Alberta Health Services

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ANNUAL REPORT 2018-19

A healthier future.
Together.

The 2018-19 AHS Annual Report was prepared in accordance with the *Fiscal Management Act*, *Regional Health Authorities Act* and instructions as provided by Alberta Health. All material economic and fiscal implications known as of May 31, 2019 have been considered in preparing the Report.

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

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Message from the AHS Board Chair and President & Chief Executive Officer

On April 1, 2019, AHS celebrated the completion of 10 years of service to Albertans. We have much to be proud of in our first decade as an organization, and our achievements and accomplishments stack up favorably against any health system in Canada.

In communities across the province, our people promote and protect wellness, improve lives and save lives with compassion, energy and expertise.

It's because of this we were named one of the Top 100 Employers in Canada for 2018, one of Canada's Top Employers for Young People and one of Alberta's Top 75 Employers.

We're a high-performing, learning organization that draws lessons from our experience and is quick to adapt to meet the needs of Albertans.

Together, we've accomplished so much. As AHS marks 10 years as a single province-wide health system, here are some of the achievements we can celebrate from the past decade:

- We created five operational zones to improve local decision-making.
- We consolidated foundational systems to create, for example, one payroll system. This is more efficient and has led to significant cost savings.
- We bring the patient and community voice into the health system through our many advisory groups.
- We launched our Strategic Clinical Networks to scale and spread new ways of care that improve outcomes for Albertans no matter where they live.
- We coordinated effective emergency and disaster response and relief, most notably during the Fort McMurray and Slave Lake wildfires, as well as the floods in Calgary and southern Alberta.
- We established Canada's only provincial electronic system for reporting adverse events, tracking and proactive interventions on patient safety issues.
- We created analytics systems which enable real-time data to help inform and manage clinical activities throughout the province. We've also become national and international leaders in many areas of healthcare:
- We have the biggest transplant program in Western Canada.
- We have the best tuberculosis program in the country, with the highest compliance and cure rates.
- We're international leaders in a new treatment for C. difficile infections.
- We reduced by half, the time from stroke diagnosis to treatment, an improvement not achieved anywhere else in the world.
- And earlier this year, healthcare leaders from around the world gathered at the 18th International Congress on Integrated Care where AHS was named one of the five most integrated healthcare systems in the world.

Moving a health care system to a higher level of performance does not happen overnight. There are many initiatives which began in previous years, which will continue to unfold over the coming years:

- The Enhancing Care in the Community initiative is continuing to improve connections between community-based healthcare providers — such as family physicians — with hospital-based healthcare teams, including specialists and emergency department staff. With comprehensive care in the community, we can help Albertans get the care they need without going to a hospital.
- AHS is developing a comprehensive wait times' strategy with our external partners to reduce the waits in seven priority areas: addictions and mental health; cancer; continuing care; specialist access; surgery; acute care, and diagnostic imaging.
- Connect Care is a large-scale project that will create a common province-wide clinical information system, which will enable consistent practices across Alberta and will improve the care we provide for patients and their families. Through Connect Care, the whole healthcare team, including patients, will have the best possible information throughout the care journey.

We have so much to be proud of and we're in a really good position to continue to evolve and succeed over the next 10 years. We consider ourselves very fortunate to work for AHS and the people of Alberta to deliver high-quality healthcare. We will continue to do so in the decades to come.

[Original Signed By]

Linda Hughes
Chair, Alberta Health Services Board

[Original Signed By]

Dr. Verna Yiu
President and CEO, Alberta Health Services

May 30, 2019

About Alberta Health Services

Who We Are

AHS is Canada's first and largest province-wide, fully integrated health system, responsible for delivering health services to more than 4.3 million people living in Alberta.

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

In 2018-19, AHS made the list for Canada's Top 100 Employers, Alberta's Top 75 Employers, Canada's Top Employers for Young People, and Canada's Best Diversity Employers. Throughout AHS, people are working together to create a culture where we all feel safe, healthy, valued and included, with opportunities to reach our full potential.

Alberta's population growth remains ahead of the national average. Alberta's population is expected to be almost 5 million in 2028, reaching almost 6 million by 2042.

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

Virtual Health connects patients/families and care providers separated by physical location using virtual innovations and technology. Last year Virtual Health supported more than 60,000 virtual connections, which enabled Albertans in remote and rural locations to avoid more than 12 million kilometres of travel.

AHS has more than 102,700 direct AHS employees (excluding Covenant Health) and almost 11,700 staff working in AHS' wholly-owned subsidiaries, such as Carewest, CapitalCare Group and Alberta Public Laboratories. The increase in subsidiary staff over last year (3,300) is attributable to the expansion from Calgary Laboratory Services to the provincial lab.

AHS is also supported by almost 11,600 physicians practicing in Alberta, almost 8,400 of whom are members of the AHS medical staff (physicians, dentists, podiatrists, and oral and maxillofacial surgeons).

AHS is supported by more than 14,100 volunteers who, in 2018, contributed more than 1 million hours to help improve the patient experience.

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

As of March 31, 2019 there were 106 acute care hospitals and five standalone psychiatric facilities; 8,483 acute beds; 472 sub-acute care beds; 27,163 continuing care beds/spaces (15,597 long-term care beds, 11,317 designated supportive living beds, and 249 community palliative and hospice beds/spaces) and 2,772 addiction and mental health beds. This is a total of 38,890 AHS operated and contracted beds in service.

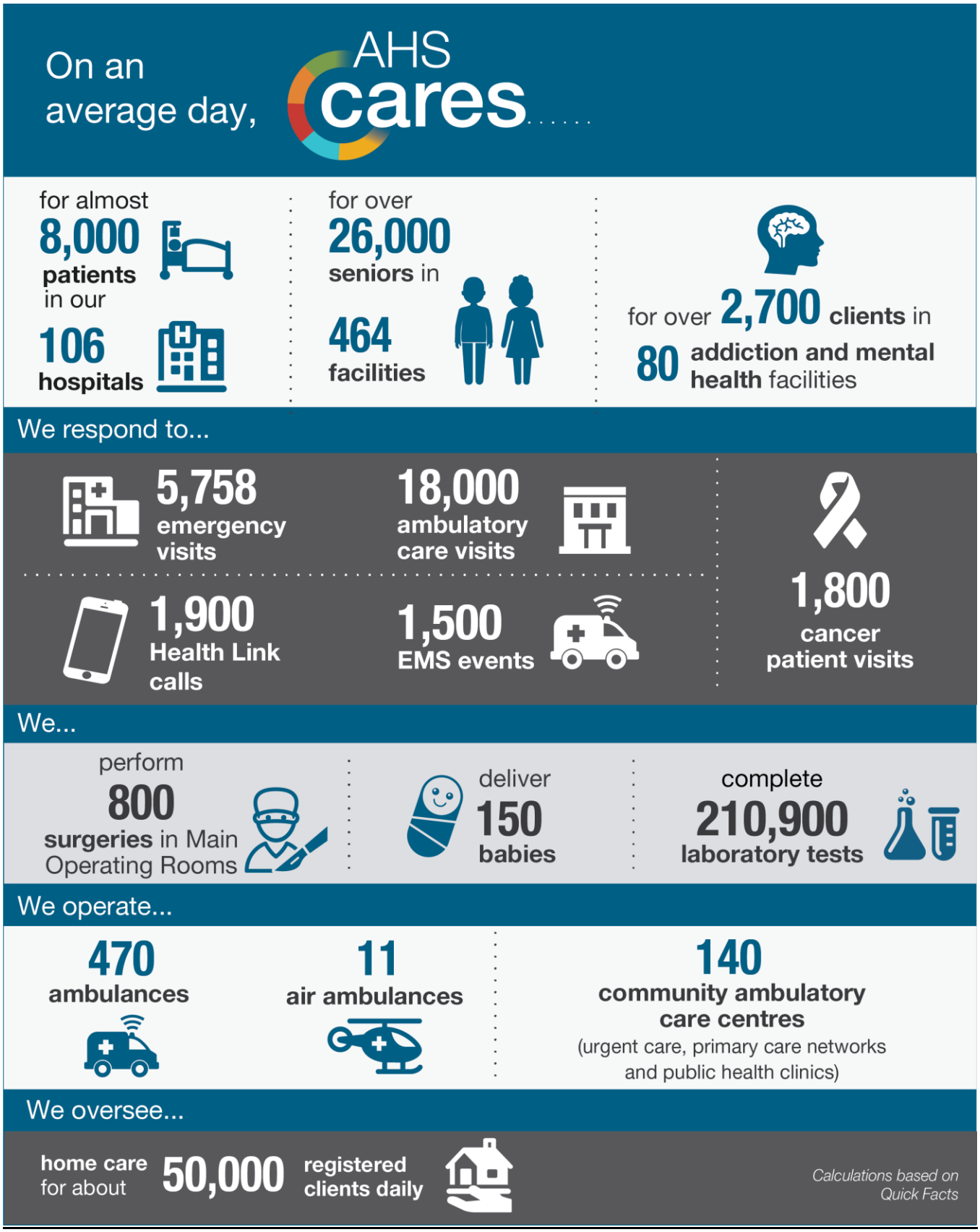
Programs and services are offered at more than 850 facilities throughout the province, including hospitals, continuing care facilities (including long-term care, designated supportive living and community palliative and hospice; includes contracted care sites), cancer centres, addiction and mental health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

Our Volunteers

Volunteers are a central part of building environments that support patient- and family-centred care.

AHS' 14,100 volunteers (which includes over 1,100 patient and family advisors) have contributed over one million volunteer hours this past year, to help keep Albertans safe and healthy.

Among their many contributions, volunteers manage patient visits, give input as advisory council members to improve the quality and safety of healthcare, play wayfinding roles and tend our retail shops to raise funds.


On an average day, AHS cares
for almost 8,000 patients in our 106 hospitals
for over 26,000 seniors in 464 facilities
for over 2,700 clients in 80 addiction and mental health facilities
We respond to...
5,758 emergency visits
18,000 ambulatory care visits
1,900 Health Link calls
1,500 EMS events
1,800 cancer patient visits
We...
perform 800 surgeries in Main Operating Rooms
deliver 150 babies
complete 210,900 laboratory tests
We operate...
470 ambulances
11 air ambulances
140 community ambulatory care centres (urgent care, primary care networks and public health clinics)
We oversee...
home care for about 50,000 registered clients daily
Calculations based on Quick Facts

How Healthy Are We?

There is a paradigm shift taking place in healthcare in Alberta. Care is moving from an illness focus to a wellness focus; from single-provider care to team-based care; from physician-focused to patient- and family-focused; and from hospital-based care to community-based care. We know that risk factors such as tobacco use, alcohol and other substance misuse, too little activity or poor nutrition can increase incidences of chronic illness and health impairments. AHS is working to give Albertans easy access to an integrated network of healthcare professionals in their community, not just when they're ill or injured, but when they want to maintain or improve their overall health and wellness. The best long-term strategy for sustaining the health system is to encourage Albertans to stay healthy.

65% rate their **health** as **good or excellent**

30% eat **5 or more servings** of fruit or vegetables daily

60% are **active** or moderately active

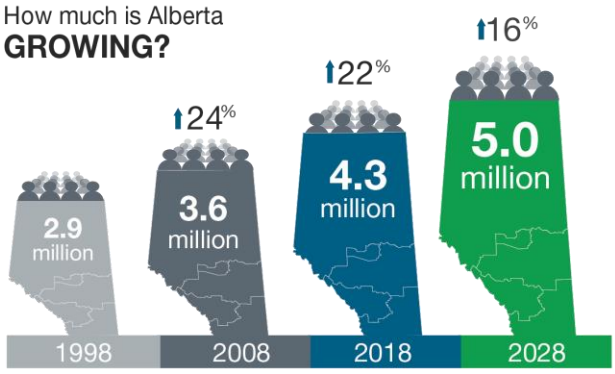
13% **smoke** everyday

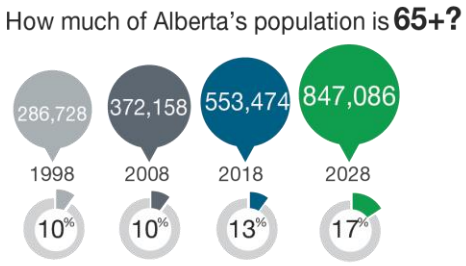
19% are **heavy drinkers** (5+ drinks on one occasion, at least once a month)

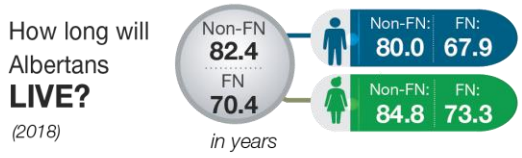
28% are **obese**

Source: Statistics Canada, Canadian Community Health Survey (CCHS), 2015

The graphics below show some of the ways Alberta's population is growing and changing.







Source(s):
- Alberta Health IHDA as of May 15, 2019

Notes:
FN-First Nations; Non FN-Non First Nations

AHS Health Plan & Business Plan

The AHS 2017-2020 Health Plan and 2018-2019 Business Plan are public accountability documents spanning three- and one-year time frames, respectively.

Developed with engagement from internal and external stakeholders and Alberta Health, the Health Plan and Business Plan describe the actions AHS will take in fulfilling its legislated responsibilities, with a primary focus on the delivery of quality health services.

This annual report reflects year two (2018-19) results, based on actions and priorities identified in the AHS 2017-2020 Health Plan and 2018-2019 Business Plan.

Vision, Mission & Values

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

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

Compassion, Accountability, Respect, Excellence, Safety
Our five **Values** are at the heart of everything that we do; they inspire, empower and guide how we work together with patients, clients, families and each other.

AHS cares

compassion
accountability
respect
excellence
safety

Foundational Strategies

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

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

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

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

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

Accreditation

Accreditation Canada's new parent company, Health Standards Organization, has taken on the role of continuously developing the standards and assessment methodologies used for accrediting organizations.

AHS has agreed to co-design the processes for applying the methodologies in large complex health systems. This collaborative effort will achieve a more integrated approach in how the accreditation process assesses health services and improves quality.

AHS and Accreditation Canada have conducted two pilots to assess several new methodologies including pre-survey attestation and unannounced onsite survey assessment. The pilots took place in the Calgary Zone in the areas of inpatient services, infection prevention and control and long term care.

Governance

The AHS Board is responsible for the governance of AHS, working in partnership with Alberta Health to ensure all Albertans have access to high-quality health services across the province. The Board is accountable to the Minister of Health.

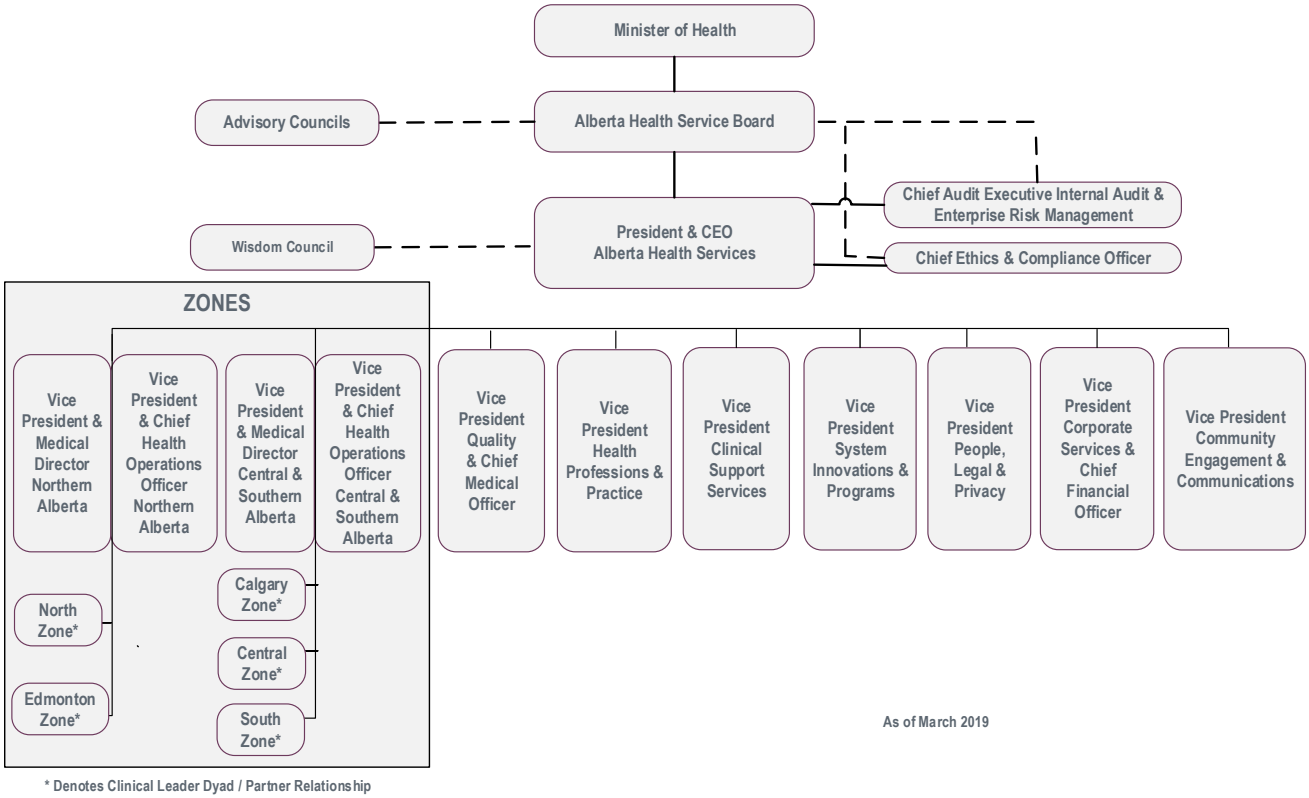
The AHS Board has established committees to assist in governing AHS and overseeing the management of AHS' business and affairs: Audit & Risk Committee, Community Engagement Committee, Finance Committee, Governance Committee, Human Resources Committee and Quality & Safety Committee. The purpose and scope of each committee is in accordance with governance best practices and is consistent with the governing legislation of AHS. The Board Chair is a member of each committee, and the President and Chief Executive Officer is a non-voting ex-officio member of each committee.

Linda Hughes (Chair)
Dr. Brenda Hemmelgarn (Vice-Chair)
David Carpenter
Richard Dicerni
Heather Hirsch
Hugh D. Sommerville
Marliss Taylor
Glenda Yeates

Note: Robb Foote was a Board member during 2018-19. He resigned effective February 1, 2019.

Organizational Structure

Dr. Verna Yiu is President and Chief Executive Officer (CEO) of AHS and leads over 102,700 caring and dedicated individuals who make up the AHS workforce. With leaders and staff in the organization, AHS is proud to have a culture that exemplifies its values, takes a provincial perspective on issues and ensures good ideas developed locally are shared across the province. AHS' organizational structure is represented below, arranged under the AHS Executive Leadership Team reporting directly to the President and CEO.



Advisory Councils – Working Together to Improve Lives

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

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

- 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 Advisory Council has between 15 and 20 members, with each individual serving for two- or three-year terms for a maximum of six years. Recruitment for membership on Health and Provincial Advisory Councils is an ongoing activity at AHS. Vacancies arise throughout the year when members who have completed their six-year maximum terms leave the Councils for other volunteer opportunities.

Wisdom Council provides guidance and recommendations on the development and implementation of culturally appropriate and innovative health service delivery for Indigenous Peoples. It is comprised of Indigenous Peoples with wide-ranging backgrounds, including traditional knowledge-holders, youth, nursing professionals and health consultants. In December, the Wisdom Council modified their terms of reference to recognize their knowledge keepers as distinct members within the Wisdom Council Elders Circle. Elders can now opt to continue to serve after their membership term ends by providing guidance to all AHS Advisory Councils, including to continue as members on the Wisdom Council.

Alberta Clinician Council is an organization-wide forum comprised of frontline clinicians from a variety of disciplines and zones. Applying their collective knowledge, experience and expertise, the council advises senior leadership on issues and opportunities to improve quality, access and patient safety.

Patient and Family Advisory Group brings patient and family voices into AHS. Partnering with senior leaders, it reviews policies and strategies and shares insights from patients' perspectives on planning and delivering healthcare services.

Patient Engagement Reference Group brings together Strategic Clinical Network™ (SCN) Patient and Family Advisors and Patient and Community Engagement Researchers (PaCERs) to incorporate the patient voice into SCN work. The group meets quarterly providing a forum for consultation, networking, and partnership building between advisors and SCN leaders.

Provincial Advisory Council on Addiction and Mental Health advises AHS on programs and services for province-wide addiction and mental health treatment. It provides evidence-based recommendations that improve quality of services and patient satisfaction through effective service planning.

Provincial Advisory Council on Cancer advises AHS on programs and service for province-wide cancer care. It provides evidence-based recommendations on prevention and screening, diagnosis, treatment and care, and research.

Seniors & Continuing Care Provincial Advisory Council was launched in January 2018. It aims to improve the delivery of services to seniors and those in continuing care (long-term care and designated supportive living) across Alberta.

Provincial Advisory Council on Sexual Orientation Gender Identity & Expression launched in early 2019. It aims to create a safer and more welcoming healthcare environment for sexual and gender minority (lesbian, gay, bisexual, transgender, queer, and 2 Spirit or LGBTQ2S+) patients and their families.

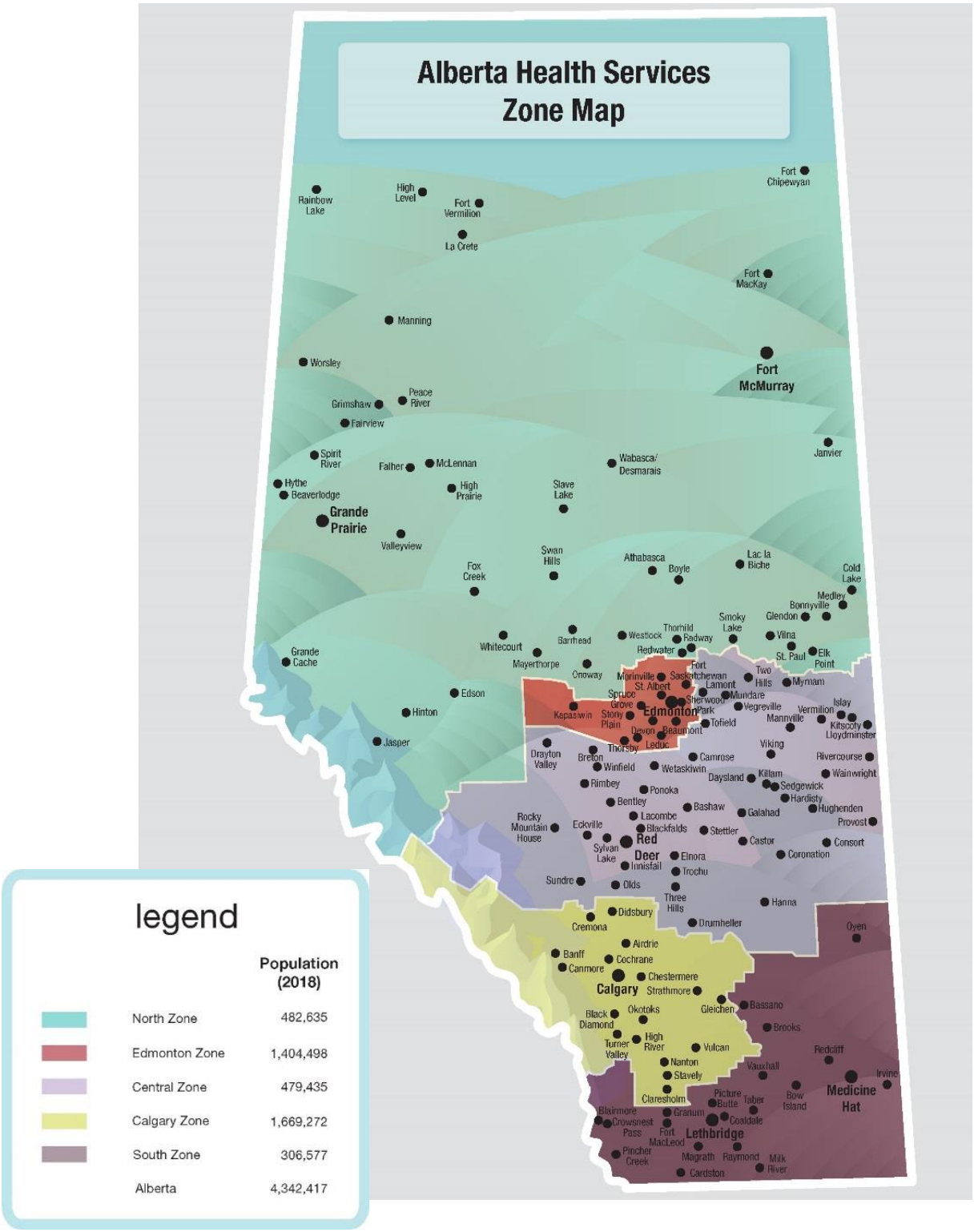
Twelve **Community Conversations** were hosted by AHS leaders and local HAC members between November 2018 and March 2019.

- The events provided an opportunity for AHS and the communities it serves to discuss ways to work together to improve healthcare for all Albertans. Participants included 304 members of the public, Health Advisory Council members, Provincial Advisory Council members, and AHS staff.
- Feedback from HAC chairs and Council members, Zone leadership, and community participants was very positive - more than 90% of evaluations stated they felt AHS values their input and uses it when making healthcare service decisions. Many requests were made for the conversation to continue.

AHS Map

AHS is organized into five geographic zones: South, Calgary, Central, Edmonton and North. Our zones enable local decision-making as well as listening and responding to local communities, local staff members, and our patients and clients.

Province-wide services, such as Emergency Medical Services, population, public and Indigenous health, diagnostic imaging, and quality and safety, work together with the zones to deliver care. The next section includes an overview and highlights of each zone.



Quick Facts

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

The trend column indicates comparison of the most recent available data compared to the previous year for each indicator. An upward arrow (⇧) indicates increased volumes by more than 3%; a horizontal arrow (⇨) indicates stability (current results are within 3% of prior results), and a downward arrow (⇩) indicates a decrease by more than 3% in volumes.

Alberta Health Services	2014-15	2015-16	2016-17	2017-18	2018-19	Trend
Primary Care / Population Health						
Ambulatory Care Visits	6,238,753	6,421,309	6,569,162	6,638,806	n/a	n/a
Number of Unique/Individual Home Care Clients	114,813	117,505	119,749	121,929	127,214	⇧
Number of People Placed in Continuing Care	7,810	7,879	7,963	7,927	8,098	⇨
Health Link Calls	813,471	755,334	744,278	706,280	694,313	⇨
Poison Information Calls (PADIS)	35,080	36,375	39,467	39,270	38,785	⇨
Seasonal Influenza Immunizations	1,254,950	1,146,569	1,171,825	1,229,350	1,317,659	⇧
EMS Events	503,769	517,640	512,167	544,744	560,434	⇨
Food Safety Inspections	92,723	92,857	82,482	78,311	65,560	⇩
Acute Care						
Emergency Department Visits (all sites)	2,181,369	2,134,945	2,079,688	2,101,629	2,055,864	⇨
Urgent Care Visits	195,312	189,775	187,519	198,108	197,169	⇨
Hospital Discharges	401,331	404,514	403,958	400,909	401,179	⇨
Births	54,203	55,283	53,647	51,692	50,793	⇨
Total Hospital Days	2,808,990	2,812,244	2,837,865	2,862,324	2,852,480	⇨
Average Length of Stay (in days)	7.0	7.0	7.0	7.1	7.1	⇨
Diagnostic / Specific Procedures						
Hip Replacements (scheduled and emergency)	5,397	5,564	6,004	6,191	6,278	⇨
Knee Replacements (scheduled and emergency)	6,377	6,645	6,692	6,556	6,613	⇨
Cataract Surgery	36,582	36,806	38,053	39,340	40,140	⇨
Main Operating Room Activity	280,218	286,445	291,352	293,516	293,979	⇨
MRI Exams	199,928	195,419	192,375	195,017	204,744	⇧
CT Exams	387,116	391,600	405,332	415,755	441,938	⇧
X-rays	1,868,044	1,874,879	1,843,076	1,857,946	1,845,811	⇨
Lab Tests	73,994,032	75,512,771	76,282,777	76,974,638	79,829,388	⇧
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	578,005	616,237	641,856	639,449	668,817	⇧
Unique/Individual Cancer Patients	52,288	55,020	57,549	58,409	59,249	⇨
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	21,260	22,646	24,183	24,471	26,106	⇧
Community Treatment Orders (CTOs) Issued	443	452	462	490	379 (Q3YTD)	n/a
Addiction Residential Treatment & Detoxification Admissions	10,342	10,919	10,591	11,009	10,604	⇩

NOTES: Data updated as of May 15, 2019. Quick Facts definitions can be found at https://www.albertahealthservices.ca/about/Page11905.aspx.

- Health Link: Lower call volumes may be due to the number of online options Albertans can use to obtain or self-serve for this type of information, including the MyHealthAlberta site.
- Food safety inspections decreased due to implementation of new software, training and some inspection work no longer being counted.
- Addiction admissions decreased due to higher client acuity and longer program stays resulting in less capacity.

Bed Numbers

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

In 2018-19, AHS opened 1,267 net new continuing care beds – compared to 572 beds in 2017-18. Since 2010, AHS has opened 7,463 new beds to support individuals who need community-based care and supports (including palliative). This means that, gradually, people are more efficiently being moved from a hospital setting to a more appropriate (and often more cost-effective) community-based setting.

To keep pace with population growth and aging, AHS needs to target increasing community capacity by approximately 1,000 designated spaces annually. This has enabled us to improve our ability to place clients within 30 days of assessment. Finally, the growing of home care services has shown to prevent or delay the need for long term care placement.

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

Number of Beds/Spaces	March 31, 2018	March 31, 2019	Difference	% Change
ACUTE CARE				
Acute Care	8,457	8,483	26	0.3%
TOTAL ACUTE CARE	**8,457**	**8,483**	**26**	**0.3%**
COMMUNITY BASED CARE				
Continuing Care - Long Term Care (LTC)				
Auxiliary Hospital	5,616	5,607	-9	-0.2%
Nursing Home	9,230	9,990	760	8.2%
Sub-Total Long Term Care (LTC)	**14,846**	**15,597**	**751**	**5.1%**
Continuing Care - Designated Supportive Living				
Designated Supportive Living 4 - Dementia	3,056	3,321	265	8.7%
Designated Supportive Living 4	6,237	6,462	225	3.6%
Designated Supportive Living 3	1,514	1,534	20	1.3%
Sub-Total Designated Supportive Living (DSL)	**10,807**	**11,317**	**510**	**4.7%**
SUB-TOTAL LONG-TERM CARE & DESIGNATED SUPPORTIVE LIVING	**25,653**	**26,914**	**1,261**	**4.9%**
Community Palliative and Hospice (out of hospital)	243	249	6	2.5%
TOTAL CONTINUING CARE (includes LTC, DSL and Palliative Care)	**25,896**	**27,163**	**1,267**	**4.9%**
Sub-acute in Auxiliary Hospitals	490	472	-18	-3.7%
TOTAL COMMUNITY BASED CARE (includes LTC, DSL, Palliative Care and Sub-Acute in Auxiliary Hospitals)	**26,386**	**27,635**	**1,249**	**4.7%**
ADDICTION & MENTAL HEALTH				
Addiction Treatment	981	976	-5	-0.5%
Community Mental Health	797	868	71	8.9%
Psychiatric (stand-alone facilities)	928	928	0	0.0%
TOTAL ADDICTION & MENTAL HEALTH	**2,706**	**2,772**	**66**	**2.4%**
PROVINCIAL TOTAL	**37,549**	**38,890**	**1,341**	**3.6%**

Source: AHS Bed Survey as of March 31, 2019

South Zone Overview

Population Statistics (2018)

Overall **Population**
306,577

48,565
Aging Population
(over 65 years)

Life **Expectancy** *(2018)*
80.5 years

Median Age
37.0 years

Source: Alberta Health IHDA

Facts at Your Fingertips

59%
rate their **health** as **good or excellent**

15%
smoke everyday

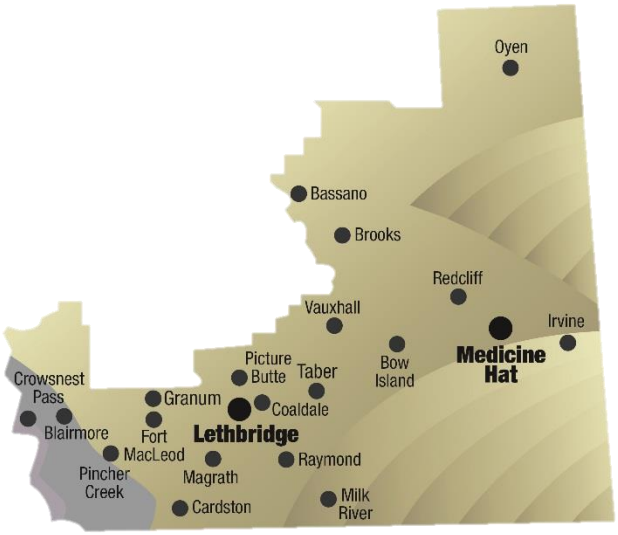
25%
eat **5 or more servings** of fruit or vegetables daily

16%
are **heavy drinkers** (5+ drinks on one occasion, at least once a month)

58%
are **active** or moderately active

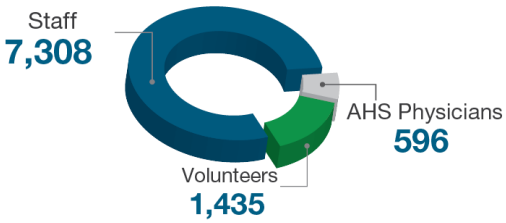
32%
are **obese**

Source: Statistics Canada, Canadian Community Health Survey (CCHS), 2015



Land Mass: 65,500 km²

Workforce



South Zone 2018-19 Highlights

- Chinook Regional Hospital in Lethbridge was selected by the American College of Surgeons for exemplary surgical outcomes through the college's National Surgical Quality Improvement Program (NSQIP). NSQIP's goal is to reduce infections, illnesses and deaths related to surgical procedures.
- Medicine Hat Regional Hospital launched the Bariatric-Friendly Hospital Initiative in January 2018 that aims to improve the healthcare experience for people who have a body weight of greater than 250lbs. This initiative will support health care providers to become more knowledgeable about obesity and its impact on quality care, develop competencies in the unique care needs of patients, and work effectively and compassionately with patients with obesity. It will also focus on safe patient handling to help prevent patient and provider injury.
- A detox facility on the Blood Reserve in Standoff was opened in February 2019, to save lives and to reduce the burden on first responders who are on the front lines of the drug epidemic. In 2018, 335 overdose calls were made by Blood Tribe EMS. It's a first of its kind for an Alberta First Nation.
- The new Ambulatory Care Building at the Medicine Hat Regional Hospital opened July 2018 and provides day surgery, cancer care, neonatal intensive care, and cardio-respiratory services. The building is also equipped with a rooftop heliport, a renal program, and sterile processing.
- Kainai Continuing Care Centre opened in Standoff, in partnership with the Blood Tribe, with 25 long-term care beds to support Indigenous people to remain in their community, close to the support of family and friends, as they age or as their care needs change.

South Zone details on beds and facilities can be found in the Appendix.

The table below provides a snapshot of South Zone's activity and demonstrates the change in services provided in the last few years. The trend column indicates comparison of the most recent available data compared to the previous year for each indicator. An upward arrow (⇧) indicates increased volumes by more than 3%; a horizontal arrow (⇨) indicates stability (current results are within 3% of prior results), and a downward arrow (⇩) indicates a decrease by more than 3% in volumes.

SOUTH ZONE QUICK FACTS	2014-15	2015-16	2016-17	2017-18	2018-19	Trend
Primary Care / Population Health						
Ambulatory Care Visits	365,293	376,743	406,163	430,483	n/a	n/a
Number of Unique/Individual Home Care Clients	12,034	12,217	12,589	12,822	13,095	⇨
Number of People Placed in Continuing Care	866	887	925	905	908	⇨
Health Link Calls	32,108	34,773	34,061	32,644	30,306	⇩
Seasonal Influenza Immunizations	96,663	88,172	90,273	92,391	95,240	⇧
Food Safety Inspections	8,609	7,866	7,707	6,401	4,926	⇩
Acute Care						
Emergency Department Visits (all sites)	194,352	194,257	192,083	193,467	189,864	⇨
Hospital Discharges	31,125	30,485	30,521	29,905	29,148	⇨
Births	4,156	4,217	3,940	3,865	3,692	⇩
Total Hospital Days	212,020	219,218	228,308	222,761	220,260	⇨
Average Length of Stay (in days)	6.8	7.2	7.5	7.4	7.6	⇨
Diagnostic / Specific Procedures						
Hip Replacements (scheduled and emergency)	571	578	591	569	582	⇨
Knee Replacements (scheduled and emergency)	822	838	784	778	830	⇧
Cataract Surgery	2,878	2,847	2,955	2,920	3,105	⇧
Main Operating Room Activity	23,501	23,209	23,352	22,491	21,842	⇨
MRI Exams	14,227	14,288	13,809	13,601	14,513	⇧
CT Exams	26,185	26,964	28,926	30,418	31,640	⇧
X-rays	163,095	166,251	165,091	162,358	163,170	⇨
Lab Tests	5,085,305	5,263,114	5,195,905	5,200,813	5,472,276	⇧
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	30,277	32,144	34,055	31,067	32,437	⇧
Unique/Individual Cancer Patients	4,349	4,273	4,379	3,733	3,045	⇩
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	2,014	2,052	2,166	2,230	2,316	⇧
Workforce						
Staff	7,238	7,280	7,431	7,533	7,308	⇩
Volunteers	1,933	1,746	1,632	1,441	1,435	⇨
AHS Physicians	613	569	578	613	596	⇩

NOTES: Data updated as of May 15, 2019. Quick Facts definitions can be found at https://www.albertahealthservices.ca/about/Page11905.aspx.

