecedented redeployment of staff and physicians whose willingness to embrace new roles and tackle new responsibilities for the common good are a living example of Alberta Health Services' values.

"Over the past year, more than ever, we have been privileged to work within AHS, and with the thousands of staff and physicians who provide frontline care and those who support them," says Dr. Sid Viner, Zone Medical Director, Calgary Zone. "The resilience and incredible experience, competence and capabilities of our frontline staff, physicians and leadership have shone throughout the past year."

Calgary Zone's uninterrupted focus on quality and patient safety - including maintaining access to surgery and outpatient services, participating in accreditation and continuing with quality assurance activities and key quality improvement initiatives – was another notable accomplishment despite the demands of the pandemic.

"We are very proud of the Zone's many accomplishments and we are thankful to all those who have contributed in so many ways to providing care for those who need it, and protecting the health of Albertans," says Lori Anderson, Chief Zone Officer, Calgary Zone. "Our people have shown tremendous courage and professionalism over the past year. It is inspiring and a true testament to the power of teamwork."

Lori Anderson
Chief Zone Officer, Calgary Zone

Dr. Sid Viner
Zone Medical Director, Calgary Zone

Message from Central Zone Leadership

Central Zone Executive Leadership believes the development of relationships and collaboration among multiple teams and sites during the pandemic response will strengthen the zone post-COVID-19.

Sandra Comer has been volunteering at the Olds Hospital and Care Centre for almost 19 years. Photo by Leah Hennel/AHS.

Chief Zone Officer Janice Stewart says as leaders have stepped up to take a turn helming the Zone Emergency Operations Centre, teams have become more familiar with one another and have collaborated in new ways that will set them up for increased success in the future.

"You could not ask for a better team-building exercise with an ongoing opportunity to practice," Stewart says, wryly.

She points to the management of outbreaks as an example of how the zone pulled together: hospitals would help nearby sites by taking their patients or supplying needed staff when positive cases or staff exclusions became a significant challenge.

"That collaboration demonstrates how we are more than a collection of sites and communities. We have worked together as a cohesive zone," says Stewart.

Zone Medical Director Dr. Jennie Bestard agrees that the pandemic has helped teams develop a true zone identity. She says prior to COVID-19, they would activate over-capacity protocols as needed on more of a crisis management basis; now during the pandemic, those pathways have proved even more helpful with teams coming together more proactively to manage capacity challenges – including the development of a short-stay protocol, which sends medically appropriate patients out to rural sites to improve zone flow.

Bestard says more frequent opportunities for connection between associate zone medical directors, facility medical directors and clinical department heads provides them with the opportunity to share updates, voice concerns, ask questions and share ideas.

"There is such respect for the various facilities and their leaders. We know each other and our sites' challenges so much better now, and it makes it easier to help one another even more," Bestard says.

Janice Stewart
Chief Zone Officer, Central Zone

Dr. Jennie Bestard
Zone Medical Director, Central Zone

Message from Edmonton Zone Leadership

Edmonton Zone teams have demonstrated incredible resiliency and an ability to come together to address the severe stressors impacting the healthcare delivery system. Emerging stronger as a result from the work they have done over the past year, zone staff has strengthened their collaboration across sites, portfolios and services, including Covenant Health and their community partners, stakeholders and municipalities.

Connect Care Wave 2 launched at suburban sites in Edmonton Zone in October 2020. Photo by Evan Isbister/AHS.

"The agility, resourcefulness and resilience our teams have shown has been incredible," notes Carol Anderson, Chief Zone Officer. "From quickly conceptualizing and operating assessment centres, pandemic response units and rapid flow-through immunization clinics, to undertaking a massive universal immunization program, and managing multiple outbreaks and ensuring bed and service availability while maintaining regular business, we engaged support from all sectors, programs and services from across the zone."

Edmonton Zone has the highest proportion of multi-bed rooms compared to other zones in the province, heightening the importance to keep their patients, staff and physicians safe. The zone team also worked together on the temporary closure of a major hospital during the initial Misericordia outbreak.

In addition to the pandemic response, the past year allowed the Edmonton Zone to accelerate various important initiatives to help improve care in the community. "Virtual health is one example where the ambulatory and virtual hospital teams have done an extraordinary job in incorporating virtual care to support patients," says Anderson. "The Edmonton Zone Integrated Operations Centre is another. We have clearly shown how having a collaborative, system-based approach to proactively managing patient flow has been absolutely critical to our success in the zone."

There was also tremendous collaboration across portfolios, sites and programs to implement the second wave of Connect Care - a major infomatics installation.

"There have been positive aspects and we definitely have to carry forward the innovative models we've created. People think of innovation as a machine or treatment, but we've created models that will better serve Albertans going forward," says Dr. David Zygun, Zone Medical Director, Edmonton Zone. "The pandemic forced us to quickly adapt. Who was important to see in person? Who can be triaged to a virtual visit? Who needs to be there? There have been benefits to these changes for both practitioners and patients."

Zygun says he has the confidence to know we will get through this, as Edmonton Zone teams have demonstrated their ability to overcome incredible challenges. He is confident they have the right people to solve the problems that need to be solved. The Zone's Executive Leadership Team has expressed their immense pride, awe and gratitude for their managers, physicians and staff.

Carol Anderson
Chief Zone Officer, Edmonton Zone

Dr. David Zygun
Zone Medical Director, Edmonton Zone

Message from North Zone Leadership

Whether it is a flood, wildfire or COVID-19, North Zone teams are prepared and equipped to respond.

In 2020, multiple AHS teams in the North Zone responded to spring flooding in Fort Vermilion and Mackenzie County, where hundreds of residents were forced to evacuate their homes. Fort McMurray experienced significant flood damage at the same time, with more than 12,000 residents evacuated from their homes. As part of the response, AHS worked closely with municipal and provincial partners to support all northern Alberta residents; including patients and staff who were impacted.

“While already facing a healthcare challenge in responding to COVID-19, I’m incredibly proud and grateful of our healthcare teams across the North Zone. Our staff responded quickly to affected flooding communities, ensuring displaced residents had the healthcare support and services they needed,” says Gregory Cummings, Chief Zone Officer, North Zone. “It’s heartening to see that in the most challenging of times, our healthcare teams and staff come together to help those in need.”

Respiratory therapist Huan Zhang receives a COVID-19 vaccine at the Queen Elizabeth II Hospital in Grande Prairie. Photo by Chris Beauchamp/AHS.

Flood evacuations presented a unique challenge for the North Zone who were in the midst of responding to COVID-19. Staff worked on multiple fronts to protect Albertans and minimize the risk of transmission. This included assessing, screening and testing Albertans for COVID-19, surge planning, fit testing, providing support to community outbreaks, providing support, engagement and resources to municipalities, and implementing and ensuring infection prevention and control measures were being followed at all AHS facilities.

“Our AHS staff and teams successfully worked together, alongside several community partners, to support evacuees and minimize the risk of COVID-19 transmission during this challenging natural disaster,” says Dr. Albert Harmse, Acting Zone Medical Director, North Zone.

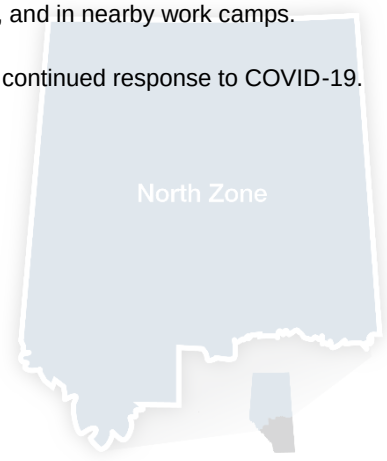
“I thank our AHS staff and teams for their passion, commitment, dedication and teamwork. Our North Zone staff and teams always rise to every occasion, and these efforts are another testament to their hard work and resiliency.”

In Fort McMurray, staff from Early Childhood Intervention, Street Connect, Public Health, Home Care, Indigenous Health, and Addiction and Mental Health supported evacuees including families, prenatal and postnatal mothers, and vulnerable populations at both the registration and evacuation centres (Oil Sands Discovery Centre, Casman Centre and Anzac Recreation Centre, respectively). Public Health nurses provided COVID-19 assessments and swabbing at the Casman Centre, while also continuing to swab residents at Fort McMurray Community Health Services, and in nearby work camps.

Zone staff focused on supporting evacuees, while ensuring their continued response to COVID-19.

Gregory Cummings
Chief Zone Officer, North Zone

Dr. Albert Harmse
Acting Zone Medical Director, North Zone



AHS Performance

Leading in Health

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

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 some data releases due to the COVID-19 pandemic. As a result, the most recent wait time data was released in July 2020.

Sources:
CIHI Your Health System: In Depth Website, May 2021 update.
CIHI Wait Times in Canada, July 2020 update.
CIHI Cardiac Care Quality Indicators, August 2020 update.

Accreditation

Accreditation compares AHS' health services with national standards of excellence to help identify what AHS is doing well and how we can improve. AHS continues to maintain accredited status with Accreditation Canada and the College of Physicians and Surgeons of Alberta. AHS-funded partners, Covenant Health and Lamont Health Care Centre, also continue to maintain accredited status with Accreditation Canada. More information can be found online at www.ahs.ca/about/Page190.aspx.

Accreditation Canada surveyors conducted approximately 900 interviews at 64 locations across Alberta during the Fall 2020 survey. Due to pandemic conditions, sites originally scheduled for the Spring 2020 survey were rescheduled and included in the Fall survey.

Twenty-two Accreditation Canada surveyors assessed South Zone rural hospitals, provincial Corrections Health Services and Emergency Medical Services, as well as the following programs in AHS' largest urban/regional hospitals: Emergency Department, Inpatient Services, Peri-Operative Services & Invasive Procedures, and Transplant and Organ & Tissue Donation. Performance related to the foundational standards of Infection Prevention and Control, Medication Management, Medical Device Reprocessing and Service Excellence were also assessed at all surveyed hospitals and programs.

Surveyors were impressed by our ongoing commitment to quality and AHS' willingness to undergo a survey during a pandemic. The surveyors commended AHS for being accreditation-ready and delivering the highest quality of care, in the safest manner possible, under challenging pandemic conditions. They were pleased with the engagement and enthusiasm of staff and were impressed with the teamwork and collaboration observed throughout the survey.

Patient Concerns

AHS has processes in place to review and respond to feedback from patients and families. If resolution is not possible at the local level, 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 volume and type of feedback received, and the concerns that required escalation to the PCO.

Concerns and Commendations	2017-18	2018-19	2019-20	2020-21
Total Number of Commendations	1,727	1,696	1,473	903*
Total Number of Concerns	10,404	10,392	10,773	11,602
Total Number of Concerns reviewed by PCO	10	3	20	18
Percent of Actions Arising from Concerns Resolved in 30 Days or Less	69%	71%	72%	76%

** Commendations received in March 2021 are not captured in the database because of capacity constraints due to COVID-19 response efforts.*
Notes:
- Data includes Covenant Health
- Due to the nature of concerns data, it is not possible to provide a rate or percentage because there is no meaningful denominator that can be used. Members of the public who have not yet accessed AHS services may identify concerns or 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 guidelines and the number of concerns escalated.

2020-21 Key Activities and Accomplishments

AHS is working hard to improve the quality of care provided to Albertans. Across the province, significant progress was made toward building a patient-focused, quality healthcare delivery system that is accessible and sustainable for all Albertans. Despite the enduring COVID-19 pandemic, AHS remained focused on all aspects of healthcare delivery and our strategic direction.

AHS Performance Review

The AHS Performance Review resulted in the development of a phased, multi-year implementation plan intended to propel the healthcare delivery system toward greater efficiency, value and integration. Together, the changes have the potential to assist with evolving AHS operations to be more responsive, patient-centred and capable of navigating future challenges. The AHS Performance Review is one component to ensure Albertans continue to receive top-quality care from AHS in a sustainable manner.

AHS has been approved, by the Government of Alberta, to take action on more than 60 initiatives from the Review using a long-term approach. Outcomes aim to strengthen financial sustainability while remaining focused on the delivery of high-quality patient care. A Sustainability Program Office was created in response to a Review recommendation and is accountable for driving all aspects of the program forward.

Transforming Service Delivery

The COVID-19 pandemic highlighted the need for continued growth in the area of virtual care. The AHS Virtual Health Strategy aims to provide “quality virtual care – anytime, anywhere”. This strategy builds on AHS’ experience with implementing various forms of virtual care since its inception in 2009. Teams continue to explore opportunities to leverage existing technology, procure new technology and scale and spread proven solutions to better meet the needs of Albertans.

In February 2021, AHS streamlined Emergency Medical Services (EMS) dispatch services across the province. This transition had been planned for over a decade and was driven by a desire to improve patient care by consolidating local dispatch functions into a single provincial system.

Clinical support staff perform administrative and clerical tasks, manage health information, conduct laboratory tests and ensure care environments are clean and safe. Several clinical support improvements involve transforming service delivery with contracted services.

- A number of accomplishments have been made within a short time frame, including establishing the Contracted Service Delivery Office and the Contracted Service Delivery Decision Framework. The framework provides details on the roles and responsibilities at all levels of the organization (e.g., operations, working groups, leadership, etc.) at each stage of the Request for Proposal (RFP) procurement process. As AHS prepares to launch a number of significant RFPs, it is important to have clear decision processes to ensure timely and appropriate approvals.

In 2019, AHS collaborated with Alberta Health to develop the Alberta Surgical Initiative (ASI) to increase system capacity and reduce surgical wait times to clinically-appropriate timeframes. The COVID-19 pandemic not only delayed implementation of ASI strategies but also required AHS to postpone elective and non-urgent surgeries in March 2020, further contributing to growing wait lists.

AHS contracts services with multiple chartered surgical facilities (CSFs) to provide publicly-funded surgical services in private facilities. The use of CSFs enables AHS to obtain additional services which improves surgical access, reduces wait times and alleviates capacity pressures within AHS’ main operating rooms. Contracts with CSFs also provide increased choice of service provider for patients and supplement the resources available in hospitals while providing good value. Expanding CSFs is a priority initiative and work is on track to expand ophthalmological and orthopedic surgical procedure contracts.

Workforce Efficiency

Since 2016, Operational Best Practice (OBP) has been benchmarking program areas with comparable counterparts, inside and outside Alberta, to understand variation in labour and supply expenditures to find efficiencies. OBP is now embedded within the Sustainability Program Office which will enable effective scale and spread of best practices across the organization.

Innovating Back Office Functions

Work is underway innovating AHS’ “back-office” functions. This work was accelerated by COVID-19 which required Human Resources (HR) functions that could support large-scale onboarding of additional employees to support pandemic response efforts. The Robotic Process Automation initiative established a centre of excellence to support this work. The focus in 2020-21 was on HR functions, and planning is underway to prioritize new automations that will provide the greatest benefit.

Acute Care and Emergency Services

The COVID-19 pandemic has placed high demands on acute services; in particular, intensive care and inpatient hospital beds. Despite these pressures, resources remain in place to deliver care to Albertans where and when they need it most. AHS continues to monitor emergency department (ED) visits and wait times to ensure patients are receiving timely and appropriate care.

In 2020-21, ED wait times at Alberta's busiest sites improved compared to previous years. Wait time reductions are likely attributable to decreased ED visit volumes during the pandemic. Reduced demand may be an indication of the effectiveness of virtual care strategies that aim to keep non-urgent patients away from emergency departments during the pandemic. These reductions could also suggest that fewer people require emergency care due to decreased movement and interaction as a result of public health measures, or that some Albertans are waiting longer to seek care for medical emergencies, which might lead to worsened health outcomes. AHS will continue to monitor these trends carefully.

AHS' community-based Urgent Care Centres (UCC) meet the urgent medical care needs of patients who do not require emergency hospital-based care. UCCs provide services to people who have unexpected but non-life-threatening health concerns that usually require same-day treatment, including broken bones, sprains, lacerations, asthma, dehydration, pain and infections. Urgent care services fill the gap between physician offices and hospitals by expanding system capacity, improving access and providing an alternate level of service delivery.

AHS implemented improvement initiatives that aim to reduce avoidable admissions, length of stay and alternate level of care (ALC) days at facilities across the province.

- Virtual Hospitals deliver acute care services in the home for individuals with low-acuity medical conditions or chronic or complex diseases. Supports enable patients to return home sooner after an acute admission, or avoid a hospital visit altogether.
    - The Edmonton Zone Virtual Hospital expanded services in 2020-21 to include surgery patients, in addition to existing ambulatory, medical, cardiac and pulmonary patients. Data continues to show significant decreases in acute readmissions and ED visits for patients receiving care through the Virtual Hospital program.
    - The Complex Care Hub in Calgary identifies emergency department patients who present for non-urgent treatment and provides a choice to receive daily care in their home instead of staying in hospital. In 2020-21, services expanded to offer virtual inpatient care to proactively manage health conditions to keep patients safely at home.
- Crisis Response Teams support clients presenting through emergency departments for urgent addiction and mental health intervention. In 2020-21, services were enhanced at three North Zone facilities (Grande Prairie, Fort McMurray and St. Paul), including extended hours of operation, improved transitions in care and standardized processes to improve access to addiction and mental health services. By connecting patients with community supports, AHS will improve patient experiences and outcomes while reducing acute system pressures.
- The RAAPID (Referral, Access, Advice, Placement, Information & Destination) program provides a single point of contact for healthcare providers to access consultation advice and transfer patients between care environments based on acuity. In 2020-21, South Zone teams began discharge planning upon admission to ensure patient and care team input is considered, which can lead to better patient outcomes and shorter lengths of stay.
- Central Zone launched a new program that provides intensive mental health treatment supports for youth and their families. Step Up Step Down involves patients and families in treatment planning decisions and can be accessed as an inpatient or outpatient service. Since launching in January, five patients have been accepted into the inpatient program, and eight clients have been accepted as outpatients, resulting in fewer acute admissions for this patient population.

Emergency Medical Services (EMS)

In collaboration with the Ministry of Health and Population & Public Health, Community Paramedics provided more than 2,000 COVID-19 tests for vulnerable populations in the community, including persons experiencing homelessness, and those with physical and developmental disabilities unable to access provincial assessment centres. Enhanced care protocols were put in place for COVID-19 patients as new evidence emerged to ensure the proper level of care was provided based on assessed need.

Alberta is home to the only Stroke Ambulance in Canada. The custom-designed ambulance is equipped with life-saving stroke interventions to provide the best opportunities for full recovery. The specialized, multidisciplinary team was dispatched approximately 12 times per month in 2020-21. A promotional awareness campaign was launched to increase physician and emergency department awareness of the program to ensure appropriate utilization of the service to improve patient outcomes by delivering timely stroke assessment and treatment.

Community Paramedics have additional training and education to provide safe, timely, mobile medical care in the community setting.

- EMS Community Response Teams are equipped to safely provide diagnostics and treatments in a patient's home which improves patient experience and outcomes while reducing the need for EMS transport and emergency department visits. In 2020-21, more than 16,700 Albertans were treated in their home through the Mobile Integrated Health Assess, Treat and Refer program.

- EMS Mobile Integrated Health supported the validation of new provincial COVID-19 testing devices by facilitating specimen collection from positive COVID-19 patients in the community for comparison against current lab standards.

Alberta Surgical Initiative

In 2019, AHS collaborated with Alberta Health to develop the Alberta Surgical Initiative (ASI), a four-year plan to improve access to surgical care in Alberta. The goal of the ASI is to ensure that all Albertans receive scheduled surgeries within clinically-appropriate timeframes through the implementation of strategies across the patient journey that shape demand, manage capacity and optimize processes.

In 2020-21, AHS continued implementing ASI strategies to improve patient experiences before, during and after surgery.

- Throughout the pandemic, Alberta successfully performed all emergency and urgent surgeries. Large scale provincewide delays in scheduled surgeries were implemented during the first wave of the pandemic, with smaller scale, localized surgical slowdowns occurring during subsequent waves. These scheduled surgical delays created system capacity to respond to increased COVID-19 demand. Despite the pandemic and uncertain system pressures, AHS completed 92 per cent of 2018-19 total surgical volumes.

- The AHS Specialty Access Bundle is a consolidation of ASI projects related to improving patient safety, experience and flow between primary care, specialty care and back. The goal of the bundle is to ensure consistent experience for primary care and specialty care providers with equitable access and supports for patients across the province. The bundle will leverage progress made by existing programs and coordinate the implementation of several projects being led by Alberta Health, AHS and the Provincial Primary Care Network Committee including specialty advice, electronic referrals, central access and triage, and pre- and post-surgical care.

In June 2020, AHS developed the Surgical Recovery Plan which outlined targeted activity and wait list goals, supported by ASI strategies, aimed at accelerating activity and improving efficiency. The recovery plan was further updated in early 2021 to incorporate the impacts of the second wave of the pandemic, targeting recovery throughout the 2021-22 fiscal year. Alberta is not alone in requiring a period of surgical recovery; a review of other Canadian jurisdictions indicated increases in surgical wait lists across the country, with estimated recovery timeframes between 12–24 months following Wave 2.

Through mitigation efforts, AHS has achieved a level of wait time reduction and stabilization throughout the course of the pandemic. In February 2020, 68,000 Albertans were waiting for surgery, with 60 per cent of those patients waiting within the clinically-appropriate time target. Following the first wave of the pandemic, approximately 77,000 patients were on the wait list with 40 per cent waiting within the clinically-appropriate time target. As of March 31, 2021, approximately 70,000 patients were waiting for surgery, with 50 per cent waiting within the clinically-appropriate time target as a result of concentrated recovery efforts.

Primary Health Care

Primary healthcare is the foundation to building healthier communities and a strong, sustainable healthcare delivery system. Primary care includes all the services received for basic, everyday health needs, including the initial care, treatment and follow-up of various conditions, as well as referrals to the rest of the health system when needed.

In collaboration with Alberta Health, AHS continues to support improving patient attachment across the province. The Central Patient Attachment Registry (CPAR) is a provincial system that shows the relationship between a primary provider and their patients. CPAR improves continuity of care by promoting stronger relationships between members of a care team, improving information-sharing and enhancing care coordination. As of March 31, 2021, 122 clinics are using the system to provide better patient care.

- In 2020-21, AHS worked with primary care providers and Alberta Health to develop a provincial strategy for physician notification of positive COVID-19 lab results for their patients. This involved the expanded use of CPAR which improved patient care by enabling over 40 per cent of positive results to be automatically sent to the appropriate primary care provider, compared to seven per cent at the beginning of the pandemic. This improvement reduced the potential for gaps in care related to the management of COVID-19 patients in the community.

A COVID-19 Safe Discharge Checklist was developed to improve continuity of care between primary care providers, public health and acute care providers. The checklist helps patients feel confident to manage their health after a COVID-19 acute care admission and follows the principles of patient-centred care.

In 2020-21, AHS worked with primary care providers to develop adult and pediatric COVID-19 care pathways to provide a consistent approach for primary care providers caring for patients who present with symptoms of, or test positive for, COVID-19. Calgary, Central, Edmonton, and North Zones adopted the pathways as a tool for care providers who are navigating unprecedented new care challenges. Scale and spread continues across zones and care areas.

Primary Care Networks (PCNs) are the most common model of primary healthcare delivery in Alberta. PCNs are groups of doctors working together with teams of healthcare professionals, such as nurses, mental health professionals, dietitians and pharmacists, to meet the primary care needs of people in their communities. In 2020-21, the Provincial PCN Committee provided advice to the Minister of Health on issues relating to PCNs and supported the implementation of initiatives that advance provincial and government priorities and strategic directions, including the patient's medical home, access to continuity values and strategies, care transitions, community information integration (CII) and CPAR adoption, and ASI Specialty Access Bundle integration.

Connect Care is the AHS provincial electronic clinical information system that houses all information needed to support care.

- This year, AHS initiated a sequenced launch of Provider Portal which provides physicians who do not use the Connect Care system with some level of access to information and services. In 2020-21, four primary care clinics piloted the onboarding process and provided suggestions for improvement.

- AHS continued to provide e-mail and website information to non-AHS community providers via the Connect Care Provider Bridge to support communication and information sharing as more geographic areas across the province become Connect Care enabled. Effective communication aims to support improved patient experience and health outcomes.

Dr. Chris Sikora and his family getting their flu shots at West Jasper Place Public Health Clinic in Edmonton. Photo by Evan Isbister/AHS.

Seniors and Continuing Care

Most continuing care sites across the province experienced COVID-19 outbreaks in 2020-21. Sites were supported to respond to emerging challenges while maintaining safe, quality care for residents.

- All AHS-funded sites are required to have emergency preparedness plans which provide guidance to staff in the event of an emergency, such as the COVID-19 pandemic. These plans allowed for timely revisions specific to COVID-19, including updated procedures, protocols and safety orders, which enabled sites to respond confidently and efficiently as new information and evidence emerged.

- AHS and Alberta Health conducted frequent site assessments and quality-monitoring visits to ensure care standards were maintained and resident quality of life was maximized, even under the difficult circumstances. Communication and collaboration with sites was a critical success factor supported by regular cross-functional calls, a rapid response telephone line and transparent information sharing.

To provide excellent healthcare experiences and to meet the needs of Alberta's growing and aging population, AHS strives to provide Albertans with care where they want it most: in their homes and communities.

- In partnership with Alberta Health and AHS Contracting, Procurement & Supply Management (CPSM), Provincial Seniors Health & Continuing Care teams identified community congregate living locations across Alberta and the number of daily staff working at these sites to ensure adequate supply of masks and other PPE could be expedited to protect the staff that care for vulnerable Albertans in the community and reduce the spread of COVID-19. AHS helped distribute masks and other PPE to the more than 45,000 staff that work in long-term care (LTC), designated supportive living (DSL), residential addiction and mental health facilities, other supportive living and lodge locations, residential group homes and home care programs across Alberta every day.

- Provincial Seniors Health & Continuing Care continues to provide regular, detailed reports regarding outbreak activity at LTC and DSL sites. AHS assisted in the development of the vaccination prioritization approach for this patient population and worked with the AHS Vaccine Task Force, zones, Provincial Population & Public Health and Information Technology to facilitate and expedite vaccination appointments for eligible continuing care and home care residents and staff in Phases 1 and 2 of Alberta's vaccination rollout strategy.

In collaboration with community partners and agencies, new activities and services were developed to address needs that have emerged as a result of increased social isolation for individuals living with dementia in community.

- Village Improv for Alzheimer's (VIA) is an innovative approach to person-centered dementia care that fosters self-expression and social engagement through improvised theatre and storytelling. The program was designed to preserve dignity and autonomy, validate perception and reality, incorporate personal identity and life experiences, and focus on failure-free experiences that highlight participants' strengths and aptitudes, not disease or preserving memory. A training manual is in development to share tools and skills with caregivers, occupational therapists, and other Albertans who engage with people living with dementia. In 2020-21, adjustments were made to incorporate public health guidelines and pandemic measures, including finding opportunities to interact virtually.

- In South Zone, the Creating Conversations: A Dementia Activity Toolkit project will adapt a toolkit originally developed in Scotland for persons with dementia, then pilot and evaluate it in Alberta. The purpose of the toolkit is to reduce social isolation for persons with dementia by providing activities to increase communication between client and caregivers. The toolkit uses gardening-based activities to provide a fun, multi-sensory experience that encompasses physical, cognitive, emotional and social elements. In 2020-21, education webinars were provided virtually and new sessions were developed on social isolation and other COVID-19-related topics.

- In Calgary Zone, the YouQuest program is dedicated to supporting people with young-onset dementia (diagnosed under 65 years) who are often too young to gain value from programs designed for the elderly. YouQuest fills a gap in services by creating a place of belonging in the community for Calgarians living with young-onset dementia and their families. Recreation therapists and dedicated community volunteers support participants in individualized activities based on personal interests, strengths and abilities. Participants enjoy a full, active day with peers, giving respite to care partners to manage work, family life and their personal health.

- In Central Zone, Opening Minds through Art uses proven art therapy principles to enhance the quality of life of people living with dementia by placing the participant at the centre of the art process. The program pairs each participant with a dedicated local volunteer, many of whom are nursing students, who learn how to work at a respectful distance and develop enhanced skills to care for people living with dementia. Supported by a safe, fail-free environment, participants are empowered to make manageable decisions at each stage of the art process. In 2020-21, the program instituted telephone check-ins with participants and distributed wellness gift bags that contained information, resources, games, crafts and goodies.

- In Edmonton Zone, the Dementia Friendly Transportation project adapted existing transportation services to be tailored to the needs of people living with dementia. Compassionate volunteer drivers provide safe, accessible and affordable transportation to allow participants to stay active within their communities for as long as possible. Volunteers are trained to address common challenges using patient-centered care principles and are given the skills required to facilitate meaningful socialization with participants to enhance overall experience. In 2020-21, sanitizing kits were provided to all volunteer drivers and weekly calls and virtual newsletter were distributed to socially-isolated participants.

- In North Zone, the Dinner Club program enables adults, particularly vulnerable seniors and those affected by dementia and their caregivers, to get together regularly for a meal and entertainment. Participants enjoy face-to-face socialization and educational opportunities that promote healthy aging in the community. Caregivers are provided with information related to care and community resources, and are offered respite while their care recipient is engaged in planned activities with peers.

Home Care Services

Home care provides personal and healthcare services to help clients remain well, safe and independent in their homes for as long as possible. This past year, AHS began developing a strategy to improve the delivery of home care services, including implementing system-wide case management practices and leveraging virtual technology options where possible.

Home care services are provided by AHS or by contracted home care providers. In 2020-21, AHS began the process of optimizing home care contracts to improve standardization and accountability. Changes will ensure that client-centred care is provided in a consistent, efficient and sustainable manner, regardless of service provider.

The COVID-19 pandemic created limitations in home care service delivery. AHS implemented changes in service hours, offerings and processes to reduce the risk of virus transmission as well as accommodate surge capacity planning. At the end of March 2021, AHS had restored capacity to near pre-pandemic levels for clients living in the community. Many clients have continued with reduced services for a variety of reasons, including wanting fewer people in their homes.

Continuing Care Services

Alberta, like many provinces across the country, experienced COVID-19 outbreaks at continuing care sites that required unique strategies to monitor and manage. Protecting high-risk populations, such as the residents and staff at continuing care facilities, remains a priority for AHS.

- AHS assisted in the development of the COVID-19 vaccination prioritization approach for continuing care sites across the province. As of March 31, 2021, 90 per cent of continuing care residents had received at least one dose of vaccine.

- Identifying risk factors for virus transmission, such as shared spaces, helped AHS proactively implement control measures to support safe environments for residents and staff. An assessment of continuing care accommodations identified approximately 6,800 spaces where more than one resident share a room and bathroom. Future planning efforts will account for enhanced safety considerations.

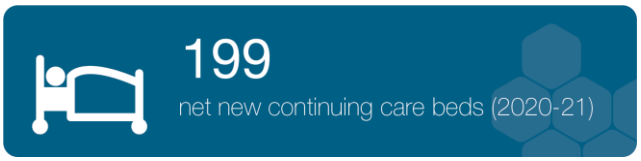
In Alberta, designated supportive living (DSL) beds allow residents more independence and privacy with health and personal care supports available on-site, while long-term care (LTC) beds support individuals with complex health needs that cannot be met at home or in supportive living.

- In 2020-21, AHS began exploring opportunities to transition LTC beds to DSL beds to better align service levels with population needs. AHS also plans to offer seniors and persons with disabilities more options for quality accommodations that suit their lifestyle and healthcare service needs.

- Edmonton Zone is enhancing the utilization of Nurse Practitioners (NPs) in the community across a variety of settings, providing services that prevent transfers from community to acute care when possible. Continuing Care NPs have proved to be invaluable during the pandemic, particularly at facilities with limited on-site health staff (e.g., supportive living sites). The provision of medical support by NPs enabled clients and residents to remain in their own homes and receive care in place. This improved client experience and reduced client transports and acute care utilization.

To keep pace with population growth and aging, AHS needs to continue to increase community capacity. In 2020-21, AHS added 199 net new continuing care beds to support individuals who need community-based care and supports.

Three new continuing care facilities also opened in 2020-21: Cambridge Manor (Calgary Zone), Oki House (Calgary Zone) and Diamond Spring Lodge (North Zone). New long-term care spaces were also added at the Grande Cache Community Health Complex in North Zone. Improving the availability of appropriate continuing care spaces will contribute to decreased waitlists and reduced emergency and acute care utilization.



In response to COVID-19, assessment and placement practices were restricted and vacant spaces were unable to be filled in continuing care facilities experiencing an outbreak. These restrictions negatively impacted community placement goals.

Registered respiratory therapist Heather Mughal with patient Gail Kidd at AgeCare Walden Heights in Calgary. Photo by Leah Hennel/AHS.

Continuing Care settings across Alberta were facing critical staffing shortages due to outbreaks of COVID-19 and restrictions put on staffing and visitation. In collaboration with Manpower Staffing Services, more than 930 Comfort Care Aides were hired and deployed to continuing care facilities across the province.

Comfort Care Aides provided assistance for a range of needs, including companionship, enrichment activities, assisting with mobile communication devices to support engagement with families and loved ones, and assisting with basic personal care, cleaning and screening.

Addiction and Mental Health

Addiction and mental health (AMH) conditions involve a complex interplay of genetics, personality, childhood experiences, trauma and social determinants of health. These factors result in a diverse range of needs that require comprehensive, culturally-appropriate, well-coordinated and integrated services within AHS and with partner organizations and ministries. Using a recovery-oriented approach, AHS empowers Albertans experiencing substance use and mental health issues to use their strengths and skills to live the life they choose by respecting their choices, autonomy, dignity and self-determination.

Access to Services

Timely access to addiction and mental health services helps Albertans address health issues as early as possible to avoid escalation and the need for more complex levels of service.

In 2020-21, AHS added 58 net new addiction treatment beds across the province through contracted service providers. A process is underway for additional withdrawal and detoxification services, residential addiction treatment services and residential recovery services, as well as youth and young adult services.

Through the Outpatient Services Redesign initiative, Calgary Zone developed a supportive discharge planning process to facilitate the transition of long-stay addiction and mental health patients to the community. Process improvements have enhanced flow through clinics, resulting in a six per cent decrease in service wait times. Many services transitioned to a virtual format early in the pandemic with in-person care offered to clients in the community when required.

Virtual mental health supports helped keep Albertans safe and well during the COVID-19 pandemic. Photo author unknown.

The Virtual Psychiatry Consultation pilot project in North Zone provides assessments via telehealth for patients presenting with addiction and mental health concerns in remote communities. Through the provision of virtual consultation, patients and families can be effectively engaged in care planning processes and can reduce unnecessary travel to the closest inpatient unit. Project evaluations are ongoing with early results showing improved patient satisfaction and efficiencies related to service utilization.

In 2020-21, Central Zone piloted a virtual care delivery model for the Psychosocial Rehabilitation Program and Concurrent Disorders Program, which were historically offered as inpatient programs. An evaluation of the Virtual Connection Program demonstrated the program's feasibility and appropriateness. Clients were very satisfied with their experience and noted that group sessions were relevant, welcoming and provided lots of opportunities to participate. A full inpatient program will continue to be offered as well as continued virtual programming.

The Level of Care Utilization System (LOCUS) provides AHS clinicians with a standardized way to determine the level of service intensity that a client requires. The system aims to improve service matching based on need, improve system navigation and care transitions, and improve the overall experience of clients and families. LOCUS is being implemented across the province and will be integrated with the Connect Care system.

User fees are one barrier to accessing services. High costs prohibit many Albertans who earn too much to qualify for income support, but not enough to pay privately, from accessing treatment. In 2020-21, fees for publically-funded residential addiction treatment services were eliminated in Alberta. This change allows teams to focus on treatment and recovery and supports improved health outcomes for patients needing care.

Child and Youth Services

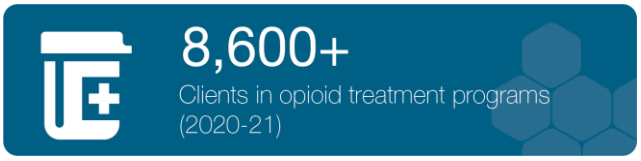
Best practice literature demonstrates that mental and emotional well-being can be developed, nurtured and supported through promotion and prevention efforts.

The Mental Health Capacity Building (MHCB) program, which uses schools as operational hubs, aims to promote positive mental health in children, youth and families by providing the support required to implement programs that are locally planned and coordinated. In 2020-21, virtual programming was launched and AHS continued to support paper forms for those without computer access. To date, the program has reached more than 183,000 students in 193 communities across Alberta.

The *Protection of Children Abusing Drugs Act* (PChAD) is an Alberta law that helps children under the age of 18 whose use of alcohol or drugs will likely cause significant psychological or physical harm to themselves or others. One of the ways AHS supports this high-risk group is by providing a 10-day inpatient program aimed at detoxifying, stabilizing and assessing each patient to ensure appropriate supports are in place to facilitate a successful discharge. In 2020-21, admissions to the program (474) decreased by 25% compared to the same period last year (630) due to COVID-19 bed closures which impacted placement practices. The average wait time remained stable at one to two days.

Opioid Response

Responding to the opioid crisis remains a priority in Alberta. More than 1,100 Albertans died of opioid poisoning in 2020; the highest number ever recorded. AHS is committed to reducing the harmful effects of substance use through expanded and enhanced addiction programming, including improved access to treatment and increased public awareness and education.



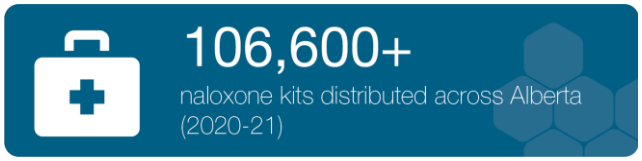
- Opioid Dependency Programs (ODP) provide medical outpatient treatment to clients dependent on opioids. Treatment often includes the administration of methadone or buprenorphine/naloxone, medications commonly used to treat opioid addiction. As of March 31, 2021, the program had 5,514 active clients. AHS is working on enhancing psychosocial (mental, emotional, social and spiritual) supports for patients in these programs.

- The Virtual Opioid Dependency Program (VODP) uses technology to serve clients in smaller communities. The program provides same-day access to medication starts and transition supports for moves between care settings such as emergency departments, detoxification centres and corrections facilities. In 2020-21, the program served approximately 3,000 clients. VODP continues to demonstrate growth and can be accessed from any location in the province.

- Injectable Opioid Agonist Therapy (iOAT) programs prescribe injectable medications that are self-administered under clinical supervision to treat opioid addiction. As of March 31, 2021, the program had 88 active clients. Future iOAT services will be transitioned into ODP programs in Calgary and Edmonton where existing iOAT clients will continue to receive treatment.

Distribution of naloxone kits remains an effective strategy to address the opioid poisoning crisis. Naloxone is a medication that is administered to temporarily reverse the effects of an opioid overdose and allow time for medical help to arrive.

- In 2020-21, the number of voluntarily reported overdose reversals, where naloxone was administered to reverse effects of an opioid overdose (9,681), increased by 43 per cent compared to the same period last year (6,749). This year, more than 106,600 community-based naloxone kits were dispensed by AHS, the Alberta Community Council on HIV agencies, community pharmacies and other community organizations across the province. In addition to regular distribution, AHS provided kits to temporary shelters that were established as part of the COVID-19 response.



- Pharmacists play an important role in the wellness of patients, friends and family impacted by substance use and are key partners of the Community Based Naloxone (CBN) Program. In 2020-21, three new on-reserve and reserve-owned pharmacies began participating in the CBN Program. These pharmacies will help support access to harm reduction tools and information in Indigenous communities across the province.

- Emergency Department (ED) visits related to opioid use disorder (OUD) and addiction continue to rise in Alberta. Buprenorphine/naloxone is a medication that reduces opioid cravings and withdrawal symptoms.

    - The Emergency Strategic Clinical Network™ (SCN™) supported the implementation of a program to appropriately screen emergency department patients for OUD, initiate treatment and provide rapid follow-up in the community. By September 2020, all 110 EDs and urgent care centres across the province had implemented the program.

    - Evaluation data was collected from 21 emergency departments. Between May 2018 and December 2020, more than 1,900 patients were initiated on the medication. Of these patients, 1,288 were eligible for community follow-up, and 69 per cent of community follow-up patients continued to fill a prescription 30-days after their initial ED visit.

In 2020-21, South Zone activated a mobile Overdose Prevention Service that provides supervised consumption services and clinical connections to recovery-oriented services such as detoxification, and social and treatment services. The program averaged 120 visits per day with 100 unique clients demonstrating regular use of the service.

In Calgary, EMS and AMH provincial teams supported the development of the Digital Overdose Response System to address overdoses that take place while using alone. The mobile application will alert emergency responders if an individual becomes unresponsive to a pre-set session timer. The program launched on March 23, 2021.

Pandemic Supports

Demand is increasing for essential AMH supports and services as a result of the COVID-19 pandemic. AHS is working collaboratively with partners to address the needs of affected populations and communities and to lessen the broader psychosocial impact on Albertans.

- AHS offers interactive workshops to the public on resilience and stress management. Led by certified professionals, participants learn about the impact of emotions on the body and develop skills to address stress through communication, decision-making and basic breathing techniques. In 2020-21, 70 workshops were completed by nearly 3,000 participants. Participant evaluations showed that 87 per cent of respondents found the workshops informative and valuable and plan to use the techniques in their personal life.

- AHS partnered with Togetherall to establish a free, online peer-to-peer mental health community to empower individuals to anonymously seek and provide support 24/7. Members have access to a variety of clinically-validated, self-guided resources and can also join group courses to learn alongside others interested in similar mental health topics. Clinical moderators monitor the platform to help keep members safe and direct users to available and appropriate resources provided on the platform, such as Health Link 811, the Mental Health Help Line and the Addiction Help Line. Since launching in October 2020, the platform has supported approximately 8,000 participants.

Text4Hope, an Alberta-based innovation, is an evidence-based tool that helps people identify and adjust the negative thoughts, feelings and behaviours a pandemic might be expected to provoke. Through a set of daily messages, people receive advice and encouragement that is helpful in developing healthy personal coping skills and resilience. The platform attracted more than 51,400 subscribers in 2020-21.

AHS developed information packages related to preventative considerations for alcohol and cannabis consumption during the COVID-19 pandemic, including cravings management and safe consumption practices. AHS also expanded family violence services in smaller community and remote areas across Alberta to protect the safety of vulnerable families. Information and resources can be found on AHS' Help in Tough Times website at www.ahs.ca/amh/page16759.aspx.

We all have stressful times at some point in our lives; we can be impacted by things such as financial pressures, unexpected difficulties, unemployment, or stressful situations such as the COVID-19 pandemic.

You are not alone. Support is available from AHS Addiction and Mental Health. Visit us online for information on topics such as:

- Substance use
- Depression and anxiety
- Promoting positive mental health
- Supporting a family member

Population and Public Health

Emergency Disaster Management

During a disaster, it is imperative to ensure that health services are available and accessible to support those who have been impacted. AHS supports disaster responses by focusing on sustaining continuity of patient care services and critical business operations necessary to ensure quality, safety and community resilience.

The AHS Emergency Coordination Centre (ECC) is activated for incidents like floods, wildfires and COVID-19, where significant communication and coordination is required between zones. AHS leaders and program areas work together to mobilize resources and make critical decisions when patients, communities and stakeholders need it most. A Zone Emergency Operations Centre (ZEOC) structure also exists to provide local support and implementation of provincial strategies.

The provincial Communicable Disease Emergency Response Plan (CDERP) defines the roles, responsibilities and strategies for AHS departments and services during a communicable disease public health emergency. The plan is intended to minimize serious illness and death during such an emergency. In 2020-21, the framework was updated to incorporate COVID-19 material. Twelve retrospective reviews of initial COVID-19 response efforts were conducted and identified areas that needed to be improved upon and successes that could be spread to other areas.

AHS remains committed to supporting local response efforts in the event of a community evacuation during a disaster, such as a wildfire or flood. In 2020-21, AHS developed a Community Evacuation Guidance document aimed at supporting community evacuations amidst a pandemic environment. The document recognizes that evacuations occurring during the COVID-19 pandemic require additional guidance and support including considerations for safe lodging, social service delivery and public health measure compliance.

Outbreak Management

AHS and Alberta Health continue to work with healthcare providers in all zones to ensure a consistent approach to disease outbreak reporting, notification and management. In 2020-21, AHS reported no cases of measles. As of March 31, no cases of seasonal influenza were reported during the 2020-21 influenza season which began in August 2020. The absence of cases in 2020-21, when compared to previous years, is likely attributable to reduced travel and public health measures to help reduce transmission of COVID-19 (e.g., wearing a mask, physical distancing, washing hands frequently). There were no outbreaks of either illness this year.

In 2020-21, AHS investigated 188 confirmed enteric outbreaks; symptoms common to an enteric outbreak include nausea, vomiting and abdominal pain. AHS also investigated 4,354 confirmed non-enteric outbreaks, a 561 per cent increase from the same period last year (659); examples of non-enteric outbreaks are chickenpox, measles and influenza.

- Non-enteric outbreak management in 2020-21 focused primarily on COVID-19 outbreaks across all levels and types of care facilities, group homes, childcare facilities, schools, workplaces, community-based organizations, events and private social gatherings. 74 per cent of non-enteric outbreaks in 2020-21 were related to COVID-19.

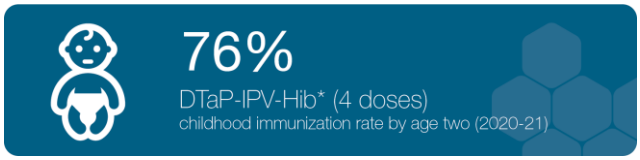
In 2020-21, AHS was a key participant in the investigation of the largest known Salmonella outbreak in Alberta's history. In total, there were 518 confirmed cases of Salmonella Newport illness linked to an outbreak in Canada, 57 per cent of which were in Alberta. AHS collaborated with food safety partners in Canada and the United States, contributing to the identification of the source. AHS teams worked quickly to identify and mitigate risks within healthcare settings.

Immunizations

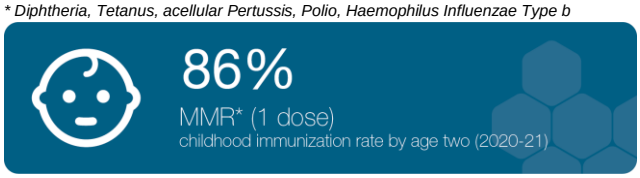
AHS collaborates with Alberta Health, patients, families and communities to improve the health of the population. This includes continuing our efforts to increase immunization rates to protect Albertans from a number of vaccine-preventable diseases.

Influenza immunization is the most effective way to prevent the flu and its complications. In 2020-21, AHS focused on increasing immunization rates for high-risk populations, including seniors, people experiencing homelessness and marginalized persons who are most at risk for morbidity and mortality due to influenza disease. During the 2020-21 influenza season, 1.65 million doses of influenza vaccine were administered. Approximately 37% of Albertans received the vaccine. The immunization coverage rate increased by 4.4% compared to last season.

While many public health resources were redirected to the COVID-19 response, AHS continued to provide infant and preschool immunizations. Clients were provided with immunization appointment reminders and communications emphasized the importance of continuing with routine immunizations for infants and children during the pandemic.



** Diphtheria, Tetanus, acellular Pertussis, Polio, Haemophilus Influenzae Type b*



** Measles, Mumps, Rubella*

Health Promotion & Disease Prevention

Approximately 30 per cent of Albertans report having at least one chronic health condition, and that number increases to over 75 per cent for those aged 65 years or older. Chronic conditions include things like diabetes, asthma, arthritis, obesity, dementia, high blood pressure, chronic obstructive pulmonary disease (COPD) and heart failure. Preventing and managing chronic conditions and diseases involves a coordinated system of supports across the continuum of care. In 2020-21, AHS continued to focus on the goals and strategies outlined in The Vision for Chronic Condition and Disease Prevention and Management, which aim to reduce the burden of chronic disease on Albertans and the healthcare delivery system.

Sexually Transmitted and Blood-Borne Infections (STBBIs) are a considerable cause of morbidity in Alberta. AHS continued to implement the STBBI Operational Strategy and Action Plan which aims to prevent infection and minimize the impact of infection on the well-being of Albertans. In 2020-21, a media campaign was released to increase awareness of the presence of STBBIs and the importance of primary and secondary prevention. Support was also provided to family physicians to promote opportunities for improved screening across the province.

Health screening is key to the early detection of risk factors or illness, enabling timely care planning and treatment. AHS Screening Programs are responsible for the coordination and operation of cancer and newborn screening programs.

- Cancer screening programs support Albertans in making informed decisions to reduce severe negative health outcomes. These programs follow the Alberta Toward Optimized Practice breast, cervical and colorectal cancer screening clinical practice guidelines which support high-quality and consistent care across the province.
- Newborn screening is the best way to identify if an infant has a screened condition before symptoms arise which supports early treatment and improved outcomes. The Early Hearing Detection & Intervention (EHDI) Program screens newborns for permanent congenital hearing loss, and the Newborn Metabolic Screening (NMS) Program uses newborn blood spot screening to test infants for 21 treatable conditions.

Public Safety and Injury Prevention

AHS expanded capacity to manage increased outbreak volumes in congregate living settings, where residents and clients receive care or services in a communal environment. In partnership with stakeholders across the system, AHS completed care audits, site assessments and reviewed COVID-19 control measures at all AHS adult congregate living sites to ensure risk factors were minimized through consistent application of improved safety processes.

Zones collaborated with government and community partners to protect and care for people experiencing homelessness during the pandemic. Hotel and event spaces were repurposed in Calgary and Edmonton to temporarily house individuals who required private rooms to self-isolate in order to reduce community transmission. By using rapid point-of-care testing, AHS was able to eliminate barriers associated with accessing standalone testing sites.

Environmental Public Health (EPH) works to keep public places safe, inform the public about health risks (e.g., unsafe water or housing) and ensure that the *Public Health Act* is being followed. EPH is a primary source of public health information, creating countless resources for home, businesses and communities to promote wellness across the province.

In 2020-21, EPH responded to more than 80,000 complaints and service requests; eight times the normal volume. Approximately 83 per cent of all requests was related to COVID-19. This year, more than 440 Orders were issues by AHS Public Health Inspectors, including nearly 100 Closure Orders related to COVID-19. Public Health Inspectors also observed more than 27,800 *Public Health Act* violations, approximately 6,000 of which were related to COVID-19.

- AHS' Safe Healthy Environments teams worked together to address internal workplace hazards associated with the high numbers of complaints and Orders by updating hazard controls to mitigate physical and psychological risks to staff.

Public Health Inspectors worked alongside Medical Officers of Health to help reduce the spread of COVID-19 by enforcing provincial and regional Health Orders. EPH teams conducted facility and site assessments and also assessed risks within places of worship, retail business and gyms.

Indigenous Health

Indigenous Peoples living in Alberta, many of whom live in smaller communities and remote areas of the province, have poorer health outcomes than non-Indigenous Albertans. This disparity becomes even more concerning during times of crisis, such as the COVID-19 pandemic.

Engaging and collaborating with Indigenous communities and organizations formed the foundation of AHS' COVID-19 response. Engagement efforts included participation in pandemic response meetings, issue identification and resolution within provincial programs and collaboration to take purposeful and coordinated action.

- In addition to coordinating community access to personal protective equipment and supporting isolation and testing requirements, AHS supported proactive community response activities by ensuring community readiness and consulting on surge capacity planning.

- Physicians from AHS' Indigenous Wellness Clinic worked with Indigenous communities to support their COVID-19 responses. Work included providing clinical and virtual care services to meet the health needs of Indigenous Peoples in urban, smaller and more remote communities, including the Peerless Trout First Nation, Enoch First Nation, Alexander Cree First Nation, Peavine Métis Settlement, Gift Lake Métis Settlement and East Prairie Métis Settlement.

Indigenous Health Liaisons provide support and health information to healthcare providers and First Nations, Métis and Inuit patients, clients and their families. Services include case management, patient advocacy, cultural teaching, language interpretation, health literacy support and logistical support for discharge planning. In 2020-21, liaisons supported 15,185 patients and families across Alberta.

Natalie Creighton, Indigenous Health Liaison at Cardston Health Centre in South Zone. Photo by Leah Hennel/AHS.

COVID-19 limited the delivery of culturally-based services due to care site restrictions and risk factors associated with sweat lodges and smudge ceremonies. However, by the end of 2020-21, most sacred spaces had re-opened for individual and limited group smudge ceremonies. Additionally, most sites supported smudging in individual hospital rooms, or provided blankets and smudge pouches to provide emotional and spiritual comfort.

Health screening is one of the most basic tools of preventive medicine. It aids in early detection of risk factors or illness and enables more timely care planning and treatment.

- AHS Screening Programs, in partnership with the Alberta First Nations Information Governance Centre, looked at outcomes of cancer screening in Alberta's First Nations population. Being able to link First Nations identifiers directly to cancer screening behaviours and outcomes is a first in Canada. A community gathering was held in 2020-21 to present the data and obtain community and Elder permission to share the findings. With support from community partners, work is now focused on addressing gaps in cancer screening, as identified in the analysis.

- The ECHO+ program aims to increase screening and supports for treatment of Hepatitis C and Sexually Transmitted Blood Bourne Infections (STBBIs) for Indigenous communities in Alberta. Extensive engagement took place in 2020-21, including a two-day virtual conference with 100 people in attendance. Panel discussions helped improve understanding of barriers and opportunities in communities across the province, and helped foster stronger relationships through shared experiences and collaborative problem-solving.

In 2020-21, AHS began developing an Anti-Racism Action Plan. More than 700 staff participated in an online survey and 150 participants joined five focus group sessions to provide feedback and insight. An Indigenous-specific focus group was also hosted and attracted 30 participants. Results from this engagement work will inform the foundation of the action plan.

AHS collaborated with national and provincial partners to launch the Alberta Indigenous Virtual Care Clinic (AIVCC) in October 2020. AIVCC provides same-day primary care services to First Nations, Métis, and Inuit patients and families through secure telephone or video interactions. The clinic can provide timely consultation on a number of concerns including allergies, health screening, home care supplies, palliative care, mental health and cognitive function, and sexual health, among others.

Information Technology

In 2020-21, enhancements were made to clinical information systems to support COVID-19 response efforts, including the addition of new COVID-19 order sets and lab items, consult and referral options, and surge bed management capabilities. The AHS Fit for Work application was also implemented to enable easy completion of a mandatory health assessment prior to entering an AHS facility. The application has been used by more than 100,000 users at a rate of approximately 15,000 uses per day.

AHS' Primary Health Care and Call Centre teams developed an online web tool for Health Link nurses to assess and triage callers based on COVID-19 symptoms, and submit information to book testing appointments. This process was originally completed on paper-based tools. The application was later enhanced for clinical and non-clinical COVID-19 vaccine calls. The application also allows nurses to capture adverse reactions and triage for follow-up care.

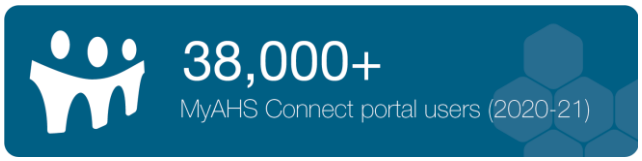
The Continuing Care Visitation Scheduler (CCVS) tool was developed to allow families the opportunity to schedule visits with their loved ones at AHS-owned and operated long-term care facilities. It allowed facility staff to manage scheduling in a manner that complied with mandatory health orders. The CCVS tool was implemented at approximately 40 facilities across the province in 2020-21, replacing paper-based processes which improved efficiency and allowed sites to plan for necessary sanitization, PPE and social distance.

Connect Care

Connect Care empowers Albertans to be at the centre of their healthcare team, supports access to personal health information, improves communication with care teams, standardizes care and improves outcomes across all areas of care delivery.

Connect Care is being implemented in multiple phases (waves) to minimize disruptions for patients and healthcare providers. Despite delays caused by the COVID-19 pandemic, AHS successfully launched Wave 2 of Connect Care at Edmonton Zone suburban sites in October 2020. Strategies were developed to ensure stability and site readiness during these uncertain times. AHS continues to prepare for future Connect Care implementation, with Wave 3 (North Zone) and Wave 4 (Edmonton and Calgary Zone sites) scheduled to launch in 2021-22.

As each Connect Care wave rolls out across the province, patients receiving care at enabled sites have the opportunity to access MyAHS Connect, which allows users to manage appointments, access test results and communicate directly with their AHS healthcare team. As of March 31, 2021, more than 38,000 Albertans have access to the system.



Accessing Your Health Information

Alberta Netcare, the provincial electronic health record, is a secure and confidential electronic system that enables health professionals to access real-time health information about patients and clients. Shared patient information leads to fewer tests, reduced adverse events and reduces the need for patients to remember and repeat detailed health information. As of March 31, 2021, 52,297 registered healthcare providers had access to the system, which is an increase of five per cent compared to the same period last year (49,578).

MyHealth Records is an online tool that lets Albertans see some of their health information from Alberta Netcare, including medications, immunizations and lab tests. In 2020-21, AHS added nearly 600 new lab test types, enabling users to view results for the most commonly ordered tests. As of March 31, 2021, approximately 565,000 Albertans have created an account.

Virtual Health

Being active participants in their own care helps Albertans better manage their personal wellness. AHS' virtual care strategy places patient needs and clinical appropriateness at its core. Prompted by the AHS Performance Review, Virtual Health teams facilitated consultation sessions with key stakeholders including patients, clinicians and healthcare leaders. Stakeholders identified clinical appropriateness, safety, privacy and security as the most important considerations for strategy development. These priority considerations were shared with care providers across the organization to support consistent virtual care delivery that meets patient and client expectations.

In response to the COVID-19 pandemic, AHS improved access to healthcare services through the expansion of virtual tools to meet the care needs of patients while adhering to public health recommendations. AHS supports virtual care encounters when clinically-appropriate and for those whom a virtual visit can effectively and safely replace an in-person visit. Virtual services also provide enhanced care options for people with limited mobility, those living in smaller communities and more remote areas, and for those in mandatory self-isolation.

- The COVID-19 pandemic and the concurrent economic downturn will have immediate and long-term effects on the mental health of many Albertans. Virtual AMH supports are available to help Albertans get the care they need, when they need it, no matter where they live. While in-person care is still available when required, supports can often be provided virtually, effectively decreasing travel and wait times. In 2020-21, approximately 50 per cent of all community AMH care was provided remotely (virtual and telephone).

Virtual hospitals utilize technology and integrated care teams to support and care for patients in their own homes while improving coordination across the healthcare delivery system. Care providers interact with patients and their community caregivers, by phone and video, to help manage problems before they become serious enough to require an acute care admission or emergency department visit.

- In 2020-21, virtual hospital patient populations expanded beyond general medicine to include surgery and respiratory patients. AHS is evaluating the use of this service delivery model in other areas of the province to improve access to care closer to home.

- In 2020-21, AHS implemented digital remote patient monitoring (RPM) for the Virtual Hospital in Edmonton Zone and Complex Care Hub in Calgary Zone. More than 400 patients in these programs used RPM to send general health information to care providers to support treatment decisions. Preliminary data suggests that emergency department admissions decreased by more than 35 per cent and acute admissions by more than five per cent, and demonstrated reduced hospital admissions and lengths of stay. RPM was also used to better monitor community COVID-19 patients at risk of declining health.

One way AHS supports appropriate distribution of care capacity across the province is through the use of telehealth. In 2020-21, the Maternal Newborn Child & Youth SCN™ initiated the Telehealth Rounding and Consultation (TRaC-K) model, which involves discussing patient care, or aspects of care, using telemedicine. Clinicians averaged two to five sessions per week providing sub-specialty, pre-transfer, pre-discharge, allied health and acute management consultations to support appropriate and timely discharge.

The COVID-19 pandemic has necessitated many ambulatory visits to take place virtually to decrease the risk of exposure and transmission to patients and providers.

- The Stroke Prevention Clinic at the University of Alberta Hospital in Edmonton decreased the wait time for all clinic appointments to zero, ensuring those at risk of stroke were examined in a timely manner. Clinicians and administrators continue to determine the best uses for virtual care based on emerging best practices.

- Tuberculosis (TB) is an infection caused by slow-growing bacteria that grow best in areas of the body that have lots of blood and oxygen. Treatment is often successful, but it is a long process. In 2020-21, virtual appointments replaced in-person visits which led to improved patient experience and continuity of care. Prior to adopting virtual care options, patients would have to attend a clinic up to five times per week for care.

Health Link provides a 24/7 provincial service to Albertans that includes nurse triage support, general health information and health system navigation assistance. In 2020-21, Health Link call volumes (2,291,243) increased by 157 per cent compared to the same period last year (891,931).

As part of the provincial COVID-19 response, Health Link introduced a number of new services:

- The AHS Rehabilitation Advice Line launched in Q1, providing free advice and information to Albertans living with disabilities in the community. The service offers activities and exercises that help with physical mobility, strategies to manage day-to-day activities, and connects clients to services and organizations that best meet their needs. In 2020-21, the Rehabilitation Advice Line averaged up to 60 calls per week totaling more than 1,800 patient interactions.
    - An evaluation of the service showed that more than 75 per cent of calls were related to pain. Therapists provided education and self-management advice to treat at home and nearly 40 per cent of respondents reported following the therapist's advice.
    - In 2020-21, there was a significant increase in the number of callers with post-COVID health conditions that persisted more than four weeks (called long COVID). The Rehabilitation Advice Line has become the central resource for patients requiring targeted rehabilitation related to COVID-19 and is providing high-quality, evidence-based interventions to help Albertans recover. A post-COVID-19 Rehabilitation Framework was also developed and released this year and includes pathways, screening tools and additional resources.
- The Coordinated Early Identification and Response (CEIR) Line launched in Q1 and provides support to operators of congregate living settings related to mandatory reporting of COVID-19 symptoms in staff and residents. The line provides guidance on situation management, procurement of personal protective equipment and reporting requirements. In 2020-21, CEIR received approximately 100 calls per day, totaling more than 25,100 calls from sites across the province.
- In Q1, AHS' Addiction and Mental Health team launched and operated the AMH Help Line during the initial stages of the COVID-19 pandemic. The team answered more than 10,000 calls before transitioning to Health Link in Q2. Since September 2020, more than 16,400 calls have been answered for assistance with information and resources, substance-misuse concerns and mental health concerns such as depression and anxiety.

811 Health Link
Health Advice 24/7

The availability of medical interpretation and translation has been a critical communication tool during the pandemic. Virtual interpretation and translation services are a high-quality, cost-effective alternative to in-person services and can be provided by phone or video anywhere in the province, which eliminates the risk of virus transmission.

- By adopting video remote services as the primary model for providing sign language interpretation, AHS has been able to effectively communicate with Albertans who are hearing-impaired across the province, including those in smaller communities who may not have had access to sign language translation in the past.
- The number of minutes of over-the-phone interpretation provided in 2020-21 (2.03M) increased by 48 per cent compared to the same period last year (1.37M). The number of patient care units using video remote interpretation (232) more than doubled compared to the same period last year (86) which increased service use by 143 per cent. In 2020-21, contact tracers made more than 7,000 calls to Albertans using phone interpretation services.

2.03 million
minutes of over-the-phone interpretation (2020-21)

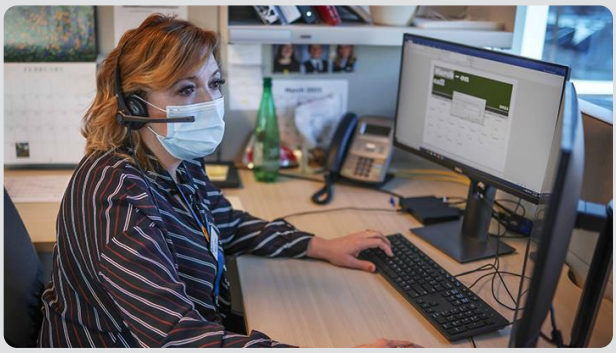


Photo by Leah Hennel/AHS.

Mary Ellen Hartmann, a registered nurse with Health Link, serves as a clinical manager with the COVID-19 response team; the team responsible for responding to questions about the virus.

"We help call people who need to quarantine, and we offer swabbing for sites with outbreaks. We also report newly symptomatic residents in group homes, shelters, day cares, schools, long-term care centres and designated and supportive living."

Cancer Care

Cancer remains a serious health issue and a leading cause of death in Alberta. Diagnosing cancer early is a complex process that requires a person to notice a persistent or worsening change in their body and seek medical attention. It also requires an assessment by a family doctor or another physician to investigate worrisome signs or symptoms with a series of tests and it requires the healthcare delivery system to provide timely access to these tests. The sooner this process starts, the better. Early cancer diagnosis results in less advanced disease, more effective treatment options, and better survival and quality of life outcomes.

- Care pathways promote organized and efficient patient care and are proven to reduce variation in clinical practice and improve patient outcomes and satisfaction. In 2020-21, AHS teams collaborated to develop new provincial cancer diagnosis pathways to expedite and support patients with suspicious symptoms or test findings. Implementation of the new colorectal cancer and lymphoma pathways are in progress. These pathways build on the success of existing lung and breast cancer care pathways.

Prior to the COVID-19 pandemic, the number of cancer diagnoses consistently increased by three per cent year-to-year. As a result of COVID-19, there was a decrease in the number of new cancers being diagnosed in Alberta. Diagnosis has since improved; however, overall diagnosis volumes for 2020 are approximately eight per cent lower than 2019 volumes.

- The resumption of primary care visits, community specialist services and AHS services in the latter part of 2020-21 helped to reverse the decline in cancer diagnosis. This trend is not unique to Alberta, but has been identified across Canada and in many other countries around the world.

The COVID-19 pandemic also significantly affected cancer screening in Alberta. The overall cancer screening volume in Alberta was reduced by approximately 35 per cent in 2020 compared to 2019. Screening programs continue to support communication with the public about the importance of cancer screening, including promoting the enhanced safety measures in place to keep patients and staff safe when accessing services during COVID-19.