- Health Link: Lower call volumes may be due to the number of online options Albertans can use to obtain or self-serve for this type of information, including the MyHealthAlberta site.
- Food inspections decreased due to focused efforts on more difficult establishments which required longer inspections.
- Cancer visits and patients declined due to the leave of absence of one oncologist.
- Volunteers decreased due to a pertussis outbreak in the South Zone.

Calgary Zone Overview

Population Statistics (2018)

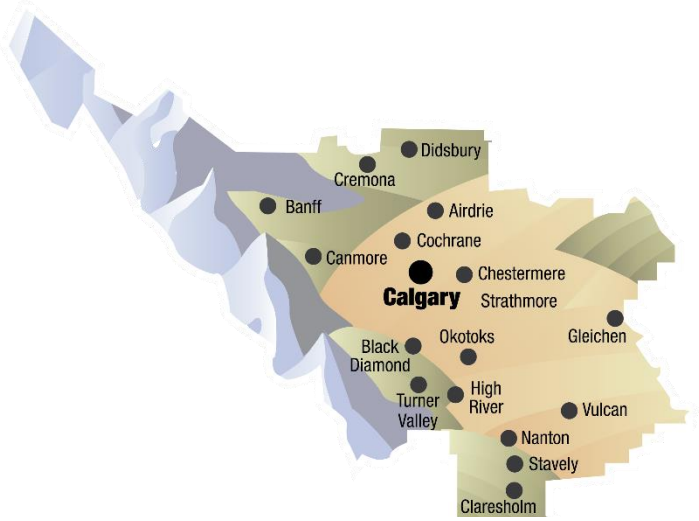
Overall **Population**
1,669,272

200,478
Aging Population
(over 65 years)

Life **Expectancy** *(2018)*
83.1 years

Median Age
37.3 years

Source: Alberta Health IHDA



Land Mass: 39,300 km²

Facts at Your Fingertips

69% rate their **health** as **good or excellent**

9% **smoke** everyday

30% eat **5 or more servings** of fruit or vegetables daily

18% are **heavy drinkers** (5+ drinks on one occasion, at least once a month)

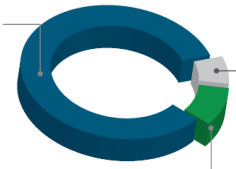
62% are **active** or moderately active

25% are **obese**

Source: Statistics Canada, Canadian Community Health Survey (CCHS), 2015

Workforce

Staff
37,755



AHS Physicians
3,120

Volunteers
4,298

Calgary Zone 2018-19 Highlights

- Over 700 continuing care beds were opened in Calgary Zone during 2018-19 including 562 long-term care beds and 165 designated supportive living beds to support individuals who need community-based care.
- Home care activity increased by 2.4% in urban and over 7% in rural settings.
- Addiction Recovery and Community Health (ARCH) Team Expansion at the Peter Lougheed Centre is aimed at improving health outcomes and healthcare access for patient with substances use disorders and/or those who are socially vulnerable.
- The Calgary Injectable Opioid Agonist Therapy (iOAT) clinic opened its doors in October 2018 at the Sheldon M. Chumir Health Centre. The new clinic provides comprehensive services for a complex population of clients with severe opioid use disorder.
- Construction of the Calgary Cancer Centre (CCC), in partnership with Alberta Infrastructure and Alberta Health, continues to make great progress, remaining on budget and on time. The CCC will increase cancer care capacity in southern Alberta by consolidating and expanding existing services in the Calgary Zone to support integrated and comprehensive cancer care. The new facility is planned for completion in 2023.
- The Urology Central Intake (UCI) program is a joint initiative developed in partnership with the Southern Alberta Institute of Urology (SAIU). Launched in January 2019, it serves as a one-stop resource for family physicians to access when referring a patient to an SAIU urologist. AHS will now receive and manage all urology referrals, matching the patient to the most appropriate urologist based upon the patient's symptoms and the specialists' particular area of expertise.

Calgary Zone details on beds and facilities can be found in the Appendix.

The table below provides a snapshot of Calgary Zone's activity and demonstrates the change in services provided in the last few years. The trend column indicates comparison of the most recent available data compared to the previous year for each indicator. An upward arrow (⇧) indicates increased volumes by more than 3%; a horizontal arrow (⇨) indicates stability (current results are within 3% of prior results), and a downward arrow (⇩) indicates a decrease by more than 3% in volumes.

CALGARY ZONE QUICK FACTS	2014-15	2015-16	2016-17	2017-18	2018-19	Trend
Primary Care / Population Health						
Ambulatory Care Visits	2,573,583	2,646,960	2,661,944	2,762,142	n/a	n/a
Number of Unique/Individual Home Care Clients	33,511	34,682	35,833	37,318	39,096	⇧
Number of People Placed in Continuing Care	2,548	2,722	2,438	2,632	2,668	⇨
Health Link Calls	325,566	318,422	310,333	292,109	289,203	⇨
Seasonal Influenza Immunizations	511,151	467,942	491,931	525,652	559,488	⇧
Food Safety Inspections	31,121	30,496	27,093	26,494	23,688	⇩
Acute Care						
Emergency Department Visits (all sites)	493,861	487,862	475,485	476,013	476,264	⇨
Urgent Care Visits	183,230	179,832	176,120	185,718	185,455	⇨
Hospital Discharges	140,563	143,063	143,659	144,354	145,415	⇨
Births	19,554	19,720	19,394	18,883	18,195	⇩
Total Hospital Days	1,025,776	1,030,612	1,024,174	1,021,481	1,036,114	⇨
Average Length of Stay (in days)	7.3	7.2	7.1	7.1	7.1	⇨
Diagnostic / Specific Procedures						
Hip Replacements (scheduled and emergency)	1,960	2,099	2,184	2,276	2,321	⇨
Knee Replacements (scheduled and emergency)	2,388	2,511	2,490	2,353	2,394	⇨
Cataract Surgery	13,378	13,577	13,490	14,439	14,425	⇨
Main Operating Room Activity	98,386	101,016	101,850	102,776	102,108	⇨
MRI Exams	78,175	76,850	77,116	77,502	78,231	⇨
CT Exams	143,496	142,863	145,678	151,370	162,445	⇧
X-rays	541,087	546,546	537,800	546,543	542,446	⇨
Lab Tests	28,407,412	28,800,108	29,212,267	29,639,947	30,882,365	⇧
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	180,811	200,599	213,828	214,536	221,104	⇧
Unique/Individual Cancer Patients	21,717	22,934	23,792	24,651	25,356	⇨
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	8,081	9,022	9,499	9,668	10,932	⇧
Workforce						
Staff	37,000	37,023	36,887	37,022	37,755	⇨
Volunteers	4,623	5,100	4,206	4,267	4,298	⇨
AHS Physicians	3,497	3,326	3,439	3,497	3,120	⇩

NOTES: Data updated as of May 15, 2019. Quick Facts definitions can be found at https://www.albertahealthservices.ca/about/Page11905.aspx.

- Health Link: Lower call volumes may be due to the number of online options Albertans can use to obtain or self-serve for this type of information, including the MyHealthAlberta site.

Central Zone Overview

Population Statistics (2018)

Overall **Population**
479,435

74,503
Aging Population
(over 65 years)

Life **Expectancy** *(2018)*
81.0 years

Median Age
38.4 years

Source: Alberta Health IHDA

Facts at Your Fingertips

62%
rate their **health** as **good or excellent**

17%
smoke everyday

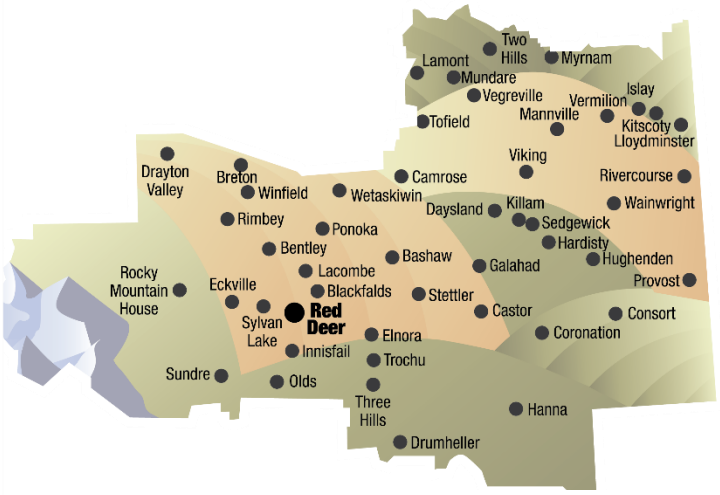
31%
eat **5 or more servings** of fruit or vegetables daily

20%
are **heavy drinkers** (5+ drinks on one occasion, at least once a month)

61%
are **active** or moderately active

32%
are **obese**

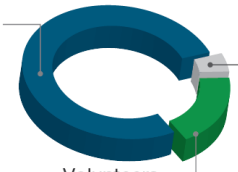
Source: Statistics Canada, Canadian Community Health Survey (CCHS), 2015



Land Mass: 95,000 km²

Workforce

Staff
12,848



AHS Physicians
786

Volunteers
2,935

Central Zone 2018-19 Highlights

- Almost 200 continuing care beds were opened in Red Deer and Wetaskiwin during 2018-19 including 60 long-term care beds and 196 designated supportive living beds to support individuals who need community-based care. This supports seniors who have more complex needs, including those with dementia, with their health and personal needs in a home-like environment.
- Since November 2018, residents of Wainwright and surrounding areas are benefitting from a newly renovated emergency department at the Wainwright Health Centre. The renovations added a second trauma room, three larger examination rooms and a dedicated procedure room for casting and day procedures. As well, it doubled the size of the patient waiting area and expanded storage space for supplies and equipment.
- In February 2019, Drayton Valley Hospital expanded their dialysis care hours from three days per week to six days per week. The extra service hours will provide space for an additional four patients from the Drayton Valley area to receive the care they need, in their community. The unit currently provides treatment for eight patients.
- The Central Zone Healthcare Plan charts the course for improvements. AHS worked with Alberta Health, community members, patients, health professionals, physicians, community health partners and health experts throughout Central Alberta to talk about the future of healthcare. The Plan captures the current state of healthcare in the Central Zone, explains why change is needed and projects what healthcare could look like in the next 15 years.

Central Zone details on beds and facilities can be found in the Appendix.

The table below provides a snapshot of Central Zone's activity and demonstrates the change in services provided in the last few years. The trend column indicates comparison of the most recent available data compared to the previous year for each indicator. An upward arrow (⇧) indicates increased volumes by more than 3%; a horizontal arrow (⇨) indicates stability (current results are within 3% of prior results), and a downward arrow (⇩) indicates a decrease by more than 3% in volumes.

CENTRAL ZONE QUICK FACTS	2014-15	2015-16	2016-17	2017-18	2018-19	Trend
Primary Care / Population Health						
Ambulatory Care Visits	471,526	479,723	501,083	481,016	n/a	n/a
Number of Unique/Individual Home Care Clients	18,233	18,693	18,987	19,227	20,367	⇧
Number of People Placed in Continuing Care	1,259	1,060	1,352	1,236	1,312	⇧
Health Link Calls	62,035	68,388	61,431	56,996	56,202	⇨
Seasonal Influenza Immunizations	115,539	105,872	106,934	112,629	118,796	⇧
Food Safety Inspections	11,234	11,390	9,944	9,508	7,511	⇩
Acute Care						
Emergency Department Visits (all sites)	380,367	360,966	344,993	347,222	327,489	⇩
Hospital Discharges	45,691	45,577	45,265	43,982	42,780	⇨
Births	4,926	5,037	4,765	4,433	4,364	⇨
Total Hospital Days	330,752	323,983	338,305	328,939	333,888	⇨
Average Length of Stay (in days)	7.2	7.1	7.5	7.5	7.8	⇧
Diagnostic / Specific Procedures						
Hip Replacements (scheduled and emergency)	569	585	632	646	654	⇨
Knee Replacements (scheduled and emergency)	654	616	678	621	706	⇧
Cataract Surgery	3,722	3,782	3,859	3,947	3,974	⇨
Main Operating Room Activity	29,330	29,999	30,930	28,603	29,573	⇧
MRI Exams	12,610	12,406	11,034	12,058	13,089	⇧
CT Exams	36,143	37,485	38,679	38,310	42,698	⇧
X-rays	256,595	255,147	251,374	251,082	255,168	⇨
Lab Tests	6,187,163	6,374,514	6,426,497	6,385,971	6,704,810	⇧
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	27,298	32,098	33,366	33,856	34,856	⇨
Unique/Individual Cancer Patients	2,461	2,762	2,970	3,038	3,268	⇧
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	2,260	2,497	2,633	2,614	2,609	⇨
Workforce						
Staff	12,631	12,772	12,813	12,910	12,848	⇨
Volunteers	3,292	3,409	2,852	3,011	2,935	⇩
AHS Physicians	749	710	725	749	786	⇧

NOTES: Data updated as of May 15, 2019. Quick Facts definitions can be found at https://www.albertahealthservices.ca/about/Page11905.aspx.

- Number of People Placed in Continuing Care declined due to a high number of outbreaks, water damage and compliance issues which resulted in temporary closures.
- Health Link: Lower call volumes may be due to the number of online options Albertans can use to obtain or self-serve for this type of information, including the MyHealthAlberta site.
- Food inspections decreased due to focused efforts on more difficult establishments which required longer inspections.
- The decrease in the number of births may be due to the economic downturn.

Edmonton Zone Overview

Population Statistics (2018)

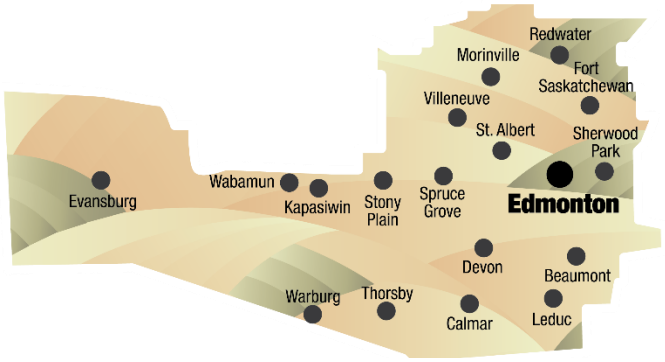
Overall **Population**
1,404,498

179,787
Aging Population
(over 65 years)

Life **Expectancy** *(2018)*
82.0 years

Median Age
36.6 years

Source: Alberta Health IHDA



Land Mass: 11,800 km²

Facts at Your Fingertips

65% rate their **health** as **good or excellent**

13% **smoke** everyday

30% eat **5 or more servings** of fruit or vegetables daily

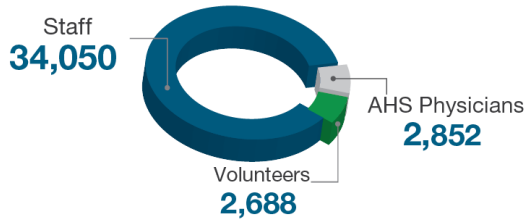
19% are **heavy drinkers** (5+ drinks on one occasion, at least once a month)

58% are **active** or moderately active

26% are **obese**

Source: Statistics Canada, Canadian Community Health Survey (CCHS), 2015

Workforce



Edmonton Zone 2018-19 Highlights

- The Edmonton Zone Mental Health Day Hospital opened its doors to patients and their families in January 2019 and makes an impact on emergency department use across the zone. The Mental Health Day Hospital provides a spectrum of care to the Zone's mental health acute care beds by offering services for more acutely-ill mental health patients while they remain in their home, functioning as an alternative to hospitalization.
- The Edmonton Zone Enhanced Home Living Program was implemented in January 2019 and provides enhanced support services for a targeted group of clients and caregivers. This Enhancing Care in the Community pilot program provides support to home living clients and also supports other programs such as Destination Home that are helping clients to return and stay home.
- The Glenrose Rehabilitation Hospital, in collaboration with community partners and patients and families, has undertaken transformative changes to improve patient experiences with, and access to, tertiary level inpatient rehabilitation. The purpose was to create improvements to the inpatient pathway by using the patient, family, and clinician voice to drive change. Four key strategies were undertaken to achieve these goals: centralized referral screening, standardized intake, bed optimization, and coordinated care transitions.
- In the fall of 2018, improvements to the University of Alberta Hospital Emergency Department were completed and include the addition of two new areas: the Rapid Transfer Unit provides comfortable and private space for patients waiting to move within the system; the Rapid Assessment Zone is for patients who are more stable to receive quicker assessment and treatment in the emergency department.
- Firefly Robotic technology is now being used in gynecological surgery at the Lois Hole Hospital for Women. This fluorescence imaging robotic technology is leading edge and provides useful real-time identification of vascular anatomy, lymph node mapping, and sentinel lymph node biopsy. This is the first robotic surgery use in gynecology in Alberta.

Edmonton Zone details on beds and facilities can be found in the Appendix.

The table below provides a snapshot of Edmonton Zone's activity and demonstrates the change in services provided in the last few years. The trend column indicates comparison of the most recent available data compared to the previous year for each indicator. An upward arrow (⇧) indicates increased volumes by more than 3%; a horizontal arrow (⇨) indicates stability (current results are within 3% of prior results), and a downward arrow (⇩) indicates a decrease by more than 3% in volumes.

EDMONTON ZONE QUICK FACTS	2014-15	2015-16	2016-17	2017-18	2018-19	Trend
Primary Care / Population Health						
Ambulatory Care Visits	2,410,006	2,490,807	2,581,917	2,561,790	n/a	n/a
Number of Unique/Individual Home Care Clients	38,096	37,985	38,436	38,266	39,666	⇧
Number of People Placed in Continuing Care	2,443	2,506	2,575	2,388	2,525	⇧
Health Link Calls	325,440	269,205	278,755	267,218	263,928	⇨
Seasonal Influenza Immunizations	417,388	384,723	389,918	406,229	443,574	⇧
Food Safety Inspections	26,170	27,788	23,188	20,484	16,673	⇩
Acute Care						
Emergency Department Visits (all sites)	535,146	541,451	545,147	552,858	552,343	⇨
Urgent Care Visits	12,082	9,943	11,399	12,390	11,714	⇩
Hospital Discharges	139,052	141,279	142,584	140,224	143,163	⇨
Births	19,258	19,751	19,849	18,758	18,949	⇨
Total Hospital Days	984,395	975,054	995,740	1,007,038	998,979	⇨
Average Length of Stay (in days)	7.1	6.9	7.0	7.2	7.0	⇨
Diagnostic / Specific Procedures						
Hip Replacements (scheduled and emergency)	1,957	1,987	2,270	2,345	2,337	⇨
Knee Replacements (scheduled and emergency)	2,068	2,166	2,191	2,241	2,199	⇨
Cataract Surgery	14,411	14,458	15,751	16,014	16,475	⇨
Main Operating Room Activity	102,467	102,463	107,015	111,249	114,866	⇧
MRI Exams	81,945	78,254	77,523	79,087	85,649	⇧
CT Exams	147,226	149,237	157,225	159,512	168,599	⇧
X-rays	609,179	613,135	603,962	609,941	601,553	⇨
Lab Tests	27,278,431	27,781,396	28,233,276	28,672,978	29,602,022	⇧
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	325,538	337,234	344,170	343,539	363,466	⇧
Unique/Individual Cancer Patients	23,868	25,074	26,442	27,150	27,726	⇨
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	5,992	6,195	6,909	6,813	7,309	⇧
Workforce						
Staff	32,657	32,921	33,473	33,969	34,050	⇨
Volunteers	2,680	2,903	2,771	2,781	2,688	⇩
AHS Physicians	2,919	2,714	2,824	2,919	2,852	⇨

NOTES: Data updated as of May 15, 2019. Quick Facts definitions can be found at https://www.albertahealthservices.ca/about/Page11905.aspx.

- Health Link: Lower call volumes may be due to the number of online options Albertans can use to obtain or self-serve for this type of information, including the MyHealthAlberta site.
- Food inspections decreased due to focused efforts on more difficult establishments which required longer inspections.
- The decrease in the number of births may be due to the economic downturn.

North Zone **Overview**

Population Statistics (2018)

Overall **Population**
482,635

50,142
Aging Population
(over 65 years)

Life **Expectancy** *(2018)*
80.0 years

Median Age
34.7 years

Source: Alberta Health IHDA

Facts at Your Fingertips

58%
rate their **health** as **good or excellent**

20%
smoke everyday

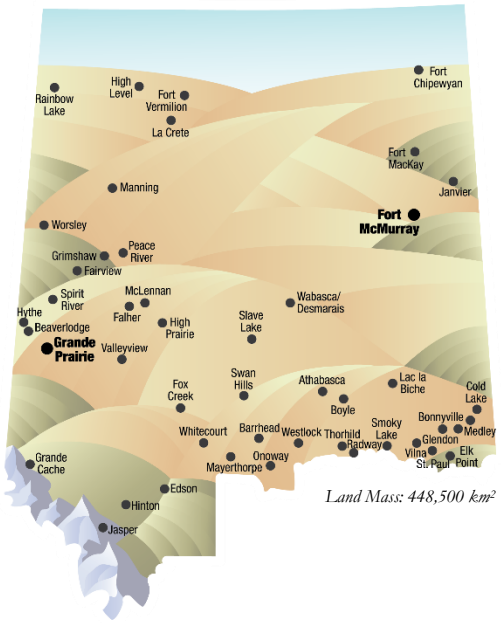
32%
eat **5 or more servings** of fruit or vegetables daily

23%
are **heavy drinkers** (5+ drinks on one occasion, at least once a month)

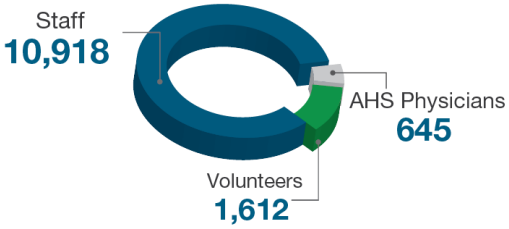
58%
are **active** or moderately active

38%
are **obese**

Source: Statistics Canada, Canadian Community Health Survey (CCHS), 2015



Workforce



North Zone 2018-19 Highlights

- A new day program for youth launched in the North Zone for the residents of Grande Prairie and the surrounding area. The Youth Day Program is a voluntary, eight-week outpatient program for youth in Grades 7-12 who have been experiencing serious problems in different areas of their life because of substance use and/or mental health issues.
- Virtual Health enables clinicians to deliver health services, expertise and information in real time over distance, improving access and eliminating barriers to patient care across Alberta and beyond. The North Zone Virtual Child and Youth Navigation Team Initiative enables weekly tele-psychiatry sessions to take place which reduces wait times for children to see a psychiatrist, as well as travel time for families. Sessions began in December 2018.
- Lac La Biche now has access to improved dialysis treatment with the opening of a new, permanent renal dialysis unit at William J. Cadzow – Lac La Biche Healthcare Centre in April 2018.
- Students now have even more access to mental health education and resources through HeartMath for Healthy Schools in 34 schools within the Fort McMurray Catholic School Division, Fort McMurray Public School Division and Northlands School Division — encompassing the region from Conklin to Fort Chipewyan.
- The Rural Opioid Dependency Program has been implemented in Bonnyville, High Prairie, and Fort McMurray.
- An Indigenous display at the St. Therese – St. Paul Healthcare Centre is receiving rave reviews and serving as a bridge to bring communities closer together.

North Zone details on beds and facilities can be found in the Appendix.

The table below provides a snapshot of North Zone's activity and demonstrates the change in services provided in the last few years. The trend column indicates comparison of the most recent available data compared to the previous year for each indicator. An upward arrow (⇧) indicates increased volumes by more than 3%; a horizontal arrow (⇨) indicates stability (current results are within 3% of prior results), and a downward arrow (⇩) indicates a decrease by more than 3% in volumes.

NORTH ZONE QUICK FACTS	2014-15	2015-16	2016-17	2017-18	2018-19	Trend
Primary Care / Population Health						
Ambulatory Care Visits	418,345	427,076	418,055	403,375	n/a	n/a
Number of Unique/Individual Home Care Clients	12,939	13,928	13,904	14,296	14,990	⇧
Number of People Placed in Continuing Care	694	704	673	766	685	⇩
Health Link Calls	68,322	64,546	59,698	57,313	54,674	⇩
Seasonal Influenza Immunizations	114,209	99,860	92,672	92,449	100,382	⇧
Food Safety Inspections	15,589	15,317	14,550	15,424	12,762	⇩
Acute Care						
Emergency Department Visits (all sites)	577,643	550,409	521,980	532,069	509,904	⇩
Hospital Discharges	44,900	44,110	41,929	42,444	40,673	⇩
Births	6,309	6,558	5,699	5,753	5,593	⇨
Total Hospital Days	256,047	263,377	251,338	282,105	263,239	⇩
Average Length of Stay (in days)	5.7	6.0	6.0	6.6	6.5	⇨
Diagnostic / Specific Procedures						
Hip Replacements (scheduled and emergency)	340	315	327	355	384	⇧
Knee Replacements (scheduled and emergency)	445	514	549	563	484	⇩
Cataract Surgery	2,193	2,142	1,998	2,020	2,161	⇧
Main Operating Room Activity	26,534	29,758	28,205	28,397	25,590	⇩
MRI Exams	12,971	13,621	12,893	12,769	13,262	⇧
CT Exams	34,066	35,051	34,824	36,145	36,556	⇨
X-rays	298,088	293,800	284,849	288,022	283,474	⇨
Lab Tests	4,883,055	5,038,109	4,937,068	4,819,741	4,885,855	⇨
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	14,081	14,162	16,437	16,451	16,954	⇧
Unique/Individual Cancer Patients	2,199	2,318	2,378	2,297	2,314	⇨
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	2,913	2,880	2,976	3,146	2,940	⇩
Workforce						
Staff	10,411	10,403	10,574	10,852	10,918	⇨
Volunteers	3,083	2,774	1,626	1,648	1,612	⇨
AHS Physicians	624	607	594	624	645	⇧

NOTES: Data updated as of May 15, 2019. Quick Facts definitions can be found at https://www.albertahealthservices.ca/about/Page11905.aspx.

- Health Link: Lower call volumes may be due to the number of online options Albertans can use to obtain or self-serve for this type of information, including the MyHealthAlberta site.

Our Performance

Leading in Health

The following indicators were developed by the Canadian Institute for Health Information (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.

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

AHS is among the lowest of all provinces and territories in Canada for total expenses on administration, according to the latest Canadian Institute for Health Information. The national average is 4.5% (2016-17).

AHS is home to:

- The largest transplant program in Western Canada
- The best tuberculosis program in the country
- One of the most effective stroke programs anywhere in the world.

Alberta is first in the country for:

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

Alberta is second in the country for:

- Fewest repeat hospital stays for mental illness
- Lowest obstetric patients readmitted to hospital
- Fewest Hospital deaths following major surgery
- Lowest restraint use in long-term care
- Fewest hospitalized heart attacks
- Fewest experiencing pain in long-term care
- Highest physical activity (age 18 and older)
- Lowest 30-day in-hospital mortality after percutaneous coronary intervention (tied)

Alberta is third in the country for:

- Fewest hospitalized strokes (tied)
- Lowest 30-day in-hospital mortality after isolated aortic valve replacements
- Fewest 30-day readmissions after percutaneous coronary intervention

Sources:
CIHI Your Health System: In Depth Website, November 2018 update
CIHI Wait Times in Canada, March 2019 update
CIHI Cardiac Care Quality Indicators, May 2018 update

Public Opinion Survey Shows Albertans' Confidence in AHS Remains High

In January 2019, AHS conducted a public opinion survey to capture current public perceptions, opinions and understanding of AHS. This was the third reputational survey completed since 2017. Results show that Albertans' confidence in AHS remains high. More than 1,000 Albertans from across all zones were contacted and asked about their impressions of Alberta Health Services.

Key highlights include:

- 90% feel AHS cares about their health (up from 86% in 2018)
- 89% feel AHS provides high-quality care (up from 88% in 2018)
- 88% feel AHS is there for them when they need healthcare (up from 86% in 2018)
- 82% feel AHS is trustworthy (up from 81% in 2018)
- 70% of Albertans feel they will receive urgent medical attention in a timely way whether that is emergency care, surgery, consultation from a specialist, or diagnostic testing (stable since 2018)

Consistent with 2017 and 2018 results, the most important healthcare issues to Albertans are:

- Wait times (about 33% of Albertans; down from 38% in 2018)
- Healthcare system accessibility (20%; up from 16% in 2018)
- Availability of a doctor (12%; up from 10% in 2018)

Reputational surveys are conducted regularly each year to continue to assess Albertans' perceptions and understanding of AHS. The results are used to inform future AHS Community Engagement and Communications strategies, messages and tactics, and to validate AHS operations and planning.

AHS Direction for 2018-19

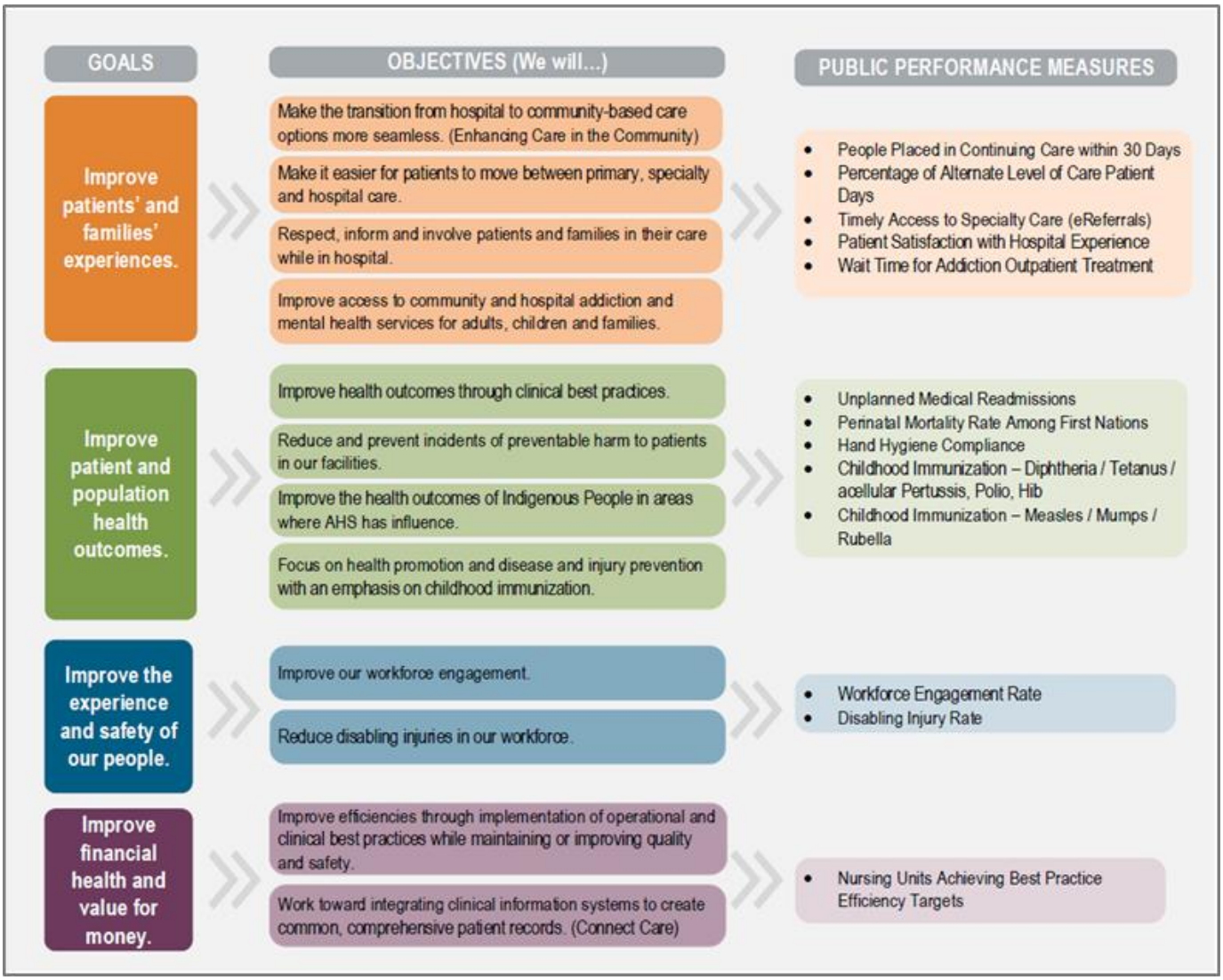
AHS continues to make progress towards building a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Albertans expect the very best from their healthcare system, and it's what we continue to strive to deliver. AHS relies on collaboration and partnerships to advance healthcare outcomes for Albertans. We know that our frontline teams of physicians and staff are committed to the highest quality of care when meeting the needs of their patients and clients.

We have set targets across the spectrum of healthcare, which we use to track and measure our progress on key areas within the healthcare system.

These measures help us monitor what we are doing, and more importantly, what we need to do to provide the very best care for our patients, clients and families.

The following annual update is designed according to the 12 objectives stated in 2017-20 Health Plan and 2018-19 Business Plan. It includes an update on actions and measures from the 2018-19 AHS Action Plan and 2018-19 Alberta Health priorities as well as the 13 AHS Performance Measures.



Highlights of 2018-19

AHS is now in the second year of its 2017-2020 Health Plan. Significant progress was made on a number of key initiatives to pursue the four goals as outlined in the Health Plan and Business Plan:

1. Improve patients' and families' experiences.
2. Improve patient and population health outcomes.
3. Improve the experience and safety of our people.
4. Improve financial health and value for money.

The Enhancing Care in the Community initiative is continuing to improve connections between community-based healthcare providers — such as family physicians — with hospital-based healthcare teams, including specialists and emergency department staff. The goal is to provide more multidisciplinary care in the community so Albertans can get the care they need without going to a hospital. The number of people waiting in acute/sub-acute hospital beds for placement into continuing care beds has decreased by 30% compared to the same period last year. The average wait time in acute/sub-acute hospital bed for continuing care placement has improved by 10% from waiting 51 days last year to 46 days in 2018-19. AHS has expanded home care and palliative care services to keep Albertans out of hospital when not required which frees up acute care beds. AHS has also added Community Paramedic programs in communities across the province to provide services in a patient's home to safely reduce the need for transfers to hospital.

Patient experience is a key area of organizational focus. Over the past four years, we have implemented initiatives to improve patient and family engagement in all programs and services to improve frontline patient care. While ratings of patient experience with hospital care is at similar levels to other reporting jurisdictions, patients in Alberta report the highest rate of communication when it comes to explaining medications while in hospital. Patient satisfaction with their hospital experience remains high, at 83%.

AHS' opioid response has been a primary focus for the organization. The naloxone program has significantly increased the number of naloxone kits distributed by AHS across the province by 96%. Since inception in October 2017, AHS has been successful in treating overdoses in AHS facilities which resulted in 986 lives saved. Also, reported overdose reversals (naloxone administered to reverse effects of an opioid overdoses) increased by 129% compared to last year.

Timely access to community addiction and mental health services will help Albertans address health issues as early as possible to avoid escalation and the need for higher level services. Many of the initiatives noted in this report under Objective #4 address the priorities identified in the Valuing Mental Health: Alberta Mental Health Review Committee report.

- The Mental Health Capacity Program is adding seven new program sites to the existing 11 sites for a total of 18 sites that will focus on underserved children and adolescent populations in rural and indigenous communities.
- The number of AHS opioid dependency treatment clinics has increased from two clinics (Edmonton and Calgary) in 2015 to 10 clinics across Alberta, plus more than 70 rural community telehealth sites in 2018.

AHS is working with Alberta Health to improve patient attachment to primary care providers across the zones.

SCNs continue to implement initiatives that impact wait times and access, reduce variation in practice, decrease length of stay, and increase quality provincially (refer to Objective #5 for more detail). The constraints on acute care capacity and increased demand has resulted in deterioration of wait times for elective surgeries.

Zones are engaging with First Nations communities to develop Indigenous Health Action Plans to improve the health and health care experience for Alberta's Indigenous peoples by working in partnership with Indigenous communities to identify health priorities and to co-design solutions.

Infection prevention and control practices such as hand hygiene practices in hospitals have improved this year and, as a result, we have seen a reduced rate of hospital acquired infections.