- AHS continues to develop strategies to recover cancer screening and diagnostic follow-up to pre-COVID-19 levels, with a focus on timely access through optimized triage processes.

With the support of the Alberta Cancer Foundation, AHS initiated a public awareness cancer campaign to remind all Albertans about the importance of seeking medical care when something changes in their health status. Information can be found online at ahs.ca/info/Page17277.aspx.

Population & Public Health strengthened relationships with inpatient, ambulatory and community resources in support of smoking cessation for people with cancer. New resources focus on integrated screening, brief intervention, referral and treatment care pathways for patients with cancer. In 2020-21, virtual training modules and resources were developed to support piloting virtual Cancer QuitCore group programs.

A provincial collaboration between Cancer Care Alberta and Alberta's Primary Health Care Integration Network aims to support continuity of care for patients who are transitioning from specialist cancer care to primary care. AHS began developing an after-treatment care pathway that integrates wellness resources with required surveillance.

The Integrated Access to Cancer Screening project seeks to address the disparity in cancer screening participation in smaller and remote communities in Northern Alberta by implementing an innovative mobile service delivery model. Since its launch in December 2020, 189 clients in six communities have participated in the integrated screening service.

AHS worked in partnership with Indigenous communities and organizations to develop and implement community-led cancer prevention and screening projects across the province. Work included developing materials and care pathways that use Indigenous teaching methods to support education around cancer and chronic disease prevention and screening. Key success factors include relationships of support, sharing circles and mentorship opportunities between Elders and youth.

The Alberta Screening and Prevention (ASaP) program supports clinics to proactively offer preventive cancer screening to all patients. In 2020-21, the Indigenous Health SCN™ supported three Indigenous primary care sites to implement the ASaP model (Saddle Lake Cree Nation, Edmonton Indigenous Wellness Clinic, and Siksika Nation). Early program evaluation results demonstrated improved clinical processes, and higher rates of body measurements (height, weight and blood pressure) and additional screening (diabetes, colorectal cancer, Pap test and tobacco use).

Indigenous Cancer Patient Navigators (ICPNs) support Indigenous Peoples who are experiencing cancer and receiving treatment in Alberta, including people from the Northwest Territories. ICPNs are intended to help minimize cultural, geographic, historical and other barriers to care, and serve as a bridge between the individual, community supports and the cancer care team. Monthly multidisciplinary patient rounds build capacity and empathy within cancer care teams and empower staff to provide culturally-safe care. The program received 76 referrals in 2020-21.

In 2020-21, progress continued on capital projects to improve infrastructure that will be necessary to support future capacity needs.

- The Calgary Cancer Centre project remained on time and on budget. As of March 31, 2021 construction was approximately 95 per cent complete and operational readiness planning was well underway with many of the programs and services that will be moving into the new facility. The new healthcare facility and academic centre will provide cancer services in southern Alberta.

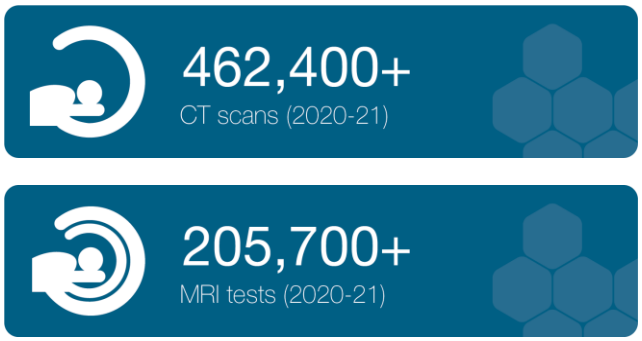
- Construction on the Grande Prairie Cancer Centre was substantially completed in 2020-21 and the building was turned over to AHS in June 2020. Large equipment installations and commissioning has begun. The cancer centre is part of the new Grande Prairie Regional Hospital project.

Kelly Cook received her last round of chemotherapy at the Tom Baker Cancer Centre in Calgary in May 2020. Photo by Leah Hennel/AHS.

Clinical Support Services

Advanced diagnostic imaging (DI) tests, such as CT scans and MRIs, have dramatically changed the way patients are diagnosed and treated. While wait times for patients in hospital or emergency departments are stable and within clinical wait time targets, wait times for outpatients referred for a CT or MRI scan are outside of clinically-approved guidelines.

- In 2020-21, AHS and Alberta Health developed the Diagnostic Imaging Action Plan which aims to address long wait times to ensure people who most need results for treatment decisions will get scans in an appropriate timeframe. The action plan includes strategies to better manage demand by reducing unnecessary exams, and to decrease costs per exam. Implementation work will be informed by data to more accurately estimate where demand pressures will occur and deploy resources to respond efficiently.

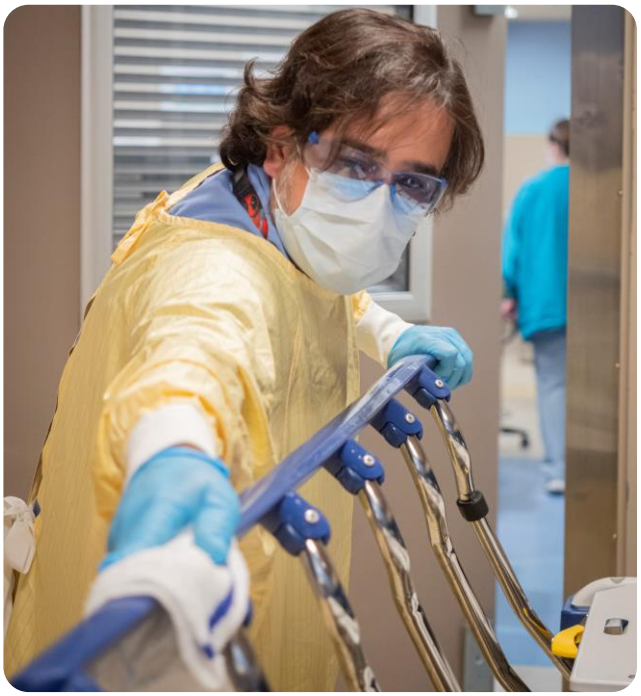


- In 2020-21, teams developed service continuity plans and cleared the backlog of DI referrals that were postponed during the peak of the pandemic. AHS continued to provide imaging services for patients with emergent and urgent needs and expanded capacity to include priority patients as part of the Alberta Surgical Initiative.

Pharmacy services are a critical component of COVID-19 response efforts. Pharmacists and pharmacy technicians supported vaccine preparation and administration, including ensuring immunization clinics had the supplies needed to effectively respond to adverse reactions, such as anaphylaxis. AHS provided epinephrine anaphylaxis kits to Public Health immunization clinics to improve safety and patient experience.

The AHS Equipment Cleaning Program provides a defined set of parameters, cleaning methods and frequencies to support the highest standards of quality and patient safety. This program helps to reduce the transmission of organisms from patient care environments and shared patient equipment. In 2020-21, AHS introduced surveillance for patients with COVID-19 to ensure proper precautions were in place. On-call and after-hours equipment cleaning services were expanded to support zones when demand increased during peak infection periods.

AHS introduced enhanced cleaning practices across the province to reduce the risk of virus transmission. High-touch areas that were cleaned once per day pre-COVID-19, are now cleaned three times per day. Linen inventory levels and privacy curtain change-out schedules were also adjusted as required. Sites that implemented efficiency initiatives were able to support effective patient flow in emergency departments, despite seeing increased demand for isolation cleanings of up to 800 per cent.



Care environment cleaning at Royal Alexandra Hospital in Edmonton. Photo by Evan Isbister/AHS.

Infection Prevention and Control (IPC) teams supported continuing care and acute care facilities during more than 300 COVID-19 outbreaks across the province in 2020-21. IPC developed hundreds of documents in support of the provincial pandemic response, including policies and procedures to support workforce questions on topics such as proper use of PPE, airborne virus precautions and symptom screening. Safety training was also provided to alleviate concerns related to COVID-19, PPE and outbreaks.

Protective Services implemented improvements to the AHS violence prevention model to ensure the safety of patients and staff, including conducting additional threat assessments, facilitating security reviews at proposed vaccine storage sites, implementing personal safety plans

and liaising with external agencies such as local police. A Safety Ambassador Program was also developed to assist with COVID-19 screening protocols for designated support persons, and to control facility access to mitigate increased incidents of violence at AHS sites.

Correctional Health Services began expanding the provision of opioid agonist therapy at all adult Alberta Provincial Correctional and Remand Centres in 2020-21. Program enhancements will increase the number of individuals receiving treatment and counselling for opioid use disorder. This project also focuses on supporting the transition of individuals to community treatment upon release which provides continuity of treatment and improved health outcomes.

Retail Food Services (RFS) provides food and beverage options to visitors, staff and physicians at facilities across the province. In addition to adopting enhanced cleaning practices, RFS increased Grab & Go and pre-order options to support physical distancing requirements and reduce contact. At many smaller community sites, staff added window artwork in the cafeterias to promote improved patient and staff morale.

Alberta Precision Laboratories

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 healthcare delivery system. The complexity, scope and volume of diagnostic testing continues to grow every year.

Alberta Precision Laboratories (APL) employs approximately 5,500 healthcare professionals and is one of the largest providers of laboratory medicine and pathology services in Canada. APL encompasses hospital and community laboratories, mobile collection services, cardiac diagnostic services, on-call services, reference laboratories, public health laboratories, patient-service centres and transportation services.

Alberta's COVID-19 testing program is a critical part of the province's pandemic response, helping to determine if an individual has COVID-19 in order to track the virus and prevent its transmission. As of March 31, 2021, APL had completed more than 3.6 million COVID-19 tests on 1.9 million Albertans. Rapid point-of-care testing was implemented at assessment centres, hospital labs, homeless shelters, and in mobile testing units to support improved access.

More information on APL can be found in the Appendix[1].

Jordan Kerluke holds his daughter Scarlett as she gets her flu shot from registered nurse Karen Brown in Calgary in October 2020. Photo by Leah Hennel/AHS.

Commitment to Comfort® (CTC) is a quality improvement initiative adapted from the Alberta Children's Hospital. It was developed to promote comfort by helping lessen pain and distress in patients requiring a needle for laboratory collection or immunization.

CTC uses five simple principles:

1. Make a comfort plan
2. Use numbing cream
3. Position comfortably
4. Use distraction

Patient food being delivered on a COVID-19 unit. Photo by Leah Hennel/AHS.

[1] *APL is included in the AHS Annual Report because of the leadership structure with AHS. Other wholly-owned subsidiaries (Carewest and CapitalCare) do not have this structure.*

AHS Workforce

Grounded in our values, AHS is focused on supporting our people, particularly during these unprecedented times. AHS has taken many steps to support the physical, psychological and social well-being of staff and volunteers in the workplace and we continue to support and protect our people during the pandemic. We want to ensure our staff, physicians, midwives and volunteers have the supports and resources they need to feel safe and healthy.

The COVID-19 pandemic changed the way people live and work. Several resources were developed to help leaders navigate the new work environment and employee needs.

- With thousands of employees working from home, AHS supported its leaders to effectively manage employees remotely. In Q4, AHS brought facilitation of the Managing People Remotely webinar series in-house, using content and resources from Gallup. Three courses are offered monthly and, since its inception in October 2020, more than 1,000 leaders have attended at least one of the courses.

- Practice Wise is a weekly lunchtime information series that provides an opportunity for clinicians, leaders, regulators, researchers and educators to collaborate and share experiences. In 2020-21, topics included *Moral Distress in a Strange Time*, *Psychology In and For a Pandemic Environment* and *COVID-19: Echoes of Spiritual Resiliency Expressed in Our People's Voices*.

- AHS' Change the Conversation initiative aims to empower leaders to create inclusive and respectful workplaces by providing the appropriate language and tools to engage in dialogue on challenging topics. Tools are customizable to suit individual need, comfort level and situation.

    - In 2020-21, new tools were released for topics including *The Importance of a Person's Name*, *Cultural Appropriation* and *Sympathy, Empathy and Compassion*.

    - New episodes of Our People Podcast were also published on topics such as *Best Friends at Work*, *Macroaggressions*, *Benevolent Sexism* and two episodes on *Black History Month*.

Physical Safety

Safe, healthy workers contribute to improved patient care and safety. Efforts to improve worker safety at AHS include targeted interventions that impact common causes of injuries in high-risk areas and enhanced programs and processes related to physical safety.

AHS continues to work towards preventing musculoskeletal injuries by exploring opportunities to provide virtual support to frontline staff via live video education with question and answer sessions. In 2020-21, a Musculoskeletal Injury Prevention Council was established to identify focus areas and priorities to support operational areas to decrease injuries across the organization. The council will focus on alternative training options, improving best practice competence and improving the quality of incident investigations.

- The COVID-19 experience has improved employee risk awareness and mindfulness. Client handling-related injuries decreased by eight per cent when compared to the same period last year (Q3YTD). Reduced facility capacity and isolation protocols resulted in reduced demand for patient handling which may have also contributed to injury reductions.

A critical care team moves a patient with COVID-19. Photo by Leah Hennel/AHS.

A Personal Protective Equipment (PPE) Task Force was established to comprehensively address the planning and management of PPE for the COVID-19 response. As part of the pandemic response, AHS created a Personal Protective Equipment Question of the Week video series where experts answered common questions from AHS staff and physicians. Videos were circulated weekly to all AHS staff.

In 2020-21, incidents of exposure to hazardous substances and blood and body fluid exposures/communicable disease exposures/outbreaks increased from the same period last year. Many of these injuries were directly (e.g., exposure or outbreak) or indirectly (e.g., continuous masking or skin integrity) related to COVID-19 and represent 19 per cent of the injuries contributing to AHS' disabling injury rate.

Psychological Safety

The Resilience, Wellness and Mental Health Resource Guide was released in 2020-21 to help support health and safety at work and at home. The guide is a collection of existing resources available to teams and individual staff, aligned with disaster management steps, to provide appropriate support during each stage of the pandemic.

"Whatever happens, I got you," registered nurse Mia Torres, left, says to her colleague, respiratory therapist Joanna d'Abadie. The pair work together in the Intensive Care Unit at the Peter Lougheed Centre in Calgary. Photo by Leah Hennel/AHS.

In 2020-21, organizational Frequently Asked Questions were issued and periodically refreshed to help address questions from staff about COVID-19 self-isolation requirements and other impacts arising from AHS' pandemic response. The document includes links to relevant resources and contact information.

Supported by the Employee and Family Assistance Program, COVID-19-specific Wellness Check-in sessions were developed to support teams after a critical incident. Sessions aim to improve workplace functioning through enhanced trigger identification, coping abilities and resilience.

Psychological first-aid (PFA) helps people immediately after a disaster or emergency. PFA training provides practical support in a way that respects a person's dignity, culture and abilities. In 2020-21, more than 300 psychosocial disaster learning series' were completed by 7,000 participants. Program evaluations demonstrated positive results, with 85 per cent reporting that they feel more confident helping people affected by a disaster or emergency, and 89 per cent reporting they would recommend the workshop to colleagues.

In compliance with the *Occupational Health and Safety Act*, AHS developed a training course related to disrespect, harassment and violence in the workplace, along with policies and procedures that prevent and respond to the four types of violence (i.e., external party, patient-to-worker, worker-to-worker and domestic/personal relationship).

- In 2020-21, the Respectful Workplaces and Prevention of Harassment & Violence Policy course was designated as a Required Organizational Learning that must be completed by every AHS employee. More than 51,700 employees completed the training in 2020-21, for a total of approximately 64,000 employees trained since its launch in February 2020.

Building a respectful workplace starts with building healthy working relationships, one conversation and one interaction at a time. AHS offers monthly learning modules, as well as other tools and resources, to support leaders, teams and individuals to navigate conflict and build respectful workplaces. Conflict resolution has been identified as a main strategy to prevent worker-to-worker harassment and violence. Through a curriculum of online sessions, skill development, videos and activities, AHS staff can develop the needed skills to address conflict in a proactive manner.

Diversity and Inclusion

Diversity includes characteristics such as race, religion, colour, gender, physical and mental disability, age, family status, sexual orientation and education. AHS aims to create an environment that is fair, just and respectful of individuals and their similarities and differences. This includes building a workforce that is reflective of the diverse communities we serve, and improving our capabilities to provide safe care and services.

AHS offers a number of online learning modules, webinars and podcasts for staff and physicians that cover various topics such as unconscious bias, intergenerational relationships and respectful workplaces. AHS also proudly partners with the Canadian Centre for Diversity and Inclusion to offer additional in-depth courses developed by field experts.

Diversity and Inclusion Committees provide a formal structure for individuals to come together to discuss, guide and inspire activities aimed at creating safer and more inclusive environments for everyone who interacts with a particular site or portfolio. Since launching in January 2020, six hospitals, two programs and one zone have initiated their own committees to promote welcoming environments.

AHS employees get ready for the Pride Parade at the Stonegate EMS Station in Calgary. Photo by Leah Hennel/AHS.

Workforce Resource Groups (WRG) provide individuals with a formal structure to connect with AHS colleagues across the province who share unique needs related to specific characteristics, including visible (e.g., race) and invisible (e.g., family status) identities. More than 1,000 members make up AHS' three WRGs (LGBTQ2S+, EMS Women in Leadership and Ethnic Minorities) with future groups being considered for People with Disabilities, Reservists, Francophones and New Parents. All WRGs include and welcome ally members.

- COVID-19 challenged AHS to innovate new ways to celebrate Pride Month in June. Led by EMS, workers from across AHS participated in the first ever AHS Pride Drive which passed by healthcare facilities around Edmonton and Calgary. AHS staff were also encouraged to "share the rainbow" using the new AHS Pride recognition e-cards and signature.

AHS' Anti-Racism Advisory Group was established in 2020-21 to develop a consistent and comprehensive approach to anti-racism activities. Members represent Indigenous, Black, People of Colour and Jewish workers from across AHS in both clinical and non-clinical environments. More than 900 people participated in consultations to inform the Position Statement and recommendations to address racism and discrimination.

- Nearly 2,100 individuals participated in an Our People webinar dedicated to the discussion of racism in Alberta's healthcare delivery system. The webinar provided a forum to discuss what AHS is doing in the workplace to combat racism and promote inclusivity, and outlined some actions our workforce can take to be anti-racist. The webinar shared powerful personal stories which, according to the post-webinar survey, created a desire to be anti-racist and to promote allyship within AHS.

- In 2020-21, AHS held its first official organization-wide celebration of Black History Month. Activities included a webinar on *Significant Contributions of Black People to the Canadian Healthcare System: A focus on Alberta* and two podcasts on the experiences of Black people in AHS related to hiring, retention and promotion practices.

More than 220,000 Albertans self-identify as Indigenous, making Alberta home to the third-largest Indigenous population in Canada. AHS will continue to build upon the experience, knowledge and skills of our workforce to better meet Indigenous Peoples' unique health needs, and increase recruitment and retention of Indigenous staff.

- All AHS staff are required to complete Indigenous Awareness training. As of March 31, 2021, 67 per cent of staff had completed the basic training. In-person training was suspended due to COVID-19 and online sessions were launched in Q2. More than 60 Zoom sessions were provided in the second half of the year. New curricula is under development and includes new Métis- and Inuit-specific courses, Indigenous determinants of health, land acknowledgements and intergenerational trauma, among other additions and improvements.

- In the week leading up to National Indigenous Peoples Day in June, AHS staff, volunteers and the public were invited to celebrate virtually using AHS' online platform Together4Health. AHS celebrated Indigenous culture by promoting contributions to an interactive cookbook and photo gallery, participation in Zoom learning sessions, and storytelling about inspirational Indigenous youth. By focusing on building greater understanding and awareness, AHS will combat racism and build a better and more inclusive healthcare delivery system.

Patient Safety in Care Environments

Preventing harm to patients during the delivery of care is foundational to all activities at AHS. It is one key way to ensure a safe and positive experience for patients and families interacting with the healthcare delivery system.

The AHS Patient Safety Plan supports shifting from a reactive approach to patient safety to a proactive approach. The plan aims to foster a culture of safety by creating processes and tools that ensure safe and reliable systems, processes and services that are supported by evidence and a spirit of continuous learning and quality improvement.

- AHS collaborated with multidisciplinary teams to identify patient safety risks with digital health technology, and Connect Care in particular, by facilitating regular eSafety surveillance and issue discussions. eSafety surveillance contributes to early identification of safety risks the system may pose to patients and assists with proactive harm-prevention activities.

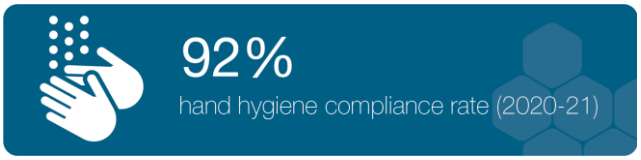
- To date, 180 end users have participated in 47 Connect Care Workflow Safety Review sessions leading to the identification of more than 600 issues that may have affected efficiency and patient safety. These review sessions enable timely resolution of potential problems before they occur.

- More than 400 COVID-19-related simulation sessions were completed in 2020-21, including simulated scenarios in emergency departments to ensure that physicians, nurses, respiratory therapists and other care providers were able to manage complex pandemic patients. Simulations enabled proactive modifications to patient treatment areas and allowed staff to become familiar with new processes and care strategies.

The provincial personal protective equipment (PPE) safety coaching program was successfully launched in acute care and continuing care settings, with more than 1,000 coaches trained in 2020-21. The program builds on locally-implemented PPE safety coach programs across the province which launched earlier in the year. All PPE safety coaches are invited to participate in monthly forums which facilitate peer-learning and strategy development. Following completion of online training, safety coaches can provide PPE guidance and support to colleagues during their shifts.

Hand hygiene is the single most effective strategy to reduce the transmission of infection in healthcare settings. Due to the COVID-19 pandemic, the use of disinfecting products and alcohol-based hand rub products increased significantly across Canada and around the world. In 2020-21, the Disinfection and Hand Hygiene Working Group was established to proactively identify and address disinfectant and hand hygiene supply issues, including the procurement of alternate products to ensure adequate supply to mitigate global supply uncertainty.

Hand hygiene reporting was suspended in Q1 due to system pressures and resumed in Q2. The 2020-21 provincial hand hygiene compliance rate (92 per cent) improved by five per cent compared to the same period last year (88 per cent). These results demonstrate our workforces' commitment to reducing the spread of COVID-19 through improved hand hygiene practices.



Antimicrobial stewardship is an interdisciplinary activity that aims to optimize antibiotic use through targeted, evidence-informed and measurable initiatives to effectively manage infections while preserving the value of antimicrobials.

- In 2020-21, AHS developed evidence-based tools to assist clinicians with optimizing urine testing and identification of urinary tract infections. This provincial project aims to reduce inappropriate urine testing and antibiotic treatment of asymptomatic bacteriuria to improve patient outcomes. Awareness is being built through online courses available to all healthcare providers.

- Another major focus in 2020-21 was appropriate drug treatments for patients requiring therapy for COVID-19. Treatment recommendations were regularly updated based on emerging evidence. Drug supply was also monitored closely to ensure adequate supply of medications required to treat COVID-19 patients.

The Appropriate Prescribing and Medication Use Strategy for Older Albertans aims to support medication optimization to improve the quality of life and safety of older adults across diverse healthcare settings, including acute care, primary care, and community and continuing care, and to enhance efficiencies in the healthcare delivery system. The strategy was released in 2020-21 and prioritizes patient-centred care principles to ensure collaborative decision-making related to medication.

Clinical Excellence & Efficiencies

Enhancing Care in the Community

Enhancing care in the community is helping people be as healthy, well and independent as they can be in their homes and communities. Work focuses on providing person-centred care within local communities and keeping Albertans out of hospital when not required. Meeting the health and social needs of people in their communities contributes to improved independence, wellness and quality of life.

Community paramedic Natalie Walker with a patient at his home in Calgary. Photo by Leah Hennel/AHS.

One way AHS is supporting care closer to home is by advancing virtual health options and providing technology-enabled hospital-level care at home to ensure clients are cared for in the most appropriate settings. Zones continue to work collaboratively with clinical and support areas, including emergency medical services, primary care, home care, seniors health, mental health, public health and others, to improve community-based care and services to reduce over-reliance on acute care services.

AHS works with government departments and agencies, municipalities, and business and volunteer sectors to provide care and support that is well-coordinated and continuous. This year, AHS supported community partners in their response to the COVID-19 pandemic. These collaborations have allowed AHS to better understand needs within communities across the province and has enabled communities and partners to feel more prepared and informed, allowing them to be nimble and responsive.

- In 2020-21, collaboration between AHS and the provincial government enabled the successful launch of Healthy Aging Collaborative Online Resources and Education Alberta (CORE Alberta), a knowledge hub for community-based seniors-serving organizations and allied agencies and individuals across the province. CORE Alberta allows organizations to share resources and coordinate services for seniors, with a focus on key COVID-19 issues, including transportation, food security, social isolation and home supports.

- AHS continued to work with community-based partners to positively impact the health of individuals and families who have recently arrived in Alberta. Examples of this work include providing translated health-related information, system navigation support, and accurate and timely information sharing. In 2020-21, teams worked to address stigma and cultural sensitivity around notifying close contacts of an exposure to COVID-19.

- Even during difficult times, Albertans want to feel connected to their communities. AHS supported efforts to advance volunteerism and reduce social isolation by connecting local volunteers with organizations looking for assistance with delivering essential items to homes and community spaces, and transporting clients to vaccine and other medical appointments. These services provided an opportunity for social connectedness and contributed to improved client experiences.

Clinical Appropriateness

AHS is supporting strategies to improve efficiencies related to clinical effectiveness and appropriateness. The aim is to improve patient care while driving better value for Albertans' healthcare dollars. In 2020-21, AHS' Improving Health Outcomes Together (IHOT) team supported the launch of eight clinical appropriateness projects and engaged with stakeholders across the continuum of care to implement initiatives across the province.

- Ordering an MRI for osteoarthritis rarely adds useful information to inform diagnosis or treatment and leads to longer wait times for patients. Improvement initiatives were successfully introduced in Calgary Zone, leading to a new process that declines low-value MRI requests that do not align with best practice recommendations. Provincial implementation is planned for 2021-22.

- The *Choosing Wisely Canada: Diving into Overuse in Hospitals* campaign was implemented in operational areas to reduce unwarranted use of laboratory and diagnostic imaging testing and promote appropriate use of pharmaceuticals within AHS. Four Calgary Zone adult hospital sites and one Edmonton Zone site achieved Level 2 designation which recognizes a hospital for demonstrating a measurable reduction in non-value added testing and treatments as per the Choosing Wisely recommendations.

- In 2018, nearly 10,000 patients were mechanically ventilated in adult ICUs in Alberta. Venting Wisely is an evidence-informed care pathway that leverages team-based care and expertise to improve ICU capacity, care outcomes and perceptions of care quality among critically ill patients. Implementation was delayed to 2021-22 due to COVID-19 response efforts. This year, site readiness assessments were completed.

Approximately 10,000 Albertans are medically ventilated in ICUs each year. Photo by Leah Hennel/AHS.

Strategic Clinical Networks™

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 healthcare delivery sustainability.

This year, efficiencies were realized through the amalgamation of several SCNs™. This work also aligned with recommendations in the AHS Performance Review.

- The Medicine SCN™ was formed by combining the Kidney Health SCN™ and the Respiratory Health SCN™. The Medicine SCN™ has three areas: Kidney Health, Respiratory Health and Hospital Medicine.

- A centre of excellence was created by combining the Seniors Provincial Program and the Seniors Health SCN™.

- A centre of excellence was created by combining the Addiction and Mental Health (AMH) Provincial Program and the AMH SCN™.

Alberta Health Services Inspiring solutions. Together.
Strategic Clinical Networks™

Below are examples of some of the work accomplished by SCNs™ in 2020-21.

- Fracture Liaison Services (FLS) help reduce the risk of future fragility fractures by optimizing management of bone health/osteoporosis as well as fall prevention strategies. FLS was expanded to an eleventh site at the Medicine Hat Regional Hospital.

- A public health campaign was launched to educate Albertans on signs and symptoms suggestive of cancer that should prompt medical attention by a family physician, and to reassure Albertans that healthcare facilities and primary care clinics are safe places to receive care during the pandemic.

- With the introduction of Connect Care, stroke orders and paper-based order sets were reviewed and virtual reporting on common stroke metrics was enabled by the Connect Care system. The use of technology to access and track information will enhance the stroke care pathway by providing timely and reliable data to inform future improvement work.

- Diabetes increases the chance of foot ulcers, a complication that accounts for 70 per cent of lower limb amputations in Alberta. The Diabetes Foot Care Clinical Pathway was developed to prevent and manage foot complication in primary care through proactive screening and treatment. Virtual screening tools are becoming available through electronic health records.

- Staff in emergency departments and urgent care centres experience some of the highest rates of harassment and violence in the workplace. An average of 17 workers per day report an incident of patient-to-worker harassment and violence. An evidence-informed toolkit was developed to provide staff with strategies to safely address workplace harassment and violence, and has been implemented at four pilot sites.

- The Adult Pressure Injury Prevention in Hospital initiative aims to eliminate preventable hospital-acquired pressure injuries. An evidence-based implementation strategy is being developed and includes a measurement system so audit data can be used to help standardize care and decrease unwarranted variations in care.

- The Reducing the Impact of Financial Strain project aims to improve understanding and screening for financial strain and other social determinants of health in primary care settings. Screening was integrated into clinic flow and documentation. Patients who screen positive are offered supports through Primary Care Networks and community agencies.

- Proton pump inhibitors (PPIs) have a high prevalence of use in acute care settings. The PPI Prescribing improvement initiative ensures appropriate prescribing of PPI therapy by providing best practice evidence and decision-support tools. Education sessions were provided to primary care practitioners and community pharmacists to promote understanding and quality improvement.

- Radon is a colourless, odourless, radioactive gas that can cause cancer. As part of the Truth and Reconciliation Calls to Action, homes on First Nations reserves and Métis settlements were tested for radon gas to promote safe housing conditions.

- Prenatal screening for congenital syphilis is being added to the antenatal care pathway. All delivering hospitals in Alberta received information about screening pregnant women in the first trimester and at delivery. Work continues on improving lab requisitions to increase uptake of appropriate screening.

- This year, AHS explored opportunities to implement and evaluate incremental dialysis protocols in Alberta, which will help increase system capacity. Improvements in dialysis care, including initiating dialysis less frequently and incrementally increasing the treatment dose as residual renal function decreases, led to improved patient experiences and health outcomes. Process and outcome metrics continue to be integrated into Connect Care.

- The Home-to-Hospital-to-Home Transitions Guideline is a unique, provincewide initiative that merges acute, primary and community care under one guideline to address the supports Albertans need to safely transition from their communities, to hospitals, and then back home again. The guideline was developed by a provincial task group reporting to the Provincial PCN Committee, and received endorsement from the Committee on September 9, 2020. Initial engagement was completed with the 14 largest acute care sites in Alberta.

- CanREACH is an innovative program that empowers physicians to identify and treat pediatric mental health conditions in the community. Evidence shows that CanREACH trained physicians utilize specialized services less often than their peers, and the referrals they do make are more appropriate. 240 physicians participated in sessions this year.

- The Elder Friendly Care (EFC) initiative supports collaboration among care teams to reduce restraints, prevent delirium and falls, increase mobility, enhance sleep, and support more effective and timely discharge of older adults. The initiative is being implemented at 14 large acute care sites in Alberta to improve experience and length of stay.

- An integrated, provincewide central access system for surgical consultation is in development and aims to decrease the wait time between referral and consultation. Two pediatric and 14 adult sites shared improvement projects and learnings to support a provincial approach to improving surgical experience and outcomes.

AHS SCNs™ partner with approximately 160 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). Advisors also participate in Patient Engagement Reference Group (PERG) meetings to facilitate consultations, networking and partnership-building between advisors and SCN™ leaders.

The Primary Health Care Virtual Patient Engagement Network (VPEN) engages patient and family advisors in activities with the Primary Health Care Integration Network (PHCIN). Despite the pandemic, engagement with patients and families accelerated in 2020-21 and leveraged Zoom technology to stay connected. Advisors provided input on nearly 30 different projects including primary care virtual visits, discharge checklists and the Alberta Surgical Initiative.

Health Care Aide Jonathan Quicho puts a blanket on patient Wayne Brown at the South Calgary Dialysis Centre. Photo by Leah Hennel/AHS.

More than 2,000 people with kidney failure are treated in Alberta every year. The Starting Dialysis on Time, at Home, on the Right Therapy (START) project optimizes the safe and effective use of peritoneal dialysis by applying service delivery improvements.

Improvement initiatives are based on clinical best practice and research, and undergo a standardized four step process:

1. Structured assessment
2. Addressing barriers
3. Knowledge translation
4. Audit and feedback

Performance Results

Over the past year, the COVID-19 pandemic significantly affected how healthcare programs and services were accessed and delivered to Albertans. But despite the ever-changing environment, it is becoming clear that AHS was able to adapt rapidly to create the space necessary to care for Albertans in critical need. This theme is broadly reflected by reductions in the number of people seeking care within emergency departments, decreases in ambulatory care sensitive condition admissions and overall reductions in acute care admissions. In addition, specific surgical services were temporarily suspended to ensure beds were available for anticipated COVID-19 surges. A number of measures remained stable when compared to last year which demonstrates that AHS is large and robust against even the most challenging circumstances.

Looking forward, with the continuation of strong public health messaging and measures, and increasing numbers of Albertans being vaccinated against COVID-19, it is now possible to anticipate which areas of healthcare delivery are likely to require additional focus after COVID-19 cases and hospitalizations reduce to negligible numbers. These areas include reducing the number of Albertans waiting for scheduled surgical procedures and resuming focus on screening and early detection of cancer. COVID-19 has necessitated the use of virtual care and AHS will continue to advance virtual care strategies to better meet the healthcare needs of Albertans.

The information below provides a summary of performance results, highlighting areas most affected by COVID-19.

Population Health

In 2020-21, Health Link calls (2,291,243) increased by 157 per cent compared to 2019-20 (891,931). Prior to the COVID-19 pandemic, the average call volume was 2,444 calls per day compared to an average of 6,277 calls per day in 2020-21. In December 2020, Health Link began assisting with booking COVID-19 vaccination appointments for eligible healthcare workers. Shortly thereafter, Health Link established a dedicated team to expand services and assist the public in booking COVID-19 immunizations. In the first two weeks of operation, Health Link booked over 17,000 appointments; in March 2021, approximately 250,000 appointment bookings were completed.

As many businesses were required to reduce hours of operation and capacity due to COVID-19 restrictions, food safety inspections in 2020-21 (26,171) decreased by 46 per cent compared to 2019-20 (48,247). While the number of inspections decreased, a high number of COVID-19-related calls continued to be received for information and other requests at many food-serving establishments.

Recently, as COVID-19 vaccinations became available, AHS worked quickly and collaboratively with Alberta pharmacies to administer as many doses as possible. By March 31, 2021, more than 568,900 Albertans had received at least one dose of the vaccine; approximately 71 per cent of which were delivered by AHS. This number continues to rise as vaccine supply becomes more predictable.

Workforce

In response to the COVID-19 pandemic, AHS' temporary workforce (8,227) increased almost twofold compared to the same period last year (4,298) (an increase of 91.4 per cent). AHS' casual workforce (23,383) also increased compared to the same period last year (21,737) (an increase of 7.6 per cent). These pandemic-driven pressures are anticipated to continue over the next year.

During the first three quarters of 2020-21, there was a 20 per cent increase in the disabling injury rate (5.06) when compared to the same period last year (4.23). While ergonomic-related injuries continue to account for the largest proportion of AHS' disabling injuries; there was a notable component, 19 per cent, either directly or indirectly related to COVID-19.

Continuing Care

In an effort to reduce the spread of COVID-19 in congregate living settings, facilities with suspected COVID-19 outbreaks suspended new placements from acute, sub-acute and community care. In 2020-21, there was a 13 per cent overall decrease in the number of Albertans placed in continuing care (7,427) compared to 2019-20 (8,521). Of those who were placed, approximately 61 per cent were placed within 30 days. This placement rate was similar to the rate in 2019-20 (60 per cent). AHS continues to review and update continuing care admission protocols to ensure the safety of all residents and staff.

Cancer Care and Wait Times

In 2020-21, the number of days that diagnosed cancer patients waited before their first consultation with an oncologist improved by up to 20 per cent, and amounted to consultations one to two days sooner compared to 2019-20. While there has not been a substantial change in the time that these patients received their first radiation therapy, there was a five per cent increase in the number of cancer patient visits (737,212) compared to 2019-20 (704,191). Although the relationship among these measures might be more complex, it is likely that the COVID-19 pandemic is associated with these trends.

Of greater concern is an emerging trend showing a lower number of new cancer diagnoses, both invasive and non-invasive forms, during 2020-21. Registrations with the Alberta Cancer Registry show more than 2,600 fewer cases than expected based on 2019 values. Most of these reductions occurred over April and May 2020 during the height of the first pandemic wave. AHS is preparing for a shift to more advanced stages of cancer being diagnosed in 2021-22.

Diagnostic Procedures

Overall, the number of completed diagnostic procedures (MRI, CT and X-ray), as well as lab tests were 10 per cent lower in 2020-21 (75,182,286) than in 2019-20 (83,633,953). Individually, the number of completed MRIs remained constant and the number of CTs increased by eight per cent compared to 2019-20, while the number of X-ray and lab tests decreased by 17 per cent and 10 per cent respectively. The decrease in lab tests was largely influenced by a reduction in service volumes, even in the face of aggressive COVID-19 testing.

Acute Care

In 2020-21, acute care inpatient occupancy in the busiest hospitals (90.3 per cent) decreased by five per cent compared to 2019-20 (95.5 per cent). Acute care inpatient discharges in the busiest hospitals (358,046) decreased by 10 per cent compared to 2019-20 (399,281). This downward trend is likely the result of the COVID-19 pandemic.

Contributing to the decrease in hospital admissions and discharges was the rate of hospitalizations due to ambulatory care sensitive conditions. The rate reduced by 25 per cent between 2019-20 (303 per 100,000 population) and 2020-21 (227 per 100,000 population).

The percentage of hospital days deemed “alternate level of care” (ALC) remained constant at 15 per cent on reduced volumes. This measure is reflective of acute care patients not requiring the level of care that an acute care setting provides; therefore, the stability of the measure on reduced volumes is likely due to a downstream reduction in continuing care placement options during the early stages of the pandemic.

The ratio of acute length of stay (ALOS) to the CIHI-derived expected length of stay (ELOS) for acute care conditions dropped nearly five per cent from 1.03 in 2019-20 to 0.98 in 2020-21, indicating an improved ability to treat patients within existing resources.

In the first three quarters of 2020-21, both unplanned medical readmissions within 30 days as well as overall unplanned readmissions within 30 days (medical, surgical, pediatric and obstetric) appeared unchanged on reduced discharge volumes.

Risk-adjusted mortality rates changed from 2019-20 as follows:

- Heart attack in-hospital mortality (five per cent) decreased by 17 per cent compared to the same period last year (six per cent). Provincially, the volume of first admission for heart attack dropped by nearly 12 per cent (149 less deaths). While the reason for this reduction is unclear at present, AHS will continue to seek greater clarity.

- Stroke in-hospital mortality remained unchanged at 12 per cent.

In 2020-21, the proportion of overall in-hospital mortality (1.06) increased by eight per cent compared to 2019-20 (0.98). However, the volume of in-hospital mortalities has decreased by 18 per cent (4,209 less deaths) since 2019-20. These trends appear to be affected by COVID-19.

Between 2019-20 and 2020-21, patient satisfaction with their hospital experience remained the same with over two thirds of surveyed patients rating their experience as either 9 or 10 out of 10.

The AHS hand hygiene compliance rate in 2020-21 (92.2 per cent) improved by five per cent compared to 2019-20 (87.7 per cent). This is the highest provincial rate to date.

Emergency Department

In 2020-21, the number of emergency department (ED) visits (1,552,016) decreased by 25 per cent compared to 2019-20 (2,062,527). The number of urgent care centre (UCC) visits (148,162) also decreased, by 27 per cent, compared to 2019-20 (202,925). Similarly, the percentage of patients that left the ED without being seen and against medical advice decreased by 22 per cent compared to last year. There was also a 31 per cent decrease in the time to initial physician assessment (and associated decrease in wait time within the ED) during the same period.

These changes reflect the impact of COVID-19 on system demand and capacity planning. Reduced demand may be an indication of the effectiveness of virtual care strategies that aim to keep non-urgent patients away from emergency departments during the pandemic. These reductions could also suggest that fewer people require emergency care due to decreased movement and interaction as a result of public health measures, or that some Albertans are waiting longer to seek care for medical emergencies, which might lead to worsened health outcomes. AHS will continue to monitor these trends carefully.

Surgery and Specific Procedures

As a direct impact of COVID-19, there was an overall decrease in surgical activity from 2019-20 to 2020-21. Activity in the main operating rooms (268,340) decreased by seven per cent (289,535) and postponements of scheduled surgeries increased substantially from 3,599 to 8,693 in the busiest hospitals. The change in system capacity resulted in approximately 21,000 fewer completed surgeries in 2020-21.

Comparing surgical activity from 2019-20 to 2020-21:

- The number of hip replacement surgeries decreased by 12 per cent, while wait times increased by 37 per cent. This resulted in 805 fewer hip replacement surgeries and a six weeks longer median wait time for those scheduled. Using the CIHI benchmark of 182 days, there was a decrease of 21 per cent in the percentage of surgeries performed with the benchmark (65.5 per cent in 2019-20 to 51.6 per cent in 2020-21).

- The number of knee replacement surgeries decreased by 18 per cent, while wait times increased by 35 per cent. This resulted in 1,108 fewer knee replacement surgeries and an eight weeks longer median wait time for those scheduled. Using the CIHI benchmark of 182 days, there was a decrease of 30 per cent in the percentage of surgeries performed with the benchmark (61.5 per cent in 2019-20 to 43.3 per cent in 2020-21).

- The number of cataract surgeries decreased by two per cent, while wait times increased by eight per cent. This resulted in 947 fewer first eye cataract surgeries and a one week longer median wait time for those scheduled. Despite the increase in median wait time, there was only a modest negative impact on the percentage of surgeries completed within the CIHI benchmark of 112 days (45.1 per cent in 2019-20 to 44.5 per cent in 2020-21).

- The median wait time for Coronary Artery Bypass Graft (CABG) surgeries increased by 21 per cent and resulted in a two weeks longer median wait time for those scheduled.

- Hip fracture repair within 48 hours of admission remained constant and did not appear to be affected by the COVID-19 pandemic.

Mental Health

In 2020-21, the number of patients discharged from acute care and psychiatric facilities (31,774) remained relatively constant compared to 2019-20 (31,154). The number of addiction and detoxification admissions (8,157) decreased by 21 per cent during the same time period (10,349). Unfortunately, during the first three quarters of 2020-21, individuals who received hospitalized treatment for mental health were nine per cent more likely to experience an unplanned readmission to hospital within 30 days (11.9 per cent) compared to the same period last year (10.9 per cent). This increase highlights the vulnerability of this population during the COVID-19 pandemic.

In 2020-21, children and youth with mental health disorders experienced no change in median wait times from referral to the date of the earliest scheduled therapeutic appointment.

As a result of COVID-19, there was an increase in appointment cancellations and a shift from face-to-face to telephone and virtual consultations. This led to lower overall patient volumes in 2020-21. In addition, bed closures allowed for physical distancing and isolation precautions for clients. The change in service delivery options explains the stability in the number of patient discharges, lower use of residential treatment and detox facilities and the relatively constant wait times in 2020-21 compared 2019-20.

AHS will continue to monitor all of these indicators to ensure timely and appropriate service delivery across the province. AHS remains committed to providing the high-quality healthcare services Albertans have come to expect.

Note: Performance Results content provided by AHS Data & Analytics and AHS Planning & Performance.

Financial Summary

Financial Statement Discussion and Analysis

For the year ended March 31, 2021

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, 2021. 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' 2020-21 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, 2021 audited consolidated financial statements, notes, and schedules.

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

Richmond Health Centre drive-through COVID-19 testing. Photo by Leah Hennel/AHS.

Highlights

COVID-19 is having an unprecedented impact on the world, Alberta, and AHS. The novel coronavirus pandemic first emerged globally in late 2019 and has continued to place unprecedented demands on the healthcare system.

AHS' response to this public health crisis has been both timely and strategic. The strength of this response is the result of the dedication and hard work of all AHS' staff, physicians, leaders, and contracted providers who have worked tirelessly to battle the spread of the virus while also providing quality care and services to patients in all facets of the health care system.

Highlights of AHS' pandemic response

- AHS focused on community education, testing, contact tracing, outbreak preparedness, treating those requiring care, and supporting colleagues and patients through these trying times.
- AHS secured a significant stockpile of supplies and personal protective equipment (PPE) for frontline staff and community providers.
- Alberta Precision Laboratories (APL) completed more than 3.6 million COVID-19 tests in 2020-21 and as of March 31, 2021, AHS was operating more than 70 assessment centres across Alberta.
- Plans for an immunization roll-out were developed and the first doses of vaccinations were administered to eligible frontline health care workers, and continuing care staff and residents. Immunizations also became available to Albertans with a higher risk of a severe COVID-19 outcome by the end of the year.

While facing the uncertainties and evolving challenges created by the pandemic, AHS was also able to work towards building a more sustainable, accessible health system that makes efficient use of public dollars while delivering high quality care to patients. This included the launch of Wave 2 of Connect Care, the development of the Surgical Recovery Plan to support the Alberta Surgical Initiative, and moving forward with several initiatives identified in the AHS Performance Review.

With AHS' response ongoing and the end of the pandemic indeterminable, AHS will continue to take required precautions to reduce the spread of COVID-19 within Alberta, while aggressively responding to outbreaks and providing ongoing health care.

Financial Results

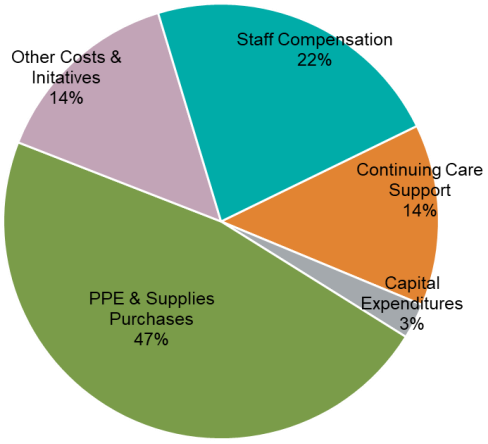
AHS finished the year with a $104 million annual operating surplus, representing 0.6% of budgeted expenses. While significant financial resources were required to respond to the pandemic, AHS also experienced one-time reductions and deferrals of activity particularly during the first half of the fiscal year in areas such as non-urgent surgeries, emergency room visits, home care service hours, and the rescheduled launch of Waves 2 and 3 of Connect Care.

The 2020-21 budget reported in the consolidated financial statements reflects the budget submitted to the Minister of Health in February 2020 and therefore excludes COVID-19. The budget was included as part of the Minister of Health's published budget submission that was approved by the legislative assembly on March 17, 2020.

The incremental cost associated with the COVID-19 response, including those summarized below, exceeded $1.7 billion in fiscal 2020-21.

- Elevated purchasing and usage of Personal Protective Equipment (PPE).
- COVID-19 testing, assessment centres, contact tracing, and increased Health-Link capacity.
- Additional funding and supports to third party providers, including long term care providers
- Capital equipment purchases and the creation of additional acute care surge capacity, including new pandemic response units.
- Programs such as the Critical Worker Benefit, which provided one-time payments to support front line workers.
- Rolling out of vaccines to Albertans.

AHS COVID-19 Costs[1]



[1] *Costs include total amounts spent related to AHS' pandemic response, including expenses, capitalized costs, and PPE and supplies inventory.*

Key Financial Trending

Annual Operating Surplus (Deficit)

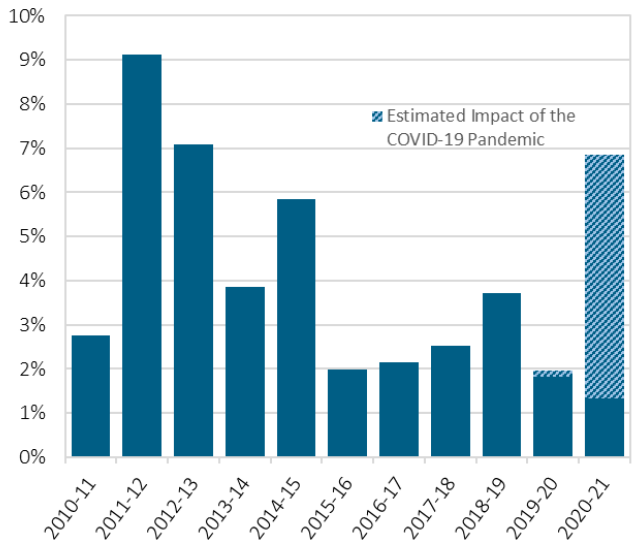
AHS' annual operating surpluses and deficits have been less than 1% of total budgeted expenses in each of the past five fiscal years.

Expense Growth

Select Annual Financial Information For the year ended March 31 (in $ millions)					
	2021	2020	2019	2018	2017
Revenue	16,789	15,468	15,274	14,856	14,470
Expenses	16,685	15,614	15,313	14,765	14,403
Annual operating surplus (deficit)	**104**	**(146)**	**(39)**	**91**	**67**
Accumulated Surplus	1,236	1,132	1,278	1,317	1,226

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

AHS Historical Expense Growth
(as a percentage)



Total expenses grew by 6.9% from the prior year which was higher than the 2019-20 growth rate of 2.0% due to the COVID-19 pandemic response. The estimated net incremental cost of COVID-19 (net of one-time activity reductions and deferrals) resulted in an approximate 5.6% increase to total expenses (2019-20 – 0.2%).

Through various organization-wide and local initiatives, AHS has been able to slow the rate of spending growth. Expenses have increased by an average of 2.2% per year since 2015-16 (excluding the estimated impact of COVID-19 in 2019-20 and 2020-21), while historically, expenses were growing an average of 5.7% per year.

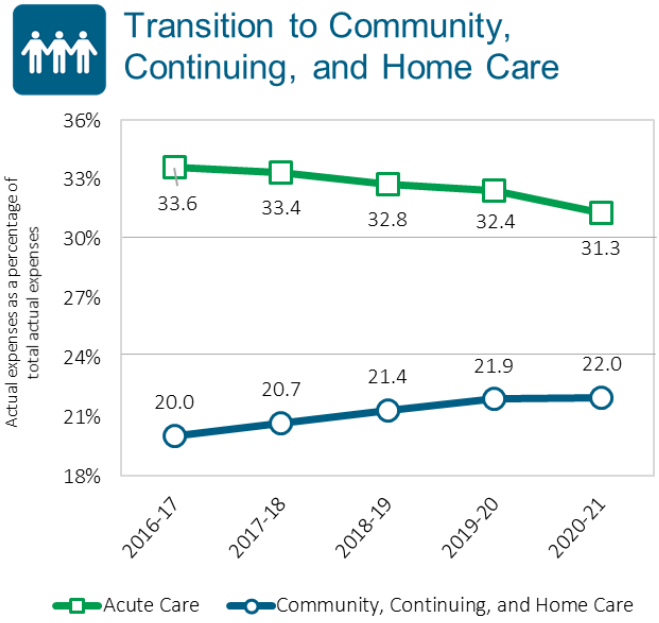
Cost Containment and Savings

AHS is working collaboratively with Alberta Health to pursue our shared vision of a healthier Alberta while finding the most cost-effective way to deliver quality care. This collaboration includes the implementation of recommendations from the AHS Performance Review conducted in 2019, which identified opportunities that could help achieve greater health system sustainability and ensure Albertans receive the greatest value from every dollar invested in the healthcare system.

In October 2020, Alberta Health approved the implementation of a number of the AHS Performance Review initiatives. AHS achieved over $80 million in savings during the 2020-21 fiscal year, which exceeded the original AHS Performance Review plan. Savings were realized in a number of areas such as reductions in discretionary costs (i.e., travel, education, and office supplies), reductions in overtime, premium savings by moving to a new liability insurance reciprocal in 2020-21, Operational Best Practices (OBP), and staff optimization. OBP continues to be a key initiative for improving the financial health and value for money at AHS by comparing healthcare delivery costs within Alberta, and with healthcare systems across Canada.

Community, Continuing, and Home Care

Alberta's population is aging and although Alberta has one of the youngest populations in Canada, by 2046 almost one in five Albertans is projected to be age 65 or older[2]. The COVID-19 pandemic also reinforced the need to protect high-risk populations such as residents and staff at continuing care facilities. Therefore, it is crucial AHS continue to expand community, continuing, and home care options to ease pressures on hospitals so resources can be directed to allow Albertans to receive safe and quality care in their homes and communities.



Over the past few years, AHS' acute care expense growth has slowed, increasing by only 8% over the past five years, while spending related to community, continuing, and home care services has increased by 27% during the same period. As of March 31, 2021, 1,427 patients were waiting for a continuing care placement in an acute care setting, a decrease of 24% since 2016-17. The average wait time in an acute care setting was 38 days in 2020-21, compared to 46 days in 2016-17.

Connect Care

Connect Care, a common provincial clinical information system, empowers Albertans to be at the centre of their health care team by supporting access to their own health information and improved communication with their care teams. 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.

With the onset of the COVID-19 pandemic, Connect Care teams were redeployed to support the pandemic response by enhancing various software and systems, including dashboards for additional COVID-19 data collection, expanded Health-Link capacity, vaccine appointment booking platforms, and various other IT services to support patient care. This delayed the launch of Waves 2 and 3.

Despite COVID-19, AHS was able to successfully launch Wave 2 of Connect Care on October 24, 2020. Wave 2 implementation included additional acute and combined acute and long-term care sites within Edmonton Zone, along with Pharmacy, Diagnostic Imaging, and Alberta Precision Labs support services at those sites. Wave 2 also included Interim Dialysis and Renal Care at the Walter C. Mackenzie Campus. Wave 3 of Connect Care, which covers north-west Alberta, successfully launched on April 10, 2021.

In 2020-21, Connect Care capital expenditures were $150 million ($510 million cumulative since 2017-18) and operating expenses were $95 million ($246 million cumulative since 2017-18).

[2] *Alberta Treasury Board. (2020, August 28). Population Projection Highlights. Retrieved from Alberta.ca:https://open.alberta.ca/dataset/90a09f08-c52c-43bd-b48a-fda5187273b9/resource/515ad97a-256a-4de1-8845-9a898b59ff8f/download/2020-2046-alberta-population-projections-highlights.pdf*

Workforce

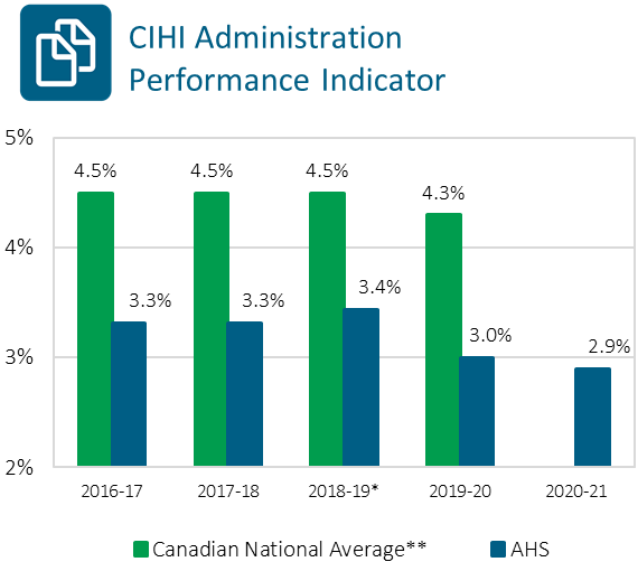
The largest cost for AHS is compensation for our workforce. Calculated Full Time Equivalents (FTEs) is a useful measure for analysing the demands placed on the health care system as it normalizes for the timing of new hires, and the prevalence of overtime, relief, and part-time employees, which is common in healthcare settings. FTEs are calculated as actual hours earned (including worked hours, vacation, training, overtime, and relief), divided by 2022.75 hours — the annual hours of a full-time employee.

CALCULATED FTEs				
	2020-21	2019-20	Increase (Decrease)	
			FTE	%
Clinical staff[3]	52,767	52,180	587	1.1
Other staff[4]	28,395	27,672	723	2.6
Management – includes both clinical and other management	3,253	3,201	52	1.6
Total FTEs	**84,415**	**83,053**	**1,362**	**1.6**

The increase in calculated FTEs in 2020-21 was mainly due to an increased number of employees and overtime required to respond to the pandemic. Over the last fiscal year, AHS' workforce grew by more than 5,000 employees, the vast majority being temporary and casual employees hired in the second half of the year for contact tracing, Health-Link, immunizations, assessment centres, and patient care. Overtime also increased in the second half of the year contributing to an overall 26% increase from the prior year.

Administration Expense

Administration expense is comprised of human resources, finance, compensation and benefits for senior leaders, 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.



** Certain amounts have been reclassified to conform to subsequent years presentation*
***CIHI Canadian national average for administration indicator for 2020-21 was not available at the time of publication of this report.*

The Canadian Institute of Health Information (CIHI) reports the corporate services expense ratio as a financial performance indicator based on administration expense and total expenses[5]. For 2020-21 AHS' indicator was 2.9% (2019-20 – 3.0%). The decrease in the ratio is primarily the result of an overall increase in the total expense base due to COVID-19.

The consolidation of many administrative systems, including payroll, information technology systems, and contracting, procurement, and supply chain management has led to significant cost savings 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.

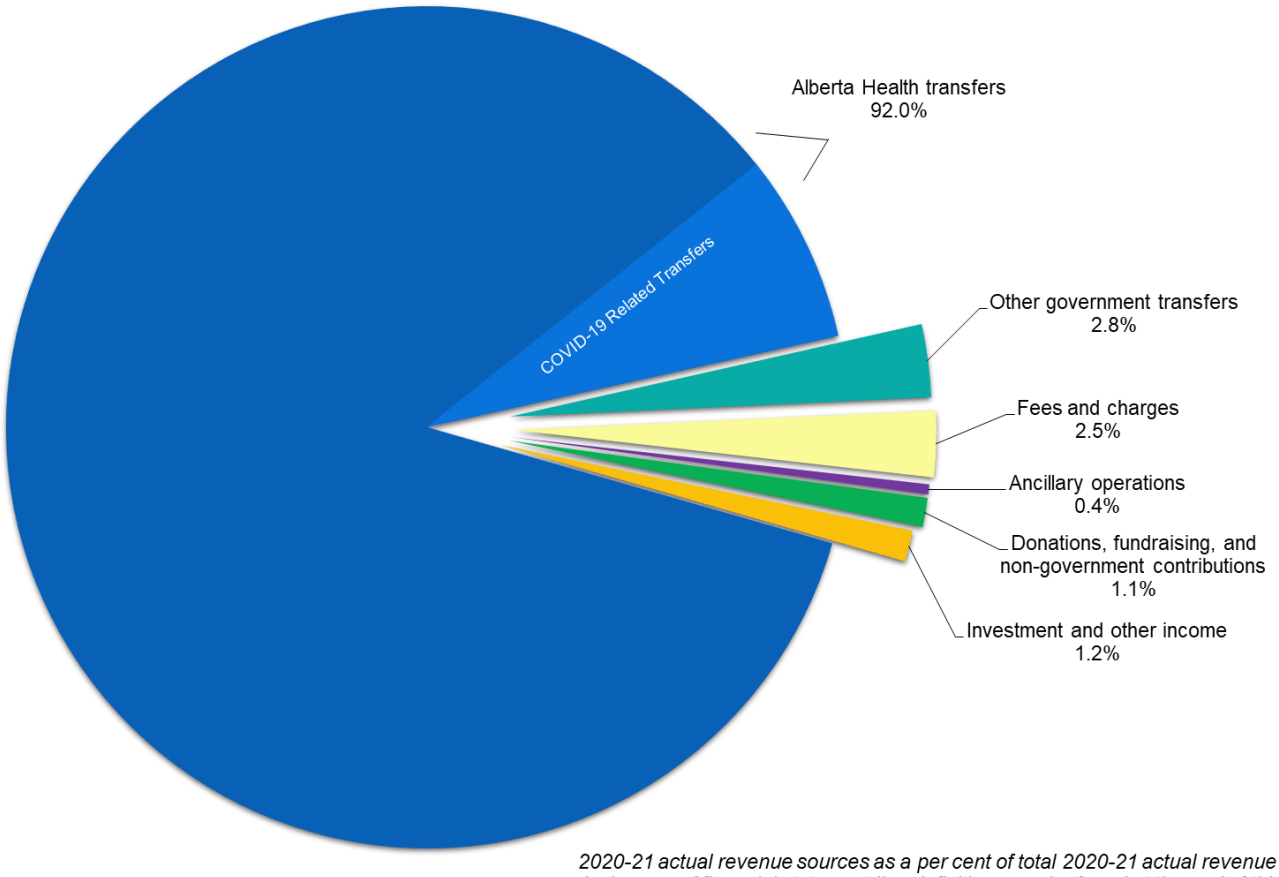
[3] Clinical staff are comprised of AHS' medical doctors, regulated nurses, health technical and professional staff, and unregulated health service providers.
[4] Other staff includes support services employees such as food services, facilities and maintenance, clerical, and administrative support staff.
[5] Canadian Institute for Health Information. (n.d.). Your Health System. Retrieved from Interactive Map: Corporate Services Expense Ratio (Percentage), 2019-20: 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 2020-21 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.

Operations – Comparison to the budget and the prior year

Revenues



2020-21 actual revenue sources as a per cent of total 2020-21 actual revenue
A glossary of financial statement line definitions can be found at the end of this FSD&A

Alberta Health transfers accounted for 92.0% of AHS' total revenues in 2020-21 (2019-20 – 90.2%). The increase in the proportion of Alberta Health revenues to total revenues is a result of COVID-19, including a combination of additional COVID-19 related transfers and a decrease in other revenue sources, such as ancillary operations and fees and charges. AHS' total revenues amounted to $16,789 million, which was $1,415 million or 9.2% higher than the budget of $15,374 million.

Revenues (in $ millions)					
	2020-21 Budget	2020-21 Actual	Variance	2019-20 Actual	Increase (Decrease)
Alberta Health transfers	13,953	15,459	1,506	13,950	1,509
Other government transfers	427	462	35	434	28
Fees and charges	520	420	(100)	532	(112)
Ancillary operations	134	63	(71)	129	(66)
Donations, fundraising and non-government contributions	161	185	24	196	(11)
Investment and other income	179	200	21	227	(27)
Total revenues	**15,374**	**16,789**	**1,415**	**15,468**	**1,321**

Significant variances or changes are explained as follows:

Alberta Health transfers were over budget and higher than the prior year due to additional funding provided to AHS for the COVID-19 pandemic response, including funding for lost revenues from fees and charges and ancillary operations.

Other government transfers were over budget and higher than the prior year due to federal contributions of PPE, partially offset by a change to the estimated useful lives of certain AHS facilities resulting in lower than budgeted recognition of externally funded capital revenue.

Fees and charges were under budget and lower than the prior year due to the COVID-19 pandemic, including reduced out of province and international patients, a reduction in certain healthcare services billable to insurance providers, and the temporary suspension of some self-pay billings in the first half of the year.

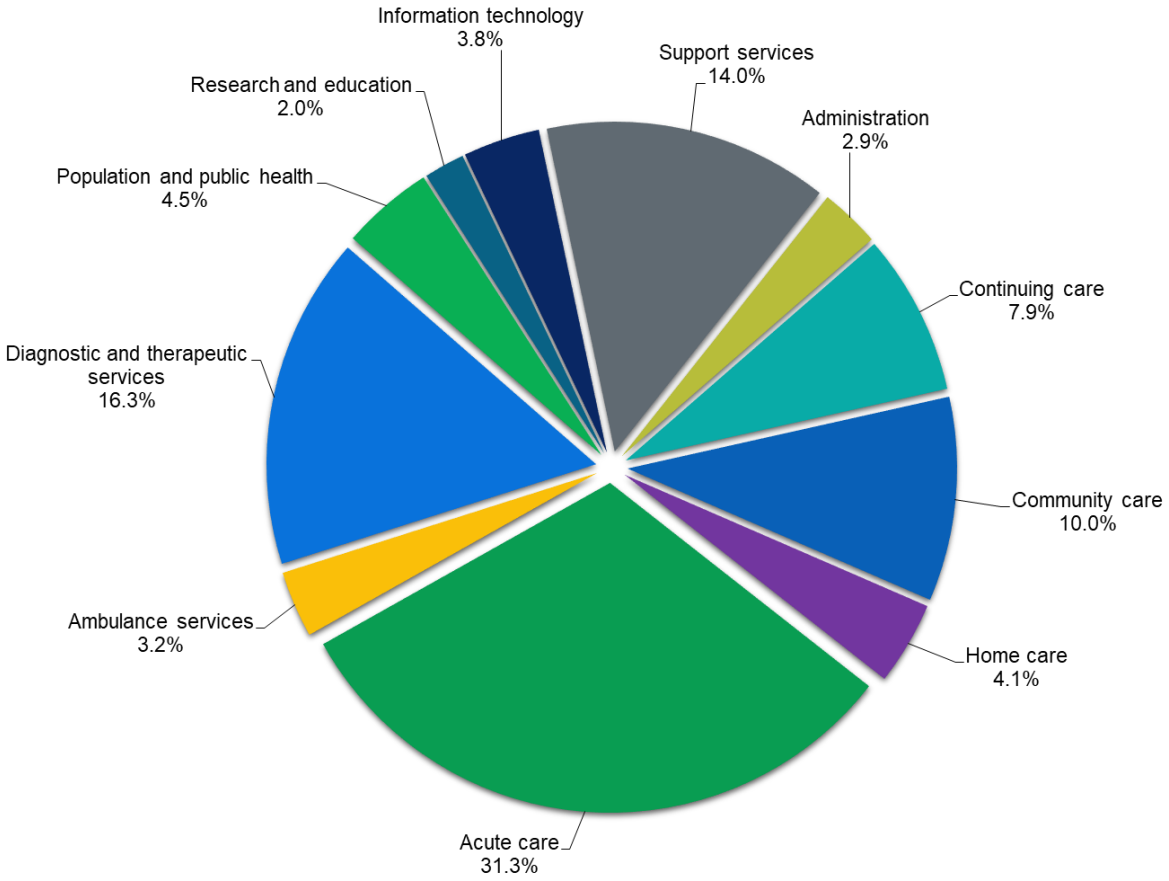
Ancillary operations were under budget and lower than the prior year due to the temporary suspension of parking fees in the first half of the year and lower traffic at retail food services locations.