AHS and Alberta Health are working with the zones to ensure a consistent approach to disease outbreak management.

AHS launched a new engagement platform, Together4Health, to increase participation and awareness of AHS initiatives and support ongoing relationship building with Albertans.

Clinical appropriateness initiatives have resulted in improved, more efficient, and more effective patient care (refer to Objective #11).

Connect Care met major milestones in 2018-19 which helps build a common, shared electronic system to store health information so it moves with patients from site to site and service to service in AHS. For instance, with a provincial clinical information system, a physician can see what tests a specialist ordered for his patient, a specialist can know what medication a family doctor has prescribed, and an emergency department physician can see a patient's medical history at a glance.

As AHS works to transform the health system, the organization continues to engage with communities, partners, stakeholders and Albertans about healthcare delivery. AHS ensures that feedback is considered during AHS decision-making.

AHS wants Albertans to be involved in their health and in their health system so we can jointly move toward the AHS vision of 'Healthy Albertans. Healthy Communities. Together.'.

Summary of Performance Measure Results:

AHS has 13 performance measures that enable us to evaluate our progress and link our objectives to specific results. Targets were established using historical performance data, benchmarking with peers, and consideration of pressures that exist within zones and sites. This approach resulted in targets that, if achieved, would reflect a performance improvement in the areas of our Health Plan's 12 objectives. Targets were endorsed by AHS and Alberta Health as published in the Year 2 2017-2020 Health Plan and 2018-19 Business Plan.

The 13 performance measures are reported as follows:

- Eight measures include the most current data available with comparable historical data.
- Four measures are reported one quarter later and are therefore posted in subsequent quarters (Q3 data will be reported in Q4; Q4 is reported in Q1, and so on). Three measures rely on patient follow-up, generally after they have been discharged from care. One measure (Disabling Injury Rate) is reported one quarter later as data continues to accumulate as individual employee cases are closed.
- One measure, AHS Workforce Engagement, is only available during the years when an engagement survey is performed. The next survey will occur in 2019-20.

The following performance summary is based on twelve measures and excludes Workforce Engagement which will be reported in 2019-20.

When looking at performance reported this year and comparing it to the performance one year ago, many measures are demonstrating improvement since last year. It is important to make comparisons on a year to year basis, as it provides a more accurate picture of trends.

Moving a health care system to a higher level of performance does not happen overnight. The targets represent goals and standards to be achieved over time and reflect current health care standards in key areas.

The fact that 10 out of 12, or 83%, of our performance measures are seeing improvement, or are stable from the same period last year, indicates Alberta's health system is performing at a high level. There is always more work to do, and it is our goal to improve upon or achieve all targets.

AHS achieved the target for one of our measures – Percentage Placed in Continuing Care in 30 Days. This means that gradually, people are more efficiently being moved after they have been waitlisted for a continuing care living option, including those who are moving from a hospital setting to a more appropriate (and often more cost-effective) community-based setting.

The remaining eleven measures that have not achieved target will continue to be addressed in 2019-20. These represent system measures that change more slowly over time. Many of these measures require partnership and joint efforts to move closer to targets. AHS cannot improve these results alone. For example, childhood immunizations (by age 2) require parental consent and understanding of the value of vaccinating, in order to improve immunization-related performance measures.

Hand hygiene is an example of a measure that has made significant improvement since 2010 (50%) and has now stabilized. As we achieve higher levels of performance, less significant gains are likely to be made. AHS acknowledges and is committed to finding ways to achieve these targets.

Four of the measures highlight improvements.

- The percentage placed in continuing care within 30 days has improved as well as achieved target.
- The percentage of alternate level of care patient days (typically used to describe a patient waiting in hospital for a community-based continuing care bed) has shown improvement from last year.
- Timely access to specialty care has improved with more specialties using our eReferral system, which allows patients to get the specialty care they need faster.
- Disabling Injury Rate has improved compared to last year with below four disabling injuries per 100 FTE.

We are seeing stability in six performance measures. Both childhood immunizations (by age 2) remain between 78% and 86%; average wait time for adults to receive addiction outpatient treatment remains at 14 days; patient satisfaction with their hospital experience remains high, at 83%; and hand hygiene rates remains high, at 87% and unplanned medical readmissions have been consistently below 14%.

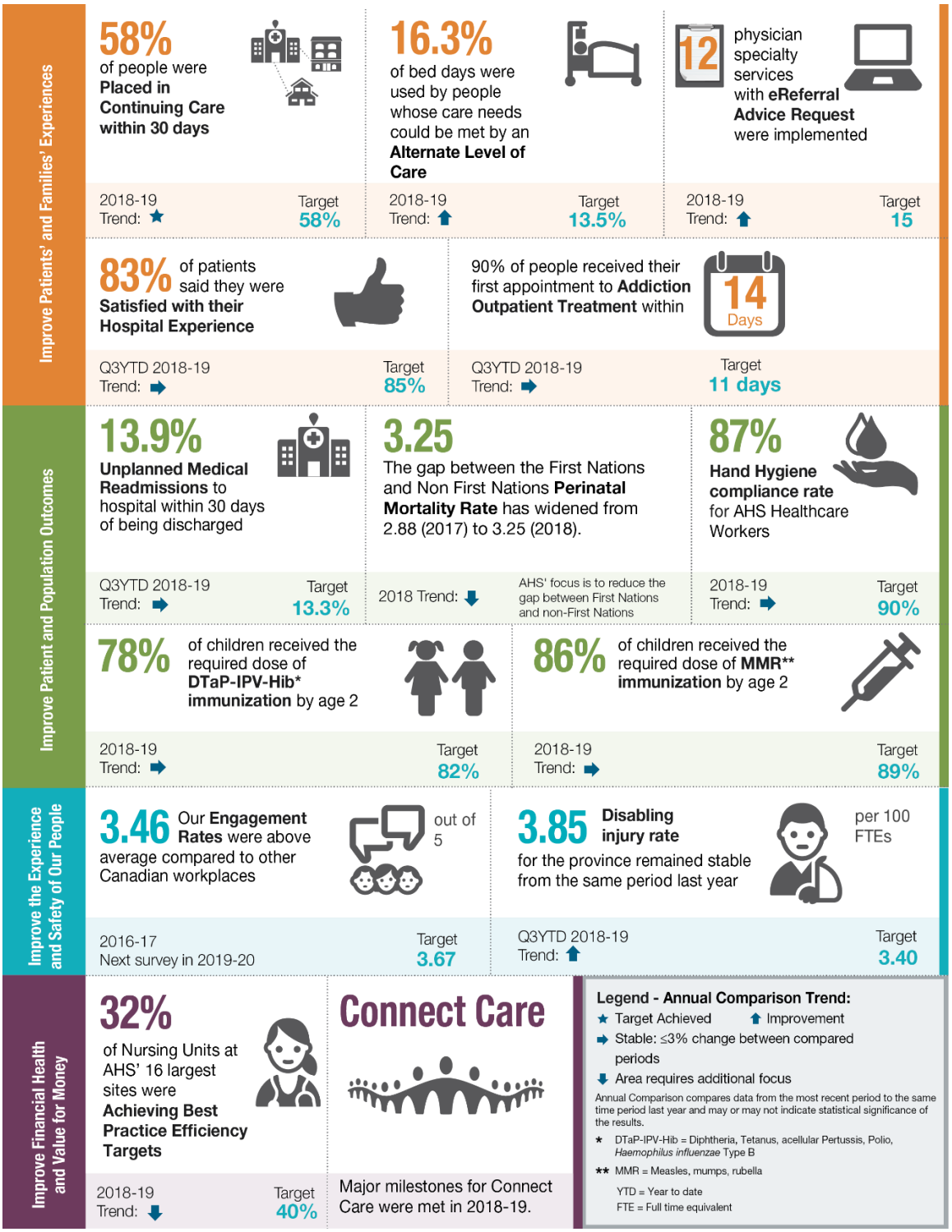
17% (2 out of 12) of the performance measures did not improve from last year.

- Reducing the gap in perinatal mortality among First Nations has deteriorated slightly in 2018 compared to 2017. However, the gap has been reduced overall by 35% since 2016. Addressing social determinants of health will influence this measure but change will take time.
- Percentage of Nursing Units Achieving Best Practice Efficiency Targets: Improving efficiencies through the implementation of Operational Best Practices, while maintaining or improving quality and safety, is a journey of continuous improvement. Since 2015-16, the 16 busiest hospitals in Alberta have implemented efficiencies. Although, annual deterioration was noted, results for Q4 2018-19 (January – March 2019) demonstrated 41% compliance, which means that we met target in that quarter. AHS is committed to continue improvements in 2019-20 to achieve target as well as demonstrate more efficiencies.

This is not a journey we can undertake alone. AHS continues our connection and collaboration with our key stakeholders including Albertans, communities, partners, organizations, and government to progress joint measures. We all have a role to play in our own health and in that of the health system we depend upon.

2018-19 Summary of Performance Results:

AHS has 13 performance measures which enable us to evaluate our progress and allow us to link our objectives to specific results. Through an extensive engagement process, we determined our objectives and identified their corresponding performance measures. Both the objectives and performance measures are specific, relevant, measurable and attainable. Provincial results are found under each objective in the front section of this report. The appendix provides zone and site drill-down information for the following performance measures.



Improve Patients' and Families' Experiences

Objective 1: Making the transition from hospital to community-based care options more seamless.

WHY THIS IS IMPORTANT

Increasing the number of home care services and community-based options reduces demand for hospital beds, improves the flow in hospitals and emergency departments, and enhances quality of life. AHS has two performance measures to assess how quickly patients are moved from hospitals into community-based care.

AHS PERFORMANCE MEASURE

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

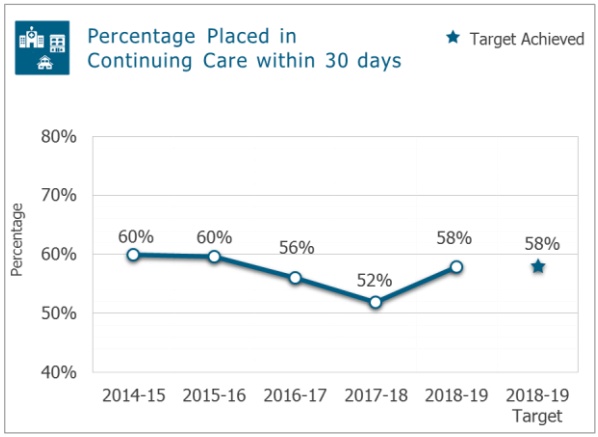
UNDERSTANDING THE MEASURE

Timely and appropriate access to Continuing Care Living Options is a major issue in Alberta. By improving access to a few key areas, AHS will be able to improve flow throughout the system, provide more appropriate care, decrease wait times, and deliver care in a more cost-effective manner. Timely placement can also reduce the stress and burden on clients and family members.

AHS wants to offer seniors and persons with disabilities more options for quality accommodations that suit their healthcare service needs and lifestyles.

This measure monitors the percentage of people who are quickly moved from hospitals and communities into community-based continuing care settings. The higher the percentage the better, as it demonstrates capacity is available for long-term care or designated supportive living (levels 3, 4, and 4-dementia).

HOW WE ARE DOING



Source: Meditech and Stratahealth Pathways

AHS performance improved as well as achieved the target in 2018-19 for this measure which means that, gradually, people are more efficiently being moved after they have been waitlisted for a continuing care living option, including those who are moving from a hospital setting to a more appropriate (and often more cost-effective) community-based setting.

WHAT WE ARE DOING

To keep pace with population growth and aging, AHS needs to target increasing community capacity by 800-1,000 designated spaces annually. In 2018-19, AHS opened 1,267 new continuing care beds.

Since 2010, AHS has opened 7,463 new beds to support individuals who need community-based care and supports (including palliative). Details on continuing care bed capacity across the province can be found in the Appendix.

In 2018-19, the average wait time for continuing care placement from acute/sub-acute care was 46 days compared to 51 days for the same period last year; a 10% improvement. The number of people waiting in acute/sub-acute care was 474 as of March 31, 2019 compared with 676 people waiting in the same period last year; a 30% improvement over last year.

In 2018-19, there were 8,098 people placed into continuing care from acute/sub-acute care and community compared to 7,927 people for the same period last year. Of these, 38% of clients were placed from the community compared to 34% from the same period last year.

It is important to note that not all of these patients are waiting in an acute care hospital bed. Many are staying in transition beds, sub-acute beds, restorative/rehabilitation care beds, and rural hospitals where system flow pressures and patient acuity are not as intense.

AHS PERFORMANCE MEASURE

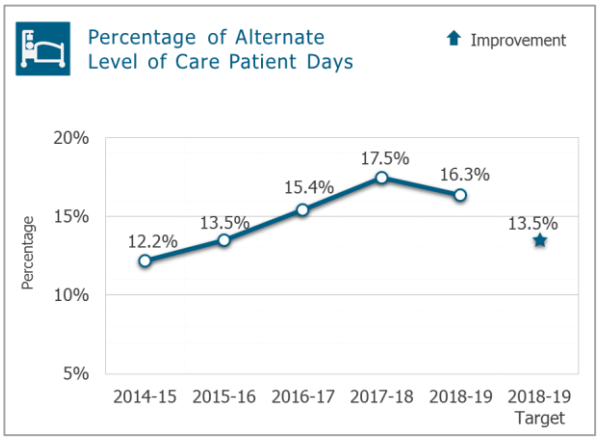
Percentage of Alternate Level of Care Patient Days is defined as the percentage of all hospital inpatient days when a patient no longer requires the intensity of care provided in a hospital setting and the patient's care could be provided in an alternate setting. This is referred to as alternate level of care (ALC).

UNDERSTANDING THE MEASURE

Hospital beds are being occupied by patients who no longer need acute care services while they wait to be discharged to a more appropriate setting. These hospital days are captured in hospitalization data as patients waiting for an alternate level of care.

If the percentage of ALC days is high, there may be a need to focus on ensuring timely accessibility to options for ALC patients. Therefore, the lower the percentage the better.

HOW WE ARE DOING



Source: Discharge Abstract Database (DAD) - AHS Provincial

This measure has shown improvement compared to last year but did not achieve target. Prior to 2018-19, the percentage of alternate level of care (ALC) days rose as AHS safely discharged more complex patients with unique housing needs who experienced higher numbers of days in hospital. By investing in new community capacity and targeted program supports aimed at serving complex clients, AHS has bent the curve and is trending in the right direction. It's important that we add 800-1,000 community beds per year to keep up with the aging population needs to sustain and further improve hospital system flow. AHS is committed to reducing the time patients wait in hospital for the appropriate level of care.

WHAT WE ARE DOING

Enhancing Care in the Community (ECC) is the roadmap for improving community-based care and services and reducing reliance on acute care services. The goal of ECC is to ensure that Albertans receive high quality care while we shift the focus of our current hospital-based care system to a community-based care focus. This way, we can provide patient-centred care within local communities, keeping Albertans out of hospital when not required. This, in turn, frees up beds for those who really need them.

- The **expansion of home care services and palliative care services** continued in 2018-19 which enables people to remain safely in their homes for longer by connecting them with care options in their local communities. In 2018-19, there were 127,214 unique/individual clients who received home care, an increase of 4.3% from 2017-18 (121,929 clients). The expansion of palliative home care services across the province grew by 14%. The average number of days home care clients spent in hospital within their last 30 days of life has dropped from 10.5 days to 8.5 days provincially and demonstrates the benefit of this expansion.

- **Emergency Medical Services Programs** (Community Paramedic Teams, and Assess, Treat and Refer (ATR) processes) are fully implemented and operational in all zones. These programs improve access to care in the community and at home. For example, **Community Response Teams** have demonstrated a high success rate in safely providing medical treatment in the community reducing the need for EMS transport, emergency department admission or hospitalization. Expanding these services will allow patients and families to remain in their own homes, avoid hospital admission, and provide referral and transportation services where appropriate.

- The **Virtual Hospital Project** in Edmonton Zone is incorporating a new operational model for the delivery of specialized transitional care by moving patients and families from hospitals to community in an integrated, collaborative and systematic way.

- The **Complex Care Hub** at Rockyview General Hospital in Calgary became operational in 2017-18. This year, the program facilitated over 100 admissions and saved over 1,350 days of acute and sub-acute care by providing care outside of hospital. An evaluation model was established and the program began its expansion to South Health Campus in Calgary. Patients receive daily care and monitoring within the comfort of their own home or at the hospital in an outpatient unit. The multidisciplinary care team can connect patients with services and supports as their needs change.

- **Enhanced Respite Day Programs** have increased the availability of services through the use of adult day programs in communities across the North Zone. These programs are aimed at decreasing social isolation, improving cognitive and physical wellbeing of community clients, and giving caregivers a break from care duties during program hours. Across Alberta, the number of respite home care clients served was 6,711 in 2018-19 (6,372 in 2017-18) and the number of adult day program clients served was 4,591 in 2018-19 (4,287 in 2017-18).

- The **Calgary Rural Palliative In-Home Initiative** increases equitable access to home care services for clients living in rural areas. This initiative has served 74 new clients this year. The percentage of deaths occurring in Calgary Zone rural hospitals has dropped from a range of 36% to 49% to under 15% in 2018-19. Meetings have been occurring with First Nations communities to determine modifications to processes that may be needed to serve Indigenous communities.

- **Intensive Home Care** programs will provide wrap-around services to clients who have recently been discharged from hospital to safely enable them to remain at home until a designated living option becomes available. The service will also be responsive to a client's changing needs in the community and provide resources to address changing health and personal care needs. This results in a decrease in less urgent Emergency Department visits for home care clients.

- The **Community Support Teams** initiative will focus on developing a multidisciplinary team that will provide urgent care and consultation, and assist with developing an intermediary care plan and follow-up care and diagnostics as required for complex clients. Services include providing home care and self-help services, enhancing primary care, addressing housing and transportation issues, and tackling social isolation. This results in a decrease in non-emergent Emergency Department visits for home care clients and continuing care clients.

AHS strives to improve quality of care for continuing care residents and those living with dementia. To support the Alberta Dementia Strategy and Action Plan, AHS continues to provide **Dementia Advice** through Health Link 811 affording Albertans equitable access to dementia supports across the province. The total number of referrals in 2018-19 (710) increased by more than 33% compared to the same period last year (532). AHS also provides dementia education for current staff, including mentorship.

Improve Patients' and Families' Experiences

Objective 2: Making it easier for patients to move between primary, specialty and hospital care.

WHY THIS IS IMPORTANT

Work continues to strengthen and improve primary healthcare across the province. Together with Albertans, patients and their families, Alberta Health, primary care, and other healthcare providers, AHS is making changes to improve how patients and their information move throughout the healthcare system.

Alberta Netcare eReferral is Alberta's first paperless referral solution and offers physicians and clinical support staff the ability to create, submit, track and manage referrals electronically.

Alberta Netcare eReferral Advice Request provides primary care physicians with the ability to request advice from other physicians or specialty services that support patient care in the community.

AHS PERFORMANCE MEASURE

Timely Access to Specialty Care (eReferral) is defined as the number of physician specialty services with eReferral Advice Request implemented.

UNDERSTANDING THE MEASURE

Having more specialists providing advice for non-urgent questions and being able to do so in an electronic format may prevent patients from waiting for an appointment they don't need, provide them with care sooner, and support them better while they are waiting for an appointment. This allows primary care physicians to support their patients in getting access to the most appropriate specialist in a timely manner.

The number of specialties using eReferral Advice Request is a cumulative measure.

HOW WE ARE DOING

With zone engagement, 12 new specialty services implemented eReferral Advice Request in 2018-19, for a total of 24 specialties to date.

The target of 15 specialty services for 2018-19 was not met despite strong interest from specialty groups. Already limited AHS information technology (IT) resources, including infrastructure and testing and development environments, have been re-prioritized to focus on Connect Care and has had an impact on AHS' ability to onboard more specialties in a timely way.

This work will continue into 2019-20 with a focus on increasing awareness, training new users, evaluation, and implementing additional specialties. E-mail notifications to providers with referral status updates will go live by summer 2019.

WHAT WE ARE DOING

In 2018-19, 7,013 **eReferral Advice Requests** were received by triage facilities; this is an increase of more than 40% compared to the same period last year (5,000). Of the Advice Requests completed, 40% were provided with advice to continue managing in the community, 58% required a referral, and 2% did not have sufficient information to receive advice.

As of August 1, 2018 a provincial system for health referral information went live. The **Alberta Referral Directory (ARD)** is a secure, online directory that healthcare providers can use to easily access all referral information; which makes identifying and selecting the right consultant and/or service easier which will mean less delays for both providers and patients. As of March 31, 2019, 3,040 services have up-to-date profiles in the ARD; this represents a 62% improvement from the same period last year.

Primary Healthcare

Primary Care Networks (PCNs) develop solutions to meet the primary healthcare needs of the local communities they serve. There are now 41 PCNs operating throughout Alberta with more than 3,800 family physicians and more than 1,000 other health practitioners involved.

AHS is working with its provincial, zone and local partners in implementing the **Primary Care Network (PCN) Governance Framework** through the development of Zone PCN Service Plans. The framework aligns PCNs and zones to allow for a better, integrated health system. This work will focus on five populations: maternal, well-at-risk, chronic comorbid, addiction and mental health, and frail elderly. A companion guide with tools and resources from each service planning stream has been completed. Zone PCN Committees are working on implementing Opioid Response initiatives.

AHS is working with Alberta Health to improve patient attachment across the zones. **The Central Patient Attachment Registry (CPAR)** is a provincial system that shows the relationship between a primary provider and their patients. CPAR will improve continuity of care by promoting stronger ongoing relationships with all members of the care team, improving information sharing and enhancing care coordination. Each zone is working with PCNs to better coordinate patient connections to family physicians.

In May 2018, the Sylvan Lake Community Health Centre was reclassified as an Advanced Ambulatory Care Service (AACS) facility. This health centre will provide both scheduled and unscheduled access to primary care services for this rapidly growing community. AACS facilities are intended to meet the needs of patients with unscheduled health needs, particularly when care is required within 24 hours.

The **Primary Health Care Integration Network (PHCIN)** is focused on improving transitions of care between primary healthcare providers and acute care, emergency departments, specialized services, and other community services.

- In February 2019, the PHCIN published a three-year plan (Transformational Roadmap) for further integration of health, social and community supports in Alberta.

- Development of a pathway and service model to support Home-to-Hospital-to-Home (H2H2H) transitions, Keeping Care in the Community and Primary Care-to-Specialty-and-Back is ongoing. This work is being done across the province for consistency in approach.

    - **Home – to – Hospital – to – Home transitions**: As patients transition from their family doctor to the hospital and back to home again, there needs to be a transfer of support and information that transitions alongside them. Poor transitions have a negative impact on patients and families, put patients at greater risk of poor health outcomes, and increase the likelihood of avoidable emergency department and hospital use. Ensuring a patient's primary care provider is part of the care team from admission to discharge is part of a system where patients are supported throughout the continuum of care.

    - **Keeping Care in the Community** simply means considering the community a person lives in and the supports available in that community while planning care. AHS continues to work with partners to create messaging and resources that promote continuity with a family physician/nurse practitioner and team.

    - **Primary Care – to – Specialty – and – Back**: There is a growing gap between specialty care capacity and the needs and expectations of the public. Long specialty wait times contribute to issues such as increased stress levels, worsening conditions, and avoidable trips to the hospital. It also impacts access to primary care services and limits availability of emergency and hospital services. Improvements can be achieved by offering advice from doctor to doctor, using the knowledge and skills of other health providers, and finding new ways to help people manage their conditions.

- AHS is collaborating with Mount Royal University in Calgary to establish a **Design Lab** with the Primary Health Care program which supports groups to use design thinking to address ideas on how to keep patients with complex care needs in the community.

AHS is focusing on improving coordination of care between acute, primary and community care through the development and implementation of **clinical pathways**, such as the digestive health primary care pathway, heart failure pathway and chronic obstructive pulmonary disease pathway.

Work continues on the **Patients Collaborating with Teams (PaCT)** initiative which helps primary care teams to better support patients to maintain their health by establishing new innovation hubs, where PCNs can test ideas. In 2018-19, additional resources were developed and disseminated to clinics. Content was focused on collaborative goal setting and action planning, care coordination, sharing information with other clinical teams, and team optimization.

CancerControl Alberta

Progress on capital projects continues to be made for improving infrastructure to address future capacity needs.

- As of March 31, 2019, the construction of the Calgary Cancer Centre continues to make great progress, remaining on budget and on time. Excavation and foundations have been completed and most of the concrete for the underground parkade has been poured. The new healthcare facility and academic centre will provide cancer services in southern Alberta.

- The Grande Prairie Cancer Centre, part of the new Grande Prairie Regional Hospital project, is proceeding with minor delays related to construction.

A replacement **linear accelerator (Linac)** was installed and operationalized to support cancer treatment in 2018-19 at the Tom Baker Cancer Centre (TBCC) in Calgary. Two additional Linac's at TBCC and one at the Cross Cancer Institute (CCI) in Edmonton are also in the process of being replaced. A linear accelerator is the device most commonly used for radiation treatments.

All of the community and supportive care positions have been filled to support increased access to specialty cancer services as well as support for patients waiting for cancer surgery, systemic therapy, radiation therapy, and supportive care. In 2018-19, CancerControl Alberta saw a 4.5% increase in the number of patient visits compared to last year; radiation therapy visits increased by 6% and system therapy visits increased by 8% over the previous year. The operating hours of some treatments have been extended to support growing patient volumes.

- As of March 2019, approximately 62% of patients were having surgery within the appropriate time frame compared to 50% in January 2018. This means that over 60% of all patients that require cancer surgery are now receiving timely cancer surgery and getting their surgery when needed.

- Wait lists have been reduced by approximately 7% since baseline. There has also been an increase of 13% in patients receiving cancer surgery within recommended wait times.

AHS continues to implement **End of Treatment and Transition of Care** processes across the province for patients who have completed cancer treatment and are returning to a family physician. Improvements have been made in eight early stage, curative populations (breast, prostate, testicular, cervical, endometrial, Hodgkin's lymphoma, B-cell lymphoma, and colorectal).

Emergency Medical Services (EMS)

EMS works with health, community, and public safety partners to provide quality services in Alberta. Emergency response and inter-facility transfers are provided by ground ambulance, non-ambulance transfer vehicles, and rotary and fixed-wing air ambulance with service coordinated through call-taking and dispatch resources.

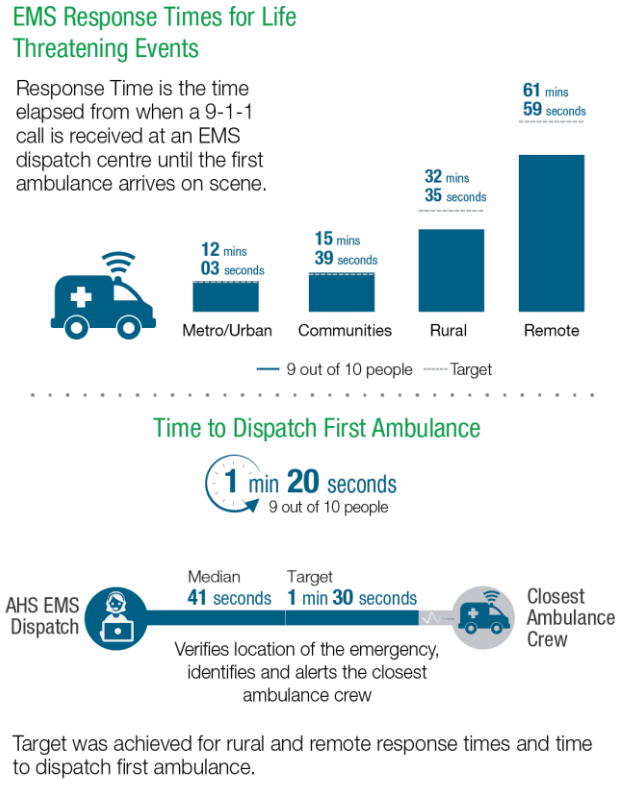
Implementation for EMS' **Mobile Integrated Health Team Program** became fully operational in all five zones in 2018-19. The program provides short-term, community based, non-emergent medical support to vulnerable populations such as frail elderly, individuals aging in place, or persons with disabilities who are at risk of a hospital admission. The program aims to improve health and reduce reliance on acute care services. There are 29 community response teams.

Targets for EMS response times for life threatening events in rural and remote areas were met in 2018-19. Results for communities with a population greater than 3,000 slightly exceeded target of 15 minutes by 39 seconds and metro/urban communities slightly exceeded target of 12 minutes by three seconds. Variance from baseline is within expected limits.

The time to dispatch of the first ambulance (includes verifying the emergency location, identifying the closest ambulance and alerting the ambulance crew) remained stable compared to last year.

Work continues on the helipad upgrade in Jasper with final drawings under review. Helipad upgrades in Medicine Hat and Fort McMurray were completed and in operation in 2018-19.

AHS publicly posts EMS-specific measures in a performance dashboard available on the AHS public website. These measures reflect areas within EMS that are important measurements of patient safety and care.



Target was achieved for rural and remote response times and time to dispatch first ambulance.

Improve Patients' and Families' Experiences

Objective 3: Respecting, informing and involving patients and families in their care while in hospital.

WHY THIS IS IMPORTANT

AHS strives to make every patient's experience positive and inclusive. Through the Patient First Strategy, we will strengthen AHS' culture and practices to fully embrace patient- and family-centred care, where patients and their families are encouraged to participate in all aspects of the care journey.

AHS PERFORMANCE MEASURE

Patient Satisfaction with Hospital Experience is defined as the percentage of patients rating hospital care as 8, 9, or 10 on a scale from 0-10, where 10 is the best possible rating. The specific statement used for this measure is "We want to know your overall rating of your stay at the hospital.".

The survey is conducted by telephone on a sample of adults within six weeks of discharge from acute care facilities.

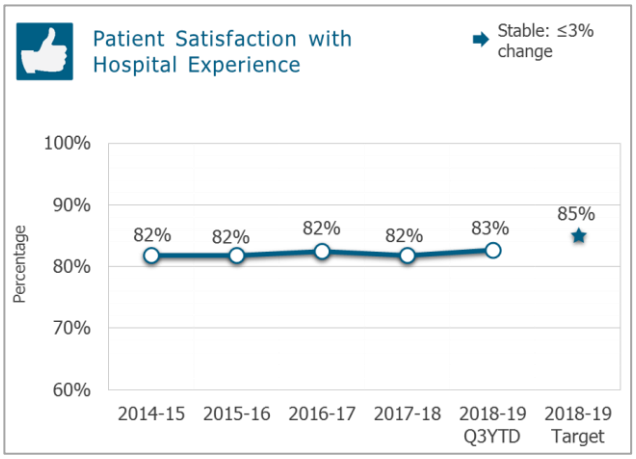
UNDERSTANDING THE MEASURE

Gathering perceptions and feedback from individuals using hospital services is a critical aspect of measuring progress and improving the health system. This measure reflects patients' overall perceptions associated with the hospital where they received care.

By acting on the survey results, we can improve care and services, better understand healthcare needs of Albertans and develop future programs and policies in response to what Albertans say.

The higher the number the better, as it demonstrates more patients are satisfied with their care in hospital.

HOW WE ARE DOING



Source: Canadian Hospital Assessment of Healthcare Providers and Systems Survey (CHCAHPS) responses.
Note: This measure is reported a quarter later due to follow-up with patients after the reporting quarter.

This measure has remained stable year-over-year and did not meet target. There are a number of contributing factors that influence performance, such as high occupancies, patients waiting in hospital for the appropriate level of care which increases transfers, off-service patients, co-ed patient accommodations, and staff vacancies.

AHS also measures patient satisfaction in other areas:

- CancerControl supports the use of **Patient Reported Outcomes (PRO)** to enhance cancer patient experiences. Sixteen out of 17 cancer care sites are collecting PRO data routinely. In 2018-19, approximately 18,500 patients completed at least one Putting Patients First (PPF) assessment per quarter for a total of 84,000. A PPF is a patient reported symptom screening tool which is used as part of a standard clinical assessment in cancer clinics to identify patients who require symptom management or support.

- Emergency Medical Services (EMS) regularly surveys patient experience. In 2018-19, 95.7% of patients agreed with the statement: "Overall, I was satisfied with my experience with EMS".

- Child Hospital Assessment of Healthcare Providers and Systems Survey (HCAHPS) measures the family experience of pediatric inpatient care. In Q3YTD 2018-19, 84% of parent/guardians rated their child's care as an 8, 9, or 10 on a scale from 0-10, where 10 is the best possible rating.

- In the fall of 2018, Health Quality Council of Alberta (HQCA) collaborated with AHS and Alberta Health to capture the experiences of and obtain feedback from seniors about their experience with home care services. Results will be shared in the summer of 2019. The survey will help highlight areas of success and identify areas for improvement in home care.

WHAT WE ARE DOING

AHS continues to apply the **Patient First Strategy** by empowering and supporting Albertans to be the centre of their healthcare teams. Initiatives focused on patient- and family-centred care were implemented across Alberta to increase the patient voice and participation in care delivery.

- Visitors and family presence are integral to patient safety, the healing process, the patient's medical and psychological well-being, comfort, and quality of life. AHS continues to advance its **Family Presence and Visitation Policy** which recognizes patients and families as partners in care. Families provide pertinent information essential to the patient's care plan and should be respected and recognized for their knowledge and expertise about the patient and his/her care needs and preferences. In 2018-19, a series of consultations were held with staff, physicians, and patients to identify improvements to the policy. This new provincial policy aims to promote consistent family presence and visitation practice across all service areas.

- The **End PJ Paralysis** program launched across the province and helps patients get up, get dressed and get moving, so they can get home sooner. PJ Paralysis is a term to describe the negative physical and psychological effects experienced by patients who spend lengthy periods of time inactive, and in their pajamas while in hospital.

- In June 2018, AHS hosted its second **What Matters to You (WMTY)** campaign that encourages patients, families, and clinicians to have conversations about what matters most to them in regard to their healthcare. An internal and external web presence was created for the campaign as well as resources and promotional material including social media using the hashtag #wmtyAB which was in the top 10 trending tags for Edmonton on June 6. In addition, 68 AHS sites registered and participated in WMTY activities.

Health Link is a vital safety net for the public, especially when other options such as family doctor offices are closed, providing free telephone service 24/7 with access to nurse advice, general health information, and health system navigation.

In 2018-19, Health Link received more than 690,000 calls, a 2% decrease from last year. The average wait time for callers was 1:51 minutes. The most frequent health concerns directed to Health Link were gastro/intestinal/abdominal symptoms, respiratory and chest symptoms, and neurological symptoms.

Health Link has developed a robust social media communications program, tweeting using the hashtag #AHS811, to increase Albertans' awareness of health information resources that are available. They also partnered with Health Unlimited Television (HUTV) to create dynamic new health information videos to reach Albertans at point of care, with 230,000 Albertans sitting in front of an HUTV screen while seeking healthcare every week. New videos on Influenza, Managing Fevers, G.I. Illness, and Reliable Health Information were produced to educate Albertans in 2018-19.

AHS launched a campaign in anticipation for AHS' 10th anniversary which was supported by the new AHS engagement tool, Together4Health. The Together4Health.ca project page saw more than 600 unique visitors.

AHS provides interpretation and translation services in 116 languages to support Albertans whose first language is not English. Almost 1.2 million minutes of over-the-phone interpretation services were accessed; an increase of 3% compared to last year.

The implementation of **Video Remote Interpretation (VRI)** supports communication and reduces the risk of language barriers that may negatively impact patient care and experience. As of March 31, 2019, 28 units have deployed VRI including five at Stollery Children's Hospital (Edmonton), two at Peter Lougheed Centre (Calgary) and eight at Alberta Children's Hospital (Edmonton).

Work is underway with Alberta Health to create a **Digital Signage/Screen Strategy** for Alberta Health's Personal Health Record solution. Strategy development continued in 2018-19 and will focus on 3 main areas: digital signage in emergency departments, process to support general and site specific messaging, and planning for future opportunities.

Patient/family advisors work with AHS to encourage partnership between those receiving health services and leaders, staff and healthcare providers to enhance the principles of patient and family centred care. In 2018-19, the Patient and Family Advisory Group consulted on various province-wide initiatives including Family Presence Policy, Patient Safety Strategy, Prevention of Violence and Harassment, and Connect Care (AHS' provincial Clinical Information System).

Collaborative Care is a healthcare approach in which inter-professional teams work together, in partnership with patients and families, to achieve optimal health outcomes. The **CoACT** program supports the implementation and optimization of Collaborative Care in multiple care settings across AHS. Zones and programs continue to sustain and spread this effort. CoACT is active in a total of 42 sites and 212 units with an additional site and 43 units actively initiating.

The 2018 HQCA Patient Experience Awards recognized three AHS initiatives that improve the patient experience in accessing and receiving healthcare services: Alberta Conservative Kidney Management Clinical Pathway, Calgary Zone's City Centre Team Mobile Paramedic Program, and Edmonton Zone's Royal Alexandra Hospital's Inner City Health and Wellness Program.