Donations, fundraising and non-government contributions were over budget due to higher utilization of high-cost cancer drugs received at no cost from suppliers and subsequently provided at no cost to patients as part of compassionate drug access programs.

Investment and other income was over budget due to higher than anticipated recoveries from external entities.

Investment and other income was lower than the prior year mainly due to a lower balance held in investments during the year.

Expenses by Function



2020-21 actual expenses by function as a per cent of total 2020-21 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' strategy, with community, continuing, and home care making up 22.0% of total expenses (2019-20 – 21.9%). Acute care, which is comprised mainly of inpatient, outpatient, and emergency services, continued to be the largest function, making up 31.3% of total expenses (2019-20 – 32.4%).

Expenses by Function (in $ millions)					
	2020-21 Budget	2020-21 Actual	Variance $	2019-20 Actual	Increase (Decrease)
Continuing care	1,175	1,318	(143)	1,176	142
Community care	1,537	1,666	(129)	1,526	140
Home care	717	680	37	717	(37)
Acute care	4,876	5,222	(346)	5,066	156
Ambulance services	535	542	(7)	531	11
Diagnostic and therapeutic services	2,454	2,720	(266)	2,539	181
Population and public health	349	754	(405)	357	397
Research and education	352	333	19	345	(12)
Information technology	643	627	16	597	30
Support services	2,270	2,331	(61)	2,287	44
Administration	466	492	(26)	473	19
Total expenses by function	**15,374**	**16,685**	**(1,311)**	**15,614**	**1,071**

Significant variances or changes are explained as follows:

Continuing care expenses were over budget and higher than the prior year due to additional funding provided to support contracted long-term care providers with enhanced staffing, PPE, sanitization requirements, and replacement of lost accommodation revenue as a result of COVID-19.

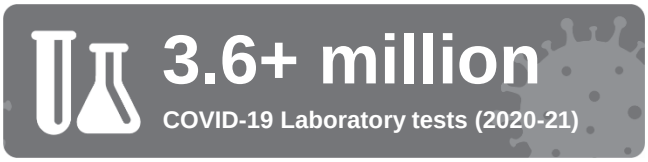
Community care expenses were over budget and higher than the prior year due to additional funding provided to support designated supportive living facilities, residential hospice operators, and other community health programs with enhanced staffing, PPE, sanitization requirements, and replacement of lost accommodation revenue as a result of COVID-19.

Home care expenses were under budget and lower than the prior year mainly due to reduced home care service hours. AHS efforts to reduce the spread of COVID-19 resulted in the provision of fewer home care service hours in the first half of the year. Many home care clients also continued with reduced service hours for a variety of reasons including wanting fewer people in their homes.

Acute care expenses were over budget and higher than the prior year mainly due to higher staffing costs, such as overtime and backfill required to care for COVID-19 patients and isolation requirements, and the Critical Worker Benefit. Further contributing were significant costs related to the utilization of PPE, sanitization supplies, and high-cost cancer drugs.

Temporary reductions in non-urgent surgeries enabled staff to be redeployed to help with the pandemic response and combined with reduced emergency room visits partially offset the overall budget variance and increase from prior year. The 2020-21 budget also included efficiencies and savings that could not be fully realized due to the COVID-19 pandemic response efforts.

Diagnostic and therapeutic services expenses were over budget and higher than the prior year due to COVID-19 testing, including the higher utilization of reagents and other laboratory supplies, higher utilization of PPE, the Critical Worker Benefit, and costs associated with the community lab outsourcing initiative. The 2020-21 budget also included efficiencies and savings that could not be fully realized due to the COVID-19 pandemic response efforts.



[6] *Government of Alberta. (2021, May 13). COVID-19 Alberta statistics. Retrieved from Alberta.ca: https://www.alberta.ca/stats/covid-19-alberta-statistics.htm#severe-outcomes*

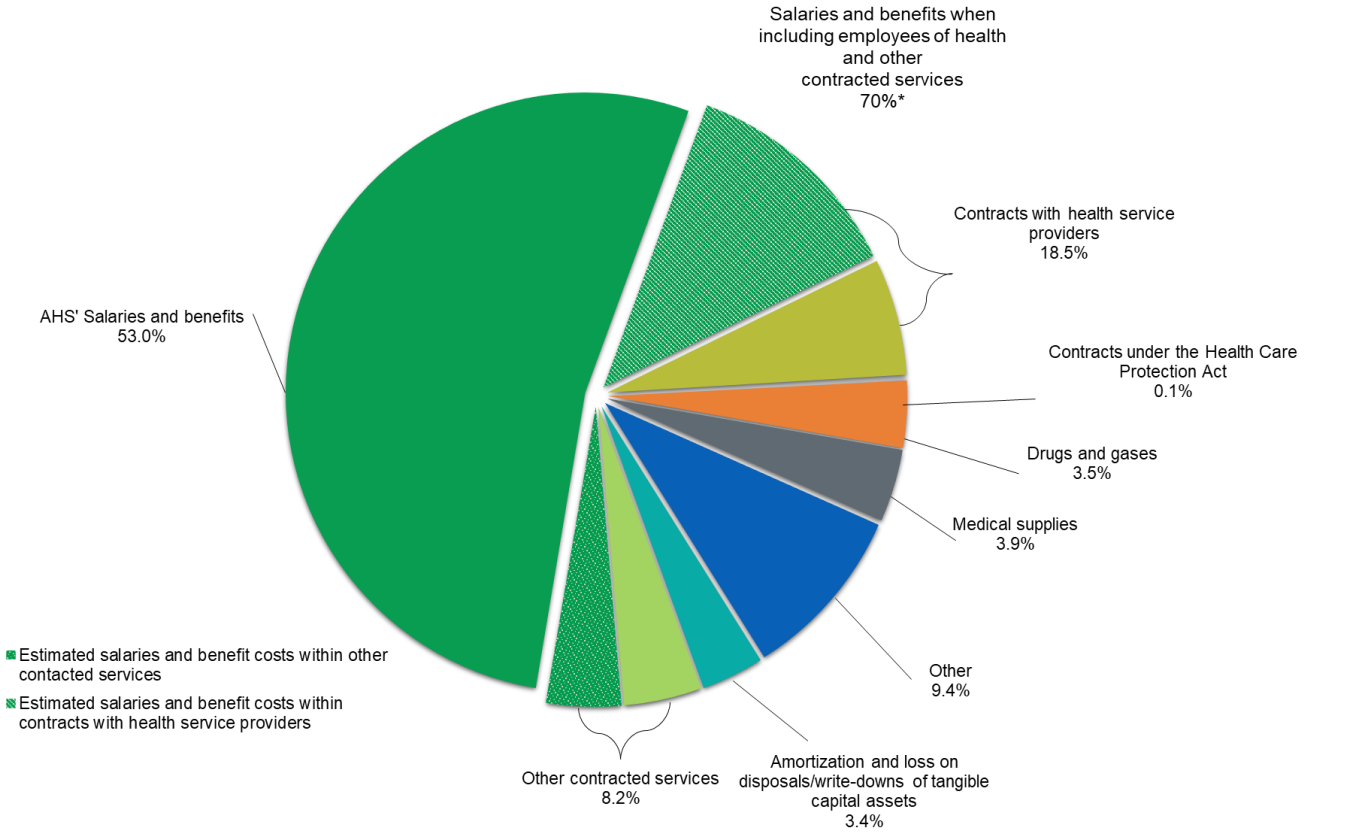
Population and public health expenses were over budget and higher than the prior year due to the utilization of PPE by visitors and patients in AHS facilities as a result of continuous masking mandates, the donation of PPE to third parties and other governments, and civilian masking initiatives. Further contributing were costs associated with Health-Link, contact tracing, the operation of assessment centres, and the vaccine rollout.

Information technology expenses were higher than the prior year due to increased software licencing costs and IT equipment to facilitate remote work arrangements due to COVID-19, and increased costs, including amortization, related to the Wave 1 launch of Connect Care in the prior year.

Support services expenses were over budget and higher than the prior year due to costs associated with the COVID-19 pandemic response, including cleaning and sanitization supplies, gowns, gloves, wipes, hand sanitizer, utilization of PPE, on-site protective services and safety ambassadors, minor equipment purchases and costs associated with setting up assessment centres, and the donation of PPE to other provinces. Lower retail food services traffic and a reduction in discretionary spending partially offset the overall budget variance and increase from prior year.

Administration expenses were over budget and higher than the prior year due to liability insurance costs which increased overall due to claims severity and experience, while being partially offset by premium savings that were achieved by moving to a new liability insurance reciprocal in 2020-21. Further contributing were costs associated with the COVID-19 pandemic response, including staff overtime and the utilization of PPE. Offsetting savings were achieved as a result of reduced discretionary spending, such as travel and office supplies.

Expenses by Object



**This figure is management's best estimate*

2020-21 actual expenses by object as a per cent of total 2020-21 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 mostly consistent with prior years, with salaries and benefits making up 53.0% of total expenses (2019-20 – 54.6%). The decrease in the proportion of AHS' salaries and benefits to total expenses is the result of the increase in proportion of other expenses due to the significant increase in utilization of PPE. 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)					
	2020-21 Budget	2020-21 Actual	Variance	2019-20 Actual	Increase (Decrease)
Salaries and benefits	8,315	8,836	(521)	8,530	306
Contracts with health service providers	2,805	3,079	(274)	2,824	255
Contracts under the *Health Care Protection Act*	28	22	6	20	2
Drugs and gases	501	593	(92)	561	32
Medical supplies	584	652	(68)	581	71
Other contracted services	1,341	1,368	(27)	1,320	48
Other	1,214	1,572	(358)	1,196	376
Amortization and loss on disposals/write-downs of tangible capital assets	586	563	23	582	(19)
Total expenses by object	**15,374**	**16,685**	**(1,311)**	**15,614**	**1,071**

Significant variances or changes are explained as follows:

Salaries and benefits expenses were over budget and higher than the prior year due to the COVID-19 pandemic, including higher overtime, backfill, and additional staff required to care for COVID-19 patients, isolation requirements, contact tracing, the operation of assessment centres, increased Health-Link calls, COVID-19 laboratory testing, the vaccine rollout, new safety ambassadors, the operation of the Emergency Coordination Centre, and the Critical Worker Benefit. The 2020-21 budget also included efficiencies and savings that could not be fully realized due to the COVID-19 pandemic response efforts.

Contracts with health service providers expenses were over budget and higher than the prior year due to additional funding provided to support contracted long-term care providers, designated supportive living facilities, residential hospice operators, and other community health programs with enhanced staffing, PPE, sanitization requirements, and replacement of lost accommodation revenue due to COVID-19.

Drugs and gases expenses were over budget and higher than the prior year due to the increased utilization of high cost cancer drugs.

Medical supplies expenses were over budget and higher than the prior year due to COVID-19 testing volumes which resulted in increased utilization of reagents and other laboratory supplies.

Other contracted services expenses were over budget and higher than the prior year due to increased on-site protective services, set-up costs associated with COVID-19 assessment centres, and increased storage facility requirements for AHS' stockpile of PPE and other supplies.

Other expenses were over budget and higher than the prior year due to higher utilization of PPE and other supplies, including procedural masks, N95 respirators, face shields, goggles, cleaning and sanitizing supplies, gowns, hand sanitizer, and various minor equipment purchases to support the COVID-19 pandemic response. Offsetting savings were achieved as a result of reduced discretionary spending.

Amortization and loss on disposals/write-downs of tangible capital assets were under budget mainly due to an increase in useful lives of certain AHS facilities resulting in lower amortization expense.

Financial Position – Comparison to Prior Year

Financial Position (in $ millions)			
	2020-21	**2019-20**	**Change**
Financial assets	3,374	2,622	752
Liabilities	(3,956)	(3,321)	(635)
Net debt	**(582)**	**(699)**	**117**
Expended deferred revenue	(8,254)	(7,360)	(894)
Non-financial assets	10,128	9,195	933
Net assets	**1,292**	**1,136**	**156**

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.

Net assets represent the extent to which total assets exceed total liabilities, including expended deferred revenue. AHS ended the year in an overall positive net asset position of $1,292 million reflecting a 13.7% increase over the prior year mainly due to the operating surplus. AHS' net assets are comprised of its unrestricted surplus, invested in tangible capital assets, endowments, and internally restricted surpluses for insurance equity requirements and foundations.

Financial Assets

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

Cash and Cash Equivalents

Cash and cash equivalents is comprised of cash on hand, held for the purpose of meeting short-term commitments. At year-end, AHS' consolidated cash balances were $477 million compared to $539 million at March 31, 2020. At March 31, 2021, AHS continues to hold sufficient cash on hand to meet cash flow requirements.

Portfolio Investments

In accordance with AHS' Investment Policy and Investment Bylaw, AHS' investment portfolio strategy invests in high quality instruments, such as government and corporate bonds and lower volatility equities. This strategy protects the original investment value while providing reasonable returns with a conservative exposure to equity markets. The portfolio is sufficiently liquid in nature to enable AHS to respond to cash flow requirements quickly and efficiently. AHS' investment portfolio generated a total return (both realized and unrealized gains) of 12.0% during 2020-21 (2019-20 – 3.9%), the result of a rebound in the market from the prior year end which was significantly impacted by the downturn in the global economy due to the pandemic.

Investments increased during the year by $759 million, or 51.5% to $2,231 million. This increase was due to the timing of cash inflows and outflows, which impacts AHS' cash and investment balances. Significant items include the receipt of Alberta Health restricted grants, including the COVID-19 pandemic response, as well as the timing of settling accounts payable and accrued liabilities. Finally, there was a large increase in the value of the investment portfolio relating to the recovery of the global markets, which last year, saw a significant decline in values at the onset of the pandemic.

Accounts Receivable

AHS' accounts receivable includes amounts related to patient receivables, such as uninsured services, services provided to non-residents, Emergency Medical Services (EMS), Workers Compensation Board (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 9.0% to $666 million during the year, mainly due to an increase in receivables related to restricted grants from Alberta Health. One-time activity reductions as a result of COVID-19 caused a corresponding reduction in patient receivables, partially offsetting the increase.

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 $321 million to $1,933 million mainly due to higher payroll accruals due to the timing of pay periods and accruals for the Critical Worker Benefit payment and the community lab outsourcing initiative.

Debt

AHS' debt is primarily comprised of debentures issued to the Government of Alberta to finance the construction of parking facilities. AHS pledges the revenue derived from all parking facilities as security for the debentures.

As at March 31, 2021, AHS' debt balance was $456 million (2019-2020 – $482 million). During the year, AHS did not obtain any new loans and total debt repayments amounted to $26 million.

Other Liabilities

Employee future benefits include 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 received by AHS for which spending restrictions, imposed by a funder or donor, exist.

Unexpended deferred operating revenue increased $236 million to $642 million as at March 31, 2021. The increase is mainly due to deferred COVID-19 pandemic response funding.

Unexpended deferred capital revenue increased $56 million to $165 million as at March 31, 2021. The increase is mainly due to deferred capital funding for COVID-19 related capital assets, information systems, and continuing care beds.

Expended Deferred 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. The increase from the prior year is the result of externally funded capital asset additions to support the development of several major capital projects partially offset by the revenue recognized. Funding from the Government of Alberta represented $7,043 million, or 90.0% of the $7,827 million total balance (2019-20 – 90.7%).

Expended deferred operating revenue represents external resources spent on the acquisition of certain inventories. These balances are recognized as revenue as the related inventories are expensed. This balance increased from $nil to $427 million in 2020-21 related to unused PPE, rapid test kits, and other supplies mainly funded by the Alberta Health COVID-19 restricted grant.

Non-Financial Assets

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

Tangible Capital Assets

To effectively provide quality healthcare 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 2020-21	Actual 2019-20	Increase (Decrease)
Cost	18,152	17,159	993
Accumulated amortization	8,797	8,303	494
Net book value	**9,355**	**8,856**	**499**

In the current year, capital assets increased by $499 million. This increase is mainly due to facility and information system additions to Work in Progress (WIP), which represents capital assets acquired but not yet ready for use, and capital equipment purchases.

Several capital projects totaling $1,127 million were completed during 2020-21, including the substantial completion of Grande Prairie Regional Hospital, Connect Care (Wave 2), the installation of building service equipment, and facility renovations.

The remaining WIP of $1,493 million includes facilities, improvements, and information technology capital expenditures that support the following initiatives:

- Connect Care
- Calgary Cancer Centre (including the parkade)
- Norwood Care Centre

Capital equipment additions in 2020-21 included equipment acquired to support the COVID-19 pandemic response, diagnostic services, information technology, EMS, and the Grande Prairie Regional Hospital.

While certain capital assets are internally funded from net assets, AHS receives significant external funding for capital expenditures, primarily from Government of Alberta ministries. In 2020-21, capital asset additions amounted to $1,063 million, of which 88.0% were externally funded (2019-20 – 85.7%)

Inventories for Consumption

AHS maintains a constant level of inventory on hand to ensure goods, such as pharmaceuticals, and medical and clinical supplies, are available for operational needs.

AHS' inventory balance increased by $437 million to $564 million from the prior year, primarily due to AHS' efforts to create and maintain a pandemic stockpile to support the COVID-19 response. The pandemic inventory primarily consists of PPE such as procedural masks, N95 respirators, gloves, gowns, face shields, goggles, and other items such as disinfecting wipes and hand sanitizer.

Net Assets

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

The unrestricted surplus of $151 million at March 31, 2021 does not have any restrictions attached to its future use.

The invested in capital assets balance at March 31, 2021 of $925 million represents the net book value of capital assets previously 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 endowments of $76 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 $21 million (2019-20 - $28 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 $63 million (2019-20 - $54 million).

Accumulated remeasurement gains represent accumulated unrealized gains on portfolio investments excluding restricted transfers or donations. The increase of $52 million from the prior year relates to increases in the fair value of AHS' portfolio investments due to the recovery in the markets from the prior year.

NET ASSETS (in $ millions)

	Actual 2020-21	Actual 2019-20	Increase (Decrease)
Unrestricted Surplus	151	35	116
Invested in tangible capital assets	925	940	(15)
Endowments	76	75	1
Internally restricted surplus for insurance equity requirements and foundations	84	82	2
Accumulated Surplus	**1,236**	**1,132**	**104**
Accumulated Remeasurement Gains	56	4	52
Total Net Assets	**1,292**	**1,136**	**156**

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

Over the next several years, AHS will implement a number of priority initiatives that will support our mission of providing patient-focused quality care that is accessible for all Albertans. AHS plans to improve wait times for surgeries and diagnostic imaging and continue to increase and enhance the availability of community, continuing, and home care options. The implementation of Connect Care will continue and, in time, give healthcare providers immediate access to tools for decision-making and 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.

Financial Risks

COVID-19 Impacts

COVID-19 has created a variety of economic and health challenges. Many Albertans are at risk of job loss, face poor mental health, and struggle with addiction or homelessness. Such factors reduce the ability to prioritize personal wellness. The pandemic also played a significant role in how healthcare programs and services are delivered to Albertans including impacts to surgery volumes and wait times, emergency department visits, and continuing care placements. AHS anticipates these factors will ultimately increase the demand for many services in our system.

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 and financial benefits from these initiatives could be delayed.

Population Growth and Demand

As Alberta's population grows and ages, the demand for healthcare services is increasing. These factors are driving increased demand and costs across all areas of the health care system. AHS will work with Alberta Health to focus on wellness instead of illness, as well as on community-based care so that we can reduce our reliance on hospital and other facility-based care. AHS will empower Albertans to be full partners in all health decisions by providing them with access to their own health information and multidisciplinary teams within their communities.

Financial Sustainability

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. AHS is committed to finding the most cost-effective way to deliver quality care. This includes the ongoing implementation of the recommendations from the AHS Performance Review. While many initiatives have been deferred due to AHS' response to the COVID-19 pandemic, we will continue to implement a portion of the initiatives in a safe and collaborative manner.

The largest cost for AHS is compensation for our workforce, including physician fees, purchased services and compensation related to contracted clinical service providers. If contracts are modified, there will be financial implications, and complying with workforce changes in accordance with collective agreement requirements may impact AHS' ability to implement savings initiatives.

Health care costs have been rising more rapidly than inflation. Costs associated with treating patients are also increasing. Expenses may be higher in areas such as drugs, medical and surgical supplies and contracted services. AHS is working on initiatives to mitigate cost increases including contract reviews and bulk purchasing opportunities.

Infrastructure

Facilities, equipment, and information technology systems are vital to the delivery of health care services. 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; however, AHS' infrastructure is aging and there is an increased need for investment to reduce future pressures. AHS will continue to work with Alberta Health and Alberta Infrastructure to develop multi-year capital plans and align investments to the highest needs.

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".

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 subcommittees, 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 an established Internal Audit function with the mandate of providing independent advisory and assurance services to management and the Board on AHS operations. Internal Audit's work takes a risk-based approach to evaluating and advising on the efficiency and effectiveness of AHS' governance, risk management practices, and financial and management controls and processes. 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 key organizational risks, as well as working with the Board and management to better understand and manage risk.

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".

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, respirology intensive care, obstetrics, pediatrics, mental health, emergency, day/night care, clinics, day surgery, communicable diseases, 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, health protection. This category also includes immunizations, traveller's health clinics, outbreaks, screening programs, and disease surveillance. Excludes activities associated with treatment of communicable diseases.

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, including personal protective equipment.

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, 2021

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the year ended March 31, 2021 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]

Colleen Purdy, CPA, CMA
Vice President Corporate Services and Chief Financial Officer
Alberta Health Services

June 1, 2021

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, 2021, and the consolidated statements of operations, remeasurement gains and losses, change in net debt, 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, 2021, 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 1, 2021
Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS YEAR ENDED MARCH 31			
	2021		2020
	Budget (Note 3)	Actual	Actual
Revenues:			
Alberta Health transfers			
Base operating	$ 12,600,000	$ 12,756,769	$ 12,598,000
One-time base operating (Note 26)	-	145,566	-
Other operating	1,292,000	2,480,646	1,290,302
Recognition of expended deferred capital revenue	61,000	76,407	61,354
Other government transfers (Note 4)	427,000	461,929	434,768
Fees and charges	520,000	419,895	532,250
Ancillary operations	134,000	63,485	129,129
Donations, fundraising, and non-government contributions (Note 5)	161,000	184,870	195,980
Investment and other income (Note 6)	179,000	199,519	226,752
TOTAL REVENUES	**15,374,000**	**16,789,086**	**15,468,535**
Expenses:			
Continuing care	1,175,000	1,318,533	1,176,468
Community care	1,537,000	1,666,107	1,525,789
Home care	717,000	680,119	716,561
Acute care	4,876,000	5,221,569	5,065,807
Ambulance services	535,000	542,463	530,662
Diagnostic and therapeutic services	2,454,000	2,719,600	2,539,566
Population and public health	349,000	754,294	357,117
Research and education	352,000	333,133	344,634
Information technology	643,000	626,792	597,005
Support services (Note 7)	2,270,000	2,330,557	2,287,205
Administration (Note 8)	466,000	492,247	473,544
TOTAL EXPENSES (Schedules 1 and 3)	**15,374,000**	**16,685,414**	**15,614,358**
ANNUAL OPERATING SURPLUS (DEFICIT)	**-**	**103,672**	**(145,823)**
Accumulated surplus, beginning of year	1,132,000	1,132,601	1,278,424
Accumulated surplus, end of year (Note 20)	**$ 1,132,000**	**$ 1,236,273**	**$ 1,132,601**

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

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31		
	2021 Actual	2020 Actual
Financial Assets:		
Cash and cash equivalents	$ 477,148	$ 538,778
Portfolio investments (Note 10)	2,231,069	1,472,195
Accounts receivable (Note 11)	665,415	610,571
	3,373,632	2,621,544
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,932,777	1,611,914
Employee future benefits (Note 13)	760,786	711,995
Unexpended deferred operating revenue (Note 14)	641,469	405,951
Unexpended deferred capital revenue (Note 15)	165,111	108,823
Debt (Note 17)	455,659	481,551
	3,955,802	3,320,234
NET DEBT	**(582,170)**	**(698,690)**
Non-Financial Assets:		
Tangible capital assets (Note 18)	9,355,263	8,855,960
Inventories for consumption (Note 19)	563,928	127,298
Prepaid expenses, deposits, and other non-financial assets	209,366	211,480
	10,128,557	9,194,738
NET ASSETS BEFORE EXPENDED DEFERRED REVENUE	9,546,387	8,496,048
Expended deferred revenue (Note 16)	8,254,337	7,359,615
NET ASSETS	**1,292,050**	**1,136,433**
Net Assets is comprised of:		
Accumulated surplus (Note 20)	1,236,273	1,132,601
Accumulated remeasurement gains	55,777	3,832
	$ 1,292,050	**$ 1,136,433**

Contractual Obligations and Contingent Liabilities (Note 21)
Impact of COVID-19 (Note 26)

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			
	2021		2020
	Budget (Note 3)	Actual	Actual
Annual operating surplus (deficit)	$ -	$ 103,672	$ (145,823)
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets (Note 18):			
Purchased tangible capital assets	(611,000)	(455,920)	(502,732)
Leased tangible capital assets	-	(63,214)	(30,751)
Contributed tangible capital assets	(627,000)	(543,751)	(523,196)
Amortization and loss on disposals/write-downs of tangible capital assets (Note 18)	586,000	563,582	581,723
Effect of other changes:			
Net increase in expended deferred capital revenue	591,000	467,277	434,497
Net increase in expended deferred operating revenue	-	427,445	-
Net decrease (increase) in inventories for consumption	50,000	(436,630)	(20,789)
Net decrease (increase) in prepaid expenses, deposits and other non-financial assets	30,000	2,114	(43,758)
Net remeasurement gains (losses) for the year	17,000	51,945	(30,637)
Decrease (increase) in net debt for the year	**36,000**	**116,520**	**(281,466)**
Net debt, beginning of year	(698,000)	(698,690)	(417,224)
Net debt, end of year	**$ (662,000)**	**$ (582,170)**	**$ (698,690)**

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

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31			
	2021		2020
	Budget (Note 3)	Actual	Actual
Unrestricted unrealized gains (losses) attributable to:			
Derivatives	$ -	$ (1,245)	$ 539
Portfolio investments	38,000	82,973	(5,933)
Amounts reclassified to the Consolidated Statement of Operations:			
Portfolio investments	(21,000)	(29,783)	(25,243)
Net remeasurement gains (losses) for the year	**17,000**	**51,945**	**(30,637)**
Accumulated remeasurement gains, beginning of year	4,000	3,832	34,469
Accumulated remeasurement gains, end of year (Note 10)	**$ 21,000**	**$ 55,777**	**$ 3,832**

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

CONSOLIDATED STATEMENT OF CASH FLOWS YEAR ENDED MARCH 31	2021 Actual	2020 Actual
Operating transactions:		
Annual operating surplus (deficit)	$ 103,672	$ (145,823)
Non-cash items:		
Amortization and loss on disposals/write-downs of tangible capital assets	563,582	581,723
Recognition of expended deferred capital revenue	(385,639)	(404,405)
Contributed inventories for consumption	107,460	-
Recognition of expended deferred operating revenue	(67,930)	-
Gain on disposal of portfolio investments	(36,946)	(28,057)
Change in employee future benefits	48,791	23,499
Decrease (increase) in:		
Accounts receivable related to operating transactions	(54,844)	(243,849)
Inventories for consumption	(436,630)	(20,789)
Prepaid expenses, deposits, and other non-financial assets	2,114	(43,758)
Increase (decrease) in:		
Accounts payable and accrued liabilities	281,460	98,823
Unexpended deferred operating revenue	235,518	(47,268)
Expended deferred operating revenue	387,915	-
Cash provided by (applied to) operating transactions	748,523	(229,904)
Capital transactions:		
Purchased tangible capital assets	(455,920)	(502,732)
Cash applied to capital transactions	(455,920)	(502,732)
Investing transactions:		
Purchase of portfolio investments	(2,339,784)	(2,686,092)
Proceeds on disposals of portfolio investments	1,669,801	3,490,385
Cash (applied to) provided by investing transactions	(669,983)	804,293
Financing transactions:		
Restricted capital contributions received	366,649	300,533
Unexpended deferred capital revenue returned	(1,196)	(4,398)
Proceeds from debt	-	157,000
Principal payments on debt	(25,892)	(23,091)
Payments on obligations under capital leases	(22,327)	(23,814)
Net (repayment) receipt of life lease deposits	(1,484)	281
Cash provided by financing transactions	315,750	406,511
(Decrease) Increase in cash and cash equivalents	**(61,630)**	**478,168**
Cash and cash equivalents, beginning of year	538,778	60,610
Cash and cash equivalents, end of year	**$ 477,148**	**$ 538,778**

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS FOR THE YEAR ENDED MARCH 31, 2021

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 revenues and expenses associated with its responsibilities. These consolidated financial statements do not reflect the complete costs of provincial health care.

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. - provides medical diagnostic services throughout Alberta. AHS owns 100% of the Class A voting shares.
- CapitalCare Group Inc. - 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 an employee of AHS.

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 *(operating as Calgary Health Foundation)*
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)

  The 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, The LPIP ceased providing new liability coverage and continues in operation for the limited purpose of winding up its affairs.

  The LPIP has a fiscal year end of December 31, 2020. Significant transactions occurring between this date and March 31, 2021 have been recorded in these consolidated financial statements.

- 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 23).

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:

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
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 24).

(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.

In addition, AHS provides administrative services to certain foundations and contracted health care providers not included in these consolidated financial statements.

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

(i) Government Transfers

Transfers from AH, other Province of Alberta 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, expended deferred capital revenue and expended deferred operating revenue. The term deferred revenue in these consolidated financial statements refers to the components of deferred revenue as described.

(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 recorded 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 deferred until recognized 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 at fair value and 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 and Cash Equivalents

Cash is comprised of cash on hand and demand deposits. Cash equivalents include amounts in interest bearing accounts and are subject to an insignificant risk of change in value. Cash and cash equivalents are held for the purpose of meeting short-term commitments rather than for investment purposes.

(f) Inventories For Consumption

Purchased inventories for consumption are valued at lower of cost (defined as moving average cost) and replacement cost. Contributed inventories for consumption are recorded at fair value when such value can reasonably be determined. Inventories for consumption are assessed for obsolescence annually and write-downs are recorded in the Consolidated Statement of Operations.

(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	10-70 years (2020 – 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 of tangible capital assets which transfer substantially all benefits and risks of ownership are accounted for as leased tangible capital assets and leasehold improvements are amortized over the term of the lease. Obligations under capital leases are recorded at the present value of the minimum lease payments excluding executory costs (e.g. insurance, maintenance costs, etc.). 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 amount 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. Write-downs are recorded as expenses in the Consolidated Statement of Operations.

Intangibles and other assets inherited by right and that have not been purchased are not recognized in these consolidated financial statements. Similarly, 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 the LAPP and MEPP which are multi-employer registered defined benefit pension plans. 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 plans' 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.

(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' 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.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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.

(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 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.

The amount recorded for amortization of tangible capital assets is based on the estimated useful life of the related assets while the recognition of expended deferred capital revenue depends on when the terms for the use of the funding are met and, when applicable, AHS complies with its communicated use of the funding. The amounts recorded for accumulating non-vesting sick leave are based on various assumptions including the estimated service life of employees, drawdown rate of sick leave banks and rate of salary escalation. The establishment of the provision for unpaid claims relies on judgment and estimates including historical precedent and trends, prevailing legal, economic, social, and regulatory trends; and expectation as to future developments.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(m) Future Accounting Changes

The following accounting standards and guideline are applicable in future years:

- **PS 3280 – Asset Retirement Obligations (effective April 1, 2022)**
  PS 3280 provides guidance on how to account for and report a liability for retirement of a tangible capital asset.

- **PS 3400 – Revenue (effective April 1, 2023)**
  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.

- **PSG-8 – Intangible Assets (effective April 1, 2023)**
  PSG-8 provides guidance on the recognition, accounting, and classification of purchased intangible assets.

AHS is currently assessing the impact of these standards and guideline on future consolidated financial statements.

Note 3 Budget

The 2020-21 annual budget was submitted to the Minister on February 3, 2020 and was included as part of the Minister's published budget submission that was approved by the Legislative Assembly on March 17, 2020.