Teams across AHS are actively identifying initiatives that will improve child and youth addiction and mental health experiences and outcomes in the emergency department. In 2018-19, AHS developed a new pathway to test alternative models of care for children and youth in the Emergency Department which aim to improve triage practices and overall wellbeing of children requiring urgent care.

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

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

Concerns and Commendations	2015-16	2016-17	2017-18	2018-19
Total Number of Commendations	1,845	1,847	1,727	1,696
Total Number of Concerns	9,845	10,596	10,404	10,392
Total Number of Concerns reviewed by PCO	24	30	10	3
Percent of actions arising from concerns resolved in 30 days or less	59%	62%	69%	71%

Includes Covenant Health

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

Improve Patients' and Families' Experiences

Objective 4: Improving access to community and hospital addiction and mental health services for adults, children and families.

WHY THIS IS IMPORTANT

Timely access to addiction and mental health services is important for reducing demand on healthcare services including the social and economic costs associated with mental illness and substance abuse, as well as reducing the personal harms associated with these illnesses.

AHS PERFORMANCE MEASURE

Wait Time for Addiction Outpatient Treatment represents the time it takes to access adult addiction outpatient treatment services, expressed as the number of days that 9 out of 10 clients have attended their first appointment since referral or first contact. This excludes opioid dependency programs.

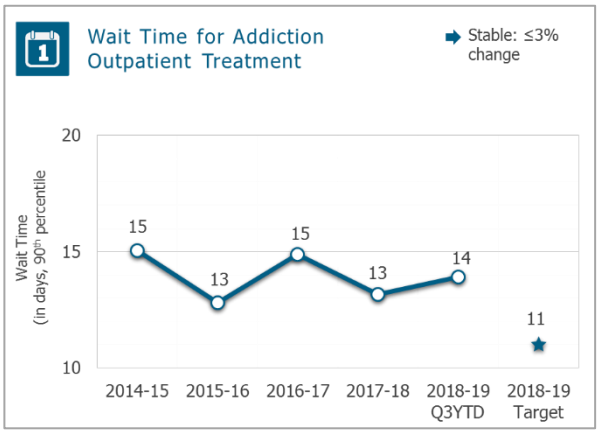
UNDERSTANDING THE MEASURE

AHS continues to work towards strengthening and transforming our addiction and mental health services.

Getting clients the care they need in a timely manner is critical to improving our services. This involves improving access across the continuum of addiction and mental health services and recognizing that there are multiple entry points and that these services assist different populations with different needs and paths to care.

The lower the number the better, as it demonstrates people are waiting for a shorter time to receive adult addiction outpatient services.

HOW WE ARE DOING



Source: AHS Addiction and Mental Health

Since 2013-14 (18 days wait), we have shown significant improvement but have not achieved target in rural zones. However, target was achieved in urban zones (Calgary and Edmonton) where same day services are available. Work continues to address issues related to the complexity and acuity of cases referred and wait times in rural areas with limited or no access to walk-in clinics. Wait times can be influenced significantly by service models used, particularly in rural and remote areas. For example, the use of travelling clinics and services that are operated fewer than five days a week can result in longer wait times. Additionally, wait times can increase with staff vacancies. Although there are challenges with recruiting and retaining staff in remote communities, active recruitment is underway.

WHAT WE ARE DOING

Timely access to community addiction and mental health services will help Albertans address health issues as early as possible to avoid escalation of issues and the need for higher level services. Many of the initiatives noted below address the priorities identified in the **Valuing Mental Health: Alberta Mental Health Review Committee** report:

- In 2018-19, AHS added 66 addiction and mental health spaces in the community to support placement for vulnerable Albertans.
- As part of the **Opioid Dependency and Crisis Response** program, treatment clinics opened in Grande Prairie and Fort McMurray. There are 118 communities in Alberta that have access to the service via Telehealth.
- In 2018-19, there were 2,220 new admissions and more than 3,100 total unique active clients in **Opioid Dependency Programs**; a 48% increase in clients from the same period last year (2,100). This includes Bonnyville and High Prairie.
- **Developmental Pathways** (formerly called InRoads) support health professionals providing addiction and mental health services in primary care and other settings. Eleven developmental pathways launched in 2018-19 with corresponding training modules accessible to all staff. A formal evaluation process is in development; results will be accompanied by a promotion plan for the 2019-20 fiscal year.
- The new **Addiction and Mental Health Day Hospital** in the Edmonton Zone opened on January 7, 2019. The Day Hospital provides programming that patients can attend as an alternative to hospitalization. This allows patients to benefit from a therapeutic setting while being able to remain in their home.

Responding to the opioid crisis is a priority for AHS. Over the past year, AHS has increased attention on improving lives and reducing the harmful effects of substance use, including expanding programming to reduce harm associated with addiction, improving access to treatment, and increasing public awareness and education.

- The **Injection Opioid Agonist Therapy (iOAT)** program in Calgary opened in Q3 and is currently running at full capacity. Edmonton's iOAT program opened in Q4 using two interim locations with limited capacity. Provincial medical and nursing protocols were approved and are in use.

- The **Addiction Recovery and Community Health (ARCH)** program provides core addiction services to admitted and emergency department patients. Programs were expanded in 2018-19 at the Royal Alexandra Hospital in Edmonton and at the Peter Lougheed Centre in Calgary.

- **Mental Health Virtual Health** uses technology to ensure clients receive help without leaving their community by linking them to mental health professionals. The demand for Virtual Health services continues to increase, with over 13,500 virtual encounters in 2018-19.

- Virtual Health technology has been deployed through the **Rural Opioid Dependency Program (RODP)** to expand services, with 479 new admissions and 527 unique active clients in 2018-19.

- AHS offers **supervised consumption services** in Calgary (Sheldon M. Chumir Health Centre) and Edmonton (Royal Alexandra Hospital).

- In 2018-19, 82,832 **take home Naloxone kits** were dispensed to Albertans by AHS, the Alberta Community Council on HIV agencies, community pharmacies and other community organizations compared to 42,342 last year

- In 2018-19, 5,745 **overdose reversals** (naloxone administered to reverse effects of an opioid overdose) were voluntarily reported in Alberta compared to 2,508 last year.

- **Suboxone™** for opioid-dependent emergency department patients is fully implemented at 15 major emergency departments and urgent care centres. The AHS Emergency Strategic Clinic Network is engaged with 30 more sites across all zones.

- Enhancements to the **Indigenous Urban Opioid Emergency Response** include collaboration with First Nations communities regarding harm reduction strategies and the opioid crisis. Opioid navigators/registered nurses have been hired at the Indigenous Wellness Clinic in Edmonton and the Elbow River Healing Lodge in Calgary.

- The **Primary Health Care Urgent Response Initiative** utilizes a harm reduction module that teach evidence-based strategies for supporting a harm reduction approach within primary care settings. This module includes recommended practices for reducing the experience of bias and stigma faced by people who use drugs, their families, and other individuals with lived experience of opioid use. The module is intended for a broad multi-disciplinary audience including physicians, nurse practitioners, and other health care providers. It will build on foundational principles of harm reduction and work already accomplished through the revisions already made to the AHS Harm Reduction Policy.

The percentage of children receiving scheduled community mental health treatment within 30 days increased to 73% in 2018-19 compared to 67% in 2017-18. The time is measured from referral to the first offered appointment with a mental health therapist.

AHS offers a variety of addiction and mental health services to children, youth and their families in the community (i.e., specialized outpatient or community services, crisis and outreach services, etc.):

- The **Alberta Youth Suicide Prevention Plan** is being completed. The plan includes distinct approaches to address the unique needs of Indigenous populations.

- The **Honouring Life program** (formerly Aboriginal Youth and Communities Empowerment Strategy) supports resiliency, empowerment and holistic suicide prevention strategy initiatives. AHS is working with communities to complete applications; 26 applications have been received and three have been completed and funded.

- A new **centralized intake** model for same-day outpatient addiction services launched in 2018-19. Wait times for the first face-to-face appointment remains at zero days which means that patients are being seen upon arriving in the clinic.

- In Calgary Zone, **Specialized Services** is expanding the use of Parent Support Groups and gathering client feedback to better understand and tailor supports for parents to manage the burdens of care. AHS' focus in 2018-19 was on enhancing staff knowledge and skills in trauma-informed practices.

- Discussions continue in South Zone to develop **pediatric acute care teams** for adolescent AMH patients requiring a higher level of care. Various partnerships are being explored to support improved integration of services. Training modules will be released in spring 2019.

- In North Zone, a **youth mental health day program** is fully operational in Grande Prairie. The program acts as an outpatient program for students who have been experiencing serious problems because of substance use and/or mental health issues.

- The **Mental Health Capacity Building (MHCB)** program provides services to over 65,000 students in 182 schools and 85 communities. The MHCB program is focusing on expanding to rural and remote areas with a focus on underserved populations such as Indigenous, Immigrant, Refugee, Ethno-Cultural and Racialized (IRER) and LGBTQ populations. MHCB staff will be available to refer children, youth, and families to early intervention and treatment services as needed. All 18 MHCB services will have First Nation Métis Indigenous (FNMI) programming.

- The **Virtual Child and Youth Navigation Team** supports timely access to mental health treatment and referral services in the North Zone. Program and service delivery models are fully operational. The Navigator has been meeting with teams in the North Zone as well as tertiary care providers in Edmonton Zone to build relationships and pathways for children needing more specialized services.

Improve Patient and Population Health Outcomes

Objective 5: Improving health outcomes through clinical best practices.

WHY THIS IS IMPORTANT

AHS strives to improve health outcomes through clinical best practices by supporting the work of our Strategic Clinical Networks™ (SCNs™), increasing capacity for evidence-informed practice and gaining better access to health information.

AHS PERFORMANCE MEASURE

Unplanned Medical Readmissions is the percentage of medical patients with unplanned readmission to hospital within 30 days of leaving the hospital. This excludes admissions for surgery, pregnancy, childbirth, mental health diseases and disorders, palliative care and chemotherapy for cancer.

UNDERSTANDING THE MEASURE

Although readmission may involve complex external factors, high rates of readmission act as a signal to hospitals to look more carefully at their practices, including discharge planning and continuity of services after discharge.

Rates may be impacted due to the nature of the population served by a facility (elderly patients and patients with chronic conditions) or due to different models of care and healthcare services accessibility.

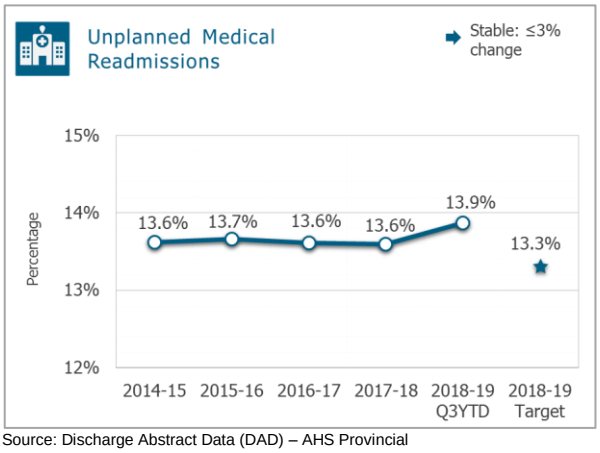
The lower the percentage, the better as it demonstrates that fewer people are being readmitted shortly after discharge. The most recent data is a quarter behind the reporting period due to various reporting system timelines.

Clinical care pathways outline a sequence of activities for specific diagnosis groups or patient populations to maximize quality of care, efficient use of resources and improve transitions of care.

SCNs™ have developed a total of 19 clinical care pathways, of which 74% have been implemented across the province. Many of our pathways focus on improving co-ordination of care between acute, primary and community care.

Trans Cranial Magnetic Stimulation ● Hip & Knee Care Clinical ● Hip Fracture ● Rectal Cancer Clinical ● Breast Cancer ● Head and Neck Cancer Perioperative ● Heart Failure ● Provincial Delirium ● Diabetic Foot Care ● Inpatient Diabetes Management: Basal Bolus Insulin Therapy ● Early Hearing Detection and Intervention ● Provincial Antenatal ● Perinatal E-Mental Health ● Pediatric Concussion ● Child with Complex Care Needs ● Postpartum and Newborn ● Neonatal Abstinence ● Neonatal Palliative Care ● Indigenous Perinatal ● Chronic Obstructive Pulmonary Disease ● Elder Friendly Care in Acute Sites ● Appropriate Use of Antipsychotics in Designated Supportive Living ● Enhanced Recovery after Surgery (various programs)

HOW WE ARE DOING



Source: Discharge Abstract Data (DAD) – AHS Provincial

Unplanned medical hospital readmission rates have remained relatively stable year-over-year but target was not achieved. In 2018-19, AHS designed several care pathways that will be implemented in 2019-20. In most cases, medical readmissions are caused by patients with complex health needs, such as chronic obstructive pulmonary disease (COPD), heart failure (HF) and pneumonia. AHS' work on the COPD/HF pathways will help drive improvement.

WHAT WE ARE DOING

AHS is implementing a number of province-wide and zone initiatives that address readmissions. Examples include:

- In Edmonton Zone, Royal Alexandra Hospital is rolling out the "**Solve it forward**" process to all acute medicine units. The process facilitates a safer transition to home by notifying the patient's family physician about discharge from hospital so that appropriate and timely follow-up can be taken.
- The **Collaborative Care Model**, with specific focus on CoACT elements and tools (e.g., Transitions in Care, Integrated Plan of Care), continues to spread across the province to improve communication and collaboration amongst patients, families, and care providers.
- Zones continue to work with Primary Care Networks™ to ensure services are in place for complex patients, such as the **Patients Collaborating with Teams (PaCT)** and the **Bridging the Gap**. These initiatives provide solutions for discharge and transition of patients with complex health needs to community family practices.
- Zones implemented clinical care pathways through the SCNs™ – Chronic Obstructive Pulmonary Disease (COPD) and heart failure, hip and knee replacement pathway, and delirium in intensive care units.

Strategic Clinical Networks™ (SCN)

Our Strategic Clinical Networks™ use readmission rates to measure success and improve outcomes for patients. This information helps us develop clinical best practices.

SCNs™ bring together clinicians, researchers, patients, and policymakers to drive innovation and research, standardize care, share best practices, improve access to services, and improve health system sustainability.

Since 2013, AHS has expanded from six to 16 SCNs™.

- Addiction and Mental Health
- Bone and Joint Health
- Cancer
- Cardiovascular Health and Stroke
- Critical Care
- Diabetes, Obesity And Nutrition
- Digestive Health
- Emergency
- Kidney Health
- Maternal Newborn Child & Youth
- Neurosciences, Rehabilitation & Vision (NEW!)
- Population, Public and Indigenous Health
- Primary Health Care Integration Network
- Respiratory Health
- Seniors Health
- Surgery

SCNs™ are continually embarking on innovative initiatives to help reduce inappropriate variation, apply consistent clinical standards, and improve health outcomes, many of which are cited throughout this report. Additional highlights for 2018-19 include:

- The Kidney SCN™ transitioned the **Starting Dialysis on Time at Home on the Right Therapy (START)** project to operations. START maximizes the safe and effective use of peritoneal dialysis, ensures patients are starting dialysis at the appropriate time, improves outcomes and experiences, and reduces healthcare costs.

- The **Provincial Breast Health Initiative**, part of the Cancer SCN™, will improve breast cancer care through design of provincial pathways to reduce diagnostic delays and unnecessary testing which facilitates faster recovery after surgery. A comprehensive perioperative education package is used to promote consistency. Patient outcomes were improved with an increase in the proportion of same-day mastectomies to 49% in Q3 YTD 2018-19 compared to the same period last year (41%) and 27% in Q3 YTD 2016-17.

- The **Elder Friendly Care (EFC)** initiative, part of the Seniors Health SCN™, 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. EFC has been implemented in 10 acute care sites across the province that provide care to 36% of all acute care patients who are over 85 years of age. The project team continues to spread the work to additional acute care locations.

- The objective of the **Chronic Obstructive Pulmonary Disease and Heart Failure (COPD/HF) Care Pathway** is to improve care across the continuum from hospital admission through discharge into the community and primary care settings. COPD and HF account for the highest hospital admission rates of all chronic diseases in Alberta. Individuals with these conditions experience long hospital stays, readmissions to hospital, and frequent emergency room visits.

Work is ongoing to support non-cancer surgical priorities in each zone with additional capacity by performing more surgeries for Cardiac (Calgary Zone), Orthopedic (Edmonton, Central and South Zones) and Cataract (North Zone) surgeries.

SCNs™ are implementing initiatives that impact wait times and access, reduce variation in practice, decrease length of stay, and increase quality surgical care provincially:

- The Surgery SCN™ worked with the zones to implement the **Enhanced Recovery After Surgery (ERAS)** program, which standardizes care before, during, and after surgery to get patients back on their feet quicker while shortening hospital stays and reducing complications after surgery. The program is implemented at nine sites for surgeries in gynecology, breast reconstruction, major head and neck, liver, urinary bladder, colorectal, pancreas, and gynecology oncology.

- The **Alberta Coding Access Targets for Surgery (ACATS)** initiative was successfully completed and transitioned to operations in all five zones with implementation for scheduled surgeries complete at 40 surgical sites in the province (AHS and Covenant Health) and to contracted non-hospital surgical facilities. ACATS is an Alberta-developed, standardized coding system to help prioritize scheduled surgeries offered at facilities throughout the province, depending on a patient's diagnosis and level of urgency. It is the only provincial patient-focused emergency and urgent surgical triage system in Canada.

- The **National Surgical Quality Improvement Program (NSQIP)** expanded from five sites in 2017-18 to 14 sites. Improvements in post-operative outcomes included a reduction in complication rates and re-admission rates, and improved patient safety. As a result, there was a reduction in associated healthcare costs.

AHS continues to increase capacity for evidence-informed practice and policy through enhanced data sharing, research, innovation, health technology assessment, and knowledge translation.

- Work is underway to implement a **Health Innovation Fund** to bridge the funding gap between evidence generation and operational funding. Funding was awarded to five innovation projects in 2018-19.

- **Partnership for Research and Innovation in the Health System (PRIHS) 4** grants awarded funding for six new projects in January 2019. ERAS and ARCH PRIHS projects continue to be implemented and spread.

A unique collaboration between provincial stakeholders in neurosciences, rehabilitation (for all conditions), and vision health was officially launched in November in the form of AHS' 16th SCN™ – **Neurosciences, Rehabilitation & Vision SCN™**. Strategic planning with stakeholders is underway towards the development of the Transformational Roadmap that outlines the mission, strategic objectives, and priority areas.

Improve Patient and Population Health Outcomes

Objective 6: Improving the health outcomes of Indigenous Peoples in areas where AHS has influence.

WHY THIS IS IMPORTANT

Alberta's Indigenous peoples, many of whom live in rural and remote areas of our province, have poorer health than non-Indigenous Albertans. AHS is building a better understanding of how historical effects and cultural care differences impact these outcomes.

Working together with Indigenous communities, the AHS Wisdom Council, and provincial and federal governments, we will adapt services to better meet the health needs of Indigenous peoples.

AHS PERFORMANCE MEASURE

Perinatal Mortality among First Nations is defined as the number of perinatal deaths per 1,000 total births among First Nations. A perinatal death is a fetal death (stillbirth) or an early neonatal death.

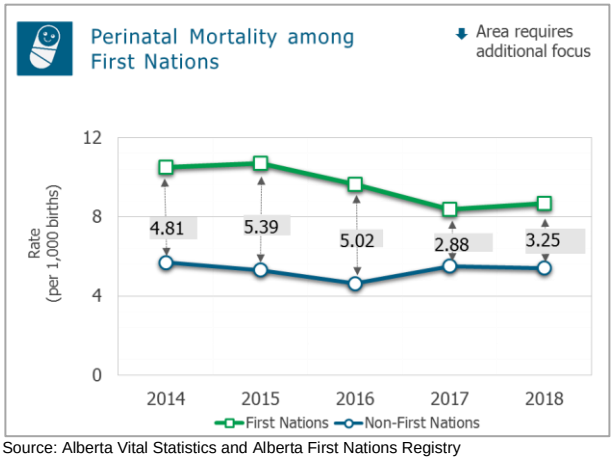
UNDERSTANDING THE MEASURE

This indicator provides important information on the health status of First Nations pregnant women, new mothers, and newborns. It allows us to see Alberta's performance on reducing the disparity between First Nations and non-First Nations populations.

Monitoring this rate helps AHS develop and adapt population health initiatives and services to better meet the health needs of First Nations and Inuit people.

The lower the number the better. AHS' focus is to reduce the health gap between First Nations and non-First Nations. This measure does not include Métis residents.

HOW WE ARE DOING



Source: Alberta Vital Statistics and Alberta First Nations Registry

As demonstrated in the graph, results for 2018 indicate that AHS slightly deteriorated in reducing the gap since 2017. AHS collaborates with many partners and must consider multiple factors to improve this indicator. However, AHS reduced the gap in perinatal mortality between First Nations and Non-First Nations by 35% from 2016. Addressing social determinants of health will influence this measure but change will take time.

WHAT WE ARE DOING

The following are examples of zone initiatives to improve maternal health of Indigenous women:

- **Midwifery** privileges have been established at Four Directions Indigenous Midwifery Services which supports access to obstetrical services for Indigenous, vulnerable and rural populations. In 2018-19, nearly 4,000 courses of care were supported by midwives in Alberta, an increase of 400 from the previous year.
- **Merck for Mothers** uses community-based ways to enhance the support of pregnant Indigenous women to overcome barriers to prenatal care:
    - In Central Zone, Maskwacis initiated a project that focuses on building resilience, promoting positive images of the community, celebrating birth and sharing Indigenous knowledge on pregnancy. A number of planting, harvesting and cooking events have taken place at a community garden which yielded twice the quantity of food than in its first year.
    - In inner-city Edmonton, Pregnancy Pathways provides safe housing and support services for pregnant Indigenous homeless women. Wrap-around services are now being offered 24/7 and include traditional sweat ceremonies, powwows and medicine picking. The program has 12 clients and 10 babies so far.
    - North Zone's Little Red River Cree Nation implemented projects that provide a community-based support model for maternal health resources and engages women early in pregnancy. A second family wellness camp is scheduled for summer 2019.

AHS is working with Indigenous leaders, communities, and related agencies to improve access to health care services:

- Community engagement sessions continue with Indigenous groups to support the enhancement of programs at the **Indigenous Wellness Clinic** in Edmonton and the **Elbow River Healing Lodge** in Calgary. Both sites have embedded the Indigenous Integrated Primary Care standards into practice. The importance of these standards are to ensure clients are receiving the best possible care and health outcomes and to improve continuity of care between urban and rural centres.

AHS is developing a provincial Indigenous Health Strategy and some zones have already begun engaging with Indigenous communities to develop **Indigenous Health Action Plans**.

- In Central Zone, community profiles are being finalized for Maskwacis, Stoney Nakoda (Big Horn) and O'Chiese to inform current state and provide cultural context and engagement channels.

- In Calgary Zone, monthly meetings have been organized with Indigenous health leaders from Siksika Nation, Stoney Nakoda and Tsuu T'ina tribal councils.

- South Zone has begun developing an Indigenous patient navigation model, with a grant from Alberta Innovates, to co-design and evaluate a navigation service to support indigenous patients and families. The service is intended to reduce some of the health inequities experienced by people from Indigenous communities in the South Zone. It is hoped that this model could be adapted for other Zones.

AHS' Screening Programs, in partnership with primary care providers and other partners, support Albertans' participation in cancer screening initiatives.

- The **First Nations Cancer Prevention and Screening Practices** program supports Indigenous communities to develop, implement, and evaluate comprehensive prevention and screening plans. Three First Nations communities (Peerless Trout First Nation, Blood Tribe and Maskwacis) continue to implement and evaluate their actions. In 2018-19, an Alberta First Nations Sustainability Model for Cancer Prevention was complete and an evaluation toolkit is now in development.

- Communities are taking action to improve cancer screening, increase opportunities for physical activity, and build individual awareness of actions that can be taken to prevent cancer. For example, picnic areas and walking paths are under construction and wellness events including community feasts and sweats are being facilitated in numerous communities.

- **Screen Test Mobile Mammography Services** offered screening mammography services to almost 15,000 women in 122 communities, including 20 First Nations communities and six Métis settlements in 2018-19.

- In 2018, 2.5 million **Cancer Screening Status Reports** were loaded onto Netcare. These new reports provide primary care providers quick and easy to access to their patients' cancer screening status. The report indicates, at a glance, if a patient is due for breast, colorectal, and/or cervical cancer screening or follow-up in a format that is clear and easy to use.

The Maternal Newborn Child & Youth (MNCY) Strategic Clinical Network (SCN) supports the improvement of the health of women and children through various initiatives. Some initiatives include:

- The **Early Hearing Detection and Intervention (EHDI)** program offers newborn hearing screening in 13 neonatal intensive care units, 18 birthing hospitals, and 33 community sites. In addition, eight new diagnostic assessment centres have been established to accept referrals from hearing screening tests. The program regularly monitors performance and quality.

- A new **antenatal care pathway** was implemented and is now available as a resource for all physicians and midwives who provide pregnancy care in the province. The pathway supports rural communities by providing clinicians with up to date information, standards of care, decision making tools, and quick access to Alberta based resources and supports.

- Work is underway to develop an acute care **neonatal abstinence syndrome (NAS) pathway**, with stakeholder input, to support babies of mothers who have been using opioids and other drugs.

- The **newborn pathway** supports the early identification of jaundice and management of risks for the vulnerable newborn population by utilizing learning modules for full implementation. The initiative will be further supported in Connect Care by order sets and clinical documentation. This work is led by the Maternal, Newborn, Child and Youth Strategic Clinical Network™.

Initiatives that support the health of other vulnerable populations include:

- The **Safe Healthy Environments (SHE)** program is aimed at reducing homelessness and providing outreach and support through a multidisciplinary approach to community housing strategies. In 2018-19, Community Paramedics joined the team to fill a gap for clients who are not attached to a primary care physician.

- The **Government Assisted Refugee Program** has seen great success with a high rate of new immigrants already attached to a local primary care provider.

- The **District Police and Crisis Team** provides clinical assessment and interventions for vulnerable individuals presenting to police with addiction and mental health concerns. A community paramedic was added to the team in 2018-19.

Engagement and Cultural Sensitivity

As of March 31, 2019, 30% of AHS staff have completed the required cultural sensitivity training (increasing from 4% last year). AHS approved recommendations on a three-year phased training approach for two required learnings: Indigenous Peoples in Alberta: Introduction course and the Indigenous Awareness and Sensitivity certificate program. Additionally, Zones are embedding traditional learning practices such as blanket exercises, smudging, and sweats.

Improve Patient and Population Health Outcomes

Objective 7: Reducing and preventing incidents of preventable harm to patients in our facilities.

WHY THIS IS IMPORTANT

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

We continue to reduce preventable harm through various initiatives such as the safe surgery checklist, antimicrobial stewardship program, medication reconciliation, and hand hygiene compliance.

AHS PERFORMANCE MEASURE

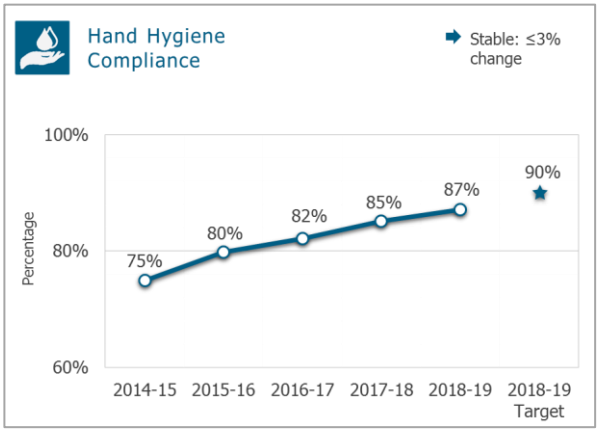
Hand Hygiene Compliance is defined as the percentage of opportunities in which healthcare workers clean their hands during the course of patient care. Healthcare workers are directly observed by trained personnel to see if they are compliant with routine hand hygiene practices according to the Canadian Patient Safety Institute's "4 Moments of Hand Hygiene" which are: before contact with a patient or patient's environment, before a clean or aseptic procedure, after exposure (or risk of exposure) to blood or body fluids, and after contact with a patient or patient environment.

UNDERSTANDING THE MEASURE

Hand hygiene is the single most effective strategy to reduce the transmission of infection in the healthcare setting. Direct observation is a recommended way to assess hand hygiene compliance rates for healthcare workers.

The higher the percentage the better, as it demonstrates more healthcare workers are complying with appropriate hand hygiene practices.

HOW WE ARE DOING



Source: AHS Infection, Prevention and Control Database

The hand hygiene compliance rate has made significant improvement since 2010 (50%) but did not achieve target in 2018-19. As AHS achieves higher levels of performance, less significant gains are likely to be made. AHS is committed to finding ways to achieve the target of 90% which requires partnership and joint efforts. Continuous efforts on program evaluation, education, and training are being made to encourage frontline healthcare providers to continue to increase their accountability and ownership of hand hygiene practices.

WHAT WE ARE DOING

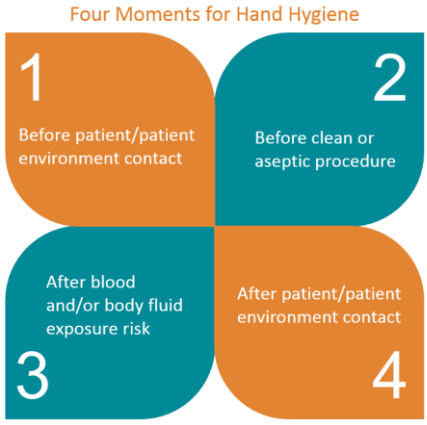
Hand hygiene improvement initiatives have been undertaken and include increased frequency of monitoring and to further stimulate improved hand hygiene practices. Other initiatives to support hand hygiene compliance across the organization include:

- The redesigned Hand Hygiene Reviewer Training was implemented in April 2018. Since then, a standardized provincial competency check testing PowerPoint has been trialed for site-based reviewers who performed hand hygiene reviews in acute care. Future work will look at further streamlining and focusing the training as well as analyzing the results of the competency check process.

- Staff were asked to submit videos of coworkers who go above and beyond the call of duty for hand hygiene. The videos will be used to create a video montage which will be released on Stop! Clean Your Hands Day in May 2019.

- In celebration of Global Handwashing Day - October 15, 2018 - the Infection, Prevention and Control Hand Hygiene Program hosted a Lunch and Learn Speakers Series with more than 200 attendees. Three presenters from Infection Prevention and Control and Workplace Health and Safety hosted sessions on "Hand Health Guiding Practices", "Hand Hygiene Review: Behaviour Modification to Improve Compliance and Facilitate Cultural Shift", and "Practical Magic: Sleight of Hand Techniques Revealed".

- AHS began introducing a new cartridge for alcohol-based hand rub which dispenses an optimal amount of sanitizer for the recommended wet contact time in a single dose. The new cartridge dispenses a higher volume of sanitizer than previous cartridges to help users to have a minimum wet contact time of 20-30 seconds as recommended by the World Health Organization.



Clinical teams across the organization are supported in reducing risk of hospital-acquired infections through ongoing surveillance and reporting of provincial rates of key infection indicators.

AHS' Infection Prevention and Control (IPC) team works closely with zones and other clinical and non-clinical teams to reduce the risk and occurrence of infection in patients, residents, and clients and to respond to the impact of emerging pathogens, infectious disease clusters, and outbreaks.

- Overall, rates for **Hospital-acquired Methicillin-resistant *Staphylococcus aureus* Bloodstream Infection (MRSA BSI)** remained stable and continue to demonstrate a downward trend, similar to last year (0.10 in 2018-19 compared to 0.20 per 10,000 patient-days in 2017-18).

- In 2018-19, rates for **Hospital-acquired *Clostridium difficile* (C-diff) infection (CDI)** continue to be lower than last year and the rates remain below the Canadian national average (2.3 in 2018-19 compared to 2.9 per 10,000 patient-days in 2017-18).

There are many provincial and zone initiatives underway to help reduce hospital-acquired infections.

- The standardized **Equipment Cleaning program** is now fully implemented at all large acute and regional hospitals across the province. The program has defined parameters, cleaning methods and frequencies, and provides clarity of accountability to support the highest standards of quality and patient safety. The program ensures the right people are performing the right work, that clinical staff know which equipment is clean, and the right disinfectants are used to increase the efficacy of cleaning procedures.

- AHS has an active **Antimicrobial Stewardship** program focused on optimal antimicrobial use. Initiatives include the use of standardized physician patient care orders to standardize treatment and reinforce appropriate infection control precautions.

- AHS is actively engaged in the design of clinical workflows required for implementation of Connect Care. Through this work, Infection Prevention and Control has validated and enhanced its province-wide approach to screening of antibiotic-resistant organisms at the time of admission to hospital. IPC has also defined content for alerts signaling the need for the application of additional precautions, such as isolation for patients with infections.

The AHS **Patient Safety Plan** was finalized and work is underway to bring this plan to life. An important part of the Plan is the adoption of a measurement and monitoring framework that supports a shift from a reactive to a proactive approach to patient safety. This shift will allow AHS to use data to enable teams to not only learn from and respond to past events, but to improve patient safety by anticipating problems before they occur.

Improve Patient and Population Health Outcomes

Objective 8: Focusing on health promotion and disease and injury prevention.

WHY THIS IS IMPORTANT

Working collaboratively with Alberta Health (AH) and other community agencies, AHS will continue to improve and protect the health of Albertans through a variety of strategies in areas of public health including reducing risk factors for communicable diseases, promoting screening, programming, increasing immunization rates, and managing chronic diseases.

Preventing and managing chronic conditions and diseases involves an integrated and coordinated system of supports, including families and communities, that empowers individuals to maintain and improve their health, their quality of life, and prevent and manage conditions/diseases independently or in partnership with health and social care

AHS PERFORMANCE MEASURE

Childhood Immunization is defined as the percentage of children who have received the required number of vaccine doses by two years of age.

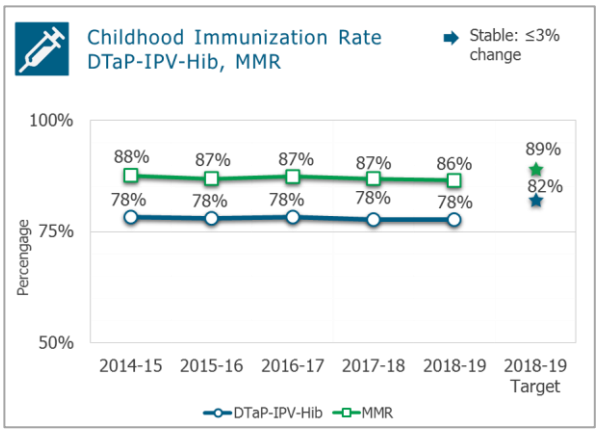
- Diphtheria, Tetanus, acellular Pertussis, Polio, *Haemophilus Influenzae* Type B (DTaP-IPV-Hib) - 4 doses
- Measles, Mumps, Rubella (MMR) - 1 dose

UNDERSTANDING THE MEASURE

A high rate of immunization for a population reduces the incidence of vaccine-preventable childhood disease and controls outbreaks. Immunizations protect children and adults from a number of vaccine-preventable diseases, some of which can be fatal or produce permanent disabilities.

The higher the percentage the better, as it demonstrates more children are vaccinated and protected from vaccine-preventable childhood diseases.

HOW WE ARE DOING



Source: Province-wide Immunization Program, Communicable Disease Control

Results indicate that provincial rates for childhood immunization (both DTaP-IPV-Hib and MMR) have remained stable from the same period last year. Immunization rates targets were not achieved in 2018-19. A significant cause for under immunization relates to vaccine hesitancy which is related to a general lack of understanding about vaccines, perceived risk of serious adverse events related to injections, and lack of appreciation for the severity of vaccine preventable diseases. Accessing vaccine services and clinics can also be a barrier.

AHS acknowledges and is committed to finding ways to achieve these targets and it will require partnership and joint efforts to influence change. Childhood immunizations, for example, require parental consent and agreement. As we achieve higher levels of performance, less significant gains are likely to be made. Coverage rate targets were achieved by the end of grade 1 due to the AHS Standard for Immunizing in the School Setting.

WHAT WE ARE DOING

Efforts continue to increase immunization coverage through provincial procedures and practices including expansion of the Recall and Reminder Guideline and Clinic Cancellation Lists.

Immunization

AHS is working with Alberta Health and continues to monitor and support childhood immunization across the province.

The AHS **Standard for Immunizing in the School Setting** (posted in the Immunization Program Standards Manual) was updated to incorporate the amendments to the *Public Health Act* and sent out to Zone Public Health in July 2018 for training and orientation of staff. Implementation was effective September 1, 2018.

- The standard allows data matching between AHS and school divisions to identify students who are either new to the province or are behind in their immunization schedules. This update was made to address differences in processes across the province and to standardize the review of student immunization histories and offer immunization.

Influenza immunization is the most effective way to prevent influenza and its complications. The influenza immunization rate for AHS healthcare workers for 2018-19 was 67.6%, an increase of 1.6% from the previous year. The overall influenza immunization rate for Albertans is 30.1% in 2018-19, an increase of 1.6%.

Rotavirus is a leading cause of acute infectious diarrhea in infants and young children and affects approximately 95% of children by the age of 3 to 5 years. Rotavirus immunization coverage rates in infants was 82.5% in 2018-19 (compared to 80.8% in 2017-18).

Human Papilloma Virus (HPV) vaccine is important to protect against cancers caused by the HPV infection. HPV vaccine administration (2017-18):

- Grade 5 – boys 66.1%, girls 68.2%.
- Grade 9 – boys 69.0%, girls 81.2%.

Coverage rate by the end of grade 1 (age six) in 2017-18 were:

- 91.9% for diphtheria, tetanus, pertussis, polio, Hib (4 doses).
- 89.3% for measles, mumps, rubella (2 doses).
- 87.5% for varicella (2 doses).

(2018-19 rates will be available September 2019)

Outbreak Management

AHS and Alberta Health (AH) are working together and with the zones to ensure a consistent approach to disease outbreak reporting, notification, and management. Disease outbreaks in each zone have decreased and there were two cases of confirmed measles reported in 2018-19. Additional highlights include:

- Actively collaborating with AH to inform new and revised Notifiable Disease Public Health Management Guidelines.
- Investigated 135 confirmed enteric outbreaks and 109 confirmed non-enteric outbreaks in 2018-19. All outbreaks met outbreak reporting criteria as per AH requirements. Symptoms common to an enteric outbreak include nausea, vomiting and abdominal pain; examples of non-enteric outbreaks are chickenpox, measles and influenza.
- The number of hospitalized influenza cases in Alberta declined to 487 in Q4 from 934 in Q3.
- Continued participation in AHS Connect Care conversations to ensure reporting systems meet Alberta Health legislation and policy requirements (e.g., Alberta Public Health Act, Communicable Diseases Regulation, etc.).
- Enhanced *E. coli* testing, identification, and reporting with support and input from Alberta Laboratory Services. The enhanced service was piloted in 2018-19 and will contribute data to national databases.
- Actively participating on an ongoing multi-provincial investigation of a *Salmonella enteritidis* outbreak. Sixty cases have been detected nationally with ten cases in Alberta in 2018-19. *Salmonella enteritidis* can be found inside contaminated, raw, or undercooked eggs.

AHS continues to collaborate with key stakeholders to develop outbreak management tools and plans for evacuation centres in support of the provincial **Communicable Disease Emergency Response Plan**.

AHS continues to implement the **2016-2020 Alberta Sexually Transmitted and Blood-Borne Infections (STBBI) Operational Strategy and Action Plan**. The strategy and action plan will increase awareness and accessibility of STBBI testing and treatment services across the province including First Nations' communities and Métis settlements. Work continued in 2018-19 with two pilot sites in South and Edmonton Zones to determine the feasibility of a wrap-around shared care model. The sexgerms.com website continues to raise awareness of sexually transmitted infections.

Environmental Risks and Hazards

In collaboration with Alberta Agriculture and Forestry, AHS has completed the first two years of a three-year project to streamline meat processing facility inspections. As of March 31, 2019, all meat processing facilities were inspected using the new baseline assessment and inspection tool. A single guide has been completed and is intended to improve consistency in the delivery of inspection services.

Chronic Disease Prevention and Management

AHS is working on developing an **Alberta Chronic Disease Inventory**, which is a searchable listing of programs, services and resources focused on chronic disease prevention and management. Consultations were completed in 2018-19.

A chronic disease self-management program (**Better Choices, Better Health®**) enhances patients' ability to self-manage their conditions at home. In-person workshops are designed to help people living with ongoing health conditions such as diabetes, heart disease, arthritis, asthma, and obesity. Having the sessions led by trained peer facilitators ensures an empathetic and encouraging environment.

Screening and Health Promotion

AHS is focusing on several screening and wellness initiatives and prevention interventions to promote lifelong health and to limit the burden of disease.

- The expanded **Newborn Metabolic Screening (NMS) Program** is about health care providers working together with parents and guardians to screen for treatable conditions. Timely screening helps find conditions early when the treatment can help an infant the most.
- **Alberta Healthy Communities Approach (AHCA)** supports communities to plan, implement, and evaluate prevention and screening interventions that address key aspects of people's living and working environments. To date, three Métis Settlements (Peavine, East Prairie and Gift Lake) have joined the 16 Alberta communities already implementing AHCA. In 2018-19, the main area of focus in Métis settlements was implementing actions related to ultraviolet radiation (UVR) protection (e.g., shade and sunscreen).
- **Comprehensive School Health** is a program that addresses a variety of health issues and can improve health, education, and social outcomes for children and youth. To date, 94% of school jurisdictions are working with AHS to implement the Comprehensive School Health framework.
- To address emerging concerns with increased utilization of tobacco like products, particularly among youth, the **Tobacco Reduction Program** developed infographics and other resources focused on vaping, hookah, and concurrent cannabis and tobacco use. The resources were developed for teachers, youth, and those who support them.
- The **Healthier Together Workplace** project supports workplaces to create a healthy environment for their employees including strategy kits that guide action in the areas of physical activity, healthy eating, mental health, and alcohol and tobacco. An Ultra Violet Radiation strategy kit was developed to promote mental health in non-office based workplaces.

Improve the Experience and Safety of Our People

Objective 9: Improving our workforce engagement.

WHY THIS IS IMPORTANT

Our People Strategy supports staff, physicians and volunteers, thereby improving patient and family experiences.

An engaged workforce will promote a strong patient safety culture and advance safe work environments. We also know patient outcomes improve when our workforce is highly engaged and when they enjoy what they are doing.

Enhancing workforce engagement will contribute to achieving a culture where people feel supported, valued, and able to reach their full potential.

AHS PERFORMANCE MEASURE

AHS Workforce Engagement is calculated as the average score of our workforce's responses to AHS' Our People Survey which utilizes a five-point scale, with one being "strongly disagree" and five being "strongly agree".

UNDERSTANDING THE MEASURE

AHS has the opportunity both to create a satisfying workplace and to deliver services in a manner that is sustainable for the future. In order to do this, it is important that AHS fully engages its people and their skills. Monitoring workforce engagement enables us to determine the effectiveness of processes/programs that support employee engagement and strengthen a patient safety culture.

The rate shows the commitment level the workforce has to AHS, their work, and their manager and co-workers. High engagement correlates with higher productivity, safe patient care and willingness to give discretionary effort at work. The higher the rate, the better, as it demonstrates that more employees feel positive about their work.

HOW WE ARE DOING

Workforce Engagement Rate

Annual Results: **3.46** out of 5 (2016-17 baseline year)

The next survey is planned for 2019-20 with a target of 3.67.

Source: Gallup Canada

WHAT WE ARE DOING

Our People Strategy's action plan addresses priority factors influencing workforce engagement at AHS.

- AHS was named one of Canada's Best Diversity Employers for 2019; this recognition was new for the organization and was the fourth Top Employer award for 2019. AHS also received awards in other categories: Canada's Top 100 Employers, Canada's Best Employers for Young People, and Alberta's Top 75 Employers.
- AHS continued to recognize its employees through the **President's Excellence Awards program**. In 2018, AHS received a record 138 nominations with three award recipients across seven award categories to recognize employees, physicians, and midwives who demonstrate innovation, collaboration, and patient-focus in their work.
- **Respectful Workplaces** continues to be a priority for the organization. Change the Conversation launched, releasing 17 documents on a range of challenging conversation topics. The purpose of Change the Conversation is to empower our people to create inclusive and respectful workplaces.
- AHS has fully transitioned to **Development Conversations** for all non-union employees. Development conversations ensure that all non-union employees at AHS can have open and ongoing communication throughout the year regarding their goals, performance, and development.
- AHS' **Prevention of Harassment and Violence** team is now fully staffed. Violence/Aggression Alerts Program resources are published on AHS' internal website and workplace health and safety subject matter experts are in place in each zone to support provincial implementation based on readiness.
- AHS is supporting Alberta Health in planning for physician resources. The 2018 **physician workforce plan** was finalized. Planning and data collection for the development of a 2019 plan is underway and will identify physician recruitment targets.
- AHS is working with Alberta Health on new and expanded **alternative relationship plans (ARPs)**. The purpose of an ARP is to support clinical innovation by remunerating physicians for providing innovative services that do not fit traditional fee for service plans. ARPs also enhance other areas of the health care system including recruitment and retention, team-based care models and patient satisfaction.

Enhancing workforce engagement will contribute to achieving a culture where people feel supported, valued, and able to reach their full potential.

Improve the Experience and Safety of our People

Objective 10: Reducing disabling injuries in our workforce.

WHY THIS IS IMPORTANT

Safe, healthy workers contribute to improving patient care and safety. AHS is committed to providing a healthy and safe work environment for all. AHS' strategy for health and safety includes four areas of focus: physical safety, psychological safety, healthy and resilient employees, and safety culture. Through knowledgeable and actively engaged staff, physicians, and volunteers, we will reduce injuries across our organization.

AHS PERFORMANCE MEASURE

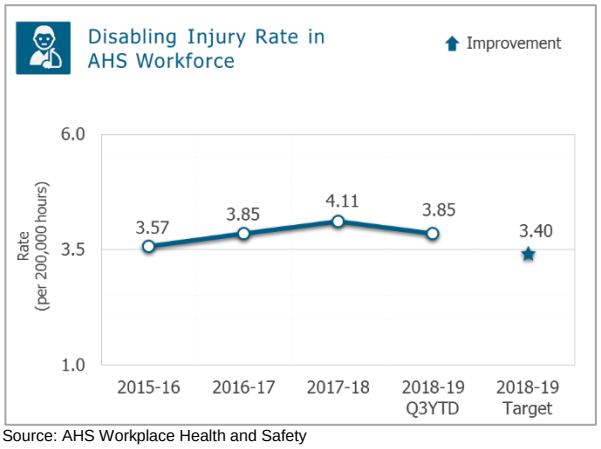
Disabling Injury Rate (DIR) is defined as the number of AHS workers injured seriously enough to require modified work or time loss from work per 200,000 paid hours (approximately 100 full time equivalent workers).

UNDERSTANDING THE MEASURE

Our disabling injury rate indicates the extent to which AHS experiences injury in the workplace. This enables us to identify the effectiveness of health and safety programs that actively engage our people in creating a safe, healthy and inclusive workplace.

The lower the rate, the better the performance, as it indicates fewer disabling injuries occurring at work.

HOW WE ARE DOING



Source: AHS Workplace Health and Safety

Comparable to other health organizations, the majority of AHS' disabling injuries are musculoskeletal injuries arising from client and material handling. This trend has held steady for many years and the injury rate is relatively stable. However, AHS did not meet the DIR target of 3.40 for 2018-19.

The top 5 causes of injuries reported to the Workers Compensation Board (WCB) include: patient handling, manual material handling, ergonomic risk factors, slips and falls and physical workplace violence. Musculoskeletal and other injury types continue to increase, despite concerted and ongoing efforts to prevent injuries. Changes to the Workers Compensation Board (WCB) Act, as well as the promotion of incident reporting and de-stigmatization of psychological harm, have increased the scope of claims accepted by WCB.

Violent incidents in AHS workplaces continue to be reported at a higher rate year over year. This trend is expected to continue as AHS continues to promote the reporting of violence incidents.

WHAT WE ARE DOING

Efforts to improve DIR include targeted interventions to impact common causes of injuries in high-risk areas and enhancing programs and processes related to physical safety, such as patient handling and manual material handling.

- AHS is investing in culturally-based initiatives that take time to impact metrics such as injury rates but foster more sustainable change: core safety training for all leaders (60% completed); focused implementation of the 2018 Occupational Health and Safety Act (OHSA); enhancing collaboration with internal operational teams and Patient Quality and Safety; and enhancing linkages with external stakeholders such as unions and Alberta Labour.

- AHS supports operational areas to ensure staff are appropriately trained on **It's Your Move** and **Move Safe** ergonomic programs, which aim to prevent lifting and handling injuries.

- To highlight ergonomic requirements for workers and prevent injuries, the **Safe Client Handling Functional Transfer** record will be included as one of the alerts in Connect Care. This record communicates individual client mobility limitations so that the care team can put the appropriate lift and transfer supports in place.

- Further strengthening of AHS' Safety Culture are expected to occur through the improvements being made as a result of changes made to the WCB Act and the OHS Act. Implementation of changes continues with a focus on accommodation requirements, joint worksite health and safety committees, and prevention of violence and harassment. AHS completed and implemented the Workplace Accommodation Policy in order to meet legislative changes.

AHS strives to provide a healthy and safe work environment with a focus on physical safety, psychological safety, healthy and resilient employees and safety culture.

- All new leaders are required to complete Leading Health and Safety in the Workplace: Fundamentals training. This course supports Our People Strategy by equipping leaders with the knowledge to create safe, healthy, and inclusive workplaces. As of March 31, 2019, 60% of AHS leaders have completed the course.

Improve Financial Health and Value for Money

Objective 11: Improving efficiencies through implementation of operational and clinical best practices while maintaining or improving quality and safety.

WHY THIS IS IMPORTANT

AHS is supporting strategies to improve efficiencies related to clinical effectiveness and appropriateness of care, operational best practice, and working with partners to support service delivery. AHS is making the most effective use of finite resources while continuing to focus on quality of care.

AHS PERFORMANCE MEASURE

Nursing Units Achieving Best Practice Efficiency Targets is defined as the percentage of nursing units at the 16 busiest sites meeting operational best practice (OBP) efficiency targets.

UNDERSTANDING THE MEASURE

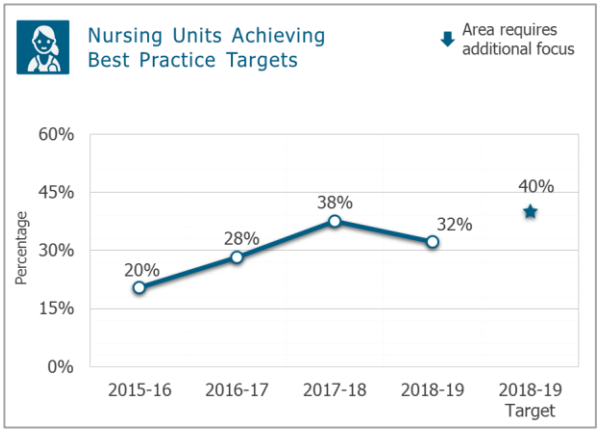
Operational best practice is one of the ways we can reduce costs while maintaining or improving care to ensure a sustainable future.

This initiative is focusing on the 16 largest hospitals in Alberta, including clinical support services and corporate services.

Using comparative data from across the county, AHS has developed OBP targets for nursing inpatient units. These targets are designed to achieve more equitable service delivery across the province with the measure used to monitor leadership's ability to meet the targets and reduce variations in the cost of delivering high quality services at AHS' sites.

A higher percentage means more efficiencies have been achieved across AHS.

HOW WE ARE DOING



Source: AHS Finance Statistical General Ledger (STAT GL)

Improving efficiencies through the implementation of OBP, while maintaining or improving quality and safety, is a journey of continuous improvement. Since 2015-16, the 16 busiest hospitals in Alberta have implemented OBP efficiencies. Results for Q4 2018-19 (January – March 2019) demonstrated 41% compliance provincially, which means that we met target in that quarter. AHS is committed to continue improvements in 2019-20 to achieve target as well as demonstrate more efficiencies.

WHAT WE ARE DOING

Operational Best Practice (OBP) compares healthcare delivery costs within Alberta, as well as with healthcare systems across Canada, to ensure we are efficient and focused on quality care and to achieve more equitable service delivery across the province.

Ongoing improvements are necessary to ensure health services for Albertans are sustainable into the future and resources are appropriately directed where they are needed most.

Clinical Best Practices

Strategic Clinical Networks™ (SCNs™) have demonstrated increased efficiencies, improved health outcomes, and reduced costs across Alberta by generating innovation and implementing best evidence into practice.

SCNs™ are required to be effective and efficient in identifying clinical best practices, as well as demonstrate their return on investment, and how they are helping AHS improve outcomes for Albertans. For example, a peer reviewed medical journal published that the NSQIP pilot showed that, for every dollar invested in this initiative, about $4.30 in savings was achieved. This program will be expanded to all hospitals.

Appropriateness of Care

Appropriateness is described as the proper or correct use of health services, products and resources. Inappropriate care can involve the overuse, underuse and/or misuse of health services, products and resources. The aim of clinical appropriateness is to improve patient care while, at the same time, driving better value for our health care dollars. In some cases this may mean doing less of some things and in other cases it may mean doing more.

Our partners are from all over the health system such as the SCNs, operations, Alberta Health, Alberta Medical Association and many others.

- **Advanced diagnostic imaging** tests, such as CT scans, MRIs and ultrasounds have dramatically changed the way patients are diagnosed and treated. Over the last year DI has successfully decreased unwarranted CT lumbar spine exams by almost 9%. In addition, there has been a reduction in MRIs for chronic knee pain of 4.8%. Work is underway to scale and spread the knee initiative. These decreases demonstrate improved efficiencies, wait times, and financial savings.

- Work is continuing on the initiative to eliminate unnecessary pre-operative chest x-rays for low-risk procedures with a provincial working group finalizing recommendations and planning a communication based intervention. For patients, this means they will not be exposed to unnecessary radiation. For the health system, this will result in cost avoidance and time savings.

- **Pharmacy Services** has implemented initiatives to improve the use of drugs that maintain or improve patient care while having a lower system cost. Examples include reduced use of select drugs, using prefilled syringes to reduce the risk of errors and a provincial initiative to properly identify and treat asymptomatic bacteriuria patients has shown at targeted sites to significantly reduce urine tests and decrease in antibiotic use.

- Alberta Public Laboratories, in collaboration with the Physician Learning Program and the Health Quality Council of Alberta (HQCA), started to develop a laboratory-specific audit and feedback tool that provided feedback to physicians to ensure that they were appropriately utilizing lab testing, thus ensuring the patient received the correct test at the right time.

- In 2018-19, Alberta Public Laboratories worked to reduce the Antinuclear Antibody (ANA) screening test in patients without specific signs or symptoms of systemic lupus erythematosus (SLE) or another connective tissue disease (CTD).

- The **Cardiovascular Health & Stroke SCN™** is conducting an initiative aimed at reducing low-value cardiovascular investigations to provide higher quality care at lower costs with an initial focus on provincial ECG use. This means higher quality cardiovascular care at lower cost.

- Work continued in partnership with the **Digestive Health SCN™** to increase appropriate use of proton pump inhibitors (PPI). The SCN™ is working with the HQCA and the Physician Learning Program to develop and report on quality indicators and to develop decision support tools for primary care physicians, pharmacists, and patients. Pharmacy Services is addressing PPI use in the emergency departments.

- The **Diabetes, Obesity and Nutrition SCN™** is continuing work to improve inpatient diabetes management through improved glycemic management for people with diabetes in acute care settings, including reduction of hyperglycemic events and, in doing so, provide better quality at lower costs.

- The **Cardiovascular Health and Stroke SCN™** and Diagnostic Imaging are working on an initiative to drive appropriate usage of computed tomography (CT) angiography (CTA) with stroke/ transient ischemic attacks (TIAs) across the province. This involves assessing CTA usage for minor stroke and TIAs to identify practice variation and opportunities for standardization.

- The **Digestive Health SCN™** is developing a provincial policy and initiating a project to implement the use of the Canada – Global Rating Scale (C-GRS) to improve colonoscopy quality and patient outcomes. Poor colonoscopy quality can lead to higher rates of colorectal cancers.

AHS plays a key role on the Appropriateness and Evidence-Based Improvements Committee (AEBIC) that is co-chaired by Alberta Health and the Alberta Medical Association and includes AHS and the College of Physicians and Surgeons of Alberta. AHS in collaboration with health system stakeholders has identified a framework that illustrates how clinical appropriateness initiatives can be implemented in acute care.

Provincial Laboratory Services

In 2018-19, the province consolidated lab services into an AHS wholly-owned subsidiary called Alberta Public Laboratories.

Diagnostic laboratory results inform the majority of patient care decisions and are a critical factor in decisions made every day for patients. An integrated, provincial lab system is a cost-effective, efficient model that will bring together similar diagnostic services and research under one organization for better collaboration and improved integration to improve the quality and timeliness of care for Albertans.

The new Chief Executive Officer (CEO), Board Chair, and Board Members commenced duties in September 2018.

Service Planning

Zone Healthcare Planning lays out a roadmap for transforming our health system to better meet the needs of Albertans. Zone Healthcare Plans were completed in Central Zone and Calgary Zone and posted on the AHS website. Plans were developed following extensive consultations with our health advisory councils, patient and family advisors, community members, partners, volunteers, physicians and staff.

The plans describe the current state of healthcare in the zone, the case for change, and detailed strategies and initiatives to transform the system. Implementation plans have been established.

AHS was engaged in a number of planning activities in 2018-19 to support service delivery, for example:

- Chronic Pain Implementation Plan (South and Edmonton Zones)
- Indigenous Health Action Plan (South, Calgary and Central Zones)
- Red Deer Regional Hospital Centre Capital Needs Assessment and Clinical Service Plan (Central Zone)
- Rehabilitation and Restorative Pillars of Care (Edmonton Zone)
- Grande Prairie and Area Service Plan (North Zone)

Improve Financial Health and Value for Money

Objective 12: Integrating clinical information systems to create a single comprehensive patient record.

WHY THIS IS IMPORTANT

Connect Care is a collaborative effort between Alberta Health and AHS staff, clinicians and patients to improve patient experiences and the quality and safety of patient care, by creating common clinical standards and processes to manage and share information across the continuum of healthcare in AHS. Connect Care will also support Albertans to take ownership of their health and care by giving them access to their own health information.

The AHS provincial **Clinical Information System (CIS)** is part of the Connect Care initiative. With a single comprehensive record and care plan for every patient, the quality and safety of the care we deliver is improved and our patients and their families across the healthcare system will have a better experience.

With **Connect Care**, efficiencies will be achieved and AHS will have a common system where health providers can access comprehensive and consolidated patient information which will travel with patients wherever they access the health system.

It is anticipated that Connect Care will be implemented provincially over time in order to allow our facilities time to prepare for this transformation.

AHS PERFORMANCE MEASURE

There is no AHS measure for this specific AHS objective. Success is measured based on meeting key milestones related to the Connect Care initiative.

HOW WE ARE DOING

Connect Care has successfully achieved all necessary 2018-19 milestones on time. This includes high-level completion of scoping, groundwork, direction setting, technical training and much of the core clinical system design.

WHAT WE ARE DOING

As Connect Care moves forward, communication teams are increasing their focus on engagement across AHS. This includes planning for quarterly Telehealth Town Halls where staff and physicians can ask questions directly to Connect Care leaders, providing resources such as a manager's toolkit, and providing regular updates in the Connect Care newsletter as well as stories in physician blogs, vlogs, newsletters, handbooks, Doc of the Week and other physician-focused online services.

AHS has completed some significant Connect Care milestones in 2018-19:

- The software workflow build was complete in Q3 and the base content build required for training activities was completed in Q4. All clinical decisions about the design of clinical documentation, decision and inquiry supports were complete in February 2019.
- Identification of staff and physician change-agents (Super Users) is underway, focusing on early-launch sites. These peers obtain extra training so they can provide elbow-to-elbow support for colleagues just before, during and after implementation.
- The data integration software development and functional testing was completed in Q3. The second of six rounds of integrated testing started on time.
- The Data Centre hardware installation was completed as of March 29, 2019.
- The Connect Care Readiness Playbooks initial chapters were released on time for Wave 1 and easily accessed by all AHS staff and physicians, with new sections offering practical guidance about steps to get ready for implementation. The latest release gives more detail about how our work will change, and emphasize positive prospects to build excitement for transformation.
- Successful Wave 2 kick-off events occurred for Calgary in March and for Central Zone in April 2019.
- The Benefits Realization Charter is now approved, and AHS is working on finalizing owners and validating expected savings.

AHS is supporting Alberta Health in enhancing and expanding Alberta Netcare and MyHealth Records to assist Albertans in taking an active role in managing their health.

Alberta Netcare is a secure and confidential electronic system of Alberta patient health information collected through a point of service in hospitals, laboratories, testing facilities, pharmacies and clinics. Access is restricted to registered healthcare providers working as an accredited Alberta healthcare provider. In 2018-19, there was an increase of 3% over the same period last year.

MyHealth.Alberta.ca is a secure online portal to trusted consumer health information, services and tools empowering Albertans to participate in and manager their healthcare journey. The site continues to grow in popularity with Albertans reaching over 15 million visits in 2018, almost double the annual usage from 2017.

FINANCIAL STATEMENT DISCUSSION AND ANALYSIS

MARCH 31, 2019

Financial Statement Discussion and Analysis
For the year ended March 31, 2019

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, 2019. In particular, 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 and other report users regarding AHS' 2018-19 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, 2019 audited consolidated financial statements, notes, and schedules.

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

2018-19 Highlights

Fiscal 2018-19 was the second year of AHS' three-year Health Plan and Business Plan (2017-2020). During the year, AHS made significant progress on new and ongoing initiatives, all of which support improvements to the quality, accessibility, and sustainability of health care for all Albertans.

Total number of home care clients served **127,214** (2018-19)

As one of the main areas of focus in the Health Plan and Business Plan, Enhancing Care in the Community remained a significant priority in 2018-19. Enhancing Care in the Community is a province-wide initiative that transforms the way AHS approaches and delivers healthcare, with the goal of providing more appropriate, community and home based care. Focusing on primary care, wellness, and prevention results in increased system-wide efficiency and cost effectiveness, and reduces reliance on acute and emergency services, the most expensive and resource intensive type of care.

In support of the Enhancing Care in the Community initiative, the 2018-19 plan included a 3.2 per cent funding increase for community care, home care, and addiction and mental health services. During 2018-19, AHS' investment in this priority initiative was $122 million. Furthermore, AHS saw the number of home care clients increased 4.3 per cent from the prior year, serving just over 127 thousand clients.

The Community Paramedic Program is also an important part of Enhancing Care in the Community. The program employs trained paramedics to provide certain services that might otherwise be provided in a hospital setting to patients in their place of residence. Additionally, to address the increasing demand for Emergency Medical Services throughout the province, AHS received additional funding in 2018-19 to hire more full-time paramedic positions in both rural and urban areas as well as support growth and inflationary pressures. As of March 31, 2019, 77 new paramedic positions had been filled.

The Continuing Care Capacity Plan is another ongoing initiative that is specifically focused on addressing the needs of patients waiting in the community or acute care for a continuing care space. The 2018-19 plan included a 4.3 per cent funding increase for continuing care. In 2018-19, AHS invested $130 million in the Continuing Care Capacity Plan, including having opened 1,267 net new long-term care, supportive living, and palliative care beds in Alberta.

The opioid crisis continued to impact families and communities across Alberta in 2018-19. Working with Alberta Health, first responders, health professionals, law enforcement, and community organizations, AHS continued to invest in programs across the province to support the prevention and treatment of opioid addiction, including the operation of safe consumption sites, the distribution of free naloxone kits, and essential Continuing Medical Education accredited training for prescribers and practitioners. AHS spent approximately $24 million on opioid specific initiatives in 2018-19 (2017-18 – $13 million).

During 2018-19, AHS met important milestones in the development of Connect Care, a transformative and essential project focused on providing a shared provincial clinical information system. Connect Care will not only replace outdated systems, but will optimize patient family centered care, improve patient experience and the quality and safety

of patient care. This will be done through the creation of common clinical standards and processes which will allow full management and sharing of information across the continuum of healthcare. Capital and operating expenditures in 2018-19 related to Connect Care were $126 million and $37 million respectively. The cumulative costs for Connect Care since 2017-18 are $159 million for capital expenditures and $53 million for operating expenditures. Significant progress was made in 2018-19 on design, application testing, data conversion, staff training, and establishment of a provincial data centre. The first wave of Connect Care implementation is scheduled to go-live in the fall of 2019.

Wait times continue to be a challenge for many healthcare jurisdictions, including Alberta. Improving wait times in the province continued to be a priority in 2018-19. AHS took various actions in 2018-19 including increasing the number of select surgeries performed, including cardiac, orthopedic, cataract, and cancer surgeries, and working to improve access to specialist care through improvements to eReferral, a paperless referral system which provides clinicians greater ability to manage referrals. AHS also increased the number of computed tomography (CT) and magnetic resonance imaging (MRI) exams performed to address the demand of these specific diagnostic exams.

Total number of CT scans **441,938** (2018-19)

Total number of MRI scans **204,744** (2018-19)

On September 1, 2018, AHS restructured laboratory services to form a single integrated lab organization for Alberta. Alberta Public Laboratories Ltd. (APL) is the newly formed wholly owned subsidiary of AHS and is modelled after the Mayo Medical Laboratory, also a wholly owned subsidiary of Mayo Clinic. Laboratory services are an essential part of the healthcare system, informing most healthcare decisions. The integration into an overarching system will drive innovation, reduce duplication and variations in testing, enhance quality and appropriateness of care, and ultimately, help keep healthcare sustainable in Alberta.

2018-19 Financial Results

AHS finished the year with a $39 million operating deficit representing 0.3 per cent of actual expenses. The deficit was mainly attributable to higher than anticipated demand for various healthcare services across the organization, resulting in staffing levels and overtime costs that were higher than expected. Higher than budgeted costs of liability insurance of $44 million further contributed to the deficit.

Overall higher fees and charges revenue relating to out-of-province and out-of-country patient volumes, a large number of vacancies throughout the organization, achieved savings through Operational Best Practices (OBP), as well as the timing of implementation of initiatives during 2018-19 offset a portion of the overall operating deficit.

AHS' net assets decreased from the prior year partly as a result of the annual operating deficit. AHS also invested internal funds of $244 million in the acquisition of capital assets, including those related to Connect Care, various clinical equipment acquisitions, parkade development, and other information technology (IT) system upgrades and replacements, which further decreased AHS' unrestricted surplus. The investment in capital assets is essential for AHS as clinical services depend heavily on them.

2018-19 Key Trending

SELECT ANNUAL FINANCIAL INFORMATION (in millions)					
	2018-19	2017-18	2016-17	2015-16	2014-15
Revenue	15,274	14,856	14,470	13,955	13,828
Expenses	15,313	14,765	14,403	14,100	13,827
Annual operating surplus (deficit)	$ (39)	$ 91	$ 67	$ (145)	$ 1
Accumulated surplus	1,278	1,317	1,226	1,159	1,304

Annual Operating Surplus (Deficit)

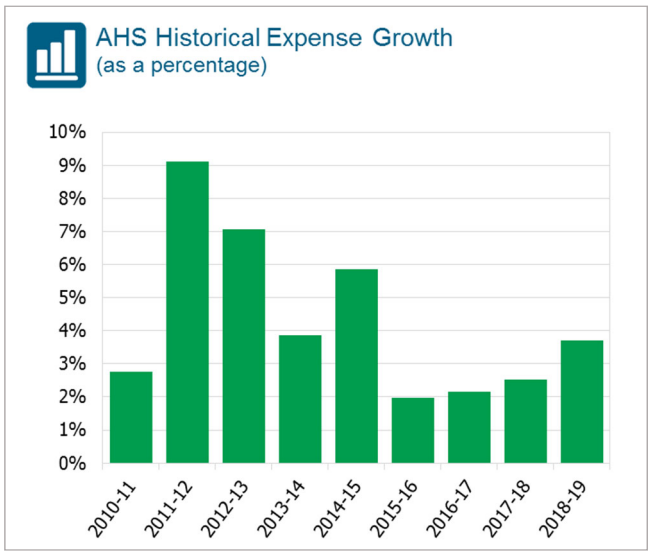
AHS operations are supported by transfers from Alberta Health and strives to operate within the budget approved by the AHS Board and the Minister of Health. Since 2014-15, AHS' operating surpluses and deficits have averaged less than one per cent of total expenses.

Accumulated Surplus

The accumulated surplus, which reflects the amount by which assets exceed liabilities, decreased slightly in 2018-19 due to AHS' current year operating deficit. The accumulated surplus balance is mainly comprised of AHS' capital assets that have been acquired with internal funds over many years, and supports the objectives of the health plan and the delivery of effective programs and services. Internal funds are a key source of funding when it comes to AHS' investment in capital assets, which includes supporting the development of Connect Care, equipment purchases and replacements, facility enhancements and upgrades, and investments in IT equipment, infrastructure, and systems.

Expense Growth

Alberta's population growth has continued to be higher than the national average, resulting in increased demand on the province's healthcare system and frontline services. Between 2013 and 2018, Alberta's population grew by 8.2 per cent, while all other provinces grew an average of 4.4 per cent during the same period[1]. In addition, Alberta's population continues to age, with the average age increasing from 37.9 years in 2017 to 41.6 years by 2046[2]. These factors contribute to AHS' challenge of remaining sustainable while providing quality healthcare for Alberta's growing and aging population.



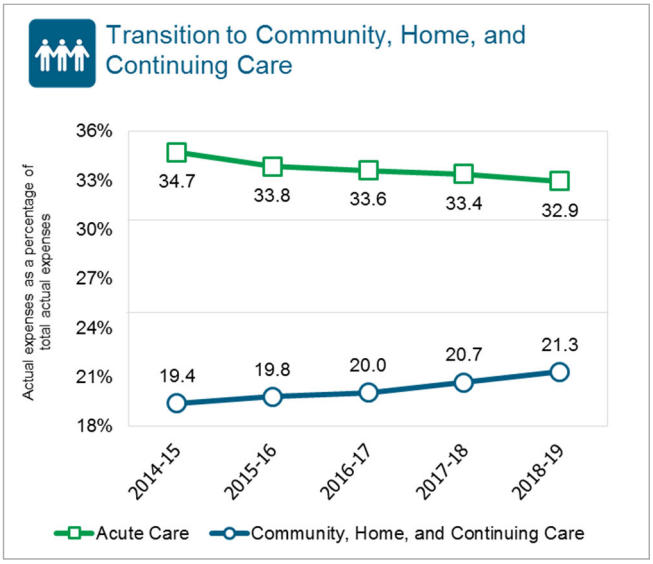
Operational Best Practices (OBP) is a key initiative for improving the financial health and value for money at AHS. The implementation of OBP operates under the principle of adherence to collective agreements, and the commitment to quality and continuous improvement in the healthcare system. Since 2016-17, the first full year of OBP, AHS has cumulatively saved approximately $178 million. However, in some areas an attrition-based strategy has resulted in some delays in the realization of savings for the current year.

Through OBP and other various organization-wide and local initiatives, AHS has been able to slow the rate of spending growth. Expenses have increased by an average of 2.6 per cent per year since 2015-16, while historically, expenses were growing an average of 5.7 per cent per year.

Total expenses grew by 3.7 per cent from the prior year which was relatively consistent with the planned growth of 3.2 per cent in the 2018-19 Health Plan and Business Plan. The increase was mainly due to planned investments in priority initiatives, such as Enhancing Care in the Community and the Continuing Care Capacity Plan, the use of resources to address higher demand across the organization such as those to address wait times for surgery and certain diagnostic exams, and the unanticipated increased costs of liability insurance. An additional three months of the Academic Medicine and Health Services Program (AMHSP) North Sector grant which was transferred to AHS from the University of Alberta part way through the prior year also contributed to the expense growth in 2018-19.

Community, Home, and Continuing Care

Enhancing community and home care options for Albertans continued to be a key priority for AHS in 2018-19. AHS has been working toward providing more appropriate community, home, and continuing care to ease pressures on hospitals so resources can be utilized in areas that will better support healthcare in the long-term for Albertans.



Over the past few years, AHS' acute care expense growth has slowed, increasing by approximately five per cent since 2014-15 while spending related to community, home and continuing care services has increased approximately 22 per cent during the same period.

With a shift towards enhancing care in the community, AHS' community, home, and continuing care expenses increased $210 million from the prior year, and represented 21.3 per cent of total expenses in 2018-19. Although acute care expenses also increased from the prior year, the proportion to total expenses continued to decline, amounting to 32.9 per cent of total expenses, a decrease of 0.5 per cent.

[1] Statistics Canada. (2019, May 10). Table 17-10-0005-01. Retrieved from Population estimates on July 1st, by age and sex: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000501

[2] Alberta Treasury Board. (2018, July 3). Population Projection Highlights. Retrieved from Alberta.ca: https://open.alberta.ca/dataset/90a09f08-c52c-43bd-b48a-fda5187273b9/resource/038f0a3f-1df1-4993-a29c-02a7f35f6ad3/download/2018-2046-alberta-population-projections-highlights.pdf

Workforce

To support the transition from hospital to the community, a corresponding shift of trained healthcare professionals from a hospital setting to community and home care settings is required. AHS continued to use an attrition-based approach to achieve this objective.

AHS reports calculated Full Time Equivalents (FTE) on Schedule 2 in its consolidated financial statements which are determined by actual hours earned divided by 2,022.75 annual base hours.