Note 4 Other Government Transfers

	Budget	2021	2020
Recognition of expended deferred capital revenue	$ 282,000	$ 275,022	$ 308,581
Restricted operating	105,000	154,063	92,152
Unrestricted operating	40,000	32,844	34,035
	$ 427,000	**$ 461,929**	**$ 434,768**

Other government transfers include $384,161 (2020 – $425,845) transferred from the Province of Alberta, $77,768 (2020 – $8,923) from government entities outside the Province of Alberta 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	2021	2020
Unrestricted operating	$ 3,000	$ 12,162	$ 3,940
Restricted operating (Note 14)	122,000	138,268	157,289
Recognition of expended deferred capital revenue (Note 16 (a))	36,000	34,210	34,470
Endowment contributions	-	230	281
	$ 161,000	**$ 184,870**	**$ 195,980**

Note 6 Investment and Other Income

	Budget	2021	2020
Investment income	$ 65,000	$ 63,660	$ 80,243
Other income:			
Province of Alberta (Note 22)	31,000	23,369	28,077
AH	11,000	12,520	12,562
Other [(i)]	72,000	99,970	105,870
	$ 179,000	**$ 199,519**	**$ 226,752**

[(i)] The Other balance of $99,970 (2020 - $105,870) mainly relates to recoveries for services provided to third parties.

Note 7 Support Services

	Budget	2021	2020
Facilities operations	$ 882,000	$ 927,997	$ 905,659
Patient health records, food services, and transportation	429,000	440,661	436,326
Housekeeping, laundry, and linen	217,000	231,855	220,500
Materials management	169,000	196,806	177,684
Support services expense of full-spectrum contracted health service providers	150,000	162,745	152,542
Ancillary operations	103,000	88,705	97,099
Fundraising expenses and grants awarded	49,000	46,861	48,635
Other	271,000	234,927	248,760
	$ 2,270,000	**$ 2,330,557**	**$ 2,287,205**

Note 8 Administration

	Budget	2021	2020
General administration	$ 213,000	$ 234,448	$ 220,679
Human resources	115,000	114,337	114,865
Finance	75,000	73,480	74,969
Communications	25,000	27,986	24,771
Administration expense of full-spectrum contracted health service providers	38,000	41,996	38,260
	$ 466,000	**$ 492,247**	**$ 473,544**

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.

The COVID-19 pandemic and the measures taken to contain the virus continue to impact the market as a whole. The situation is dynamic and the ultimate duration and magnitude of the impact on the economy and the financial effect on AHS is not known at this time.

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 3.10% (2020 – 3.24%) 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 $50,016 (2020 – $28,877).

Note 9 Financial Risk Management

(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 $49,592 or 2.21% of total portfolio investments (March 31, 2020 – $42,045 or 2.84%).

(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 and money market instruments.

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $52,994 (March 31, 2020 – $53,634).

Interest bearing securities have the following average maturity structure:

	2021	2020
0 – 1 year	58%	9%
1 – 5 years	20%	47%
6 – 10 years	10%	19%
Over 10 years	12%	25%

	Average Effective Market Yield	
Asset Class	**2021**	**2020**
Money market instruments	0.20%	0.83%
Fixed income securities	1.35%	2.03%

(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. Cash and cash equivalents and portfolio investments denominated in foreign currencies are 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, 2021, investments in non-Canadian equities represented 13.1% (March 31, 2020 – 18.4%) of total portfolio investments.

Note 9 Financial Risk Management (continued)

Foreign exchange fluctuations on cash balances are mitigated by derivatives and holding minimal foreign currency cash balances. AHS holds US dollar forward contracts to manage currency fluctuations relating to its US dollar accounts payable requirements. As at March 31, 2021, AHS held derivatives in the form of forward contracts for future settlement of $8,000 (2020 – $12,000). The fair value of these forward contracts as at March 31, 2021 was $8 (2020 – $1,253) 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.

The following table summarizes AHS' investment in debt securities by counterparty credit rating at March 31, 2021. The unrated securities consist of low volatility pooled mortgages that are not rated on an active market.

Credit Rating	2021	2020
Investment Grade (AAA to BBB)	96%	89%
Unrated	4%	11%
	100%	**100%**

(c) Liquidity Risk

Liquidity risk is the risk that AHS will encounter difficulty under both normal and stressed conditions in meeting obligations associated with financial liabilities that are settled by delivery of cash and cash equivalents or another financial asset. Liquidity requirements of AHS are met through funding provided 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, which have not been drawn upon, as described in Note 17(b).

Note 10 Portfolio Investments

	2021		2020	
	Fair Value	Cost	Fair Value	Cost
Cash held for investing purposes	**$ 119,313**	**$ 119,313**	**$ 112,072**	**$ 112,072**
Interest bearing securities:				
Money market securities	818,910	818,910	38,076	38,076
Fixed income securities	786,459	783,669	891,544	876,913
	1,605,369	**1,602,579**	**929,620**	**914,989**
Equities:				
Canadian equity investments	54,802	43,885	44,554	47,368
Canadian equity funds	83,912	65,759	66,937	73,807
Global equity funds	327,050	235,030	278,175	256,183
	465,764	**344,674**	**389,666**	**377,358**
Real estate pooled funds	**40,623**	**40,342**	**40,837**	**40,267**
	$ 2,231,069	**$ 2,106,908**	**$ 1,472,195**	**$ 1,444,686**

	2021	2020
Items at fair value		
Portfolio investments designated to the fair value category	$ 2,176,259	$ 1,426,388
Portfolio investments in equity instruments that are quoted in an active market	54,802	44,554
Derivatives	8	1,253
	$ 2,231,069	**$ 1,472,195**

Included in portfolio investments is $227,688 (2020 – $233,282) that is restricted for use as per the requirements in Sections 99 and 100 of the *Insurance Act* (Alberta). Endowment principal included in portfolio investments amounts to $75,668 (2020 – $75,438).

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

	2021	2020
Accumulated remeasurement gains	$ 55,777	$ 3,832
Restricted unrealized net gains attributable to unexpended deferred operating revenue (Note 14(b))	68,384	23,677
	$ 124,161	**$ 27,509**

Fair Value Hierarchy

	2021			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ 119,313	$ -	$ -	$ 119,313
Interest bearing securities:				
Money market securities	-	818,910	-	818,910
Fixed income securities	-	734,874	51,585	786,459
Equities:				
Canadian equity investments	54,802	83,912	-	138,714
Global equity funds	-	327,050	-	327,050
Real estate pooled funds	-	-	40,623	40,623
	$ 174,115	**$ 1,964,746**	**$ 92,208**	**$ 2,231,069**
Percent of total	8%	88%	4%	100%

Note 10 Portfolio Investments (continued)

	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	-	816,331	75,213	891,544
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	**$ 1,199,519**	**$ 116,050**	**$ 1,472,195**
Percent of total	11%	81%	8%	100%

Reconciliation of Investments classified as level 3

	2021		
	Fixed income securities	Real estate pooled funds	Total
Beginning of year	$ 75,213	$ 40,837	$ 116,050
Purchases	1,828	74	1,902
Sales	(24,045)	-	(24,045)
Loss (gain) included in the Consolidated Statement of Remeasurement Gains and Losses	1,708	(288)	1,420
Transfers out	(3,119)		(3,119)
End of year	**$ 51,585**	**$ 40,623**	**$ 92,208**

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

Note 11 Accounts Receivable

	2021			2020
	Gross	Allowance for Doubtful Accounts	Net	Net
AH operating transfers receivable	$ 317,233	$ -	$ 317,233	$ 268,119
Other capital transfers receivable	74,409	-	74,409	62,716
Patient accounts receivable	104,341	34,490	69,851	99,976
Drugs rebates receivable	59,731	-	59,731	60,624
AH capital transfers receivable	55,822	-	55,822	40,707
Other operating transfers receivable	17,540	-	17,540	21,667
Other accounts receivable	71,230	401	70,829	56,762
	$ 700,306	**$ 34,891**	**$ 665,415**	**$ 610,571**

Accounts receivable are unsecured and non-interest bearing. At March 31, 2020, the total allowance for doubtful accounts was $35,016.

Note 12 Accounts Payable and Accrued Liabilities

	2021	2020
Payroll payable and related accrued liabilities	$ 796,747	$ 611,513
Trade accounts payable and accrued liabilities	713,204	636,041
Provision for unpaid claims[(a)]	214,611	208,830
Obligations under capital leases[(b)]	144,877	103,990
Other liabilities	63,338	51,540
	$ 1,932,777	**$ 1,611,914**

Accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $338,379 (2020 – $305,843). Of these amounts, $11,518 (2020 – $13,002) comprise life lease deposits received from tenants of certain AHS' long term care facilities, amounts payable to AI of $97,050 (2020 – $109,150) 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 1.90% (2020 – 2.25%) plus a provision for adverse deviation, based on actuarial estimates.

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

The obligations will be settled between 2021 and 2039 and have an implicit interest rate payable ranging from 0.92% to 5.07% (2020 – 1.93% to 5.07%).

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

Year ended March 31	Minimum Contract Payments
2022	$ 34,643
2023	21,627
2024	10,372
2025	9,434
2026	8,462
Thereafter	88,625
	173,163
Less: interest	(28,286)
	$ 144,877

Note 13 Employee Future Benefits

	2021	2020
Accrued vacation pay	$ 626,599	$ 582,819
Accumulating non-vesting sick leave[(a)]	130,745	124,652
SERP/SPP pension plans	3,442	4,524
	$ 760,786	**$ 711,995**

(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.

	2021	2020
Funded status – deficit	$ 149,885	$ 153,419
Unamortized net actuarial (loss) gain	(19,140)	(28,767)
Accrued benefit liability	**$ 130,745**	**$ 124,652**

Note 13 Employee Future Benefits (continued)

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

	2021	2020
Estimated average remaining service life	13 years	13 years
Draw down rate of accumulated non-vesting sick leave bank	18.30%	18.30%
Discount rate – beginning of year	2.14%	3.51%
Discount rate – end of year	1.77%	2.14%
Rate of compensation increase per year	2020-21	2019-20
	0.25%	0.75%
	2021-22	2020-21
	0.25%	0.75%
	Thereafter	Thereafter
	2.25%	2.75%

(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 47% (2020-46%) 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

The LAPP carried out an actuarial valuation as at December 31, 2019 and these results were then extrapolated to December 31, 2020.

	December 31, 2020	December 31, 2019
LAPP net assets available for benefits	$ 53,599,237	$ 50,520,461
LAPP pension obligation	48,637,900	42,607,200
LAPP surplus	**$ 4,961,337**	**$ 7,913,261**

The 2021 and 2020 LAPP contribution rates are as follows:

Calendar 2021		Calendar 2020	
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

	2021	2020
Local Authorities Pension Plan	$ 536,504	$ 547,168
Defined contribution pension plans and group RRSPs	43,561	45,029
Other pension plans	4,417	2,473
	$ 584,482	**$ 594,670**

Note 14 Unexpended Deferred Operating Revenue

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

	2021				2020
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 115,061	$ 25,019	$ 265,871	$ 405,951	$ 453,219
Received or receivable during the year, net of repayments	3,051,861	48,361	141,468	3,241,690	1,493,467
Unexpended deferred operating revenue returned	(4,170)	(56)	(690)	(4,916)	(14,134)
Restricted investment income	153	2,031	10,833	13,017	13,128
Transferred from unexpended deferred capital revenue [(ii)]	4,499	40,680	1,486	46,665	32,253
Transferred to expended deferred operating revenue	(789,166)	-	-	(789,166)	-
Recognized as revenue	(2,079,395)	(86,133)	(138,268)	(2,303,796)	(1,539,743)
Miscellaneous other revenue recognized	(154)	178	(12,707)	(12,683)	(13,565)
	298,689	**30,080**	**267,993**	**596,762**	**424,625**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	1,507	(519)	43,719	44,707	(18,674)
Balance, end of year	**$ 300,196**	**$ 29,561**	**$ 311,712**	**$ 641,469**	**$ 405,951**

[(i)] The balance at March 31, 2021 for other government includes $677 (2020 – $1,007) of unexpended deferred operating revenue received from government entities outside the Province of Alberta. The remaining balance in other government all relates to the Province of Alberta, see Note 22.

[(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.

Note 14 Unexpended Deferred Operating Revenue (continued)

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

	2021				2020
	AH	Other Government	Donors and Non-Government	Total	Total
Research and education	$ 10,038	$ 3,505	$ 175,335	$ 188,878	$ 176,891
COVID-19 pandemic response and Support (Note 26)	108,040	-	374	108,414	-
Support services	1,298	383	56,487	58,168	62,622
Physician revenue and alternate relationship plans	47,842	374	-	48,216	36,684
Addiction and mental health	41,379	3,753	765	45,897	35,127
Cancer prevention, screening and treatment	43,704	11	1,676	45,391	6,473
Primary Care Networks	21,095	-	-	21,095	24,778
Promotion, prevention and community	16,081	1,022	259	17,362	3,929
Long term care partnerships	-	17,304	-	17,304	15,093
Others less than $10,000	9,121	190	13,049	22,360	20,677
	298,598	**26,542**	**247,945**	**573,085**	**382,274**
Unrealized net gain attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 10)	1,598	3,019	63,767	68,384	23,677
	$ 300,196	**$ 29,561**	**$ 311,712**	**$ 641,469**	**$ 405,951**

Note 15 Unexpended Deferred Capital Revenue

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

	2021				2020
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 37,670	$ 4,637	$ 66,516	$ 108,823	$ 128,394
Received or receivable during the year	247,143	115,609	50,562	413,314	332,786
Unexpended deferred capital revenue returned	(1,196)	-	-	(1,196)	(4,398)
Transferred to expended deferred capital revenue	(204,524)	(75,359)	(29,282)	(309,165)	(315,706)
Transferred to unexpended deferred operating revenue[(ii)]	(4,499)	(40,680)	(1,486)	(46,665)	(32,253)
Balance, end of year	**$ 74,594**	**$ 4,207**	**$ 86,310**	**$ 165,111**	**$ 108,823**

[(i)] The balance at March 31, 2021 for other government all relates to the Province of Alberta, see Note 22.
[(ii)] The transfer is mainly comprised of restricted capital funding of approved expenditures that did not meet the definition of a tangible capital asset.

Note 15 Unexpended Deferred Capital Revenue (continued)

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

	2021	2020
AH		
COVID-19 related projects and equipment	$ 29,380	$ -
Continuing Care Beds	20,000	-
Information systems	4,214	11,118
Medical Equipment Replacement Upgrade Program	322	1,457
Diagnostic equipment	216	18,189
Other equipment	20,462	6,906
Total AH	**74,594**	**37,670**
Other government		
Facilities and improvements	4,207	4,637
Total other government	**4,207**	**4,637**
Donors and non-government		
Equipment	74,540	59,809
Facilities and improvements	11,764	6,707
COVID-19 related projects and equipment	6	-
Total donors and non-government	**86,310**	**66,516**
	$ 165,111	**$ 108,823**

Note 16 Expended Deferred Revenue

	2021	2020
Expended deferred capital revenue[(a)]	$ 7,826,892	$ 7,359,615
Expended deferred operating revenue[(b)]	427,445	-
	$ 8,254,337	**$ 7,359,615**

(a) Expended deferred capital revenue

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

	2021				2020
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 459,415	$ 6,698,991	$ 201,209	$ 7,359,615	$ 6,925,118
Transferred from unexpended deferred capital revenue	204,525	75,358	29,282	309,165	315,706
Contributed tangible capital assets	-	543,418	333	543,751	523,196
Less: amounts recognized as revenue	(76,407)	(275,022)	(34,210)	(385,639)	(404,405)
Balance, end of year	**$ 587,533**	**$ 7,042,745**	**$ 196,614**	**$ 7,826,892**	**$ 7,359,615**

[(i)] The balance includes $5 of expended deferred capital revenue received from government entities outside the Province of Alberta (2020 – $20). The remaining balance relates to the Province of Alberta, see Note 22.

Note 16 Expended Deferred Revenue (continued)

(b) Expended deferred operating revenue

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

	2021			2020
	AH	Other Government[(i)]	Total	Total
Balance, beginning of year	$ -	$ -	$ -	$ -
Transferred from unexpended deferred operating revenue	789,166	-	789,166	-
Contributed inventories for consumption	-	107,460	107,460	-
Less: amounts recognized as revenue	(401,251)	(67,930)	(469,181)	-
Balance, end of year	**$ 387,915**	**$ 39,530**	**$ 427,445**	**$ -**

[(i)] The balance relates to contributions received from a government entity outside the Province of Alberta (2020 – $ nil)

The balance at March 31, 2021 of expended deferred operating revenue pertains to purchased or contributed but unused COVID-19 supplies of $417,201 (2020 - $ nil) (Note 19) and a related prepayment of $10,244 (2020 - $nil).

Note 17 Debt

	2021	2020
Debentures [(a)]:		
Parkade loan #1	$ 20,257	$ 23,447
Parkade loan #2	20,334	22,984
Parkade loan #3	28,493	31,338
Parkade loan #4	116,390	124,680
Parkade loan #5	28,498	30,388
Parkade loan #6	20,559	21,576
Parkade loan #7	45,388	47,479
Parkade loan #8	155,200	157,000
Energy savings initiative loan	20,540	22,336
Other	-	323
	$ 455,659	**$ 481,551**

(a) In November 2019, *the Reform of Agencies, Boards and Commissions and Government Enterprises Act, 2019* (Bill 22) received Royal Assent in the Legislative Assembly of Alberta. This legislation included the new *Local Authorities Capital Financing Act* allowing for the dissolution of the Alberta Capital Finance Authority (ACFA) and the transfer of ACFA's operations to the Province of Alberta.

Alberta Treasury Board and Finance (TBF), on behalf of the Province, became responsible for the administration of ACFA's lending program effective November 1, 2020 following dissolution of ACFA on October 31, 2020.

AHS issued debentures to TBF, 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 TBF 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 relating to its debentures as at March 31, 2021.

Note 17 Debt (continued)

The maturity dates and interest rates for the outstanding 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, 2021, AHS has access to a $220,000 (2020 - $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, 2021, AHS has $nil (2020 - $nil) draws against this facility.

AHS also has access to a $33,000 (2020 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2021, AHS has $3,772 (2020 – $4,687) 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 as at March 31, 2021.

(c) AHS is committed to making principal and interest payments with respect to its outstanding debt as follows:

Year Ended March 31	Principal	Interest	Total
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
2026	31,565	12,967	44,532
Thereafter	310,351	131,906	442,257
	$ 455,659	**$ 209,258**	**$ 664,917**

During the year, the total interest related to debt was $18,827 (2020 – $15,864). Accrued interest at March 31, 2021 amounted to $3,006 (2020 - $3,153).

Note 18 Tangible Capital Assets

Cost	2020	Additions[a]	Transfers	Disposals/write-downs[b]	2021
Facilities and improvements	$ 9,645,300	$ -	$ 874,506	$ (1,954)	$ 10,517,852
Work in progress	1,744,688	875,266	(1,127,112)	-	1,492,842
Equipment	2,623,616	162,205	(7,147)	(53,851)	2,724,823
Information systems	1,827,799	25,414	175,590	(14,010)	2,014,793
Building service equipment	840,122	-	78,034	-	918,156
Land[c]	116,926	-	-	(86)	116,840
Leased facilities and improvements	255,393	-	1,307	-	256,700
Land improvements	105,581	-	4,822	(380)	110,023
	$ 17,159,425	**$ 1,062,885**	**$ -**	**$ (70,281)**	**$ 18,152,029**

Accumulated Amortization	2020	Amortization Expense	Effect of Transfers	Disposals/write-downs[b]	2021
Facilities and improvements	$ 4,175,901	$ 245,717	$ -	$ (1,250)	$ 4,420,368
Work in progress	-	-	-	-	-
Equipment	2,034,711	149,694	-	(53,109)	2,131,296
Information systems	1,356,789	104,110	-	(11,297)	1,449,602
Building service equipment	476,980	47,366	-	-	524,346
Land[c]	-	-	-	-	-
Leased facilities and improvements	187,033	9,192	-	-	196,225
Land improvements	72,051	3,258	-	(380)	74,929
	$ 8,303,465	**$ 559,337**	**$ -**	**$ (66,036)**	**$ 8,796,766**

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	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[c]	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	2020
Facilities and improvements	$ 3,915,175	$ 263,455	$ -	$ (2,729)	$ 4,175,901
Work in progress	-	-	-	-	-
Equipment	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[c]	-	-	-	-	-
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**

Note 18 Tangible Capital Assets (continued)

	Net Book Value	
	2021	2020
Facilities and improvements	$ 6,097,484	$ 5,469,399
Work in progress	1,492,842	1,744,688
Equipment	593,527	588,905
Information systems	565,191	471,010
Building service equipment	393,810	363,142
Land[(c)]	116,840	116,926
Leased facilities and improvements	60,475	68,360
Land improvements	35,094	33,530
	$ 9,355,263	**$ 8,855,960**

(a) Additions

Additions include total contributed tangible capital assets of $543,751 (2020 – $523,196) consisting of $543,417 from AI (2020 – $523,196) and $334 from other sources (2020 – $nil). Also included in additions is $45,525 (2020 - $nil) (Note 26) of COVID-19 related tangible capital assets. Capital lease additions amounted to $63,214 (2020 – $30,751).

(b) Write-Downs

Write-downs include work in progress of $nil (2020 - $22,615)

(c) 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

(d) Leased Tangible Capital Assets

Tangible capital assets acquired through capital leases includes equipment, information systems and facilities with a cost of $258,813 (2020 – $192,092) and accumulated amortization of $56,357 (2020 – $43,354).

Note 19 Inventories for consumption

Included in the March 31, 2021 inventory balance is $417,201 (2020 - $nil) (Note 26) of COVID-19 supplies such as personal protective equipment (PPE) and rapid test kits.

Note 20 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2021					2020
	Unrestricted Surplus	Invested in Tangible Capital Assets[a]	Endowments[b]	Internally Restricted Surplus for Insurance Equity Requirements and Foundations[c]	Total	Total
Balance, beginning of year	$ 34,417	$ 940,370	$ 75,438	$ 82,376	$ 1,132,601	$ 1,278,424
Annual operating surplus (deficit)	103,672	-	-	-	103,672	(145,823)
Net investment in tangible capital assets	14,807	(14,807)	-	-	-	-
Transfer of insurance equity requirements and foundations surpluses	(1,574)	-	-	1,574	-	-
Transfer of endowment contributions	(230)	-	230	-	-	-
Balance, end of year	**$ 151,092**	**$ 925,563**	**$ 75,668**	**$ 83,950**	**$ 1,236,273**	**$ 1,132,601**

(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:

	2021	2020
Tangible capital assets (Note 18)	$ 9,355,263	$ 8,855,960
Less funded by:		
Expended deferred capital revenue (Note 16 (a))	(7,826,892)	(7,359,615)
Debt (Note 17)	(455,659)	(481,551)
Unexpended debt	9,246	42,568
Obligations under capital leases (Note 12b)	(144,877)	(103,990)
Life lease deposits (Note 12)	(11,518)	(13,002)
	$ 925,563	**$ 940,370**

(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 $230 (2020 - $281) of contributions received in the year (Note 5).

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

Insurance equity requirements comprise surpluses of $20,912 (2020 - $28,237) related to equity of the LPIP mainly relating to legislative requirements per the Insurance Act. Foundations comprise surpluses amounting to $63,038 (2020 - $54,139) related to donations received by AHS' Controlled Foundations without external restrictions attached.

Note 21 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	Capital Projects	Total
2022	$ 3,361,378	$ 494,204	$ 62,635	$ 223,898	$ 4,142,115
2023	1,601,636	291,095	55,084	32,442	1,980,257
2024	1,192,785	169,780	45,978	2,331	1,410,874
2025	938,482	107,136	38,349	-	1,083,967
2026	811,574	70,342	28,136	-	910,052
Thereafter	7,803,650	101,449	97,951	-	8,003,050
March 31, 2021	**15,709,505**	**1,234,006**	**328,133**	**258,671**	**17,530,315**
March 31, 2020	**$ 14,162,596**	**$ 1,167,818**	**$ 297,858**	**$ 211,492**	**$ 15,839,764**

(i) Service obligations mainly relate to contracts with third parties for the provision of long-term care and home care services.
(ii) Other obligations mainly relate to contracts with third parties for maintenance, information technology services, software, equipment, acquisitions, and procurement of medical supplies and food.

(b) Contingent Liabilities

i. Legal Claims

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, 2021, 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 314 legal claims (2020 – 262 claims) related to conditions in existence at March 31, 2021 where the likelihood of the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 258 claims have $728,811 in specified amounts and 56 have no specified amounts (2020 – 222 claims with $498,678 of specified claims and 40 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that is different than the claimed amount.

ii. Collective Agreements

AHS currently has 19 (2020 – nil) collective agreements that have expired and are currently under negotiation at March 31, 2021. The outcome of these negotiations is not determinable at this time and no accrual has been made in the consolidated financial statements.

Note 22 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 Schedules 2A and 2B of these consolidated financial statements. Related party transactions with key management personnel primarily consist of compensation related payments and are undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length.

AHS is a related party with respect to those entities consolidated or included on a modified equity basis in the consolidated financial statements of the Province of Alberta. 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	
	2021	2020	2021	2020
Alberta Advanced Education	$ 55,415	$ 56,092	$ 182,453	$ 191,053
Alberta Infrastructure[c]	319,155	343,065	252	222
Other ministries[d]	35,040	58,326	57,497	29,794
Total for the year	**$ 409,610**	**$ 457,483**	**$ 240,202**	**$ 221,069**

	Receivable from		Payable to	
	2021	2020	2021	2020
Alberta Advanced Education[b]	$ 6,115	$ 6,545	$ 32,561	$ 33,967
Alberta Infrastructure[c]	43,834	25,477	97,050	109,150
Other ministries[d]	8,395	12,128	459,148	488,080
Balance, end of year	**$ 58,344**	**$ 44,150**	**$ 588,759**	**$ 631,197**

(a) Revenues with Province of Alberta ministries include other government transfers of $384,161 (2020 – $425,845), (Note 4), other income of $23,369 (2020 – $28,077) (Note 6), and fees and charges of $2,080 (2020 – $3,561).

(b) Most of AHS' transactions with Alberta 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 AI relate to the construction and funding of tangible capital assets. These transactions include operating transfers of $44,614 (2020 – $35,271) and recognition of expended deferred capital revenue of $274,541 (2020 – $307,794) 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 $543,417 (2020 – $523,196).

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

At March 31, 2021, AHS has recorded deferred revenue from other ministries within the Province of Alberta, excluding AH, of $28,884 (2020 – $24,012) related to unexpended deferred operating revenue (Note 14), $4,207 (2020 – $4,637) related to unexpended deferred capital revenue (Note 15) and $7,042,740 (2020 – $6,698,971) related to expended deferred capital revenue (Note 16 (a)).

Contingent liabilities in which AHS has been jointly named with other government entities within the Province of Alberta are disclosed in Note 21.

Note 23 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.

	2021	2020
Financial assets (portfolio investments, accounts receivable, other assets)	$ 67,275	$ 74,273
Liabilities (trade accounts payable, unexpended deferred operating revenue)	67,275	74,273
Accumulated surplus	$ -	$ -
Total revenues	$ 260,508	$ 260,975
Total expenses	260,508	260,975
Annual surplus	**$ -**	**$ -**

Note 24 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 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.

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

	2021	2020
Financial assets	$ 108,516	$ 128,181
Liabilities	17,698	17,486
Net financial assets	$ 90,818	$ 110,695
Non-financial assets	12	4
Net assets	**$ 90,830**	**$ 110,699**

AHS has included in prepaid expenses $57,179 (2020 – $74,828) representing in substance a prepayment of future premiums to the HBTA. For the fiscal year ended March 31, 2021, AHS paid premiums of $431,569 (2020 – $407,512) which is approximately 98% (2020 – 98%) of the total premiums received by the HBTA

(b) Other Trust Funds

AHS holds 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, 2021, the balance of funds held in trust by AHS for research and development is $100 (2020 – $100).

AHS holds funds in trust from continuing care residents for personal expenses. As at March 31, 2021, the balance of these funds is $1,595 (2020 – $1,390). 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, 2021, there are $30,329 in plan assets (2020 - $29,181). These amounts are not included in the consolidated financial statements.

Note 25 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.

(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.

Note 25 Segment Disclosure

(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, public relations, risk management, internal audit, and legal.

Note 26 Impact of COVID-19

The World Health Organization declared 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 with various public health measures implemented across the province throughout the year.

AHS continues to support Albertans with contact tracing, testing and treatment required in the response against COVID-19. AHS is working with the Province on deployment of the COVID-19 vaccine program as vaccine doses are received from AH.

The pandemic continues to impact AHS in many areas, including:

- The provision of personal protective equipment for the overall safety of Albertans. AHS continues to enter into significant purchase commitments to secure essential supplies required for the delivery of healthcare services. At the direction of the Minister, AHS also acquired personal protective equipment to provide to other provinces;
- Increases in funding provided to third party service providers, including long term care providers which have been significantly impacted by COVID-19;
- The operation of assessment and treatments centers, including significantly higher laboratory testing relating to COVID-19;
- Increasing capacity at acute care sites for treatment of COVID-19 cases as a result of increased demand for hospital supplies and equipment;
- Delays or deferrals of certain health care related services;
- Programs such as the critical worker benefit, which provide one-time payments to support front line workers;
- Redeployment of parts of the AHS workforce as the organization responded with measures such as contact tracing and testing, and health link support;
- Vaccine deployment initiatives including staffing and operational and information technology costs relating to the setup of various vaccination facilities;
- Temporary suspension of parking fees at all sites for patients and staff;
- Delays in the implementation of certain information systems initiatives; and
- Receiving donated ventilators, supplies and personal protective equipment as Albertans came together to assist in the response to COVID-19.

Note 26 Impact of COVID-19 (continued)

In order to support COVID -19 initiatives, AHS received contributions totaling approximately $2,042,730 during the year which were utilized as follows:

- $817,213 for incremental operating expenditures arising from activities performed by AHS as described above;
- $896,626 relating mainly to the purchase and contributions received of inventory items, of which $417,201 remained on hand as at March 31, 2021 (see Note 19);
- $145,566 for lost revenue resulting from reduced out of province and out of country patient billings, parking, self-pay medical fees, retail food services and rent abatements; and
- $45,525 in the acquisition of tangible capital assets (see Note 18(a)).

The remaining unexpended contributions have been included in unexpended deferred operating revenue of $108,414 (see Note 14(b)) and unexpended deferred capital revenue of $29,386 (see Note 15(b)) and will be utilized in the next fiscal year.

As Alberta progresses through the response to COVID-19, AHS continues to closely monitor the impacts of COVID-19 on its operations. 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 27 Corresponding Amounts

Certain amounts have been reclassified to conform to 2021 presentation.

Note 28 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on June 1, 2021 and submitted to the Minister for approval.

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

	2021		2020
	Budget (Note 3)	Actual	Actual
Salaries and benefits	$ 8,315,000	$ 8,836,269	$ 8,530,683
Contracts with health service providers	2,805,000	3,078,611	2,823,741
Contracts under the Health Care Protection Act	28,000	21,828	20,041
Drugs and gases	501,000	592,640	560,661
Medical supplies	584,000	652,304	581,490
Other contracted services	1,341,000	1,368,110	1,319,640
Other[a]	1,214,000	1,572,070	1,196,379
Amortization and loss on disposals/write-downs of tangible capital assets (Note 18)	586,000	563,582	581,723
	$ 15,374,000	**$ 16,685,414**	**$ 15,614,358**
(a) Significant amounts included in Other are:			
Housekeeping, laundry and linen, staff wearing apparel, plant maintenance and biomedical engineering supplies[i]	$ 81,000	$ 439,087	$ 86,877
Equipment expense	217,000	237,216	223,174
Utilities	114,000	129,022	115,577
Building rent	116,000	128,496	126,387
Building and ground expenses	124,000	95,966	85,683
Minor equipment purchases	47,000	74,794	51,922
Food and dietary supplies	77,000	69,530	80,855
Insurance and liability claims	39,000	58,180	42,439
Office supplies	51,000	57,701	60,311
Fundraising and grants awarded	49,000	47,323	52,298
Telecommunications	36,000	34,339	39,983
Travel	49,000	22,473	39,809
Licenses, fees and memberships	19,000	21,116	21,650
Education	18,000	8,325	11,893
Other	177,000	148,502	157,521
	$ 1,214,000	**$ 1,572,070**	**$ 1,196,379**

[i] Includes PPE, such as procedural masks, N95's, gowns, face shields and goggles, as well as other COVID-19 supplies such as hand sanitizers, disinfecting wipes and other cleaning supplies.