Total FTEs amounted to 81,566 compared to the prior year of 79,442 FTE, representing an increase of 2,124 FTE or 2.7 per cent. Clinical FTEs, including medical doctors, regulated nurses, health technical and professional staff, and unregulated health service providers account for the majority of AHS' FTE's. Clinical FTE's, which accounted for 73 per cent of the overall increase, increased 3.1 per cent compared to the prior year. Other staff FTEs, which includes support services such as food services, facilities and maintenance, clerical staff, and secretarial support, increased 1.9 percent. Total management FTEs which includes both clinical and other management, increased 1.6 per cent compared to the prior year.

The FTE increases described above were primarily due to increased worked hours. The increase in worked hours is mainly driven by higher activity related to the planning and implementation of AHS' priority initiatives, such as Enhancing Care in the Community, increasing the number of surgeries and diagnostic exams to address wait times, and Connect Care. Higher overtime also contributed to the increased FTEs.

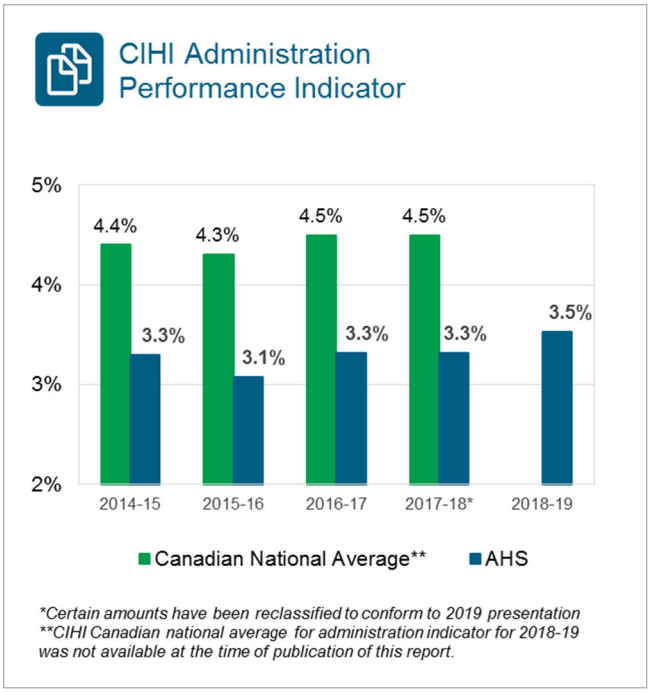
AHS continues to be one of the leanest managed organizations in Canada with managers, including managers of frontline staff, overseeing an average of 31 employees. The average ratio for Canadian public agencies, according to The Conference Board of Canada, was 9 employees per manager in 2017[3].

AHS negotiated a zero per cent increase for unionized employees for 2018-19, however there continues to be increases related to collective agreement step increases. Additionally, a wage freeze for management and non-union employees has been in place since 2014 and continues through to September 2019.

Administration

Administration expense is comprised of human resources, finance, quality assurance, senior leaders, insurance, and other general administration functions such as infection control, public relations, telecommunications, mail services, utilization management, internal audit, legal, and planning and development. Costs that directly support clinical activities are excluded from administration expense.

AHS has continued to improve healthcare system efficiency through local and site-based decision-making. Over the past decade, AHS has reduced the number of senior leadership roles by nearly half, and their compensation has remained in the low to mid-range when compared to other national healthcare systems and the rest of the Alberta public sector. Additionally, the consolidation of many administrative systems, including payroll, contracting, and supply chain management, and IT systems, has led to significant cost savings for the province since the formation of AHS.



CIHI reports administration expense as a financial performance indicator calculated based on administration expense and total expenses[4]. In 2017-18 AHS' indicator was 3.3% which was among the lowest of all the provinces. For 2018-19 AHS' indicator was 3.5 per cent. Since 2014-15, AHS' administration expenses have remained relatively constant averaging 3.3 per cent of total expenses over the period. Higher than budgeted costs of liability insurance increased the administration indicator by 0.3 per cent in 2018-19.

[3] Conference Board of Canada. (2017). Talent Management Benchmarking: Human Resources Trends and Metrics. Retrieved from Ottawa: The Conference Board of Canada.: https://www.conferenceboard.ca/e-library/abstract.aspx?did=8551

[4] Canadian Institute for Health Information. (n.d.). Your Health System. Retrieved from Interactive Map: Administrative Expense (Percentage), 2016–2017: https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en&_ga=2.14406708.221575360.1556214366-662852099.1551116985#/indicator/041/2/C20018/

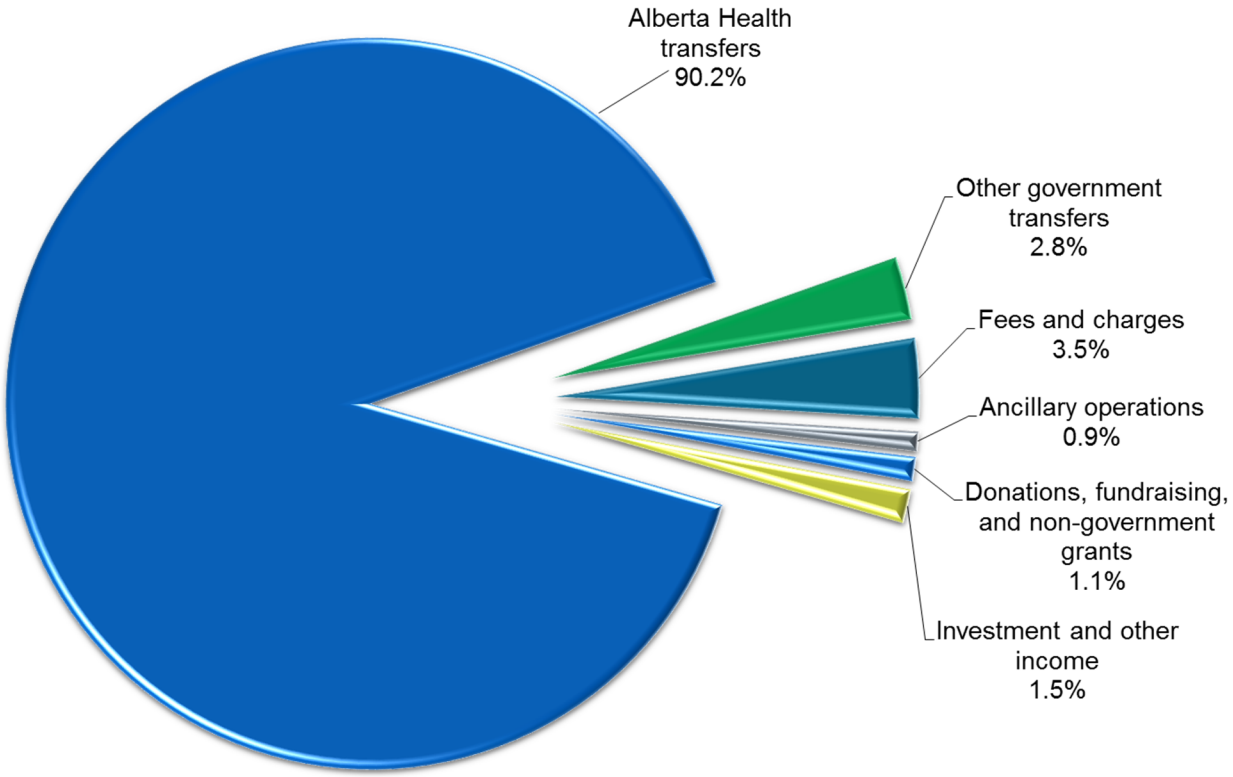
Financial Analysis

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 2018-19 operations are analyzed in comparison to the budget and the prior year in this report. A glossary of financial statement line definitions can be found at the end of this FSD&A. An analysis of AHS' financial position compared to prior year is also discussed in this section.

Certain prior year amounts have been reclassified to conform to 2019 presentation.

Operations – Comparison to the budget and the prior year

Revenues



2018-19 actual revenue sources as a per cent of total 2018-19 actual revenue
A glossary of financial statement line definitions can be found at the end of this FSD&A

The overall distribution of revenues remained consistent with the prior year. Alberta Health transfers accounted for 90.2 per cent of AHS' total revenues (2017-18 – 90.0 per cent). AHS' total revenues amounted to $15,274 million, which was $34 million or 0.2 per cent higher than the budget of $15,240 million.

REVENUES (in millions)					
	2018-19 Budget	2018-19 Actual	Variance $	2017-18 Actual	Change $
Alberta Health transfers	13,831	13,773	(58)	13,363	410
Other government transfers	427	430	3	438	(8)
Fees and charges	488	539	51	519	20
Ancillary operations	136	133	(3)	133	-
Donations, fundraising and non-government contributions	149	167	18	160	7
Investment and other income	209	232	23	243	(11)
Total revenues	**$ 15,240**	**$ 15,274**	**$ 34**	**$ 14,856**	**$ 418**

Significant variances are explained as follows:

Comparison to Budget

Alberta Health transfers were $58 million lower than the budget mainly due to lower restricted grant spending in physician services programs as a result of vacancies, lower than anticipated rates, and lower activity, as well as slower than anticipated expansion of the Academic Medicine and Health Services Program (AMHSP) in the North Sector. The AMHSP grant, which is provided to universities, ensures physicians are compensated for services that are non-billable under the fee-for-service model by providing clinical and non-clinical funding, including support for research, education, and administrative functions. Lower spending on specialized high cost drugs resulting from reduced drug prices, lower activity, and volume rebates further contributed to the variance. The overall variance was partially offset by unbudgeted one-time base operating funding for contracted health services providers.

Fees and charges were $51 million higher than the budget mainly due to a higher than budgeted number of patients, including those who reside outside Alberta, requiring healthcare services that are billable to other Canadian jurisdictions, non-residents of Canada, and other responsible parties.

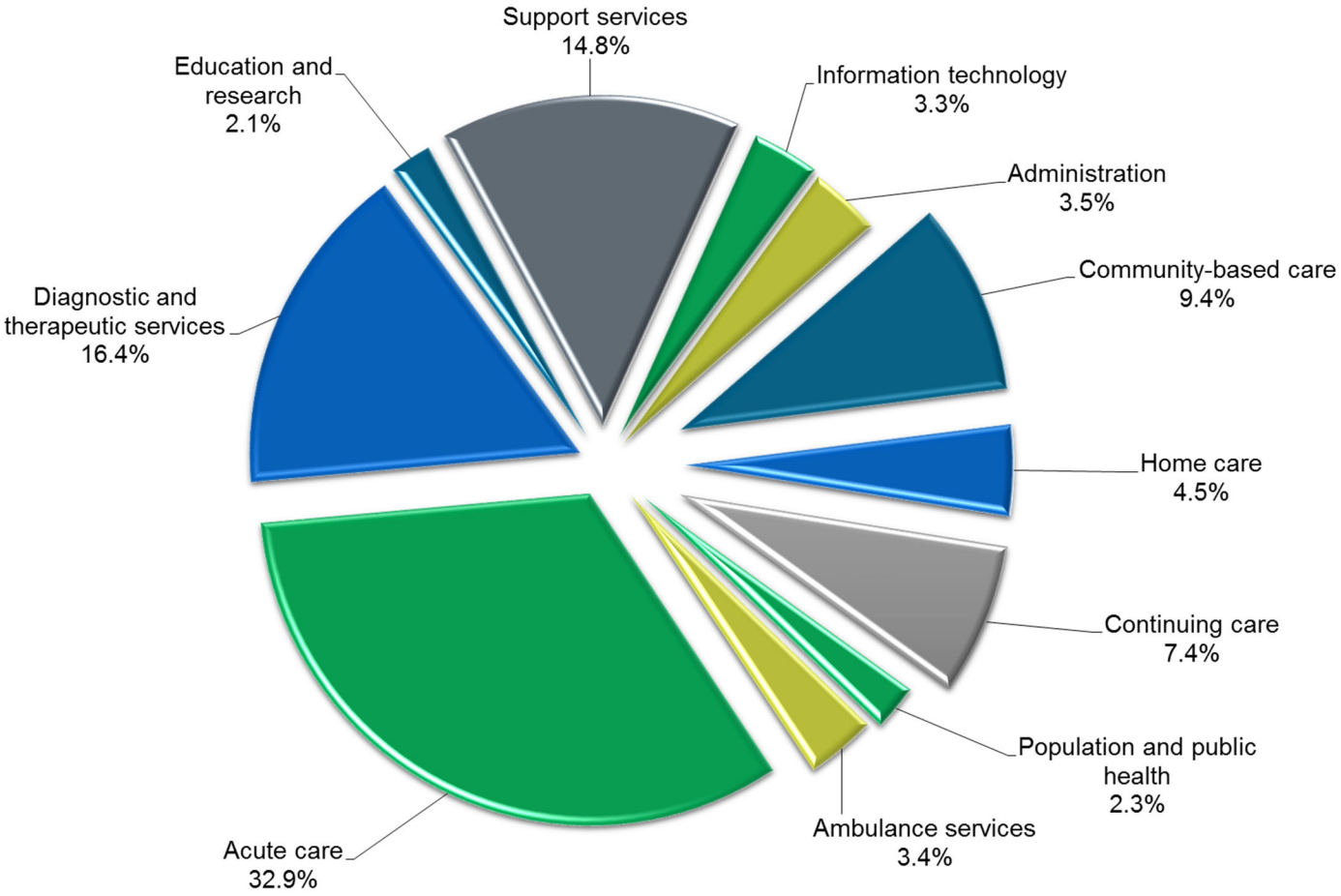
Investment and other income was $23 million higher than the budget mainly due to higher than anticipated recoveries from external entities, such as contracted health service providers and the Worker's Compensation Board (WCB), and unbudgeted outpatient cancer drugs received at no cost from suppliers through compassionate drug access programs.

Comparison to Prior Year

Alberta Health transfers were $410 million higher than the prior year mainly due to a base operating increase of $338 million. Newly approved cancer drugs, new and increased grant funding related to a full year of the AMHSP North Sector grant and various addiction and mental health grants to address the opioid crisis further contributed to the increase.

Fees and charges were $20 million higher than the prior year mainly due to an increased number of patients, including those who reside outside Alberta, requiring healthcare services that are billable to other Canadian jurisdictions, non-residents of Canada, and other responsible parties.

Expenses by Function



2018-19 actual expenses by function as a per cent of total 2018-19 actual expenses
A glossary of financial statement line definitions can be found at the end of this FSD&A

Expenses by function are segmented to represent AHS' major distinguishable activities and services. The overall distribution of expenses by function changed slightly from the prior year, consistent with AHS' efforts, with community-based, home, and continuing care making up 21.3 per cent of total expenses (2017-18 – 20.7 per cent). Acute care continued to be the largest function, making up 32.9 per cent of total expenses (2017-18 – 33.4 per cent). Operating expenses amounted to $15,313 million, which was $73 million or 0.5 per cent higher than the budget of $15,240 million.

EXPENSES BY FUNCTION (in millions)					
	2018-19 Budget	2018-19 Actual	Variance $	2017-18 Actual	Change $
Community-based care	1,514	1,439	75	1,370	69
Home care	692	688	4	610	78
Continuing care	1,118	1,136	(18)	1,073	63
Population and public health	352	348	4	344	4
Ambulance services	527	528	(1)	503	25
Acute care	5,054	5,045	9	4,929	116
Diagnostic and therapeutic services	2,450	2,505	(55)	2,413	92
Education and research	317	316	1	299	17
Support services	2,210	2,260	(50)	2,223	37
Information technology	497	508	(11)	511	(3)
Administration	509	540	(31)	490	50
Total expenses by function	**$ 15,240**	**$ 15,313**	**$ (73)**	**$ 14,765**	**$ 548**

Significant variances are explained as follows:

Comparison to Budget

Community-based care was $75 million lower than the budget mainly due to vacancies and the timing of implementation of various initiatives, including the Continuing Care Capacity Plan. Further contributing to the variance was a shift in actual expenses to continuing care related to new bed openings during the year, while the related budget remained in community-based care.

Diagnostic and therapeutic services were $55 million higher than the budget mainly due to achieved savings during the year being less than budgeted, in part due to third party contracts that were in arbitration and certain delayed OBP initiatives. Increased activity related to certain laboratory and diagnostic imaging tests, including unbudgeted genetic resource centre testing, increased colorectal cancer screening, and additional spending for CT and MRI scans above what was originally planned in order to address wait times further contributed to the variance. The overall variance was partially offset by vacancies.

Support services were $50 million higher than the budget mainly due to the reclassification of bad debt expense from acute care to support services to align with CIHI's Management Information System (MIS) standards. Increased activity, including increased contracted security services, and costs related to the carbon levy also contributed to the variance. The overall variance is partially offset by vacancies and the timing of capital management projects and general maintenance.

Administration was $31 million higher than the budget mainly due to higher than budgeted costs of liability insurance, partially offset by vacancies.

Comparison to Prior Year

Community-based care was $69 million higher than prior year mainly due to increased spending and activity in part related to various initiatives, including the opening of new beds as part of the Continuing Care Capacity Plan and new hires related to Enhancing Care in the Community, both of which aim to help Albertans get the right care in the right place. Clinical contract inflation also contributed to the increase.

Home care was $78 million higher than prior year mainly due increased spending related to Enhancing Care in the Community. As of March 31, 2019, approximately 90 per cent of the positions related to this initiative had been filled. Increased home care hours and contract inflation related to self-managed care clients, also contributed to the increase.

Continuing care was $63 million higher than the prior year mainly due increased spending related to the opening of new beds under the Continuing Care Capacity Plan.

Ambulance services were $25 million higher than the prior year mainly due increased spending related to various initiatives, including the Community Paramedic Program. There were a total of 560,434 EMS events in 2018-19, a 2.9 per cent increase from the prior year, which also contributed to the higher costs.

Acute care was $116 million higher than the prior year mainly due to increased utilization of newly approved cancer drugs, a full year of AMHSP expenses compared to a partial year in 2017-18, and increased activity including a higher number of surgeries performed. Increased compensation costs, mainly due to collective agreement step increases and overtime also contributed to the increase.

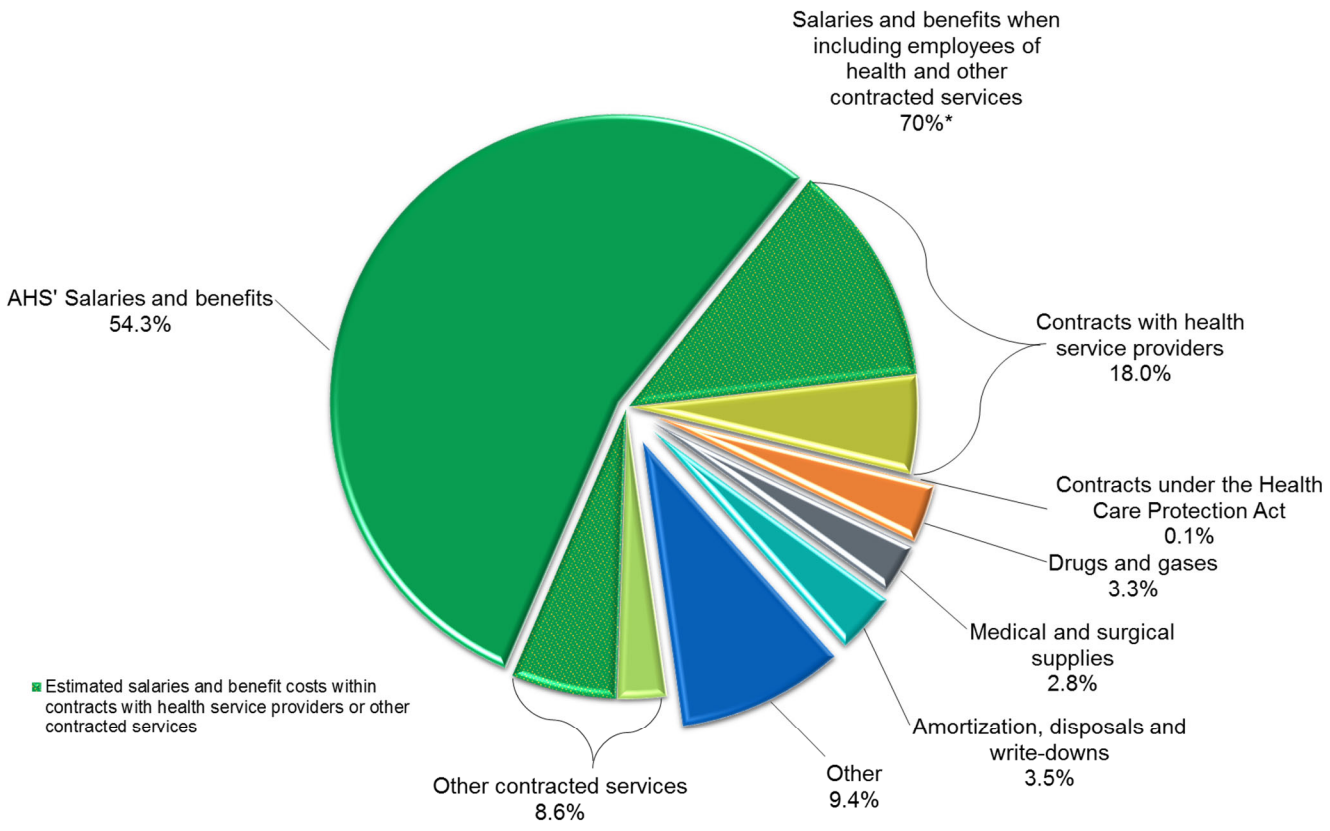
Comparison to Prior Year (continued)

Diagnostic and therapeutic services were $92 million higher than the prior year mainly due to intentionally increased activity related to certain laboratory and diagnostic imaging tests, including colorectal cancer screening, 441,938 CT and 204,744 MRI scans, which increased by 6.3 and 5.0 per cent respectively from the prior year, as well as increased drug utilization and surgical activity.

Support services were $37 million higher than the prior year mainly due to increased contracted security services, leasing costs to support the demand for emergency medical services and IT services, as well as increased spending related to the support of various initiatives, including Enhancing Care in the Community.

Administration was $50 million higher than the prior year mainly as a result of increased costs of liability insurance, a decrease in vacancies from the prior year, and the impact of the overall increase in activity throughout the organization.

Expenses by Object



**This figure is approximate and represents management's best estimate*

2018-19 actual expenses by object as a per cent of total 2018-19 actual expenses
A glossary of financial statement line definitions can be found at the end of this FSD&A

The overall distribution of expenses by object remained consistent with prior years with salaries and benefits making up 54.3 per cent of total expenses (2017-18 - 54.7 per cent). When including the employees of AHS' contracted health service providers and other contracted services, the largest of which is Covenant Health, the percentage increases to approximately 70 per cent.

EXPENSES BY OBJECT (in millions)					
	2018-19 Budget	2018-19 Actual	Variance $	2017-18 Actual	Change $
Salaries and benefits	8,239	8,322	(83)	8,082	240
Contracts with health service providers	2,762	2,750	12	2,621	129
Contracts under the Health Care Protection Act	18	17	1	18	(1)
Drugs and gases	496	506	(10)	466	40
Medical and surgical supplies	427	431	(4)	401	30
Other contracted services	1,381	1,323	58	1,253	70
Other expenses	1,384	1,435	(51)	1,385	50
Amortization and disposals of tangible capital assets	533	529	4	539	(10)
Total expenses by object	**$ 15,240**	**$ 15,313**	**$ (73)**	**$ 14,765**	**$ 548**

Significant variances are explained as follows:

Comparison to Budget

Salaries and benefits were $83 million higher than the budget mainly due to overall higher than budgeted activity combined with achieved savings in the year being less than was budgeted, primarily within ambulatory services, home care, diagnostic and therapeutic services, and acute care, which resulted in staffing levels, overtime, and relief costs that were higher than budgeted. This overall variance is partially offset by vacancies throughout the organization and delayed hiring as a result of the timing of implementation of various initiatives, including Enhancing Care in the Community and the Continuing Care Capacity Plan.

Other contracted services were $58 million lower than the budget mainly due to lower than planned spending for new initiatives and various restricted grants, including the AMHSP, partially due to vacancies and delayed expansionary programs. Physician vacancies and cost mitigation also contributed to the variance. Achieved savings being less than budgeted, in part related to third party contracts that were in arbitration, non-compensation inflation, and increased activity, including increased contracted security services, partially offset the variance.

Other expenses were $51 million higher than the budget mainly due to higher than budgeted costs of liability insurance. Increased activity, mainly related to computer replacements and third party technology services costs, and the impact of the carbon levy further contributed to the variance. Achieved mitigation strategies across the organization partially offset the overall variance.

Comparison to Prior Year

Salaries and benefits were $240 million higher than the prior year mainly driven by hiring for major priority initiatives such as Enhancing Care in the Community, Continuing Care Capacity Plan, Connect Care, addressing surgery and diagnostic exam wait time initiatives, and opioid dependency treatment programs. Further contributing to the increase was more worked hours and overtime by existing staff, which was primarily driven by higher activity combined with the high number of vacancies.

Contracts with health service providers were $129 million higher than the prior year mainly due to new beds and facilities related to the Continuing Care Capacity Plan, higher home care vendor hours, and contract inflation.

Drugs and gases were $40 million higher than the prior year mainly due to increased utilization of newly approved cancer drugs.

Medical and surgical supplies were $30 million higher than the prior year mainly due to increased operating room activity which was mainly related to new initiatives to increase the number of surgeries.

Other contracted services were $70 million higher than the prior year mainly due to increased spending on various priority initiatives, a full year of AMHSP expenses compared to a partial year in 2017-18, and increasing the number of surgeries and the number of MRI and CT exams performed in order to address wait times. Contract inflation related to self-managed care contracts also contributed to the increase.

Other expenses were $50 million higher than the prior year mainly due to increased costs of liability insurance, third party technology services costs, and expenses related to the development of Connect Care.

Financial Position - Comparison to Prior Year

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

FINANCIAL POSITION (in millions)			
	Actual 2018-19	Actual 2017-18	Increase (Decrease) $
Financial assets	2,785	2,810	(25)
Liabilities	3,202	3,030	172
Net debt	**$ (417)**	**$ (220)**	**$ 197**
Non-financial assets	8,655	8,294	361
Expended deferred capital revenue	6,925	6,736	189
Net assets	**$ 1,313**	**$ 1,338**	**$ (25)**

Net assets represents the extent to which total assets exceed total liabilities, including expended deferred capital revenue. AHS ended the year with an overall net asset position of $1,313 million reflecting a 1.9 per cent decrease over the prior year. AHS' net assets are mainly comprised of its investment in capital assets, internally restricted surplus for future purposes, and unrestricted surplus.

AHS saw its net debt ratio of liabilities to financial assets increase slightly to 1.15 (2017-18 – 1.08). The increase is mainly due to an increase in liabilities related to capital asset acquisitions combined with the decrease in AHS' portfolio investments as a result of transfers to cover cash requirements during the year based on the timing of grant funding received. The net asset ratio of total assets to total liabilities remained positive and stable at 1.13 (2017-18 – 1.14).

Financial Assets

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

Investments

In accordance with AHS' Investment Policy and Investment Bylaw, AHS' investment portfolio employs a conservative strategy and is highly liquid in nature, enabling AHS to respond to cash flow requirements quickly and efficiently. Focusing on prudent stewardship of funds, AHS monitors its bank balances closely and transfers cash to or from its investment portfolio to ensure cash balances earn maximum returns until they need to be utilized.

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

Investments decreased during the year by $38 million, or 1.6 per cent to $2,279 million, primarily due to the timing of cash inflows and outflows at year-end. These financial assets are used to fund AHS' liabilities, both short and medium term, including accounts payable, accrued liabilities, employee future benefits, and debt.

AHS' investment portfolio generated a return of 2.8 per cent during 2018-19 (2017-18 - 2.7 per cent), benefitting from stronger returns from its equity investments, offset by lower yielding fixed income investments.

Accounts receivable

AHS' accounts receivable include amounts related to patient receivables, such as uninsured services, services provided to non-residents, and EMS services, as well as the Workers' Compensation Board 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 4.2 per cent to $445 million during the year, mainly due to an increase in receivables for capital grants from Alberta Infrastructure, partially offset by Alberta Health operating grant funding received during the year that was receivable in the prior year.

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, interest amounts owing, and other obligations, including obligations under capital leases.

Accounts payable and accrued liabilities increased by $93 million to $1,506 million mainly due to construction expenditures at the Calgary Cancer Centre parkade and an increase in the provision for unpaid claims, which is based on actuarial estimates.

Debt

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

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

During the year, AHS entered into an agreement with ACFA to borrow $157 million to fund the construction of the Calgary Cancer Centre parkade. AHS will receive the loan proceeds in December 2019 and will begin making principal repayments in June 2020. As a result, this amount was not included in the debt balance as at March 31, 2019. The total repayments during the year on all other outstanding debt amounted to $22 million.

AHS also has access to a $220 million revolving demand loan facility with a Canadian chartered bank, which may be used for operating purposes. This facility was not utilized during the year. AHS also has access to a $33 million revolving demand letter of credit facility of which $4 million in letters of credit were outstanding at March 31, 2019 (2017-18 - $5 million).

Remaining liabilities saw minimal increases and are comprised of employee future benefits, which includes vacation benefits payable and accumulated non-vested sick leave, and unexpended deferred operating revenue and unexpended deferred capital revenue, which are comprised of unspent operating and capital funds that have been received by AHS for which spending restrictions, imposed by a funder or donor, exist.

Expended deferred capital revenue

Expended deferred capital revenue represents external resources spent on the acquisition of capital assets, stipulated for use in the provision of services over their useful lives. These resources are recognized as revenue over the useful lives of the assets acquired. The assets include hospitals and other related facilities, equipment, and IT systems. Funding from the Government of Alberta, mainly Alberta Infrastructure, represents $6,392 million, or 92.3 per cent of the $6,925 million total balance.

Non-Financial Assets

Non-financial assets are assets that are not intended to be monetized for settling AHS' liabilities. While capital assets is the most significant non-financial asset, it also includes inventories and prepaid expenses which had minimal increases from the prior year.

CAPITAL ASSETS (in millions)			
	Actual 2018-19	Actual 2017-18	Increase (Decrease)
Cost	16,234	15,509	725
Accumulated amortization	7,853	7,478	375
Net book value	**$ 8,381**	**$ 8,031**	**$ 350**

Capital assets

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

In the current year, capital assets increased by $350 million. This increase is mainly within work in progress (WIP), which represents assets acquired but are not yet ready for use. Several capital projects totaling $246 million were brought into service during 2018-19, including facility renovations and the installation of building service equipment for the Foothills Medical Centre, the University of Alberta Hospital, and the Royal Alexandria Hospital.

The WIP of $1,626 million at the end of the year includes infrastructure and IT capital expenditures that support the following initiatives:

- Grande Prairie Regional Hospital Development (including the parkade)
- Connect Care (design and build)
- Calgary Cancer Centre (including the parkade)
- Foothills Medical Centre parkade

While certain capital assets are internally funded from net assets, AHS receives significant external funding for capital expenditures, primarily from Alberta Government ministries. In 2018-19, capital asset additions amounted to $879 million, of which 72 per cent were externally funded (2017-18 – 75 per cent).

Net Assets

AHS is in an overall net asset position – a measure that represents the net economic position of the organization from all years of operations.

NET ASSETS (in millions)			
	Actual 2018-19	Actual 2017-18	Increase (Decrease)
Unrestricted Surplus	46	188	(142)
Invested in capital assets	940	817	123
Internally restricted surplus for future purposes	217	237	(20)
Endowments	75	75	-
Accumulated Surplus	**$ 1,278**	**$ 1,317**	**$ (39)**
Accumulated Remeasurement Gains	35	21	14
Total Net Assets	**$ 1,313**	**$ 1,338**	**$ (25)**

The unrestricted surplus of $46 million at March 31, 2019 does not have any restrictions attached to its future use and may be used at AHS' discretion for operating or capital purposes. The decrease in the current year relates to the purchase of capital assets with internal funds and the current annual operating deficit.

The accumulated surplus invested in capital assets at March 31, 2019 of $940 million represents the net book value of capital assets that have previously been purchased with AHS' unrestricted surplus. AHS has no plans to monetize these assets to cover future operations.

The internally restricted surplus for future purposes at March 31, 2019 of $217 million has been approved by the Board for various requirements.

The endowments of $75 million are comprised of financial resources received by AHS 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.

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 financial reports are available at **www.albertahealthservices.ca** under "Publications and Transparency".

AHS performance measures correspond with the AHS 2017-20 Health Plan 12 Objectives built on the four areas of focus in AHS' Quadruple Aim (patient experience, patient and population outcomes, our people, and financial health and value for money). AHS believes when we balance all four areas, we are doing the best we can for patients and for the health system.

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

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

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

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

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

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

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

Forward-Looking Statements Disclosure

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

Outlook

AHS must continue to enhance and improve health services and operate within the budget approved by AHS' Board of Directors and the Minister of Health.

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

Risks

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

The following are risks to the outlook:

Population and demand

The population of Alberta continues to increase and is aging and living longer. On average, AHS is providing more health care per person compared to previous generations. These factors are driving increased demand and costs in many areas of the health care system. AHS will work with Alberta Health to increase Albertan's understanding of the health system and to reallocate funding to support the transformation towards a more sustainable system.

Financial

Healthcare costs have been rising more rapidly than general inflation and our costs per unit of service are also increasing. Including physician fees, purchased services and compensation related to clinical contracted providers, AHS' salaries and benefits expenses represent the largest cost for AHS. AHS will continue to mitigate cost increases by reviewing contracts and bulk purchasing opportunities and will work with the Government of Alberta to negotiate agreements for employees and physicians. AHS will also continue to focus on improving quality, which saves the health system money through fewer complications, fewer hospital readmissions, shorter hospital lengths of stay, and more seniors capable of remaining safe and independent in their homes.

Workforce

To support a transition from "hospital to community" there is a need for trained health care workers to also shift from a hospital setting to community and home care settings. AHS respects staff preferences and is committed to using an attrition-based approach to allocate staff where they are needed most. It will take time before savings will be realized and the growth of expenses decreases.

Multiple priorities

AHS must continue to work with Alberta Health to find the right balance of programs and services to ensure the needs of Albertans are met while working efficiently. Connect Care continues to be a priority for AHS and will be implemented in waves across the organization over the next five years. AHS staff and health care professionals will collaborate to ensure a smooth transition to the new provincial clinical information system while also ensuring day-to-day operations and other priorities are also appropriately supported. To do this successfully, AHS must continue to ensure that resources are used efficiently and effectively without compromising on quality care for Albertans.

Engagement

Enhancing care and managing cost growth requires engagement from multiple stakeholders, including Albertans, AHS' employees, physicians, other health care providers, and the Government of Alberta. AHS will work with these key stakeholders to support our priorities, while managing cost growth and maximizing the value of each dollar we spend.

Glossary of Financial Statement Line Definitions

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

Community-based care refers to the services provided to those who need care and support in their living environments including supportive living, palliative, and hospice care, but excludes community-based dialysis, oncology, and surgical services. This category also consists of community programs including Primary Care Networks, Family Care Clinics, urgent care centres, and community mental health.

Home care is comprised of home nursing and support.

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

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

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.

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

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.

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

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.

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. This includes clinical and corporate enterprise systems and infrastructure, as well as support of provincial systems.

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. Activities and costs directly supporting clinical activities are excluded.

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

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

Other expenses relate to those expenses not classified elsewhere.

Amortization, disposals and write-downs 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.

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2019

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the year ended March 31, 2019 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]

Deborah Rhodes, CPA, CA
Vice President Corporate Services and Chief Financial Officer
Alberta Health Services

May 30, 2019

Auditor General OF ALBERTA

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, 2019, 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, 2019, 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

May 30, 2019
Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS YEAR ENDED MARCH 31	2019		2018
	Budget (Note 3)	Actual	Actual
Revenues:			
Alberta Health transfers			
Base operating	$ 12,486,000	$ 12,485,595	$ 12,147,985
One-time base operating	-	29,558	14,683
Other operating	1,283,000	1,192,862	1,134,483
Recognition of expended deferred capital revenue	62,000	65,104	66,085
Other government transfers (Note 4)	427,000	429,665	438,127
Fees and charges	488,000	538,721	518,930
Ancillary operations	136,000	133,513	132,661
Donations, fundraising, and non-government contributions (Note 5)	149,000	167,192	160,076
Investment and other income (Note 6)	209,000	232,494	242,813
TOTAL REVENUE	**15,240,000**	**15,274,704**	**14,855,843**
Expenses:			
Community-based care	1,514,000	1,439,434	1,369,846
Home care	692,000	688,295	609,579
Continuing care	1,118,000	1,136,343	1,072,800
Population and public health	352,000	347,726	344,283
Ambulance services	527,000	528,045	503,274
Acute care	5,054,000	5,044,824	4,928,854
Diagnostic and therapeutic services	2,450,000	2,505,411	2,413,056
Education and research	317,000	316,285	299,179
Support services (Note 7)	2,210,000	2,259,472	2,222,553
Information technology	497,000	507,605	510,835
Administration (Note 8)	509,000	539,895	490,188
TOTAL EXPENSES (Schedules 1 and 3)	**15,240,000**	**15,313,335**	**14,764,447**
ANNUAL OPERATING (DEFICIT) SURPLUS	**-**	**(38,631)**	**91,396**
Accumulated surplus, beginning of year	1,317,000	1,317,055	1,225,659
Accumulated surplus, end of year (Note 19)	**$ 1,317,000**	**$ 1,278,424**	**$ 1,317,055**

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

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31	2019 Actual	2018 Actual
Financial Assets:		
Cash	$ 60,610	$ 66,253
Investments (Note 10)	2,279,068	2,316,752
Accounts receivable (Note 11)	445,208	426,558
	2,784,886	2,809,563
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,505,873	1,412,913
Employee future benefits (Note 13)	688,496	673,136
Unexpended deferred operating revenue (Note 14)	453,219	420,245
Unexpended deferred capital revenue (Note 15)	206,880	153,751
Debt (Note 17)	347,642	369,775
	3,202,110	3,029,820
NET DEBT	**(417,224)**	**(220,257)**
Non-Financial Assets:		
Tangible capital assets (Note 18)	8,381,004	8,031,307
Inventories for consumption	106,509	96,573
Prepaid expenses and other non-financial assets	167,722	165,721
	8,655,235	8,293,601
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	8,238,011	8,073,344
Expended deferred capital revenue (Note 16)	6,925,118	6,735,454
NET ASSETS	**1,312,893**	**1,337,890**
Net Assets is comprised of:		
Accumulated surplus (Note 19)	1,278,424	1,317,055
Accumulated remeasurement gains	34,469	20,835
	$ 1,312,893	**$ 1,337,890**

Contractual Obligations and Contingent Liabilities (Note 20)

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

Approved by the Board of Directors:

[Original Signed By]

Linda Hughes
Board Chair

[Original Signed By]

David Carpenter, FCPA, FCA
Audit & Risk Committee Chair

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT YEAR ENDED MARCH 31			
	2019		2018
	Budget (Note 3)	Actual	Actual
Annual operating (deficit) surplus	$ -	$ (38,631)	$ 91,396
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets (Note 18)	(1,406,000)	(879,325)	(950,869)
Amortization and disposals of tangible capital assets (Note 18)	533,000	529,628	538,639
Effect of other changes:			
Net increase in expended deferred capital revenue	709,000	189,664	185,684
Net decrease (increase) in inventories for consumption	7,000	(9,936)	(4,691)
Net decrease (increase) in prepaid expenses and other non-financial assets	7,000	(2,001)	(37,663)
Net remeasurement (losses) gains for the year	(1,000)	13,634	(8,031)
Increase in net debt for the year	**(151,000)**	**(196,967)**	**(185,535)**
Net debt, beginning of year	(220,000)	(220,257)	(34,722)
Net debt, end of year	**$ (371,000)**	**$ (417,224)**	**$ (220,257)**

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

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31			
	2019		2018
	Budget (Note 3)	Actual	Actual
Unrestricted unrealized gains (losses) attributable to:			
Derivatives	$ -	$ 253	$ (40)
Portfolio Investments	(16,000)	17,751	8,730
Amounts reclassified to the Consolidated Statement of Operations:			
Portfolio Investments	15,000	(4,370)	(16,721)
Net remeasurement gains (losses) for the year	**(1,000)**	**13,634**	**(8,031)**
Accumulated remeasurement gains, beginning of year	21,000	20,835	28,866
Accumulated remeasurement gains, end of year (Note 10)	**$ 20,000**	**$ 34,469**	**$ 20,835**

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

CONSOLIDATED STATEMENT OF CASH FLOWS YEAR ENDED MARCH 31	2019 Actual	2018 Actual
Operating transactions:		
Annual operating (deficit) surplus	$ (38,631)	$ 91,396
Non-cash items:		
Amortization and disposals of tangible capital assets	529,628	538,639
Recognition of expended deferred capital revenue	(383,405)	(384,337)
Revenue recognized for acquisition of land	-	(6,286)
Decrease (increase) in:		
Accounts receivable related to operating transactions	48,303	2,116
Inventories for consumption	(9,936)	(4,691)
Prepaid expenses and other non-financial assets	(2,001)	(37,663)
Increase (decrease) in:		
Accounts payable and accrued liabilities related to operating transactions	76,173	61,996
Employee future benefits	15,360	20,099
Unexpended deferred operating revenue	(31,957)	(37,555)
Cash provided by operating transactions	203,534	243,714
Capital transactions:		
Acquisition of tangible capital assets	(593,957)	(612,961)
Increase in accounts payable and accrued liabilities related to capital transactions	19,732	142,554
Cash applied to capital transactions	(574,225)	(470,407)
Investing transactions:		
Purchase of investments	(3,161,266)	(3,168,353)
Proceeds on disposals of investments	3,220,278	3,109,935
Cash provided by (applied to) investing transactions	59,012	(58,418)
Financing transactions:		
Restricted capital contributions received	331,364	264,565
Unexpended deferred capital revenue returned	(250)	(7,381)
Proceeds from debt	-	67,300
Principal payments on debt	(22,133)	(17,612)
Payments on obligations under capital leases	(2,349)	(2,207)
Payment on life lease deposits	(596)	596
Cash provided by financing transactions	306,036	305,261
(Decrease) increase in cash	**(5,643)**	**20,150**
Cash, beginning of year	66,253	46,103
Cash, end of year	**$ 60,610**	**$ 66,253**

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS FOR THE YEAR ENDED MARCH 31, 2019

Note 1 Authority, Purpose and Operations

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

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

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

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

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

Under the *Income Tax Act (Canada)*, AHS is a registered charity.

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

- Foundations:

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

- Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP)
- Queen Elizabeth II Hospital Child Care Centre

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

(ii) Government Partnerships

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

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

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

(iii) Trusts under Administration

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

(iv) Other

AHS is responsible for the delivery and operation of the public health system in Alberta (Note 1), and contracts with various voluntary and private health service providers to provide health services throughout the province. 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 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 statement of operations.

(b) Revenue Recognition

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

(i) Government Transfers

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

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

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

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

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

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

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

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

(iii) Transfers and Donations related to Land

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

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

Fees and charges, ancillary operations, and other income are recognized in the period that goods are delivered or services are provided. 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 investments are sold. When realized, these gains or losses are recognized in the Consolidated Statement of Operations. Investment income and unrealized gains and losses from restricted transfers or donations are allocated to their respective balances according to the provisions within the individual 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

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
Cash and 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.

PSAS requires investments in equity instruments quoted in an active market to be recorded under the fair value category and AHS may choose to record other financial assets under the fair value category if there is an investment strategy to evaluate the performance of a group of these financial assets on a fair value basis. AHS has elected to record its money market securities, fixed income securities, and certain other equity 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 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 investments are expensed as incurred. Investment management fees are expensed as incurred. The purchase and sale of investments are accounted for using trade date accounting.

(e) Cash

Cash is comprised of cash on hand. Cash on hand is held for the purpose of meeting short-term commitments rather than for investment purposes.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(f) Inventories For Consumption

Inventories for consumption or distribution at no charge are valued at lower of cost (defined as moving average cost) and replacement cost.

(g) Tangible Capital Assets

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

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

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

	Useful Life
Facilities and improvements	10-40 years
Equipment	3-20 years
Information systems	3-10 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 use.

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

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

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(h) Employee Future Benefits

(i) Registered Benefit Pension Plans

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

(ii) Other Defined Contribution Pension Plans

AHS sponsors Group Registered Retirement Savings Plans (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.

(iii) Supplemental Retirement Plan for Designated Employees (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.

The obligations and related costs of SERP benefits are determined annually through an actuarial valuation as at March 31 using the projected benefit method pro-rated on service. AHS uses a discount rate based on plan asset earnings to calculate the accrued benefit obligation.

The net SERP retirement benefit cost reported in these consolidated financial statements is comprised of the retirement benefits expense and the retirement benefits interest expense. Costs shown reflect the total estimated cost to provide annual pension income over an actuarially determined post-employment period. The key components of retirement benefits expense include the cost of any plan amendments including related net actuarial gains or losses incurred in the period, gains and losses from any plan settlements or curtailments incurred in the period, and amortization of actuarial gains and losses. Retirement benefit costs are not cash payments in the period but are the period expense for rights to future compensation. The retirement benefits interest expense is net of the interest cost on the accrued benefit obligation and the expected return on plan assets.

AHS amortizes actuarial gains and losses over the average remaining service life of the related employee group.

Prior period service costs arising from plan amendments are recognized in the period of the plan amendment. When an employee's accrued benefit obligation is fully discharged, all unrecognized amounts associated with that employee are fully recognized in the net retirement benefit cost in the following year.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(iv) 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.

(v) Sick Leave Liability

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

AHS accrues its liabilities for accumulating non-vesting sick leave benefits but does not record a liability for sick leave benefits that do not accumulate beyond the current reporting period as these are renewed annually.

The accumulating non-vesting sick leave liability is actuarially 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 rates, and mortality. The liability associated with these benefits is calculated as the present value of expected future payments pro-rated for service.

Any resulting net actuarial gain (loss) is deferred and amortized on a straight-line basis over the expected average remaining service life of the related employee groups.

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(k) Internally Restricted Surplus for Future Purposes

Certain amounts, as approved by the AHS Board, are set aside in accumulated surplus for use by AHS for future operating and capital purposes, to meet legislative insurance equity requirements and to recognize certain donor commitments by AHS' controlled foundations. Transfers to, or from, internally restricted surplus for future purposes are recorded to the respective surplus account when approved.

(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. The amount recorded for amortization of tangible capital assets is based on the estimated useful life of the related tangible capital 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 employee future benefits are based on estimated future cash flows. The provision for unpaid claims, allowance for doubtful accounts and accrued liabilities are subject to significant management estimates and assumptions. The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals; historical precedent and trends; prevailing legal, economic, social, and regulatory trends; and expectation as to future developments. The process of determining the provision necessarily involves risks that the actual results will deviate perhaps materially from the best estimates made. 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, which may be material, could require adjustment in subsequent reporting periods.

(m) Changes in Accounting Policy

AHS has prospectively adopted the following accounting standard as of April 1, 2018:

PS 3430 – Restructuring Transactions

PS 3430 provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related programs or operating responsibilities. The adoption of this standard did not have any impact on AHS' consolidated financial statements.

(n) Future Accounting Changes

The following accounting standards are applicable in future years:

- **PS 3280 – Asset Retirement Obligations (effective April 1, 2021)**
  PS 3280 provides guidance on how to account for and report a liability for retirement of a tangible capital asset.

- **PS 3400 – Revenue (effective April 1, 2022)**
  PS 3400 provides guidance on how to account for and report revenue.

AHS is currently assessing what the impact of these new standards will have on future consolidated financial statements.

Note 3 Budget

The AHS Health Plan and Business Plan, which included the 2018-19 annual budget, was approved by the AHS Board on May 31, 2018 and by the Minister of Health on October 3, 2018.

Note 4 Other Government Transfers

	Budget	2019	2018
Unrestricted operating	$ 31,000	$ 32,790	$ 38,571
Restricted operating (Note 14)	115,000	114,269	112,460
Recognition of expended deferred capital revenue (Note 16)	281,000	282,606	287,096
	$ 427,000	**$ 429,665**	**$ 438,127**

Other government transfers include $420,622 (2018 – $429,855) transferred from the GOA, $9,043 (2018 – $8,272) from government entities outside the GOA, and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

Note 5 Donations, Fundraising, and Non-Government Contributions

	Budget	2019	2018
Unrestricted operating	$ 3,000	$ 4,073	$ 2,281
Restricted operating (Note 14)	119,000	126,961	126,311
Recognition of expended deferred capital revenue (Note 16)	27,000	35,695	31,156
Endowment contributions and reinvested income	-	463	328
	$ 149,000	**$ 167,192**	**$ 160,076**

Note 6 Investment and Other Income

	Budget	2019	2018
Investment income	$ 68,000	$ 68,521	$ 69,215
Other income:			
GOA (Note 21)	31,000	30,847	32,004
AH	20,000	12,698	16,361
Other	90,000	120,428	125,233
	$ 209,000	**$ 232,494**	**$ 242,813**

Note 7 Support Services

	Budget	2019	2018
Facilities operations	$ 899,000	$ 893,598	$ 872,817
Patient: health records, food services, and transportation	426,000	424,288	408,825
Materials management	182,000	174,916	176,438
Housekeeping, laundry, and linen	218,000	217,296	211,762
Support services expense of full-spectrum contracted health service providers	152,000	154,714	151,616
Ancillary operations	113,000	103,122	110,046
Fundraising expenses and grants awarded	54,000	45,689	46,279
Other	166,000	245,849	244,770
	$ 2,210,000	**$ 2,259,472**	**$ 2,222,553**

Note 8 Administration

	Budget	2019	2018
General administration	$ 265,000	$ 286,312	$ 235,338
Human resources	97,000	116,116	112,776
Finance	80,000	73,075	76,627
Communications	28,000	24,415	24,737
Administration expense of full-spectrum contracted health service providers	39,000	39,977	40,710
	$ 509,000	**$ 539,895**	**$ 490,188**

Note 9 Financial Risk Management

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

(a) Market Risk

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

In order to earn financial returns at an acceptable level of market risk, the consolidated investment portfolio is governed by an investment bylaw 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 2.26% (2018 – 2.85%) 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 deferred revenue and endowments of $38,130 (2018 – $50,819).

(i) Price Risk

Price risk relates to the possibility that equity 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 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 $50,535 or 2.22% of total investments (March 31, 2018 – $53,428 or 2.31%).

(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 investments 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 bonds and mortgage funds are sensitive to changes in the level of interest rates, with longer term interest bearing securities being more sensitive to interest rate changes than shorter term bonds.

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $78,148 (March 31, 2018 – $71,683).

Note 9 Financial Risk Management (continued)

Fixed income securities include bonds and money market securities. The fixed income securities have the following average maturity structure ranging from 2019 and 2067:

	2019	2018
0 – 5 years	77%	80%
6 – 10 years	8%	8%
Over 10 years	15%	12%

	Effective Market Yield			Average Effective Market Yield
Asset Class	< 1 year	1-5 years	> 5 years	
Interest bearing securities	2.44%	2.05%	2.92%	2.47%

(iii) Foreign Currency Risk

Foreign currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates. The fair value of cash and investments denominated in foreign currencies is translated into Canadian dollars on a daily basis using the reporting date exchange rate. Both the realized gain/loss and remeasurement gain/loss comprise actual gains or losses on the underlying investment 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 pooled 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, 2019, investments in non-Canadian equities represented 14.5% (March 31, 2018 – 16.2%) of total portfolio investments.

Foreign exchange fluctuations on cash balances are mitigated by forward contracts and holding minimal foreign currency cash balances. At March 31, 2019, AHS held US dollar forward contracts with ATB Financial to manage currency fluctuations relating to its US dollar accounts payable requirements. As at March 31, 2019, AHS held derivatives in the form of forward contracts for future settlement of $18,000 (2018 – $24,000). The fair value of these forward contracts as at March 31, 2019 was $714 (2018 – $461) and is included in 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, Workers' Compensation Board, 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 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. Short selling is not permitted.

Note 9 Financial Risk Management (continued)

The following table summarizes AHS' investment in debt securities by counterparty credit rating at March 31, 2019. The unrated securities consist of low volatility pooled mortgages that are not rated on an active market.

Credit Rating	2019	2018
Investment Grade (AAA to BBB)	87%	89%
Unrated	13%	11%
	100%	**100%**

(c) Liquidity Risk

Liquidity risk is the risk that AHS will encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivery of cash or another financial asset. Liquidity requirements of AHS are met through funding provided in advance by AH, income generated from investments, and by investing in liquid assets, such as money market investments, equities, and bonds traded in an active market that are easily sold and converted to cash.

Note 10 Investments

	2019		2018	
	Fair Value	Cost	Fair Value	Cost
Cash held for investing purposes	**$ 110,887**	**$ 110,887**	**$ 118,012**	**$ 118,012**
Interest bearing securities:				
Money market securities	177,199	177,199	124,320	124,320
Fixed income securities	1,485,637	1,467,856	1,540,138	1,549,534
	1,662,836	**1,645,055**	**1,664,458**	**1,673,854**
Equities:				
Canadian equity investments	45,866	38,488	24,350	17,477
Canadian equity funds	129,525	119,364	133,680	125,451
Global equity funds	329,954	288,454	376,252	326,465
	505,345	**446,306**	**534,282**	**469,393**
	$ 2,279,068	**$ 2,202,248**	**$ 2,316,752**	**$ 2,261,259**

	2019	2018
Items at Fair Value		
Portfolio investments designated to the FV category	$ 2,232,488	$ 2,291,941
Portfolio investments in equity instruments that are quoted in an active market	45,866	24,350
Derivatives	714	461
	$ 2,279,068	**$ 2,316,752**

Included in investments is $212,323 (March 31, 2018 – $173,725) that is restricted for use as per the requirements in Sections 99 and 100 of the *Insurance Act* of Alberta. Endowments included in investments amount to $75,157 (March 31, 2018 – $74,694).

The following are the total net remeasurement gains on investments:

	2019	2018
Accumulated remeasurement gains	$ 34,469	$ 20,835
Restricted unrealized net gains attributable to unexpended deferred operating revenue and endowments (Note 14(b))	42,351	34,658
	$ 76,820	**$ 55,493**

Note 10 Investments (continued)

Fair Value Hierarchy

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

	2018			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ 118,012	$ -	$ -	$ 118,012
Interest bearing securities:				
Money market securities	-	124,320	-	124,320
Fixed income securities	-	1,393,124	147,014	1,540,138
Equities:				
Canadian equity investments	24,350	133,739	-	158,089
Global equity funds	-	376,193	-	376,193
	$ 142,361	**$ 2,027,377**	**$ 147,014**	**$ 2,316,752**
Percent of total	6%	88%	6%	100%

Note 11 Accounts Receivable

	2019			2018
	Gross	Allowance for Doubtful Accounts	Net	Net
Patient accounts receivable	$ 127,952	28,440	99,512	$ 105,364
AH operating transfers receivable	36,768	-	36,768	81,104
AH capital transfers receivable	34,356	-	34,356	38,766
Other operating transfers receivable	14,824	-	14,824	30,025
Other capital transfers receivable	157,776	-	157,776	86,413
Other accounts receivable	102,498	526	101,972	84,886
	$ 474,174	**28,966**	**445,208**	**$ 426,558**

Accounts receivable are unsecured and non-interest bearing. At March 31, 2018, the total allowance for doubtful accounts was $25,986.

Note 12 Accounts Payable and Accrued Liabilities

	2019	2018
Payroll remittances payable and related accrued liabilities	$ 543,427	$ 522,604
Trade accounts payable and accrued liabilities	608,740	572,282
Provision for unpaid claims[a]	202,511	157,583
Obligations under capital leases[b]	97,053	112,675
Other liabilities	54,142	47,769
	$ 1,505,873	**$ 1,412,913**

Accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $284,970 (2018 – $268,183).

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

The provision has been estimated using the discounted value of claim liabilities using a discount rate of 2.45% (2018 – 2.35%) plus a provision for adverse deviation, based on actuarial estimates.

(b) Obligations under capital leases include a site lease with the University of Calgary, a site lease for the Northern Communications Centre in Peace River, vehicle leases and obligations related to a clinical information system.

The obligations expire between 2020 and 2036 and have an implicit interest rate payable ranging from 2.37% to 7.04% (2018 – 2.42% to 6.97%).

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

Year ended March 31	Minimum Contract Payments
2020	$ 25,758
2021	24,444
2022	23,521
2023	11,504
2024	2,867
Thereafter	22,156
	110,250
Less: interest	(13,197)
	$ 97,053

(c) Liability for Contaminated Sites

At March 31, 2019, AHS has not identified or accepted any liability for contaminated sites (2018 – $nil).

Note 13 Employee Future Benefits

	2019	2018
Accrued vacation pay	$ 566,415	$ 553,875
Accumulating non-vesting sick leave liability[a]	122,081	119,261
Registered defined benefit pension plans[b] [c]	-	-
	$ 688,496	**$ 673,136**

(a) Accumulating Non-Vesting Sick Leave Liability

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

The AHS sick leave liability is based on an actuarial valuation as at March 31, 2015 and extrapolated to March 31, 2019.

The following table summarizes the accumulating non-vesting sick leave liability.

	2019	2018
Change in accrued benefit obligation and funded status		
Accrued benefit obligation and funded status, beginning of year	$ 99,998	$ 115,177
Current service cost	8,498	10,595
Interest cost	3,517	3,779
Benefits paid	(8,156)	(8,870)
Actuarial gain	-	(20,683)
Accrued benefit obligation and funded status, end of year	**$ 103,857**	**$ 99,998**
Reconciliation to accrued benefit liability		
Funded status – deficit	$ 103,857	$ 99,998
Unamortized net actuarial gain	18,224	19,263
Accrued benefit liability	**$ 122,081**	**$ 119,261**
Components of expense		
Current service cost	$ 8,498	$ 10,595
Interest cost	3,517	3,779
Amortization of net actuarial gain	(1,039)	1,267
Net expense	**$ 10,976**	**$ 15,641**
Assumptions		
Discount rate – beginning of year	3.38%	2.02%
Discount rate – end of year	3.51%	3.38%
Rate of compensation increase per year	2018-2019 0.75% 2019-2020 0.75% Thereafter 2.75%	2017-2018 0.75% 2018-2019 0.75% Thereafter 2.75%

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the 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.

Note 13 Employee Future Benefits (continued)

(ii) LAPP Surplus

LAPP carried out an actuarial valuation as at December 31, 2016 and these results were then extrapolated to December 31, 2018. The LAPP's December 31, 2018 net assets available for benefits divided by the LAPP's pension obligation shows that the LAPP is 108% (2017 – 113%) funded.

	December 31, 2018	December 31, 2017
LAPP net assets available for benefits	$ 44,468,547	$ 42,728,515
LAPP pension obligation	40,999,200	37,893,000
LAPP surplus	**$ 3,469,347**	**$ 4,835,515**

The 2018 and 2019 LAPP contribution rates are as follows:

Calendar 2019		Calendar 2018	
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	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess	9.39% of pensionable earnings up to the YMPE and 13.84% of the excess

(c) Pension Expense

	2019	2018
Local Authorities Pension Plan	$ 556,609	$ 587,007
Defined contribution pension plans and group RRSPs	48,408	49,021
Supplemental Pension Plan	2,265	2,303
Supplemental Executive Retirement Plans	812	(1,826)
Management Employees Pension Plan	378	393
	$ 608,472	**$ 636,898**

Note 14 Unexpended Deferred Operating Revenue

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

	2019				2018
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 137,662	$ 26,371	$ 256,212	$ 420,245	$ 411,079
Received or receivable during the year, net of repayments	1,206,568	59,771	148,795	1,415,134	1,349,839
Restricted investment income	1,058	1,611	6,796	9,465	7,176
Transferred from unexpended deferred capital revenue	3,407	53,127	703	57,237	44,874
Recognized as revenue	(1,192,862)	(114,269)	(126,961)	(1,434,092)	(1,373,254)
Miscellaneous other revenue recognized	(1,271)	(17)	(21,175)	(22,463)	(21,316)
	154,562	**26,594**	**264,370**	**445,526**	**418,398**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	740	2,985	3,968	7,693	1,847
Balance, end of year	**$ 155,302**	**$ 29,579**	**$ 268,338**	**$ 453,219**	**$ 420,245**

[(i)] The balance at March 31, 2019 for other government includes $506 of unexpended deferred operating revenue received from government entities outside the GOA (March 31, 2018 – $506). The remaining balance in other government all relates to the GOA, see Note 21.

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

	2019				2018
	AH	Other Government	Donors and Non-Government	Total	Total
Research and education	$ 23,478	$ 1,554	$ 157,731	$ 182,763	$ 171,295
Physician revenue and alternate relationship plans	36,724	346	-	37,070	39,658
Primary Care Networks	24,354	-	-	24,354	27,332
Long term care partnerships	-	18,329	-	18,329	16,735
Promotion, prevention and community	13,354	1,665	758	15,777	16,373
Addiction and mental health	31,129	-	539	31,668	16,252
Cancer prevention, screening and treatment	5,863	-	1,096	6,959	14,198
Administration and support services	2,497	1,268	54,500	58,265	55,090
Others less than $10,000	16,787	3,432	15,464	35,683	28,654
	154,186	**26,594**	**230,088**	**410,868**	**385,587**
Unrealized net gain attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 10)	1,116	2,985	38,250	42,351	34,658
	$ 155,302	**$ 29,579**	**$ 268,338**	**$ 453,219**	**$ 420,245**

Note 15 Unexpended Deferred Capital Revenue

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

	2019				2018
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 48,336	$ 8,858	$ 96,557	$ 153,751	$ 137,806
Received or receivable during the year	141,144	169,246	87,927	398,317	306,947
Other transfers	(18)	18	-	-	-
Unexpended deferred capital revenue returned	(242)	-	(8)	(250)	(7,381)
Transfer to expended deferred capital revenue	(131,951)	(118,822)	(36,928)	(287,701)	(238,399)
Transferred to unexpended deferred operating revenue[(ii)]	(3,407)	(53,127)	(703)	(57,237)	(44,874)
	53,862	**6,173**	**146,845**	**206,880**	**154,099**
Changes in unrealized net gain on portfolio investments related to unexpended deferred capital revenue	-	-	-	-	(348)
Balance, end of year	**$ 53,862**	**$ 6,173**	**$ 146,845**	**$ 206,880**	**$ 153,751**

[(i)] The balance at March 31, 2019 for other government all relates to the GOA, see Note 21.
[(ii)] The transfer mainly comprises restricted funding related to capital expenditures that do not meet AHS' capitalization criteria.

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

	2019	2018
AH		
Information systems	$ 16,712	$ 42,132
Medical Equipment Replacement Upgrade Program	2	147
Diagnostic Equipment	19,585	-
Other equipment	17,563	6,057
Total AH	**53,862**	**48,336**
Other government		
Facilities and improvements	6,173	8,858
Total other government	**6,173**	**8,858**
Donors and non-government		
Equipment	138,334	92,626
Facilities and improvements	8,511	3,931
Total donors and non-government	**146,845**	**96,557**
	$ 206,880	**$ 153,751**

Note 16 Expended Deferred Capital Revenue

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

	2019				2018
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 273,582	$ 6,270,765	$ 191,107	$ 6,735,454	$ 6,549,770
Transferred from unexpended deferred capital revenue	131,951	118,822	36,928	287,701	238,399
Contributed tangible capital assets	-	285,322	46	285,368	331,622
Less: amounts recognized as revenue	(65,104)	(282,606)	(35,695)	(383,405)	(384,337)
Balance, end of year	**$ 340,429**	**$ 6,392,303**	**$ 192,386**	**$ 6,925,118**	**$ 6,735,454**

[(i)] The balance at March 31, 2019 for other government includes $36 of expended deferred capital revenue received from government entities outside the GOA (March 31, 2018 – $52). The remaining balance in other government all relates to the GOA, see Note 21.

Note 17 Debt

	2019	2018
Debentures payable[(a)]:		
Parkade loan #1	$ 26,500	$ 29,424
Parkade loan #2	25,522	27,951
Parkade loan #3	34,048	36,630
Parkade loan #4	132,577	140,098
Parkade loan #5	32,200	33,938
Parkade loan #6	22,557	23,505
Parkade loan #7	49,516	51,500
Energy savings initiative loan	24,089	25,800
Other	633	929
	347,642	**369,775**

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

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

AHS is in compliance with all performance requirements of its debenture loans. The maturity dates and interest rates for the debentures are as follows:

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

Note 17 Debt (continued)

(b) At March 31, 2019, AHS had entered into an agreement to borrow $157,000 from ACFA. The proceeds will be received by AHS in December 2019 for the construction of the Calgary Cancer Center parkade. The loan matures March 2059 and has a fixed interest rate of 3.6%. Semi-annual principal and interest payments of $3,719 will commence June 2020. Commitments related to this agreement have been included in the table below.

AHS is committed to making payments as follows:

	Debentures Payable and Other Loans Payable
Year ended March 31	**Principal Payments**
2020	$ 23,091
2021	25,893
2022	26,666
2023	27,810
2024	29,008
Thereafter	372,174
	$ 504,642

During the year, the total interest related to debt was $15,199 (2018 – $14,551).

As at March 31, 2019, AHS holds a $220,000 (March 31, 2018 - $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, 2019, AHS has $nil (March 31, 2018 - $nil) draws against this facility.

AHS also has access to a $33,000 (March 31, 2018 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2019, AHS has $4,419 (March 31, 2018 – $4,790) in a letter of credit outstanding against this facility. AHS is in compliance with performance requirements relating to this letter of credit.

Note 18 Tangible Capital Assets

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

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

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

Note 18 Tangible Capital Assets (continued)

Cost	2017	Additions[a]	Transfers out of Work in Progress	Disposals	2018
Facilities and improvements	$ 8,996,755	$ 3,646	$ 304,041	$ (3,979)	$ 9,300,463
Work in progress	914,106	681,588	(416,625)	-	1,179,069
Equipment[b]	2,302,819	248,781	1,640	(40,352)	2,512,888
Information systems	1,362,656	10,568	68,023	(2,700)	1,438,547
Building service equipment	611,021	-	37,391	(60)	648,352
Land[c]	110,589	6,286	-	-	116,875
Leased facilities and improvements	224,968	-	4,097	-	229,065
Land improvements	82,764	-	1,433	-	84,197
	$ 14,605,678	**$ 950,869**	**$ -**	**$ (47,091)**	**$ 15,509,456**

Accumulated Amortization	2017	Amortization Expense	Effect of Transfers	Disposals	2018
Facilities and improvements	$ 3,412,872	$ 257,586	$ -	$ (3,979)	$ 3,666,479
Work in progress	-	-	-	-	-
Equipment[b]	1,802,535	136,123	-	(39,963)	1,898,695
Information systems	1,180,818	99,000	-	(2,698)	1,277,120
Building service equipment	365,016	33,244	-	(60)	398,200
Land[c]	-	-	-	-	-
Leased facilities and improvements	162,322	10,048	-	-	172,370
Land improvements	63,038	2,247	-	-	65,285
	$ 6,986,601	**$ 538,248**	**$ -**	**$ (46,700)**	**$ 7,478,149**

	Net Book Value	
	2018	2017
Facilities and improvements	$ 5,633,984	$ 5,583,883
Work in progress	1,179,069	914,106
Equipment[b]	614,193	500,284
Information systems	161,427	181,838
Building service equipment	250,152	246,005
Land[c]	116,875	110,589
Leased facilities and improvements	56,695	62,646
Land improvements	18,912	19,726
	$ 8,031,307	**$ 7,619,077**

(a) Contributed Tangible Capital Assets

Additions include total contributed tangible capital assets of $285,368 (2018 – $337,908) consisting of $285,322 from AI (2018 – $337,837), of which $nil (2018 - $6,286) was related to the transferred land and $285,322 (2018- $331,551) was related to other tangible capital assets. AHS also received $46 from other sources (2018 – $71).

(b) Leased Equipment

Equipment includes tangible capital assets acquired through capital leases at a cost of $17,240 (2018 – $13,352) with accumulated amortization of $12,119 (March 31, 2018 – $11,637). For the year ended March 31, 2019, leased equipment included a net increase of $4,363 related to vehicles under capital leases (2018 – net increase of $494).

Note 18 Tangible Capital Assets (continued)

(c) Leased Land

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

Site	Leased from	Lease Expiry
Cross Cancer Institute Parkade	University of Alberta	July 2019
Evansburg Community Health Centre	Yellowhead County	April 2031
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

Note 19 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2019					2018
	Invested in Tangible Capital Assets[a]	Endowments[b]	Internally Restricted Surplus for Future Purposes[c]	Unrestricted Surplus[d]	Total	Total
Balance, beginning of year	$ 817,160	$ 74,694	$ 237,176	$ 188,025	$ 1,317,055	$ 1,225,659
Annual operating (deficit) surplus	-	-	-	(38,631)	(38,631)	91,396
Tangible capital assets acquired with internal funds	244,268	-	(44,482)	(199,786)	-	-
Amortization of internally funded tangible capital assets	(146,223)	-	-	146,223	-	-
Principal payments on debt	22,133	-	-	(22,133)	-	-
Payments on obligations under capital leases	2,349	-	-	(2,349)	-	-
Payment on life lease deposits	596	-	-	(596)	-	-
Transfer of internally restricted surplus	-	-	24,532	(24,532)	-	-
Transfer of endowment contributions	-	463	-	(463)	-	-
Balance, end of year	**$ 940,283**	**$ 75,157**	**$ 217,226**	**$ 45,758**	**$ 1,278,424**	**$ 1,317,055**

(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. AHS has no plans to monetize these assets to cover future operations

Note 19 Accumulated Surplus (continued)

(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 $463 (2018 - $328) of contributions and reinvested income received in the year (Note 5) offset by other transfers of $nil (2018 - $344).

(c) Internally Restricted Surplus for Future Purposes

The Board has approved the restriction of accumulated surplus for future purposes as follows:

	2019	2018
Ancillary services [(i)]	$ 112,508	$ 124,525
Insurance equity requirements [(ii)]	21,568	34,835
Foundations [(iii)]	42,816	41,395
Other [(iv)]	40,334	36,421
Internally restricted surplus for future purposes	**$ 217,226**	**$ 237,176**

(i) Restriction of ancillary operation surpluses from parking, retail food services, and controlled entities.
(ii) Restriction of surplus related to equity of the LPIP.
(iii) Restriction of surplus related to AHS' Controlled Foundations.
(iv) Restriction of surplus to address funding of expenses for certain initiatives spanning multiple fiscal years.

(d) Unrestricted Surplus

Unrestricted surplus represents the portion of accumulated surplus that has not been internally restricted for future purposes, invested in tangible capital assets, or endowments.

Note 20 Contractual Obligations and Contingent Liabilities

(a) Leases

AHS is contractually committed to future operating lease payments as follows:

Year ended March 31	Total Lease Payments
2020	$ 61,390
2021	54,899
2022	51,788
2023	45,550
2024	36,295
Thereafter	103,790
	$ 353,712

(b) Contingent Liabilities

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

Accruals have been made in specific instances where it is likely that losses will be incurred based on a reasonable estimate. As at March 31, 2019, 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.

Note 20 Contractual Obligations and Contingent Liabilities (continued)

AHS has been named in 225 legal claims (2018 – 223 claims) related to conditions in existence at March 31, 2019 where the likelihood of the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 205 claims have $415,883 in specified amounts and 20 have no specified amounts (2018 – 208 claims with $308,012 of specified claims and 15 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that is different than the claimed amount.

AHS has been named as a co-defendant, along with the GOA, in a certified Class Action (the Claim) arising from increases to long-term accommodation charges implemented by Alberta Government regulations enacted on and after August 1, 2003, and paid by residents of long-term care facilities. The Claim was originally dismissed after trial, but is now currently under appeal. The likelihood of the Claim is considered by AHS to be indeterminable, and the amount of the Claim has not yet been specified.

Note 21 Related Parties

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

The Minister of Health 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 table below.

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

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

	Revenues[a]		Expenses	
	2019	2018	2019	2018
Ministry of Advanced Education [b]	$ 57,266	$ 55,936	$ 184,812	$ 179,759
Ministry of Infrastructure [c]	340,892	350,196	1	276
Other ministries [d]	55,399	58,101	31,064	31,460
Total for the year	**$ 453,557**	**$ 464,233**	**$ 215,877**	**$ 211,495**

	Receivable from		Payable to	
	2019	2018	2019	2018
Ministry of Advanced Education [b]	$ 7,692	$ 4,578	$ 35,618	$ 22,749
Ministry of Infrastructure [c]	50,566	21,526	65,000	-
Other ministries [d]	8,483	16,891	349,886	378,440
Balance, end of year	**$ 66,741**	**$ 42,995**	**$ 450,504**	**$ 401,189**

(a) Revenues with GOA ministries include other government transfers of $420,622 (2018 – $429,855), (Note 4), other income of $30,847 (2018 – $32,004), (Note 6), and fees and charges of $2,088 (2018 – $2,374).

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

Note 21 Related Parties (continued)

(c) The transactions with the Ministry of Infrastructure (AI) relate to the construction and funding of tangible capital assets. These transactions include operating transfers of $58,957 (2018 – $63,699) and recognition of expended deferred capital revenue of $281,935 (2018 – $286,497) 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 $285,322 (2018 – $337,837).

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

At March 31, 2019, AHS has recorded deferred revenue from other ministries within the GOA, excluding AH, of $29,073 (March 31, 2018 – $25,865) related to unexpended deferred operating revenue (Note 14), $6,173 (March 31, 2018 – $8,858) related to unexpended deferred capital revenue (Note 15) and $6,392,267 (March 31, 2018 – $6,270,713) related to expended deferred capital revenue (Note 16).

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

Note 22 Government Partnerships

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

	2019	2018
Financial assets	$ 71,913	$ 74,306
Liabilities	71,913	74,306
Accumulated surplus	$ -	$ -
Total revenues	$ 247,615	$ 248,123
Total expenses	247,615	248,123
Annual surplus	**$ -**	**$ -**

Note 23 Trusts under Administration

(a) Health Benefit Trust of Alberta (HBTA)

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

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

	2018	2017
Financial assets	$ 145,274	$ 131,234
Liabilities	15,887	15,340
Net financial assets	$ 129,387	$ 115,894
Non-financial assets	6	6
Net assets	**$ 129,393**	**$ 115,900**

AHS has included in prepaid expenses $93,784 (March 31, 2018 – $91,077) representing in substance a prepayment of future premiums to HBTA. For the fiscal year ended March 31, 2019, AHS paid premiums of $391,734 (2018 – $382,090) to HBTA.