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

SCHEDULE 2A – BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2021

	Term	2021 Committees	2021 Remuneration	2020 Remuneration
Board Chairs[f]				
David Weyant	Since Aug 20, 2019	AOC, ARC, CEC, FC, GC, HRC, QSC	$ 71	$ 43
Linda Hughes	Nov 27, 2015 to Aug 19, 2019	-	-	26
Board Members				
Dr. Sayeh Zielke (Vice Chair)	Since Sep 28, 2020	ARC, CEC, FC, GC, HRC, QSC	21	-
Dr. Brenda Hemmelgarn (Vice Chair)	Nov 27, 2015 to Jan 22, 2021	CEC (Chair), FC, QSC	36	49
Deborah Apps	Since Jan 19, 2021	CEC, FC, QSC	6	-
David Carpenter	Since Nov 27, 2015	ARC (Chair), FC (Chair), HRC	37	34
Heather Crowshoe	Nov 3, 2016 to Nov 2, 2019	-	-	17
Tony Dagnone	Since Jan 19, 2021	FC, HRC, QSC	8	-
Richard Dicerni	Nov 27, 2015 to Aug 31, 2020	FC, HRC (Chair)	10	28
Sherri Fountain	Since Jan 19, 2021	AOC, FC, GC (Chair), HRC	8	-
Linda Hughes	Aug 20, 2019 to Sep 30, 2019	-	-	1
Stephen Mandel	Since Sep 25, 2019	AOC (Chair), CEC, FC, QSC	32	16
Heidi Overguard	Since Sep 25, 2019	AOC, CEC, FC, GC, HRC (Chair)	33	17
Natalia Reiman	Since Jan 19, 2021	CEC, FC, GC, HRC	8	-
Hugh Sommerville	Nov 27, 2015 to Jan 25, 2021	ARC, FC, GC (Chair)	24	32
Marliss Taylor	Nov 27, 2015 to Oct 24, 2019	-	-	18
Brian Vaasjo	Since Aug 20, 2019	AOC, ARC, FC, GC	32	19
Glenda Yeates	Since Nov 27, 2015	ARC, FC, QSC (Chair)	33	32
Vicki Yellow Old Woman	Since Sep 28, 2020	ARC, CEC (Chair), FC, GC, HRC	19	-
Board Committee Participants[g]				
Dr. Brian Postl	Since Jan 1, 2018	QSC	3	2
Gord Winkel	Since Nov 27, 2015	QSC	3	2
Total Board			**$ 384**	**$ 336**

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

SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2021

	2021						
For the Current Fiscal Year	**FTE [a]**	**Base Salary [b,h]**	**Other Cash Benefits [c]**	**Other Non-Cash Benefits [d]**	**Subtotal**	**Severance [e]**	**Total**
Board Direct Reports							
Andrea Beckwith-Ferraton – Chief Ethics and Compliance Officer[i]	0.57	$ 121	$ -	$ 25	$ 146	$ -	$ 146
Ronda White – Chief Audit Executive[j,s]	1.00	277	1	75	353	-	353
Dr. Verna Yiu – President and Chief Executive Officer[k,t]	1.00	574	-	119	693	-	693
CEO Direct Reports							
Dr. Francois Belanger – VP, Quality and Chief Medical Officer[l,s]	1.00	464	-	73	537	-	537
Dr. Ted Braun – VP and Medical Director, Clinical Operations[s]	1.00	397	-	92	489	-	489
Mauro Chies – VP, Cancer Care Alberta and Clinical Support Services[s]	1.00	330	-	81	411	-	411
Sean Chilton – VP, People, Health Professions and Information Technology[m,s]	1.00	330	1	68	399		399
Tina Giesbrecht – General Counsel[n,s]	0.43	109	3	30	142	-	142
Todd Gilchrist – VP, People[o,u]	0.57	255	-	39	294	-	294
Deb Gordon – VP and Chief Operating Officer, Clinical Operations[s]	1.00	370	-	135	505	-	505
Robert Hawes – Interim VP, Corporate Services and Chief Financial Officer[p,v]	0.27	96	9	4	109	-	109
Dr. Mark Joffe – VP and Medical Director, Cancer Care Alberta, Clinical Support Services and Provincial Clinical Excellence[q,w]	1.00	450	33	44	527	-	527
Colleen Purdy – VP, Corporate Services and ChiefFinancial Officer[r,s]	0.75	301	-	90	391	-	391
Dr. Kathryn Todd – VP, Provincial Clinical Excellence[q,w]	1.00	289	14	47	350	-	350
Colleen Turner – VP, Community Engagement and Communications[s]	1.00	330	-	72	402	-	402
Total Executive	**12.59**	**$ 4,693**	**$ 61**	**$ 994**	**$ 5,748**	**$ -**	**$ 5,748**

SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS (CONTINUED)
FOR THE YEAR ENDED MARCH 31, 2021

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

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 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 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.

	2021			2020			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2020	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2021
Andrea Beckwith-Ferraton - Chief Ethics and Compliance Officer	$ 4	$ -	$ 4	$ 6	$ 25	$ 7	$ 32
Dr. Francois Belanger - VP, Quality and Chief Medical Officer	35	-	35	36	326	66	392
Dr. Ted Braun - VP and Medical Director, Clinical Operations							
SERP	-	11	11	-	206	12	218
SPP	27	-	27	28	189	43	232
Mauro Chies - VP, Cancer Care Alberta and Clinical Support Services	19	-	19	20	138	30	168
Sean Chilton - VP, People, Health Professions and Information Technology	19	-	19	20	198	35	233
Tina Giesbrecht - General Counsel	10	-	10	11	64	17	81
Todd Gilchrist - VP, People	19	-	19	34	191	(191)	-
Deb Gordon - VP and Chief Operating Officer, Clinical Operations							
SERP	-	36	36	(1)	642	41	683
SPP	23	-	23	25	219	36	255
Robert Hawes - Interim VP, Corporate Servicesand Chief Financial Officer[v]	-	-	-	-	-	-	-
Dr. Mark Joffe - VP and Medical Director, Cancer Care Alberta, Clinical Support Servicesand Provincial Clinical Excellence[w]	-	-	-	-	-	-	-
Colleen Purdy - VP, Corporate Services and Chief Financial Officer	20	-	20	-	-	20	20
Dr. Kathryn Todd - VP, Provincial Clinical Excellence[w]	-	-	-	-	-	-	-
Colleen Turner - VP, Community Engagement and Communications	19	-	19	20	150	33	183
Ronda White - Chief Audit Executive	12	-	12	13	118	21	139
Dr. Verna Yiu - President and Chief Executive Officer	48	-	48	49	203	66	269

(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 plan's 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 SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2021

Definitions

a. For this schedule, full time equivalents (FTE) are determined by actual hours earned divided by 2,022.75 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.

c. Other cash benefits include, as applicable, honoraria, acting pay, membership fees, and lump sum payments. 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 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, 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.

Board and Board Committee Participants

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

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

Executive

h. 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, 2021, the number of work days at AHS is 261 (2020 – 262 work days).

i. As a result of restructuring, the incumbent ceased to be a direct report to the Board effective October 26, 2020.

j. 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.

k. 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.

l. The incumbent received a vacation payout of $35 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 received vacation payouts totaling $26 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.

n. As a result of restructuring, the incumbent became a direct report to the President and Chief Executive Officer effective October 26, 2020.

o. The incumbent held the position until October 23, 2020 at which time the incumbent left AHS. At this time, the incumbent received a vacation payout of $49 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.

p. The term of the temporary position ended July 8, 2020.

q. 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.

r. The incumbent was appointed to the position effective July 1, 2020.

Termination Obligations

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

FOOTNOTES TO THE CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS (CONTINUED) FOR THE YEAR ENDED MARCH 31, 2021

t. 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.

u. Based on the provision of the applicable SPP, the following outlines the benefits received by the incumbent who terminated employment with AHS within the 2020-21 fiscal period. As a result of this termination, the incumbent is entitled to the benefits accrued to them up to the date of termination. For participants of SPP, the benefit includes the account balances as at March 31, 2020 and the current period benefit costs and investment gains or losses related to the account that were incurred during the current year.

Supplemental Plan Commencement Date	Benefit (not in thousands)	Frequency	Payment Terms
May 4, 2015	$219,030	Once	November 2020

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

w. 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.

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

	2021								
	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	$ 330,419	$ 930,329	$ -	$ 8,301	$ 5,679	$ 9,293	$ 31,942	$ 2,570	$ 1,318,533
Community care	693,825	836,030	-	4,427	3,549	59,099	68,546	631	1,666,107
Home care	339,150	215,509	-	194	9,716	86,642	28,867	41	680,119
Acute care	3,084,131	406,462	21,828	546,778	339,940	556,025	200,813	65,592	5,221,569
Ambulance services	311,550	172,407	-	2,001	4,878	1,499	31,427	18,701	542,463
Diagnostic and therapeutic services	1,665,709	300,123	-	25,632	246,237	313,965	117,549	50,385	2,719,600
Population and public health	437,911	15,572	-	2,668	32,663	31,650	233,510	320	754,294
Research and education	188,877	2,161	-	96	1,993	120,234	19,653	119	333,133
Information technology	302,708	18,285	-	-	7	28,092	175,120	102,580	626,792
Support services	1,113,775	164,706	-	2,541	7,406	130,816	591,618	319,695	2,330,557
Administration	368,214	17,027	-	2	236	30,795	73,025	2,948	492,247
Total	**$ 8,836,269**	**$ 3,078,611**	**$ 21,828**	**$ 592,640**	**$ 652,304**	**$ 1,368,110**	**$ 1,572,070**	**$ 563,582**	**$ 16,685,414**

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF SEGMENT DISCLOSURES (CONTINUED) 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	$ 321,316	$ 806,123	$ -	$ 7,881	$ 4,533	$ 5,802	$ 28,489	$ 2,324	$ 1,176,468
Community care	698,728	698,918	-	4,445	3,451	52,003	67,693	551	1,525,789
Home care	338,741	257,699	-	187	9,308	88,298	22,244	84	716,561
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**

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, 2022. 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 to attract, retain, and engage talented and committed employees. AHS' total compensation is comprised of direct, indirect, and non-financial 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. Non-financial compensation includes employee appreciation initiatives that support the health and well-being of employees.

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) and terms and conditions.

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 $172,221 in 2020. 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, 2021 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, 2020, and March 31, 2021. 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, 2021. The Schedule 2 information on total compensation philosophy and practices can be found on the AHS website.

Total Compensation 2020-21 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 $132,924 in the 2019 calendar year on AHS' external website and the Alberta Government compensation disclosure database by June 30, 2020. AHS will continue this process by disclosing the names and compensation of employees whose earnings are over $135,317 for the 2020 calendar year.

Effective April 1, 2018, the Government of Alberta also enacted a new Salary Restraint Regulation which formalizes the 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 2021, the Government of Alberta extended the salary freeze without interruption and with the same key provisions for the salary restraint up to March 31, 2022.

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 is required to submit an executive compensation plan to government. This compensation plan is submitted annually to demonstrate how AHS aligns to the key compensation principles outlined in RABCCA and help ensure alignment of its compensation practices. Transparency will continue through mandated salary disclosure.

Appendix

Quick Facts

The table below provides a snapshot of AHS activity and demonstrates service level changes over the last few years.

Provincial Quick Facts	2017-18	2018-19	2019-20	2020-21
Primary Care / Population Health				
Ambulatory Care Visits	6,638,806	6,578,463	Not available	Not available
Number of Unique/Individual Home Care Clients	114,874	119,974	125,143	118,093
Number of People Placed in Continuing Care	7,927	8,098	8,521	7,427
Health Link Calls*	706,280	694,313	891,931	2,291,243
Poison Information Calls (PADIS)	39,270	38,785	39,253	38,718
Seasonal Influenza Immunizations	1,229,350	1,317,659	1,438,866	1,650,836
EMS Events	544,744	560,434	589,498	602,283
Food Safety Inspections	78,311	65,560	48,247	26,171
Acute Care				
Emergency Department Visits (all sites)	2,101,629	2,056,631	2,062,527	1,552,016
Urgent Care Visits	198,108	197,401	202,925	148,162
Hospital Discharges	400,909	401,208	399,281	358,046
Births	51,692	50,793	49,981	46,604
Total Hospital Days	2,862,324	2,853,001	2,852,150	2,505,056
Average Length of Stay (in days)	7.1	7.1	7.1	7.0
Diagnostic / Specific Procedures				
Hip Replacements (scheduled and emergency)	6,191	6,279	6,605	5,800
Knee Replacements (scheduled and emergency)	6,556	6,617	6,233	5,125
Cataract Surgery	39,340	40,554	45,236	44,289
Main Operating Room Activity	290,783	291,444	289,535	268,340
MRI Exams	195,017	204,744	201,118	205,793
CT Exams	415,755	441,938	427,508	462,443
X-rays	1,857,946	1,845,811	1,846,918	1,532,099
Lab Tests	76,974,638	80,237,687	81,188,409	72,981,951
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)	639,449	668,817	704,191	737,212
Unique/Individual Cancer Patients	58,409	59,249	62,513	60,902
Addiction and Mental Health				
Mental Health Hospital Discharges (acute care sites)	24,087	25,725	26,443	27,083
Community Treatment Orders (CTOs) Issued	492	494	538	578
Addiction Residential Treatment & Detoxification Admissions	11,021	10,551	10,349	8,157

Data updated as of May 17, 2021. Definitions can be found at https://www.ahs.ca/about/Page11905.aspx.
** Health Link call volumes include COVID-19 inquiries and vaccination appointment booking (beginning 2019-20 Q4).*
Notes:
- Ambulatory Care Visits in Edmonton Zone are not available starting from 2019-20 Q3. Therefore, a provincial total is not available. Teams are working to consolidate data after system migration to Connect Care.
- The methodology for calculating the Number of Unique/Individual Home Care Clients was changed in 2020-21 to align with other provincial reporting; historical numbers have been restated.
- Lab Test volumes continue to adjust due to Connect Care system migration.

South Zone Quick Facts

The table below provides a snapshot of South Zone activity and demonstrates service level changes over the last few years.

	2017-18	2018-19	2019-20	2020-21
Population Statistics				
Overall Population	305,134	307,033	308,924	311,514
Aging Population (over 65)	46,988	48,662	50,362	52,332
Life Expectancy	80.4	80.5	81.1	79.7
Median Age	37	37	38	37
Primary Care / Population Health				
Ambulatory Care Visits	430,483	461,425	455,409	328,315
Number of Unique/Individual Home Care Clients	12,635	12,833	13,253	12,649
Number of People Placed in Continuing Care	905	908	870	947
Health Link Calls*	32,644	30,306	37,182	72,671
Seasonal Influenza Immunizations	92,391	95,240	101,651	98,286
Food Safety Inspections	6,401	4,926	3,557	1,951
Acute Care				
Emergency Department Visits (all sites)	193,467	189,864	194,338	153,843
Hospital Discharges	29,905	29,148	28,692	26,291
Births	3,865	3,692	3,671	3,587
Total Hospital Days	222,761	220,260	216,396	183,276
Average Length of Stay (in days)	7.4	7.6	7.5	7.0
Diagnostic / Specific Procedures				
Hip Replacements (scheduled and emergency)	569	582	619	547
Knee Replacements (scheduled and emergency)	778	830	821	758
Cataract Surgery	2,920	3,105	3,080	3,165
Main Operating Room Activity	22,242	22,823	20,580	18,888
MRI Exams	13,601	14,513	15,333	14,857
CT Exams	30,418	31,640	32,976	36,574
X-rays	162,358	163,170	162,798	135,836
Lab Tests	5,200,813	5,473,081	5,618,502	5,017,578
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)	31,067	32,437	35,948	41,189
Unique/Individual Cancer Patients	3,733	3,045	3,183	3,523
Addiction and Mental Health				
Mental Health Hospital Discharges (acute care sites)	2,230	2,316	2,527	2,410
Workforce				
AHS Staff	7,533	7,308	7,284	7,501
AHS Volunteers	1,441	1,435	1,663	1,381
AHS Physicians	613	596	556	656

Data updated as of May 17, 2021. Definitions can be found at https://www.ahs.ca/about/Page11905.aspx.
** Health Link call volumes exclude COVID-19 inquiries and vaccination appointment booking (beginning 2019-20 Q4).*
Note: The methodology for calculating the Number of Unique/Individual Home Care Clients was changed in 2020-21 to align with other provincial reporting; historical numbers have been restated.

Calgary Zone Quick Facts

The table below provides a snapshot of Calgary Zone activity and demonstrates service level changes over the last few years.

	2017-18	2018-19	2019-20	2020-21
Population Statistics				
Overall Population	1,641,318	1,669,272	1,696,765	1,710,560
Aging Population (over 65)	190,551	200,478	211,374	225,072
Life Expectancy	82.9	83.0	83.7	82.6
Median Age	37	37	38	38
Primary Care / Population Health				
Ambulatory Care Visits	2,762,142	2,663,827	2,764,235	2,405,744 (Q3YTD)
Number of Unique/Individual Home Care Clients	34,233	35,965	37,443	36,794
Number of People Placed in Continuing Care	2,632	2,668	2,757	2,399
Health Link Calls*	292,109	289,203	314,209	443,913
Seasonal Influenza Immunizations	525,652	559,488	630,305	698,552
Food Safety Inspections	26,494	23,688	16,814	12,277
Acute Care				
Emergency Department Visits (all sites)	476,013	476,267	488,612	387,420
Urgent Care Visits	185,718	185,450	189,776	138,302
Hospital Discharges	144,354	145,427	145,962	132,760
Births	18,883	18,195	18,116	16,940
Total Hospital Days	1,021,481	1,036,176	1,024,585	923,146
Average Length of Stay (in days)	7.1	7.1	7.0	7.0
Diagnostic / Specific Procedures				
Hip Replacements (scheduled and emergency)	2,276	2,321	2,292	2,210
Knee Replacements (scheduled and emergency)	2,354	2,398	2,345	2,094
Cataract Surgery	14,439	14,425	18,050	18,800
Main Operating Room Activity	102,776	102,108	103,514	97,669
MRI Exams	77,502	78,231	78,925	83,670
CT Exams	151,370	162,445	157,162	172,842
X-rays	546,543	542,446	543,709	459,010
Lab Tests	29,639,947	31,010,367	31,733,664	27,575,380
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)	214,536	221,104	230,955	241,589
Unique/Individual Cancer Patients	24,651	25,356	26,094	26,092
Addiction and Mental Health				
Mental Health Hospital Discharges (acute care sites)	9,529	10,792	11,083	11,716
Workforce				
AHS Staff	37,022	37,755	38,126	40,889
AHS Volunteers	4,267	4,298	4,918	3,600
AHS Physicians	3,497	3,120	3,181	3,639

Data updated as of May 17, 2021. Definitions can be found at https://www.ahs.ca/about/Page11905.aspx.
** Health Link call volumes exclude COVID-19 inquiries and vaccination appointment booking (beginning 2019-20 Q4).*
Notes:
- Ambulatory Care Visits data is lagged by one quarter.
- The methodology for calculating the Number of Unique/Individual Home Care Clients was changed in 2020-21 to align with other provincial reporting; historical numbers have been restated.

Central Zone Quick Facts

The table below provides a snapshot of Central Zone activity and demonstrates service level changes over the last few years.

	2017-18	2018-19	2019-20	2020-21
Population Statistics				
Overall Population	476,519	479,435	482,349	476,674
Aging Population (over 65)	72,001	74,503	77,408	80,600
Life Expectancy	80.2	81.0	81.1	80.0
Median Age	38	38	39	39
Primary Care / Population Health				
Ambulatory Care Visits	481,016	493,336	485,158	401,623
Number of Unique/Individual Home Care Clients	18,569	19,660	20,690	19,733
Number of People Placed in Continuing Care	1,236	1,312	1,468	1,156
Health Link Calls*	56,996	56,202	61,687	102,548
Seasonal Influenza Immunizations	112,629	118,796	126,288	162,234
Food Safety Inspections	9,508	7,511	5,788	3,437
Acute Care				
Emergency Department Visits (all sites)	347,222	328,256	325,882	239,564
Hospital Discharges	43,982	42,801	41,726	37,629
Births	4,433	4,364	4,038	3,743
Total Hospital Days	328,939	334,361	333,885	270,629
Average Length of Stay (in days)	7.5	7.8	8.0	7.2
Diagnostic / Specific Procedures				
Hip Replacements (scheduled and emergency)	646	654	683	630
Knee Replacements (scheduled and emergency)	621	706	664	595
Cataract Surgery	3,947	4,221	4,040	4,213
Main Operating Room Activity	28,603	29,573	29,469	29,638
MRI Exams	12,058	13,089	13,845	14,957
CT Exams	38,310	42,698	42,457	45,600
X-rays	251,082	255,168	262,054	211,462
Lab Tests	6,385,971	6,707,603	6,863,306	6,105,188
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)	33,856	34,856	37,857	42,855
Unique/Individual Cancer Patients	3,038	3,268	3,586	3,980
Addiction and Mental Health				
Mental Health Hospital Discharges (acute care sites)	3,011	2,935	3,118	2,610
Workforce				
AHS Staff	12,910	12,848	12,894	13,038
AHS Volunteers	3,011	2,935	3,118	2,397
AHS Physicians	749	786	783	857

Data updated as of May 17, 2021. Definitions can be found at https://www.ahs.ca/about/Page11905.aspx.
** Health Link call volumes exclude COVID-19 inquiries and vaccination appointment booking (beginning 2019-20 Q4).*
Note: The methodology for calculating the Number of Unique/Individual Home Care Clients was changed in 2020-21 to align with other provincial reporting; historical numbers have been restated.

Edmonton Zone Quick Facts

The table below provides a snapshot of Edmonton Zone activity and demonstrates service level changes over the last few years.

	2017-18	2018-19	2019-20	2020-21
Population Statistics				
Overall Population	1,383,025	1,404,498	1,424,837	1,442,009
Aging Population (over 65)	172,297	179,787	188,087	198,630
Life Expectancy	82.0	82.0	82.3	81.1
Median Age	36	37	37	37
Primary Care / Population Health				
Ambulatory Care Visits	2,561,790	2,555,649	Not available	Not available
Number of Unique/Individual Home Care Clients	35,849	37,300	38,902	35,106
Number of People Placed in Continuing Care	2,388	2,525	2,685	2,231
Health Link Calls*	267,218	263,928	301,610	450,111
Seasonal Influenza Immunizations	406,229	443,574	473,086	548,309
Food Safety Inspections	20,484	16,673	13,140	4,920
Acute Care				
Emergency Department Visits (all sites)	552,858	552,341	553,259	417,526
Urgent Care Visits	12,390	11,951	13,149	9,860
Hospital Discharges	140,224	143,163	142,911	125,792
Births	18,758	18,949	18,693	17,247
Total Hospital Days	1,007,038	998,979	1,003,776	892,467
Average Length of Stay (in days)	7.2	7.0	7.0	7.1
Diagnostic / Specific Procedures				
Hip Replacements (scheduled and emergency)	2,345	2,337	2,604	1,984
Knee Replacements (scheduled and emergency)	2,242	2,199	1,940	1,285
Cataract Surgery	16,014	16,642	18,572	16,682
Main Operating Room Activity	108,765	112,350	111,771	98,738
MRI Exams	79,087	85,649	81,244	81,166
CT Exams	159,512	168,599	158,734	170,929
X-rays	609,941	601,553	594,029	479,779
Lab Tests	28,672,978	29,879,909	29,955,722	25,763,165
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)	343,539	363,466	380,991	388,054
Unique/Individual Cancer Patients	27,150	27,726	28,810	28,013
Addiction and Mental Health				
Mental Health Hospital Discharges (acute care sites)	6,568	7,067	7,238	7,627
Workforce				
AHS Staff	33,969	34,050	34,292	36,328
AHS Volunteers	2,781	2,688	2,904	2,143
AHS Physicians	2,919	2,852	2,839	2,970

Data updated as of May 17, 2021. Definitions can be found at https://www.ahs.ca/about/Page11905.aspx.
** Health Link call volumes exclude COVID-19 inquiries and vaccination appointment booking (beginning 2019-20 Q4).*
Notes:
- Ambulatory Care Visits in Edmonton Zone are not available starting from 2019-20 Q3. Teams are working to consolidate data after system migration to Connect Care.
- The methodology for calculating the Number of Unique/Individual Home Care Clients was changed in 2020-21 to align with other provincial reporting; historical numbers have been restated.

North Zone Quick Facts

The table below provides a snapshot of North Zone activity and demonstrates service level changes over the last few years.

	2017-18	2018-19	2019-20	2020-21
Population Statistics				
Overall Population	480,002	482,179	484,941	480,924
Aging Population (over 65)	48,126	50,045	52,197	54,338
Life Expectancy	79.6	79.9	79.8	79.2
Median Age	34	35	35	35
Primary Care / Population Health				
Ambulatory Care Visits	403,375	404,226	388,688	316,354
Number of Unique/Individual Home Care Clients	13,588	14,216	14,855	13,811
Number of People Placed in Continuing Care	766	685	741	694
Health Link Calls*	57,313	54,674	60,829	103,464
Seasonal Influenza Immunizations	92,449	100,382	107,352	143,319
Food Safety Inspections	15,424	12,762	8,948	3,586
Acute Care				
Emergency Department Visits (all sites)	532,069	509,903	500,436	353,663
Hospital Discharges	42,444	40,669	39,990	35,574
Births	5,753	5,593	5,463	5,087
Total Hospital Days	282,105	263,225	273,508	235,538
Average Length of Stay (in days)	6.6	6.5	6.8	6.6
Diagnostic / Specific Procedures				
Hip Replacements (scheduled and emergency)	355	384	407	429
Knee Replacements (scheduled and emergency)	563	484	463	393
Cataract Surgery	2,020	2,161	1,494	1,429
Main Operating Room Activity	28,397	25,590	24,201	23,407
MRI Exams	12,769	13,262	11,771	11,125
CT Exams	36,145	36,556	36,179	36,498
X-rays	288,022	283,474	284,328	246,012
Lab Tests	4,819,741	4,893,157	4,995,108	4,483,724
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)	16,451	16,954	18,440	23,525
Unique/Individual Cancer Patients	2,297	2,314	2,199	2,477
Addiction and Mental Health				
Mental Health Hospital Discharges (acute care sites)	3,146	2,939	2,808	2,720
Workforce				
AHS Staff	10,852	10,918	10,911	11,133
AHS Volunteers	1,648	1,612	1,847	1,532
AHS Physicians	624	645	628	670

Data updated as of May 17, 2021. Definitions can be found at https://www.ahs.ca/about/Page11905.aspx.
** Health Link call volumes exclude COVID-19 inquiries and vaccination appointment booking (beginning 2019-20 Q4).*
Note: The methodology for calculating the Number of Unique/Individual Home Care Clients was changed in 2020-21 to align with other provincial reporting; historical numbers have been restated.

Commonly Tracked Measures

There are a number of measures AHS tracks to help inform performance across the healthcare delivery system. These measures 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 departments, and surgery. The measures below include what we historically have called Monitoring Measures, and also include measures we are considering as part of the AHS 2020-22 Health Plan & 2021-22 Business Plan.

Data was updated as of May 17, 2021.
Definitions can be found online at https://www.albertahealthservices.ca/about/Page12640.aspx.

LIFE EXPECTANCY	2017	2018	2019	2020
The number of years a person would be expected to live, starting at birth, on the basis of mortality statistics.				
Provincial	81.7	81.9	82.3	81.2
Females	84.0	84.3	84.4	83.7
Males	79.5	79.6	80.2	78.9
First Nations	71.0	70.9	70.3	66.8
Non-First Nations	82.1	82.3	82.8	81.9

POTENTIAL YEARS OF LIFE LOST	2017	2018	2019	2020
The total number of years not lived (per 1,000 population) by an individual who died before their 75th birthday.				
Both	51.0	50.7	47.1	56.2
Females	38.3	37.1	35.5	41.2
Males	63.3	63.8	58.4	70.8

PERINATAL MORTALITY RATE BY POPULATION (single year)	2017	2018	2019	2020
The number of full-term stillbirths and infants up to 7-days of age divided by the number of live births and stillbirths multiplied by 1,000.				
Provincial	5.53	5.62	5.25	5.73
First Nations	9.05	7.52	11.10	14.32
Non-First Nations	5.37	5.49	4.90	5.17
Rate Gap	3.68	2.03	6.20	9.15

PERINATAL MORTALITY RATE BY POPULATION (three-year average)	2015-2017	2016-2018	2017-2019	2018-2020
The number of full-term stillbirths and infants up to 7-days of age divided by the number of live births and stillbirths multiplied by 1,000.				
First Nations	9.94	8.72	9.20	10.90
Non-First Nations	4.94	5.06	5.25	5.19
Rate Gap	**5.00**	**3.66**	**3.95**	**5.71**

EMERGENCY DEPARTMENT (ED)	2017-18	2018-19	2019-20	2020-21
Total Number of ED Visits (all sites)	2,101,629	2,056,631	2,062,527	1,552,016
Percentage of Patients Treated and Admitted to Hospital Within 8 Hours (all sites)	43.9%	45.4%	42.9%	44.3%
Percentage of Patients Treated and Admitted to Hospital Within 8 Hours (busiest sites)	35.5%	37.9%	35.9%	38.0%
Percentage of Patients Treated and Discharged Within 4 Hours (all sites)	76.0%	74.4%	72.2%	71.8%
Percentage of Patients Treated and Discharged Within 4 Hours (busiest sites)	60.1%	58.7%	55.1%	57.5%
ED Time to Physician Initial Assessment (median) (busiest sites) (in hours)	1.4	1.4	1.6	1.1
Percentage of Patients Left Without Being Seen and Against Medical Advice	4.3%	4.5%	5.1%	4.0%

ACUTE CARE	2017-18	2018-19	2019-20	2020-21
Hospital Discharges	400,909	401,208	399,281	358,046
Acute Care Occupancy: percentage of patient days in hospital compared to available bed days in the reporting period for top 16 AHS sites	98.0%	96.2%	95.5%	90.3%
Acute Length of Stay to Expected Length of Stay Ratio	1.02	1.02	1.03	0.98
Hospital-Acquired *Clostridium difficile* Infection Rate (per 10,000 patient days)	3.0	2.5	2.6	2.6
Hospital Standardized Mortality Ratio (HSMR)	102	97	98	106
30-day Overall Unplanned Readmissions (medical, surgical, pediatric and obstetric)	9.4%	9.5%	9.4%	9.3% (Q3YTD)
Medical Readmissions Within 30 Days (risk adjusted)	14.1%	14.4%	14.0%	14.1% (Q3YTD)
Mental Health Readmissions Within 30 Days (risk adjusted)	9.6%	10.7%	10.7%	11.9% (Q3YTD)
Surgical Readmissions Within 30 Days (risk adjusted)	6.5%	6.6%	6.5%	6.4% (Q3YTD)
Heart Attack in Hospital Mortality Within 30 Days (risk adjusted)	5.4%	5.7%	6.5%	5.1% (Q3YTD)
Stroke in Hospital Mortality Within 30 Days (risk adjusted)	12.8%	12.4%	12.4%	12.6% (Q3YTD)
Percentage of Alternate Level of Care (ALC) Days	17.5%	16.5%	15.4%	15.2%
Patient Satisfaction with Hospital Experience*	64.2%	65.5%	66.3%	67.2% (Q3YTD)
Hand Hygiene Compliance Rate	85.1%	87.1%	87.7%	92.2%

** The Patient Satisfaction measure was amended to include ratings of 9 or 10 on a scale from 0-10. Previous years also included ratings out of 8. Historical results have been restated using the new methodology.*

SURGERY WAIT TIMES in weeks		2017-18	2018-19	2019-20	2020-21
Coronary Artery Bypass Graft (CABG) Ready To Treat (RTT) for Scheduled Surgeries	50th Percentile (scheduled)	6.6	7.0	7.7	9.3
	90th Percentile (scheduled)	22.2	19.4	15.2	24.8
	Volume (scheduled)	355	403	364	308
	Volume (all)	1,453	1,636	1,599	1,397
Cataract Surgery RTT	50th Percentile (scheduled)	14.9	16.9	18.3	19.0
	90th Percentile (scheduled)	38.6	48.0	49.3	53.0
	Volume (scheduled 1st eye)	24,393	24,824	27,370	26,565
	Volume (all)	39,340	40,554	45,236	44,289
Hip Replacement RTT	50th Percentile (scheduled)	18.1	18.9	19.3	25.1
	90th Percentile (scheduled)	36.7	38.0	39.9	54.6
	Volume (scheduled)	4,334	4,483	4,505	3,845
	Volume (all)	6,191	6,278	6,605	5,800
Knee Replacement RTT	50th Percentile (scheduled)	20.7	19.1	21.1	29.4
	90th Percentile (scheduled)	40.7	43.7	46.9	63.1
	Volume (scheduled)	6,202	6,492	6,100	5,063
	Volume (all)	6,558	6,617	6,233	5,125
Hip Fracture Repair: Percentage Within 48 Hours		92.8%	94.1%	92.4%	91.6%

Source: Volumes (scheduled) data comes from OR medical records; volumes (all) data comes from administrative databases.
Notes:
- Surgery volumes were affected by the COVID-19 pandemic beginning 2019-20 Q4.
- Volumes (scheduled) include elective/scheduled procedures only; volumes (all) include elective/scheduled and non-elective/emergency procedures.

SURGERIES PERFORMED WITHIN CIHI BENCHMARK		2017-18	2018-19	2019-20	2020-21
Percentage of Scheduled Surgeries Performed Within CIHI Benchmark	Cataract	53.3%	48.2%	45.1%	44.5%
	Hip	70.5%	68.5%	65.5%	51.6%
	Knee	64.6%	65.0%	61.5%	43.3%

CONTINUING CARE	2017-18	2018-19	2019-20	2020-21
Total Number of People Placed into Continuing Care	7,927	8,098	8,521	7,427
Number of Patients Placed from Acute/Subacute Hospital Bed into Continuing Care	5,218	5,005	5,113	4,663
Number of Clients Placed from Community (at home) into Continuing Care	2,709	3,093	3,408	2,764
Average Wait Time for Continuing Care Placement (in days)	62	61	54	55
Average Wait Time in Acute/Subacute Care Hospital Bed for Continuing Care Placement (in days)	51	46	36	38
Average Wait Time for Long-Term Care Placement (in days)	46	39	35	49
Average Wait Time for Supportive Living Placement (in days)	86	95	80	77
Total Number Waiting for Continuing Care Placement	1,937	1,508	1,412	1,427
Number of Persons Waiting in Acute/Subacute Hospital Bed for Continuing Care Placement	676	474	410	422
Number of Persons Waiting in Community (at home) for Continuing Care Placement	1,261	1,034	1,002	1,005
Number of Unique Home Care Clients*	114,874	119,974	125,143	118,093
Percentage Placed in Continuing Care Within 30 Days	51.8%	57.9%	60.0%	61.3%

** The methodology for calculating the Number of Unique Home Care Clients was changed in 2020-21 to align with other provincial reporting; historical numbers have been restated.*

PRIMARY HEALTH CARE	2017-18	2018-19	2019-20	2020-21
Albertans Enrolled in a Primary Care Network	82%	81%	81%	80%
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)	320	311	303	227
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	21.4%	20.5%	20.7%	16.2%
Number of Health Link calls*	706,280	694,313	891,931	2,291,243
Percentage of Health Link Calls Answered Within Two Minutes	73%	74%	60%	49%

** Health Link call volumes include COVID-19 inquiries and vaccination appointment booking (beginning 2019-20 Q4).*

CHILDRENS MENTAL HEALTH SERVICES	2017-18	2018-19	2019-20	2020-21
Percentage of Children (aged 0 to 17 years) *Offered* Scheduled Mental Health Treatment*	74%	82%	Not available	Not available
Percentage of Children (aged 0 to 17 years) R*eceiving* Scheduled Mental Health Treatment*	67%	72%	75% (Q3YTD)	Not available
Child and Youth Mental Health Wait Times (90th percentile) (in days)	53.0	48.0	55.0	48.0 (Q3YTD)
Child and Youth Mental Health Wait Times (median) (in days)	15.0	14.0	15.0	14.0 (Q3YTD)

** Data is no longer available due to clinical information system upgrades; measures were replaced with wait time metrics.*

INFLUENZA IMMUNIZATION	2017-18	2018-19	2019-20	2020-21
Seasonal Influenza Immunizations	1,229,350	1,317,659	1,438,866	1,650,836
Seniors (65+ years)	60.1%	61.2%	61.4%	62.7%
Children (6 to 23 months)	34.6%	40.7%	43.2%	51.7%
AHS Healthcare Workers*	66.0%	67.6%	67.2%	64.8%

** Rate excludes Covenant Health.*

COVID-19 IMMUNIZATION	2017-18	2018-19	2019-20	2020-21
Total Alberta Residents who Received the COVID-19 Vaccination (at least first dose)*	n/a	n/a	n/a	568,947

** Immunizations for COVID-19 began in 2020-21 Q3.*

CHILDHOOD IMMUNIZATION	2017-18	2018-19	2019-20	2020-21
Childhood Immunization Rate - DTaP-IPV-Hib	77.8%	77.7%	78.6%	76.4%
Childhood Immunization Rate – MMR	86.9%	86.5%	87.9%	86.4%

CANCER SCREENING	2017-18	2018-19	2019-20	2020-21
Breast Cancer Participating Rate	64.4%	65.2%	60.1%	Not available
Colorectal Cancer Participating Rate*	55.6%	55.7%	50.6%	Not available
Cervical Cancer Participating Rate	64.3% (2016-18)	63.6% (2017-19)	60.4% (2018-20)	Not available
Early Detection of Cancers	71.2% (2017)	74.5% (2018)	74.6% (2019)	Not available

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

CANCER CARE in weeks, 90th percentile	2017-18	2018-19	2019-20	2020-21
Radiation Oncology Access: referral to first consult (from referral to the time of their first appointment with a radiation oncologist)	5.0	6.7	7.0	5.6
Medical Oncology Access: referral to first consult (from referral to the time of their first appointment with a medical oncologist)	5.6	6.1	7.0	5.9
Radiation Therapy Access: ready to treat to first therapy	2.7	2.7	2.9	2.9

SYSTEM SUSTAINABILITY	2017-18	2018-19	2019-20	2020-21
Annual Rate of Change in Operational Expenditures*	2.5%	3.7%	1.8%	-1.2%
Cost of a Standard Hospital Stay (in dollars)	$7,907	$8,031	$8,169	$9,380

** Change in total annual expenditures, excluding COVID-19 costs.*

AHS WORKFORCE	2017-18	2018-19	2019-20	2020-21
AHS Workforce Engagement Rate*	No survey	No survey	3.57	No survey
Disabling Injury Rate (per 100FTE)	4.11	4.12	4.14	5.06 (Q3YTD)

** Baseline results for the AHS Workforce Engagement Rate were based on 2016-17 survey results (3.46 out of 5).*

ACCESS TO INFORMATION	2017-18	2018-19	2019-20	2020-21
MyAHS Connect Portal Users*	n/a	n/a	9,461	38,017

** Connect Care launched in 2019-20 Q3. Prior data is not available.*

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. The AHS Whistleblower Policy is aligned with PIDA.

PIDA's 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.

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

Over the past year, AHS has:

- Made submissions to the Legislative Assembly of Alberta Standing Committee on Resource Stewardship regarding proposed amendments to PIDA.
- Updated the organization's online whistleblower learning module.
- Taken steps to standardize the intake and initial analysis of disclosures to the Designated Officer.

Consistent with direction from Alberta Public Interest Commissioner, reports to the Designated Officer of non-compliance with orders issued by the Chief Medical Officer of Health to support Alberta's response to the COVID-19 public health emergency are not considered as disclosures under PIDA.

In compliance with legislated reporting requirements, from April 1, 2020 to March 31, 2021, AHS reports that 23 disclosures were received by or referred to AHS' Designated Officer:

- 23 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.

AHS counts the reporting or referral of a matter to the Designated Officer as a disclosure under PIDA if the allegation(s), if founded, would constitute wrongdoing (as defined in PIDA and the AHS Whistleblower Policy) by AHS or by a member of the AHS workforce.

Common reasons for not commencing an investigation under PIDA and the AHS Whistleblower Policy are:

- The allegation, if founded, will not meet the definition of "wrongdoing" under PIDA and the AHS Whistleblower Policy.
- The allegation pertains to an individual who is not a member of the AHS workforce or other circumstances outside the authority of AHS to investigate.
- The allegation is anonymous without contact information and the disclosure does not contain sufficient particulars to form the basis of an investigation.

Common actions taken by the Designated Officer to manage a disclosure that is not subject to an investigation include:

- Referring the matter to another AHS department for action.
- Referring the matter to an external agency for action.

Chartered Surgical Facility Contracts under the *Health Facilities Act* (Alberta)

AHS contracts services with multiple chartered surgical facilities (CSFs) to provide insured surgical services for ophthalmology, oral maxillofacial (OMF), otolaryngology (ENT), plastic surgery, dermatology, restorative dental, pregnancy terminations, and podiatry. The use of chartered surgical facilities enables AHS to obtain services to enhance surgical access and alleviate capacity pressures within AHS main operating rooms. Maintaining quality of services in CSFs will require deliberate, targeted, and significant effort. AHS works with Alberta Health and the College of Physicians and Surgeons of Alberta to coordinate activities addressing CSF accreditation, patient safety, quality, and compliance with the *Health Facilities Act* and regulations (previously known as the *Health Care Protection Act)*.

As a part of the Alberta Surgical Initiative (ASI), contracted service areas will be expanded beginning in 2021-22. Volumes for existing services are also expected to increase in the upcoming fiscal year.

The table below summarizes chartered surgical facility contracts by service area for 2020-21:

2020-21 CHARTERED SURGICAL FACILITIES		
Contracted Service Area	**# of Contracted Operators**	**# of Contracted Procedures Performed**
Dermatology– Edmonton Zone	1	7
Dermatology Calgary Zone*	2	240
Dermatology - Edmonton Zone	1	148
Ophthalmology – Calgary Zone	4	19,873
Ophthalmology – Edmonton Zone	4	6,098
Oral and Maxillofacial (OMF) – Calgary Zone	8	1,775
Oral and Maxillofacial (OMF) – Edmonton Zone	10	3,856
Otolaryngology (ENT) – Edmonton Zone	2	207
Plastic Surgery – Edmonton Zone	3	1,136
Pregnancy Termination – Calgary Zone	1	5,300
Pregnancy Termination – Edmonton Zone	1	5,560
Restorative Dental – South Zone	6	170
Restorative Dental – Calgary Zone*	1	3
Restorative Dental – Edmonton Zone	2	187
Podiatry – Calgary Zone	2	723

Note: There are no surgical contracts with CSFs in the Central and North Zones that fall under the Health Facilities Act.
***** *Procedure totals provided by AHS Clinical Quality Metrics, Provincial CSF Procedures Dashboard. All remaining procedure totals provided by AHS Bill 11, billing system. Calgary Zone data captured as of April 23, 2021.*

AHS Facilities and Beds

AHS Facilities

Facility Definitions

Facility	Definition
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.
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 for young adult treatment.
Community Mental Health	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).
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. In addition, care is also provided by licensed practical nurses.
Designated Supportive Living (DSL)	Designated Supportive Living (DSL) 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 designated supportive living services generally reside in lodges, retirement communities, or designated supportive living facilities.
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 AACS 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. 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	8	11	**40**
Public Health Centres	17	25	31	24	51	**148**
Addiction and Mental Health						
Addiction	6	11	6	10	6	**39**
Community Mental Health*	6	15	2	26	1	**50**
Community Mental Health Sites with Multiple Locations ** The number of facilities for Community Mental Health does not include contracted sites with multiple locations. These facilities are also noted in Zone Beds by Facility.*	-	2	-	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	76	79	92	61	**359**
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	3	6	4	**23**

Source: AHS Bi-Annual Bed Survey as of March 31, 2021.
Note: 2019-2020 - 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, 8,273 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**
March 2021	15,800	11,916	27,716	198	1	**199**
Total Net New Beds Since 2010	**1,371**	**6,827**	**8,198**	**8,198**	**75**	**8.273**

Source: AHS Bi-Annual Bed Survey as of March 31, 2021.
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 2020-21. AHS is working with Alberta Health on a number of projects for additional capacity that did not open in 2020-21 but are planned to open in 2021-22. AHS does not include future capacity in any bed reporting.

Continuing Care – New Facilities

In 2020-21, 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 supportive living. The table below reflects where clients were placed from the AHS waitlists into the new facilities that opened.

New Facilities Opened in 2020-21	Zone	Location	Date Opened	Long-Term Care	Designated Supportive Living 4-Dementia	Designated Supportive Living 4	Designated Supportive Living 3	Total
Cambridge Manor	Calgary	Calgary	July 15, 2020	155	-	-	-	**155**
Oki House	Calgary	Calgary	October 5, 2020	-	-	4	-	**4**
Diamond Spring Lodge	North	Redwater	October 19, 2020	-	12	-	-	**12**
Grande Cache Community Health Complex	North	Grande Cache	December 15, 2020	4	-	-	-	**4**
TOTAL				**159**	**12**	**4**	**0**	**175**

Source: AHS Bi-Annual Bed Survey as of March 31, 2021.
Note: Data does not reflect closures or beds opened in existing facilities.

Continuing Care – Facilities by Provider

As of March 31, 2021, there were 27,716 Designated Long-Term Care (LTC) and Designated Supportive Living (DSL) spaces staffed and in operation in the province in more than 350 facilities. These facilities encompass AHS, AHS subsidiaries (Carewest and CapitalCare), private (Extendicare, AgeCare, etc.), not-for-profit, non-profit (Covenant, Good Samaritan, etc.) and Saskatchewan Health Authority (Lloydminster) ownership.

Continuing Care Facilities by Operator	Number of Facilities as of March 31, 2021								
	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	**81**	**4,260**	**20**	**592**	**6**	**386**	**210**	**107**	**5,448**
South	12	243	1	10	-	-	-	13	253
Calgary	6	239	1	38	-	-	-	7	277
Calgary Subsidiary (Carewest)	8	888	1	10	1	175	30	10	1,103
Central	23	1,058	2	32	2	111	31	27	1,232
Edmonton	2	54	1	72	-	-	-	3	126
Edmonton Subsidiary (CapitalCare)	6	994	5	208	-	-	-	11	1,202
North	24	784	9	222	3	100	149	36	1,255
Private	**37**	**4,723**	**74**	**5,138**	**13**	**944**	**1,230**	**124**	**12,035**
South	3	288	9	563	3	130	122	15	1,103
Calgary	14	2,382	17	1,217	6	462	858	37	4,919
Central	2	133	20	1,201	1	220	60	23	1,614
Edmonton	14	1,694	22	1,950	-	-	-	36	3,644
North	4	226	6	207	3	132	190	13	755
Non-Profit	**37**	**4,438**	**76**	**4,038**	**13**	**939**	**708**	**126**	**10,123**
South	2	35	18	1,106	3	276	144	23	1,561
Calgary	11	1,685	8	814	3	253	213	22	2,965
Central	8	474	14	405	5	215	235	27	1,329
Edmonton	15	2,214	25	1,460	2	195	116	42	3,985
North	1	30	11	253	-	-	-	12	283
Saskatchewan Health Authority - Lloydminster	**2**	**110**	-	-	-	-	-	**2**	**110**
Total	**157**	**13,531**	**170**	**9,768**	**32**	**2,269**	**2,148**	**359**	**27,716**

Source: AHS Bi-Annual Bed Survey as of March 31, 2021.
Notes:
- 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.
- LTC facility includes 1 Standalone Sub-Acute facility.

Addiction and Mental Health

The Addiction and Mental Health (AMH) portfolio co-ordinates, plans, delivers and evaluates a provincewide 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, 2021

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	79	**87**	5	37	**42**	0	0	**0**	0	72	**72**	0	0	**201**
Calgary	15	294	**309**	22	431	**453**	0	153	**153**	49	238	**287**	0	0	**1,202**
Central	13	101	**114**	0	31	**31**	0	330	**330**	8	42	**50**	0	0	**525**
Edmonton	21	371	**392**	20	324	**344**	18	427	**445**	54	183	**237**	372	50	**1,840**
North	4	131	**135**	0	5	**5**	0	0	**0**	0	40	**40**	0	0	**180**
Provincial Total	**61**	**976**	**1,037**	**47**	**828**	**875**	**18**	**910**	**928**	**111**	**575**	**686**	**372**	**50**	**3,948**

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 for young adult treatment. 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 237 publicly-funded child and youth mental health and addiction 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, 2021

Zone	2016/17	2017/18	2018/19	2019/20	2020/21	Net Change Since 2017
South	74	74	82	82	87	13
Calgary	296	301	301	291	309	13
Central	66	66	70	89	114	48
Edmonton	379	399	399	399	392	13
North	143	131	118	118	135	-8
Provincial Total	**958**	**971**	**970**	**979**	**1,037**	**79**

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, 2021

Zone	2016/17	2017/18	2018/19	2019/20	2020/21	Net Change Since 2017
South	42	42	42	42	42	0
Calgary	418	423	459	456	453	35
Central	31	31	31	31	31	0
Edmonton	245	296	329	344	344	99
North	5	5	5	5	5	0
Provincial Total	**741**	**797**	**866**	**878**	**875**	**134**

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, 2021	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
Hospital Acute & Sub-Acute Care						
Hospital Acute Care	521	2,179	925	2,412	861	**6,898**
Neonatal Intensive Care (NICU Levels II and III)	23	126	17	140	10	**316**
Special Care (includes ICU, SCU, CCU, CVICU and PICU)	24	136	18	202	12	**392**
Palliative Beds in Acute Care	0	29	51	25	21	**126**
Sub-acute in Acute Care	9	32	32	22	0	**95**
Psychiatric in Acute Care	72	287	50	237	40	**686**
TOTAL HOSPITAL ACUTE & SUB-ACUTE CARE	**649**	**2,789**	**1,093**	**3,038**	**944**	**8,513**
ADDICTION AND MENTAL HEALTH						
Psychiatric (standalone facilities)	0	153	330	445	0	**928**
Addiction Treatment	87	309	114	392	135	**1,037**
Community Mental Health	42	453	31	344	5	**875**
TOTAL ADDICTION AND MENTAL HEALTH	**129**	**915**	**475**	**1,181**	**140**	**2,840**
COMMUNITY-BASED CARE						
Continuing Care – Long-Term Care (LTC)						
Auxiliary Hospital	286	1,037	1,370	2,206	692	**5,591**
Nursing Home	686	5,047	951	2,945	580	**10,209**
Sub-Total Long-Term Care (LTC)	**972**	**6,084**	**2,321**	**5,151**	**1,272**	**15,800**
Continuing Care – Designated Supportive Living (DSL)						
Designated Supportive Living Level 3	315	233	361	395	209	**1,513**
Designated Supportive Living Level 4	1,078	2,068	1,049	2,208	521	**6,924**
Designated Supportive Living Level 4 - Dementia	552	879	554	1,203	291	**3,479**
Sub-Total Designated Supportive Living (DSL)	**1,945**	**3,180**	**1,964**	**3,806**	**1,021**	**11,916**
SUB-TOTAL LTC & DSL	**2,917**	**9,264**	**4,285**	**8,957**	**2,293**	**27,716**
Community Palliative and Hospice (out of hospital) PEOLC	20	121	18	85	13	**257**
TOTAL CONTINUING CARE (includes LTC, DSL and Palliative Care)	**2,937**	**9,385**	**4,303**	**9,042**	**2,306**	**27,973**
Sub-acute in Auxiliary Hospital (includes transition, rehab, community support beds, etc.)*	24	285	0	168	0	**477**
TOTAL COMMUNITY-BASED CARE (includes LTC, DSL, Palliative Care and Sub-Acute in Auxiliary Hospital)	**2,961**	**9,670**	**4,303**	**9,210**	**2,306**	**28,450**
Alberta Total	**3,739**	**13,374**	**5,871**	**13,429**	**3,390**	**39,803**

Source: AHS Bi-Annual Bed Survey as of March 31, 2021.
** 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

AHS-operated facilities are denoted by an X.
*Community Mental Health sites with multiple locations are denoted by an *.*

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								75	75		
Extendicare Fort Macleod		Fort Macleod							50		50		
Foothills Detox Centre		Fort Macleod	19								19		
Fort MacLeod Health Centre	X	Fort Macleod				ED			10		10		
Pioneer Lodge		Fort Macleod								10	10		
Chinook Regional Hospital	X	Lethbridge	8	5		296					309		
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		

South Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Good Samaritan South Ridge Village		Medicine Hat							80	48	128		
Leisure Way		Medicine Hat								16	16		
Masterpiece Southland Meadows		Medicine Hat							50	81	131		
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			**87**	**42**	**0**	**649**	**24**	**20**	**972**	**1,945**	**3,739**		

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				12			25		37		
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						15	177	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		
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							233		233		
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		
Cambridge Manor		Calgary							155		155		
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					40		95		135		
Carewest Signal Pointe	X	Calgary							54		54		
Clifton Manor		Calgary							175		175		

Calgary Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
CBI- Complex Needs Client		Calgary		1							1		
Community Living Alternatives for the Mentally Disabled Association (Community LAMDA)- LAMDA 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				1,087					1,087		
Fresh Start Recovery Centre		Calgary	31								31		
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							130		130		
Oki House		Calgary								4	4		
Oxford House		Calgary	23								23		
Personal Care Homes - Continuing Care		Calgary								223	223		
Peter Lougheed Centre	X	Calgary				536					536		
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		

Calgary Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Richmond Road Diagnostic & Treatment Centre	X	Calgary				OP							
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
Simon House Recovery Centre		Calgary	8								8		
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 Healing Lodge		Calgary	34								34		
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	

Calgary Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
High River General Hospital	X	High River				27			50		77		
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			**309**	**453**	**153**	**2,789**	**285**	**121**	**6,084**	**3,180**	**13,374**		

*Note: Community Mental Health sites with multiple locations are denoted by an *.*

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	46								46		
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				33			88	12	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	40	55		
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	

Central Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Lloydminster Continuing Care Centre		Lloydminster							60		60		
Lloydminster Hospital		Lloydminster				37					37		
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		
Step Up Step Down	X	Red Deer	5								5		
The Hamlets at Red Deer		Red Deer								136	136		
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						1		88	89		
Stettler Hospital and Care Centre	X	Stettler				26			50		76		
Myron Thompson Health 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

Central Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
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		
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				24					24		
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			**114**	**31**	**330**	**1,093**	**0**	**18**	**2,321**	**1,964**	**5,871**		

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								23	23		
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								105	105		
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		
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		
East Edmonton Health Centre	X	Edmonton											CACC /UCC

Edmonton Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Edmonton Chinatown Care Centre		Edmonton							96		96		
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	41								41		
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	62								62		
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								8	8		
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				911					911		
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	86	155		
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				690			-		690		
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		
Wild Rose Retirement Residence	X	Edmonton								27	27		
Youth Stabilization and Residential Services	X	Edmonton	21								21		

Edmonton Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Good Samaritan Pembina Village		Evansburg							40		40		
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		
Country Cottage Retirement Residence		Sherwood Park								26	26		
Chartwell Emerald Hills		Sherwood Park								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		St. Albert	86								86		
St. Albert Retirement Residence		St. Albert								92	92		
Sturgeon Community Hospital	X	St. Albert				157					157		
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			**392**	**344**	**445**	**3,038**	**168**	**85**	**5,151**	**3,806**	**13,429**		

*Note: Community Mental Health sites with multiple locations are denoted by an *.*

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	28								28		
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				8			4		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	60								60		
Prairie Lake Seniors Community		Grande Prairie						10	50	95	155		
Queen Elizabeth II Hospital	X	Grande Prairie				181			35	71	287		
Emerald Gardens Retirement Residence		Grande Prairie								15	15		
Youth Detoxification Services	X	Grande Prairie	4								4		
Grimshaw/Berwyn and District Community Health Centre	X	Grimshaw				ED		1	19		20		
Stone Brook		Grimshaw								56	56		

North Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
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				34			40		74		
Points West Living Peace River		Peace River								42	42		
Radway Continuing Care Centre	X	Radway							30		30		
Diamond Spring Lodge		Redwater								12	12		
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		
St. Therese - St. Paul Healthcare Centre	X	St Paul				42			30		72		
Swan Hills Healthcare Centre	X	Swan Hills				6					6		

North Zone – Beds by Facility

Facility Name	Operator	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
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			**135**	**5**	**0**	**944**	**0**	**13**	**1,272**	**1,021**	**3,390**		

Change in Bed Numbers by Zone from 2019-20 to 2020-21

Reported Beds Staffed & In Operation Summary as of March 31, 2021

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 (PEOLC)	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 + DSL4D)			
South	649	0	87	42	24	20	286	686	**972**	315	1,078	552	**1,945**	**2,917**	**2,937**	**3,739**
Calgary	2,789	153	309	453	285	121	1,037	5,047	**6,084**	233	2,068	879	**3,180**	**9,264**	**9,385**	**13,374**
Central	1,093	330	114	31	0	18	1,370	951	**2,321**	361	1,049	554	**1,964**	**4,285**	**4,303**	**5,871**
Edmonton	3,038	445	392	344	168	85	2,206	2,945	**5,151**	395	2,208	1,203	**3,806**	**8,957**	**9,042**	**13,429**
North	944	0	135	5	0	13	692	580	**1,272**	209	521	291	**1,021**	**2,293**	**2,306**	**3,390**
PROVINCIAL TOTAL	**8,513**	**928**	**1,037**	**875**	**477**	**257**	**5,591**	**10,209**	**15,800**	**1,513**	**6,924**	**3,479**	**11,916**	**27,716**	**27,973**	**39,803**

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, 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 (PEOLC)	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 + DSL4D)			
South	641	0	82	42	24	20	286	686	**972**	315	1,046	548	**1,909**	**2,881**	**2,901**	**3,690**
Calgary	2,789	153	291	456	280	121	1,042	4,962	**6,004**	233	2,064	879	**3,176**	**9,180**	**9,301**	**13,270**
Central	1,097	330	89	31	0	17	1,370	951	**2,321**	361	1,010	569	**1,940**	**4,261**	**4,278**	**5,825**
Edmonton	3,027	445	399	344	168	85	2,206	2,929	**5,135**	395	2,199	1,225	**3,819**	**8,954**	**9,039**	**13,422**
North	948	0	118	5	0	13	657	576	**1,233**	209	521	279	**1,009**	**2,242**	**2,255**	**3,326**
PROVINCIAL TOTAL	**8,502**	**928**	**979**	**878**	**472**	**256**	**5,561**	**10,104**	**15,665**	**1,513**	**6,840**	**3,500**	**11,853**	**27,518**	**27,774**	**39,533**

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Change from March 31, 2020 to March 31, 2021

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 (PEOLC)	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 + DSL4D)			
South	8	-	5	-	-	-	-	-	-	-	32	4	36	**36**	**36**	**49**
Calgary		-	18	(3)	5	-	(5)	85	80	-	4	-	4	**84**	**84**	**104**
Central	(4)	-	25	-	-	1	-	-	-	-	39	(15)	24	**24**	**25**	**46**
Edmonton	11	-	(7)	-	-	-	-	16	16	-	9	(22)	(13)	**3**	**3**	**7**
North	(4)	-	17	-	-	-	35	4	39	-	-	12	12	**51**	**51**	**64**
PROVINCIAL TOTAL	**11**	**-**	**58**	**(3)**	**5**	**1**	**30**	**105**	**135**	**-**	**84**	**(21)**	**63**	**198**	**199**	**270**

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

ALBERTA PRECISION LABORATORIES

Leaders in Laboratory Medicine

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

Alberta Precision Laboratories' third year as a provincewide public laboratory system highlighted the critical role lab services play across the healthcare spectrum. Alberta Precision Laboratories (APL) employs approximately 5,500 healthcare professionals and is one of the largest providers of laboratory medicine and pathology services in Canada. APL comprises hospital and community laboratories, mobile collection services, cardiac diagnostic services, on-call services, reference laboratories, public health laboratories, patient-service centres, and transportation services.

Structure and Governance

A subsidiary of AHS, APL reports to the AHS President and CEO via a sole board chair, who is represented by AHS's Vice President of Cancer Care Alberta & Clinical Support Services. APL's governance structure ensures integrated laboratory services are embedded into clinical decisions and operations to improve quality and appropriateness of care. APL executives work closely with AHS executives to ensure all Albertans have access to high-quality laboratory services across the province.

Year at a Glance

APL's third year as a provincewide public laboratory system highlighted the critical role lab services play across the healthcare spectrum. As the COVID-19 pandemic gained momentum throughout 2020, APL was thrust into the spotlight as never before. It is truly inspiring to see how our people rose to the occasion by navigating a year of constantly changing demands and unexpected challenges with an unwavering commitment to protecting the health of Albertans while demonstrating our shared values of Kindness, Inclusion, Innovation, Agility and Accuracy.

2020-21 Notable Accomplishments

The list of accomplishments achieved throughout 2020-21 reinforces the value of an integrated and coordinated provincial lab program. Some highlights include developing one of the country's leading COVID-19 testing programs, successfully implementing the second wave of Connect Care, and launching a search for private sector partners to help deliver community lab services over the long term. APL has made significant progress on key business priorities during a period of unprecedented demand and uncertainty.

COVID-19 Testing Program

Alberta's testing program for COVID-19 is a critical part of the province's pandemic response, helping to determine who has COVID-19 in order to track the virus and prevent its transmission. APL was well prepared to begin large-scale testing, as provincial lab teams had developed in-house polymerase chain reaction (PCR) testing capabilities at the beginning of 2020. After the first positive test was confirmed on March 5, 2020, APL was able to quickly ramp up testing capacity to handling the exponential growth in demand as Alberta led the country in offering testing to residents.

Independent validation of rapid point-of-care (POC) testing systems led to deployment of POC testing across the province at COVID-19 assessment centres, hospital labs, homeless shelters, and in mobile testing units that are visiting congregate living facilities, schools and worksites where outbreaks are suspected. Thousands of rapid tests are also being used to screen staff in all long-term care and supportive living facilities.

APL scientists confirmed one of the first cases of a Variant of Concern from the United Kingdom in Canada in December. They then developed APL's own lab-developed tests used to quickly screen all of Alberta's positive cases for mutations associated with all Variants of Concern.

By the end of March 2021, APL completed more than 3.6 million tests on 1.9 million people. The success of Alberta's COVID-19 testing and surveillance program has served as a model for other jurisdictions around the world, and many of the tools put in place are now providing a valuable platform for managing the public immunization program.

AHS Performance Review Initiatives

After almost a year of preparation, APL and AHS launched a request for proposals (RFP) in December to find private sector partners to deliver community lab services beginning in April 2022. The RFP closed in February 2021 and evaluation of the proposals is underway, led by a third-party sourcing facilitator. The successful proponents(s) are expected to be chosen in the summer of 2021.

Connect Care

The implementation of a single enterprise-wide Laboratory Information System (LIS) is a foundational step toward integrated laboratory services in the province that will allow laboratory test results to be available to providers faster and be accessible to all Albertans.

Hundreds of APL staff are involved in the AHS-wide Connect Care project, which successfully transitioned 10 APL sites in the suburban Edmonton area to the new LIS in Wave 2 in November 2020. Wave 3 successfully launched in April 2021, bringing 15 APL sites and three DynaLIFE sites in the western half of the North Zone onto the new system.

Connect Care implementation is also showing tangible benefits related to reducing unnecessary or inappropriate lab test orders. The University of Alberta Hospital laboratory included recommendations from Choosing Wisely Canada regarding appropriate lab utilization when it moved to Connect Care in Wave 1 in late 2019. A decrease of approximately 20,000 tests per month was recorded at this site in 2020 following this change.

How Do We Know We Are Succeeding?

APL's Business Plan helps ensure we are doing the right things at the right time as we continue to build and improve on our provincial laboratory system. APL continues to work with AHS, our partners, and research collaborators to identify, design, and validate transformational opportunities for laboratory medicine, regardless of the uncertainty.

The Business Plan identifies four strategic goals that have been identified to guide and align our decision making, along with meaningful mechanisms for measuring and monitoring our achievements and performance.

2020-21 Strategic Goals and Key Achievements

Improve health outcomes and patient experience

- Safely relaunched community lab service during the COVID-19 pandemic.
- Expanded patient access to 95 per cent of commonly ordered test results on MyHealth Records.
- Improved access to cancer screening and for a number of hereditary cancers.
- Improved newborn screening processes leading to a significant reduction in unnecessary repeat testing. More than 40 newborns were diagnosed with treatable conditions through newborn metabolic screening
- Enhanced molecular testing capacity to better enable personalized medicine in cancer treatment.
- Continued implementation of standard community lab requisitions, including an online requisition generator for healthcare providers.

Improve the experience and safety of our people

- APL staff strongly adhered to requirements for personal protective equipment, hand-washing, and other additional safety measures.
- Several policy suites were developed to create consistency in workplace health and safety, respectful workplaces, prevention of harassment and violence, and transport of dangerous goods programs.
- Introduction of quarterly virtual Pathology Rounds to enhance peer-teaching and learning opportunities.

Improve financial health and value for money

- Implemented an enhanced vacancy management process to support optimized staffing levels.
- Focused on reducing discretionary spending.
- Upgraded and standardized chemistry equipment, yielding greater efficiency and cost savings.
- Seventeen initiatives identified to improve appropriate lab testing in alignment with the AHS Review, including revised Thrombophilia testing standard that has resulted in an 80 per cent reduction in inappropriate use.

Improve influence of lab medicine in the health system

- Eighteen APL sites assessed for accreditation by College of Physicians and Surgeons of Alberta, and specialized transplant laboratories received American Society for Histocompatibility and Immunogenetics accreditation.
- Advanced research and innovation strategy, harmonized processes for entering research and innovation partnerships and safely accessing biorepositories and health data.

APL continues to work with AHS to identify, design, and validate transformational opportunities for laboratory medicine. These opportunities, in addition to Connect Care implementation and our COVID-19 response, will drive decision-making and strategic management of the Business Plan. Visit APL online at www.albertaprecisionlabs.ca.

Our appreciation and gratitude to all those who contributed to the 2020-21 Annual Report.

Alberta Health Services