Note 23 Trusts under Administration (continued)

(b) Other Trust Funds

AHS receives funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to appropriate the funds or to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2019, the balance of funds held in trust by AHS for research and development is $100 (March 31, 2018 – $150).

AHS receives funds in trust from continuing care residents for personal expenses. As at March 31, 2019, the balance of these funds is $1,452 (March 31, 2018 – $1,686). 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, 2019, there are $32,674 in plan assets (March 31, 2018 - $34,474). These amounts are not included in the consolidated financial statements.

Note 24 Segment Disclosure

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

AHS' revenues, as reported on the 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) Community-based care

Community-based 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.

(b) Home care

Home care is comprised of home nursing and support.

(c) Continuing care

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

(d) Population and public health

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

(e) Ambulance services

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

Note 24 Segment Disclosure (continued)

(f) 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.

(g) Diagnostic and therapeutic services

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

(h) Education and research

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

(i) 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.

(j) 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.

(k) Administration

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

Note 25 Corresponding Amounts

Certain amounts have been reclassified to conform to 2019 presentation.

Note 26 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on May 30, 2019.

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

	2019		2018
	Budget (Note 3)	Actual	Actual
Salaries and benefits (Schedule 2)	$ 8,239,000	$ 8,321,637	$ 8,081,785
Contracts with health service providers	2,762,000	2,749,686	2,621,371
Contracts under the Health Care Protection Act	18,000	17,186	18,337
Drugs and gases	496,000	506,662	465,753
Medical and surgical supplies	427,000	431,125	400,795
Other contracted services	1,381,000	1,322,806	1,253,012
Other[a]	1,384,000	1,434,605	1,384,755
Amortization and loss on disposals of tangible capital assets (Note 18)	533,000	529,628	538,639
	$ 15,240,000	**$ 15,313,335**	**$ 14,764,447**
(a) Significant amounts included in Other are:			
Equipment expense	$ 198,000	$ 212,312	$ 217,147
Other clinical supplies	146,000	161,392	153,879
Utilities	109,000	118,372	118,091
Building and ground expenses	120,000	118,206	119,590
Building rent	115,000	112,921	112,318
Insurance and liability claims	54,000	90,867	58,398
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies	85,000	90,608	86,825
Food and dietary supplies	74,000	80,827	79,346
Office supplies	43,000	63,279	63,583
Minor equipment purchases	53,000	59,246	49,204
Fundraising and grants awarded	56,000	51,336	51,621
Travel	50,000	45,423	38,646
Telecommunications	39,000	38,917	38,026
Licenses, fees and memberships	31,000	17,211	19,216
Education	18,000	12,428	12,695
Other	193,000	161,260	166,170
	$ 1,384,000	**$ 1,434,605**	**$ 1,384,755**

SCHEDULE 2 - CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2019

	2019								2018	
						Severance [e]				
	FTE[a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Number of Individuals	Amount	Total	FTE [a]	Total
Total Board (Sub-Schedule 2A)	10.82	$ -	$ 334	$ -	$ 334	-	$ -	$ 334	9.25	$ 311
Total Executive (Sub-Schedule 2B)	14.00	5,165	57	806	6,028	-	-	6,028	14.12	6,085
Management Reporting to CEO Direct Reports	56.86	12,876	285	2,636	15,797	-	-	15,797	72.86	20,069
Other Management	3,031.59	363,150	4,333	81,856	449,339	30	3,377	452,716	2,964.39	438,982
Medical Doctors not included above[f]	141.84	44,184	1,235	3,519	48,938	3	996	49,934	148.12	49,908
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	19,566.39	1,862,083	272,500	410,140	2,544,723	4	86	2,544,809	19,137.97	2,479,561
LPNs	5,233.39	343,230	45,744	75,851	464,825	2	58	464,883	4,987.54	440,381
Other health technical and professional	16,948.48	1,523,761	92,622	346,116	1,962,499	14	502	1,963,001	16,461.03	1,901,555
Unregulated health service providers	9,310.80	467,839	60,249	110,357	638,445	2	7	638,452	8,908.36	613,100
Other staff	27,251.74	1,712,694	99,212	373,098	2,185,004	45	1,100	2,186,104	26,738.08	2,132,245
Sub-total	**81,565.91**	**6,334,982**	**576,571**	**1,404,379**	**8,315,932**	**100**	**6,126**	**8,322,058**	**79,441.72**	**8,082,197**
Less amounts included in Other contracted services		(345)	(2)	(74)	(421)	-	-	(421)		(412)
Total		**$ 6,334,637**	**$ 576,569**	**$ 1,404,305**	**$ 8,315,511**	**100**	**$ 6,126**	**$ 8,321,637**		**$ 8,081,785**

This schedule does not include $27,393 in capitalized salaries and benefits (2018 - $10,303).

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

SUB-SCHEDULE 2A – BOARD REMUNERATION
FOR THE YEAR ENDED MARCH 31, 2019

	Term	2019 Committees	2019 Remuneration	2018 Remuneration
Board Chair				
Linda Hughes[g]	Since Nov 27, 2015	ARC, CEC, FC, GC, HRC, QSC	$ 69	$ 67
Board Members				
Dr. Brenda Hemmelgarn (Vice Chair)	Since Nov 27, 2015	CEC (Chair), HR, QSC	49	48
David Carpenter	Since Nov 27, 2015	ARC (Chair), CEC, FC (Chair), HR	35	35
Heather Crowshoe (nee Hirsch)	Since Nov 3, 2016	CEC, GC, QSC	30	31
Richard Dicerni	Since Nov 27, 2015	CEC, FC, HRC (Chair)	27	30
Robb Foote	Apr 12, 2018 to Feb 1, 2019	CEC, FC, GC	24	-
Hugh Sommerville	Since Nov 27, 2015	ARC, GC (Chair)	31	33
Marliss Taylor	Since Nov 27, 2015	CEC, GC, HRC (Chair), QSC	34	32
Glenda Yeates	Since Nov 27, 2015	ARC, FC, QSC (Chair)	31	33
Board Committee Participants[h]				
Dr. Brian Postl	Since Jan 1, 2018	QSC	2	-
Gord Winkel	Since Nov 27, 2015	QSC	2	2
Total Board			**$ 334**	**$ 311**

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

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

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

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2019

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

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2019 (CONTINUED)

	2018						
For the Prior Fiscal Year	**FTE [a]**	**Base Salary [b]**	**Other Cash Benefits [c]**	**Other Non-Cash Benefits [d]**	**Subtotal**	**Severance [e]**	**Total**
Board Direct Reports							
Andrea Beckwith-Ferraton – Chief Ethics and Compliance Officer	0.79	$ 166	$ -	$ 40	$ 206	$ -	$ 206
Ronda White – Chief Audit Executive	1.00	276	-	64	340	-	340
Dr. Verna Yiu – President and Chief Executive Officer	1.00	572	-	104	676	-	676
CEO Direct Reports							
Dr. Francois Belanger – VP, Quality and Chief Medical Officer	1.00	462	-	43	505	-	505
Dr. Ted Braun – VP and Medical Director, Central and Southern Alberta	1.00	395	-	47	442	-	442
Mauro Chies – VP, Clinical Support Services	1.00	304	-	52	356	-	356
Sean Chilton – VP, Collaborative Practice, Nursing and Health Professions	1.00	329	-	72	401	-	401
Todd Gilchrist – VP, People, Legal and Privacy	1.00	449	-	64	513	-	513
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta	1.00	369	-	27	396	-	396
Karen Horon – Acting VP, Clinical Support Services	0.19	44	-	8	52	-	52
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta	1.00	369	-	45	414	-	414
Noela Inions – Chief Ethics and Compliance Officer	0.06	13	-	3	16	-	16
Dr. Mark Joffe – VP and Medical Director, Northern Alberta	1.00	449	35	44	528	-	528
Dr. David Mador – VP and Medical Director, Northern Alberta	0.08	36	-	4	40	-	40
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer	1.00	433	-	68	501	-	501
Dr. Kathryn Todd – VP, System Innovations and Programs	1.00	286	15	39	340	-	340
Colleen Turner – VP, Community Engagement and Communications	1.00	329	-	30	359	-	359
Total Executive	**14.12**	**$ 5,281**	**$ 50**	**$ 754**	**$ 6,085**	**$ -**	**$ 6,085**

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

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

	2019			2018			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2018	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2019
Andrea Beckwith-Ferraton - Chief Ethics and Compliance Officer	$ 6	$ -	$ 6	$ 5	$ 12	$ 5	$ 17
Dr. Francois Belanger - VP, Quality and Chief Medical Officer	36	-	36	36	219	20	239
Dr. Ted Braun - VP and Medical Director, Central and Southern Alberta							
SERP	-	5	5	(10)	215	5	220
SPP	28	-	28	28	117	23	140
Mauro Chies - VP, CancerControl Alberta and Clinical Support Services	18	-	18	17	87	15	102
Sean Chilton – VP, Health Professions and Practice	20	-	20	20	139	17	156
Todd Gilchrist - VP, People, Legal and Privacy	34	-	34	34	104	28	132
Deb Gordon - VP and Chief Health Operations Officer, Northern Alberta							
SERP	-	15	15	(31)	666	17	683
SPP	25	-	25	24	147	18	165
Karen Horon - Interim VP, Clinical Support Services	6	-	6	4	21	6	27
Brenda Huband - VP and Chief Health Operations Officer, Central and Southern Alberta							
SERP	-	9	9	(18)	389	11	400
SPP	25	-	25	24	`155	19	174
Dr. Mark Joffe - VP and Medical Director, Northern Alberta[m]	-	-	-	-	-	-	-
Deborah Rhodes - VP, Corporate Services and Chief Financial Officer	27	-	27	32	211	18	229
Dr. Kathryn Todd - VP, System Innovations and Programs[m]	-	-	-	-	-	-	-
Colleen Turner - VP, Community Engagement and Communications	20	-	20	20	94	14	108
Ronda White - Chief Audit Executive	14	-	14	14	80	10	90
Dr. Verna Yiu - President and Chief Executive Officer	49	-	49	49	90	47	137

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

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2019

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.

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

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

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

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

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

Board and Board Committee Participants

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

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

Executive

i. 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.

j. The incumbent held the position of Vice President, Clinical Support Services until April 2, 2018 at which time the incumbent was seconded to Calgary Laboratory Services/Alberta Public Laboratories (CLS/APL) to serve as Interim Chief Executive Officer and was no longer a direct report to the President and Chief Executive Officer at AHS. During this tenure, CLS/APL reimbursed AHS for the incumbent's base salary and benefits. The incumbent held the position of Interim Chief Executive Officer at CLS/APL until September 24, 2018 at which time the incumbent resumed the role of Vice President, Clinical Support Services at AHS and returned to being a direct report to the President and Chief Executive Officer at AHS. As a result of additional responsibilities effective November 1, 2018, the incumbent's position was retitled Vice President, CancerControl Alberta and Clinical Support Services.

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

l. The incumbent held the position of Senior Operating Officer, Pharmacy Services until April 2, 2018 at which time the incumbent was appointed to Interim Vice President, Clinical Support Services and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in base salary for the Interim Vice President, Clinical Support Services position. The incumbent held the position of Interim Vice President, Clinical Support Services until September 24, 2018 at which time the incumbent resumed the role of Senior Operating Officer, Pharmacy Services and is no longer a direct report to the President and Chief Executive Officer.

m. 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.

Termination Obligations

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

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2019 (CONTINUED)

o. 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.

p. 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

	2019								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Care Protection Act	Drugs and gases	Medical and surgical supplies	Other contracted services	Other	Amortization and loss on disposals of tangible capital assets	Total
Community-based care	$ 676,683	$ 657,092	$ -	$ 3,562	$ 3,668	$ 31,951	$ 66,106	$ 372	$ 1,439,434
Home care	327,974	246,052	-	179	7,651	83,441	22,850	148	688,295
Continuing care	316,452	775,491	-	7,600	4,030	5,278	25,340	2,152	1,136,343
Population and public health	299,568	9,860	-	6,840	4,089	14,836	12,218	315	347,726
Ambulance services	299,635	174,932	-	1,953	2,538	1,572	30,246	17,169	528,045
Acute care	2,990,169	394,435	17,186	461,210	344,354	600,224	172,436	64,810	5,044,824
Diagnostic and therapeutic services	1,563,024	293,708	-	22,738	60,534	291,808	228,911	44,688	2,505,411
Education and research	186,064	2,911	-	15	78	98,743	28,309	165	316,285
Support services	1,069,471	154,714	-	2,560	3,931	112,198	593,575	323,023	2,259,472
Information technology	241,201	514	-	-	16	37,156	152,125	76,593	507,605
Administration	351,396	39,977	-	5	236	45,599	102,489	193	539,895
Total	**$ 8,321,637**	**$ 2,749,686**	**$ 17,186**	**$ 506,662**	**$ 431,125**	**$ 1,322,806**	**$ 1,434,605**	**$ 529,628**	**$ 15,313,335**

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

	2018								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Care Protection Act	Drugs and gases	Medical and surgical supplies	Other contracted services	Other	Amortization and loss on disposals of tangible capital assets	Total
Community-based care	$ 627,454	$ 621,358	$ -	$ 3,145	$ 3,487	$ 34,256	$ 79,651	$ 495	$ 1,369,846
Home care	286,788	220,857	-	200	6,271	72,220	22,930	313	609,579
Continuing care	311,317	717,001	-	7,417	3,967	4,271	27,115	1,712	1,072,800
Population and public health	296,632	9,584	-	7,342	2,620	13,702	13,967	436	344,283
Ambulance services	284,172	167,566	-	2,191	2,480	1,376	32,105	13,384	503,274
Acute care	2,958,575	392,382	18,337	429,181	321,496	600,951	152,921	55,011	4,928,854
Diagnostic and therapeutic services	1,514,809	300,341	-	13,360	57,078	264,219	222,739	40,510	2,413,056
Education and research	181,971	3,135	-	10	90	84,733	28,891	349	299,179
Support services	1,044,967	151,616	-	2,365	3,017	104,698	594,678	321,212	2,222,553
Information technology	226,839	584	-	-	-	37,570	141,772	104,070	510,835
Administration	348,261	36,947	-	542	289	35,016	67,986	1,147	490,188
TOTAL	**$ 8,081,785**	**$ 2,621,371**	**$ 18,337**	**$ 465,753**	**$ 400,795**	**$ 1,253,012**	**$ 1,384,755**	**$ 538,639**	**$ 14,764,447**

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

A total compensation strategy is the blueprint for an organization's total compensation program. It includes the mix of direct and indirect compensation to be provided to employees and the means through which it will be provided in order 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 "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 competitive and fair total compensation 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
- 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. Salary ranges are published on the AHS website. AHS is currently under a salary freeze that applies to all government agencies, boards and commissions until September 30, 2019. The job rates for Executive and Senior Leadership salary ranges are intended to be representative of the median of the national healthcare and Alberta public sector market. Outside of the salary freeze environment, to ensure total compensation remains market competitive, AHS reviews its market positioning on a regular basis and, in any event, no less than once every second year. However, due to the current salary freeze, AHS has not conducted a comprehensive review of its market positioning nor adjusted its pay bands since 2014.

Preliminary analysis indicates that the extended salary freeze has impacted AHS' market position and alignment with market median.

AHS' Total Compensation programs and practices encourage behaviours that will promote a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Total Compensation Plan Structure

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

Direct Compensation includes pay received as wages and salaries. AHS has no incentive, variable pay or pay at risk of any kind. Base salary ranges are intended to be competitive compared to the 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. Salary range adjustments (when applicable) are in alignment with typical adjustments provided to organizations within our comparator market (AB Public Sector and National Health Care).

Indirect Compensation includes benefits and pension (including supplemental pension plan), terms and conditions, and employee appreciation. AHS' benefits and pension plans support the health and well-being of our employees and financial security upon retirement. AHS provides a competitive benefits program that includes pension, health and dental-care benefits, life insurance, illness and long-term disability coverage.

All AHS employees are eligible to participate in the Local Authorities Pension Plan (LAPP). This is a defined benefit pension plan. It 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 Year's Maximum Pensionable Earnings under the Canada Pension Plan and 2.0% on the excess. Benefits under this plan are capped at the maximum pension benefit limit allowed under the federal *Income Tax Act*, a salary of $168,498 in 2019.

As pensionable earnings are limited under LAPP, AHS provides a Supplemental Pension Plan (SPP). Unlike the Local Authorities Pension, 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 allows AHS to maintain a competitive position, but at less cost and 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 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 and Chief Executive Officer (CEO) and Vice Presidents.
- Reviewing the compensation philosophy recommended by the President and 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, 2019, provides complete disclosure of salary, benefits, and all other compensation earned for years ended March 31, 2019 and March 31, 2018 by the direct reports to the Board and direct reports to the President & CEO. The Board's compensation is disclosed in Schedule 2 – Consolidated Schedule of Salaries and Benefits in the annual audited consolidated financial statements for the year ended March 31, 2019.

The Schedule 2 Information on total compensation philosophy and practices can be found on the AHS website.

Total Compensation 2018-19 Information Updates

The *Public Service Compensation Transparency Act* requires compensation disclosure from Alberta agencies, boards and commissions including AHS. AHS was required to disclose the names and compensation of employees whose earnings were over $127,765 per year. AHS disclosure under the Act was required by June 30, 2018, and was posted on AHS' external website. For 2018-19, AHS will be disclosing the names and compensation of employees whose earnings are over $129,809. The Alberta government has frozen salaries for all non-union and exempt employees at provincial agencies, boards and commissions as part of the province's ongoing restraint measures to reduce government operating costs. AHS is among the organizations affected by the freeze. The freeze will be in effect for 18 months, beginning April 1, 2018 and expiring September 30, 2019.

A 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 *Alberta Public Agencies Governance Act (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. Alternatively, AHS has submitted an executive compensation plan to Government, which will be an annual process. This annual compensation plan will demonstrate how AHS aligns to the key compensation principles outlined in the Regulation and help ensure scrutiny of its compensation practices. Transparency will continue to be provided through mandated salary disclosure.

Effective April 1, 2018, the Government of Alberta also enacted a new Salary Restraint Regulation which formalizes the current salary restraint measures for APAGA agencies. This regulation outlines key provisions regarding the salary restraint, extends the salary freeze for public agencies until September 30, 2019 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.

Appendix

- Year-End Performance Measure Results
- Monitoring Measures
- *Public Interest Disclosure (Whistleblower Protection) Act*
- Non-Hospital Surgical Facility Contracts under the *Health Care Protection Act* (Alberta)
- AHS Facilities and Beds

Year-End Performance Measure Results

AHS has 13 performance measures which enable us to evaluate our progress and allow us to link our objectives to specific results. Through an extensive engagement process, we determined our objectives and identified their corresponding performance measures. Both the objectives and performance measures are specific, relevant, measurable and attainable. Provincial results are found under each objective in the front section of this report. This appendix provides zone and site drill-down information for the following performance measures.

AHS Performance Measure	2014-15	2015-16	2016-17	2017-18	2018-19	Year-to-Year Trend	2018-19 Target
Improve Patients' and Families Experiences							
Percentage Placed in Continuing Care within 30 Days	60%	60%	56%	52%	58%	☆	58%
Percentage of Alternate Level of Care (ALC) Patient Days	12.2%	13.5%	15.4%	17.5%	16.3%	⇧	13.5%
Timely Access To Specialty Care (eReferral)	3	0	1	8	12	⇧	15
Patient Satisfaction with Hospital Experience	82%	82%	82%	82%	83% (Q3YTD)	⇨	85%
Addiction Outpatient Treatment Wait Time	15	13	15	13	14 (Q3YTD)	⇨	11
Improve Patient and Population Outcomes							
Unplanned Medical Readmissions	13.6%	13.7%	13.6%	13.6%	13.9% (Q3YTD)	⇨	13.3%
Perinatal Mortality Rate - First Nations (Difference: Rate Gap)	4.81	5.39	5.02	2.88	3.25	⇩	AHS' focus is to reduce the gap between First Nations and Non-First Nations
Hand Hygiene Compliance	75%	80%	82%	85%	87%	⇨	90%
Childhood Immunization Rate - DTaP-IPV-Hib	78%	78%	78%	78%	78%	⇨	82%
Childhood Immunization Rate – MMR	88%	87%	87%	87%	86%	⇨	89%
Improve the Experience and Safety of Our People							
AHS Workforce Engagement Rate	n/a		3.46	The next survey is planned for 2019-20			
Disabling Injury Rate	n/a	3.57	3.85	4.11	3.85 (Q3YTD)	⇧	3.40
Improve Financial Health and Value for Money							
Percentage of Nursing Units Achieving Best Practice Targets	n/a	20%	28%	38%	32%	⇩	40%

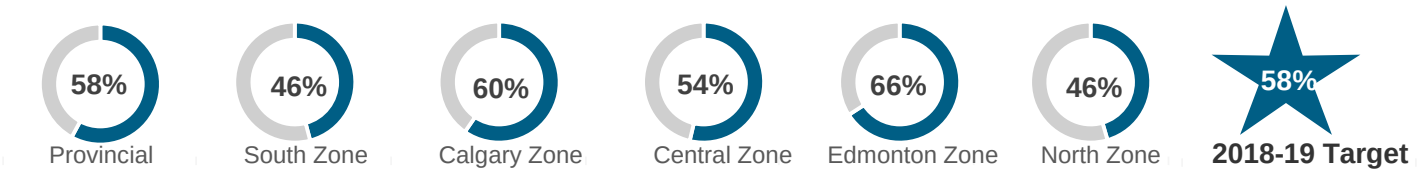
Trend Legend:
☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

AHS Report on Performance FY 2018-19

PEOPLE PLACED IN CONTINUING CARE WITHIN 30 DAYS

This measure monitors the percentage of people who are quickly moved from hospitals and communities into community-based continuing care. The higher the percentage the better, as it demonstrates capacity is available for long-term care or designated supportive living (levels 3, 4, and 4-dementia).

Percentage Placed in Continuing Care within 30 Days, FY 2018-19



Percentage Placed in Continuing Care within 30 Days Trend

Zone Name	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Trend	2018-19 Target
Provincial	**69.2%**	**59.9%**	**59.6%**	**56.1%**	**51.8%**	**57.9%**	☆	**58%**
South Zone	77.2%	59.5%	47.6%	45.9%	43.3%	45.9%	⇧	58%
Calgary Zone	72.0%	57.1%	58.4%	57.4%	58.7%	59.6%	☆	58%
Central Zone	40.7%	54.6%	61.5%	60.3%	54.6%	53.7%	⇨	58%
Edmonton Zone	78.4%	66.2%	64.5%	55.8%	48.7%	65.9%	☆	58%
North Zone	62.8%	58.8%	58.7%	57.5%	43.9%	45.5%	⇧	58%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total Clients Placed

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

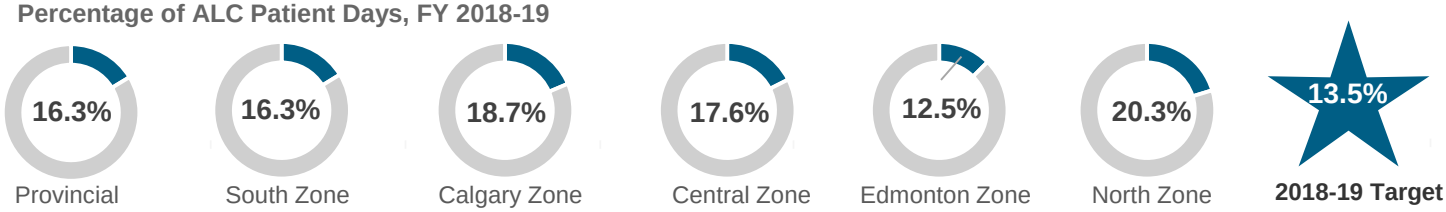
Source: AHS Seniors Health Continuing Care Living Options Report, as of April 25, 2019

AHS Report on Performance FY 2018-19

PERCENTAGE OF ALTERNATE LEVEL OF CARE PATIENT DAYS

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

Percentage of ALC Patient Days, FY 2018-19



Percentage of ALC Patient Days Trend

Zone Name	Site Name	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Trend	2018-19 Target
Provincial	**Provincial**	**10.1%**	**12.2%**	**13.5%**	**15.4%**	**17.5%**	**16.3%**	⇧	**13.5%**
South Zone	**South Zone**	**6.9%**	**9.0%**	**12.6%**	**13.9%**	**15.7%**	**16.3%**	⇩	**13.5%**
	Chinook Regional Hospital	5.0%	4.4%	7.8%	8.6%	12.3%	17.3%	⇩	13.5%
	Medicine Hat Regional Hospital	9.2%	14.6%	18.9%	18.9%	22.0%	13.4%	☆	13.5%
	Other South Hospitals	7.1%	9.4%	11.5%	17.3%	11.6%	18.1%	⇩	13.5%
Calgary Zone	**Calgary Zone**	**11.7%**	**15.2%**	**16.7%**	**16.9%**	**19.2%**	**18.7%**	⇨	**13.5%**
	Alberta Children's Hospital	0.0%	0.2%	1.3%	1.2%	2.0%	4.4%	☆	13.5%
	Foothills Medical Centre	11.5%	15.7%	14.7%	15.2%	19.2%	18.8%	⇨	13.5%
	Peter Lougheed Centre	11.0%	14.6%	13.6%	16.8%	14.4%	15.6%	⇩	13.5%
	Rockyview General Hospital	13.7%	16.2%	21.9%	22.2%	26.0%	23.3%	⇧	13.5%
	South Health Campus	12.1%	14.4%	20.4%	17.6%	19.6%	19.5%	⇨	13.5%
	Other Calgary Hospitals	17.5%	26.4%	27.2%	21.0%	21.9%	21.8%	⇨	13.5%
Central Zone	**Central Zone**	**13.0%**	**13.1%**	**12.0%**	**15.3%**	**15.9%**	**17.6%**	⇩	**13.5%**
	Red Deer Regional Hospital Centre	10.3%	11.4%	8.8%	12.4%	12.2%	13.5%	⇩	13.5%
	Other Central Hospitals	14.9%	14.4%	14.3%	17.2%	18.3%	20.4%	⇩	13.5%
Edmonton Zone	**Edmonton Zone**	**7.8%**	**9.1%**	**9.5%**	**14.0%**	**15.6%**	**12.5%**	☆	**13.5%**
	Grey Nuns Community Hospital	8.7%	10.2%	9.2%	11.1%	10.8%	9.3%	☆	13.5%
	Misericordia Community Hospital	8.0%	10.8%	12.8%	14.7%	17.4%	17.2%	⇨	13.5%
	Royal Alexandra Hospital	8.4%	10.6%	11.0%	18.5%	18.7%	14.5%	⇧	13.5%
	Stollery Children's Hospital	0.1%	0.0%	1.8%	0.6%	0.2%	0.1%	☆	13.5%
	Sturgeon Community Hospital	10.7%	12.3%	12.3%	18.9%	22.5%	19.2%	⇧	13.5%
	University of Alberta Hospital	6.8%	6.0%	6.2%	11.7%	15.3%	9.9%	☆	13.5%
	Other Edmonton Hospitals	9.2%	11.8%	12.1%	12.1%	14.4%	14.9%	⇩	13.5%
North Zone	**North Zone**	**11.7%**	**13.8%**	**18.5%**	**16.4%**	**21.3%**	**20.3%**	⇧	**13.5%**
	Northern Lights Regional Health Centre	9.4%	7.4%	18.5%	12.0%	8.0%	17.0%	⇩	13.5%
	Queen Elizabeth II Hospital	8.5%	14.0%	20.4%	15.2%	26.0%	19.2%	⇧	13.5%
	Other North Hospitals	13.2%	14.9%	17.9%	17.5%	21.8%	21.3%	⇨	13.5%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total ALC Discharges

Zone	2015-16	2016-17	2017-18	2018-19
Provincial	**10,294**	**13,681**	**17,227**	**15,375**
South Zone	624	674	663	746
Calgary Zone	4,684	5,027	6,232	6,510
Central Zone	1,085	1,327	1,418	1,406
Edmonton Zone	3,046	5,518	7,709	5,816
North Zone	815	967	1,077	897

National Comparison:
Alberta ranks
6 out of 9

Source(s): AHS Provincial Discharge Abstract Database (DAD), as of May 2, 2019
Notes:
- Results may change due to data updates in the source information system or revisions to the measure inclusion and exclusion criteria.

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TIMELY ACCESS TO SPECIALTY CARE

When Advice Request is enabled within eReferral, a referring provider can send an Advice Request asking for guidance or advice to a non-urgent question. Advice requests will allow the specialty service to reply back to the request within 5 days. The advice provided may suggest a referral be submitted or provide guidance for ongoing management of the patient's condition.

Number of Specialty Services with eReferral Advice Request Available, FY 2018-19

Provincial | **2018-19 Target**

Specialty Services with eReferral Advice Request Available, FY 2018-19

Referral Specialty	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Province	Total Year to Date 2018-19	Trend
Cardiology		✓	✓				1	
Chronic Pain Medicine		✓					1	
Community Pediatrics		✓					1	
Gastroenterology – Adult*			✓				-	
General Surgery – Breast		✓					1	
Infectious Disease				✓			1	
Neurology		✓					1	
Obstetrics/Gynecology – Maternal Fetal Medicine				✓			1	
Ophthalmology – Adult						✓	1	
Ophthalmology – Pediatrics						✓	1	
Otolaryngology			✓				1	
Palliative Care Medicine		✓					1	
Urology – Adult*			✓				-	
Urology – Pediatrics				✓			1	
Total Specialties Enabled in at least one Zone/Province							**12**	⇧

** Historically, these specialties were already enabled in zones in 2017-18.*

The following specialties were available for eReferral in 2017-18 and prior:

Referral Specialty	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Province	Total Specialties
Addiction and Mental Health – Opiate Agonist Therapy						✓	1
Endocrinology		✓					1
Gastroenterology – Adult	✓	✓	✓	✓	✓		1
General Internal Medicine		✓					1
Nephrology		✓		✓			1
Neurosurgery – Spinal		✓					1
Obstetrics/Gynecology		✓					1
Oncology – Breast Cancer	✓	✓	✓	✓	✓		1
Oncology – Lung Cancer	✓	✓	✓	✓	✓		1
Orthopedic Surgery – Hip and Knee Joint Replacement	✓	✓	✓	✓	✓		1
Pulmonary Medicine		✓					1
Urology – Adult				✓			1
Total Specialties Enabled in at least one Zone/Province in 2017-18 and prior							**12**

Source: Netcare Repository, as of May 2, 2019.

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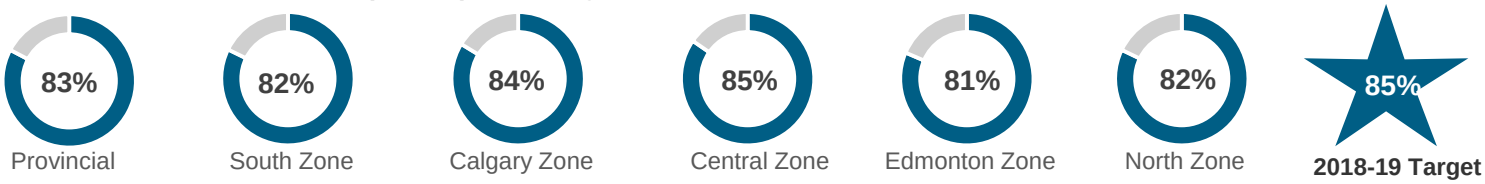
PATIENT SATISFACTION WITH HOSPITAL EXPERIENCE

This measure reflects patients' overall perceptions associated with the hospital where they received care. The higher the number, the better, as it demonstrates more patients are satisfied with their care in hospital.

Patient Satisfaction with Hospital Experience, Q3YTD 2018-19



Patient Satisfaction with Hospital Experience Trend

Zone Name	Site Name	2013-14	2014-15	2015-16	2016-17	2017-18	Q3YTD 2017-18	Q3YTD 2018-19	Trend	2018-19 Target
Provincial	**Provincial**	**81.5%**	**81.8%**	**81.8%**	**82.4%**	**81.8%**	**81.7%**	**82.7%**	⇨	**85%**
South Zone	**South Zone**	**81.7%**	**81.8%**	**80.9%**	**82.2%**	**79.8%**	**79.8%**	**82.2%**	⇧	**85%**
	Chinook Regional Hospital	80.5%	76.6%	78.2%	82.3%	80.2%	79.8%	79.9%	⇨	85%
	Medicine Hat Regional Hospital	80.7%	85.7%	81.3%	81.3%	77.1%	77.2%	83.0%	⇧	85%
	Other South Hospitals	83.5%	88.3%	87.2%	85.5%	85.3%	85.6%	87.4%	☆	85%
Calgary Zone	**Calgary Zone**	**80.1%**	**83.2%**	**82.0%**	**83.0%**	**82.3%**	**81.9%**	**83.7%**	⇨	**85%**
	Foothills Medical Centre	76.6%	80.8%	80.8%	80.3%	80.2%	80.0%	82.9%	⇧	85%
	Peter Lougheed Centre	80.9%	79.9%	77.2%	78.7%	77.7%	77.1%	78.1%	⇨	85%
	Rockyview General Hospital	82.9%	85.4%	81.7%	85.1%	83.6%	82.7%	85.4%	☆	85%
	South Health Campus	91.9%	89.7%	90.1%	90.9%	90.1%	89.8%	89.6%	☆	85%
	Other Calgary Hospitals	79.3%	90.3%	92.9%	92.2%	92.9%	92.7%	91.7%	☆	85%
Central Zone	**Central Zone**	**83.5%**	**84.8%**	**83.4%**	**85.0%**	**83.7%**	**84.4%**	**84.6%**	☆	**85%**
	Red Deer Regional Hospital Centre	81.1%	83.0%	82.2%	82.7%	81.5%	83.0%	82.1%	⇨	85%
	Other Central Hospitals	84.5%	86.7%	84.8%	87.0%	85.7%	85.9%	86.8%	☆	85%
Edmonton Zone	**Edmonton Zone**	**81.5%**	**80.3%**	**81.6%**	**80.8%**	**80.7%**	**80.8%**	**81.4%**	⇨	**85%**
	Grey Nuns Community Hospital	86.4%	87.2%	86.1%	86.4%	85.5%	85.4%	86.2%	☆	85%
	Misericordia Community Hospital	78.5%	75.3%	77.2%	79.8%	75.2%	74.8%	78.1%	⇧	85%
	Royal Alexandra Hospital	79.9%	76.5%	77.3%	76.6%	77.8%	78.2%	78.3%	⇨	85%
	Sturgeon Community Hospital	89.8%	87.6%	89.8%	88.0%	88.0%	89.2%	83.7%	⇩	85%
	University of Alberta Hospital	77.1%	80.2%	83.5%	80.4%	81.8%	81.4%	82.8%	⇨	85%
	Other Edmonton Hospitals	70.9%	85.3%	86.3%	85.7%	84.8%	84.4%	86.3%	☆	85%
North Zone	**North Zone**	**81.0%**	**80.6%**	**81.3%**	**83.2%**	**82.6%**	**82.3%**	**82.1%**	⇨	**85%**
	Northern Lights Regional Health Centre	75.4%	74.7%	78.6%	82.2%	82.1%	82.7%	78.4%	⇩	85%
	Queen Elizabeth II Hospital	76.0%	77.2%	78.6%	80.3%	79.9%	78.3%	79.8%	⇨	85%
	Other North Hospitals	83.4%	83.7%	83.5%	84.8%	84.0%	83.7%	84.3%	⇨	85%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total Eligible Discharges

Zone	2015-16	2016-17	2017-18	Q3YTD 2017-18	Q3YTD 2018-19	Number of Completed Surveys Q3YTD 2018-19	Margin of Error (±) Q3YTD 2018-19
Provincial	**218,546**	**246,917**	**246,227**	**184,636**	**186,100**	**19,018**	**0.54%**
South Zone	19,737	19,840	19,642	14,759	14,489	1,541	1.91%
Calgary Zone	61,044	83,208	83,397	62,469	63,378	6,279	0.91%
Central Zone	29,272	29,531	29,238	22,048	21,462	2,371	1.45%
Edmonton Zone	82,559	89,005	87,951	65,829	67,673	6,637	0.94%
North Zone	25,934	25,333	25,999	19,531	19,098	2,190	1.60%

Source: AHS Canadian Hospital Consumer Assessment of Healthcare Providers and Systems (CH-CAHPS) Survey, as of April 23, 2019
Notes:
- The results are reported a quarter later due to requirements to follow-up with patients after end of reporting quarter.
- The margin of errors were calculated using a normal estimated distribution for sample size greater than 10. If the sample size was less than 10, the Plus two & Plus four methods were used.
- Provincial and zone level results presented here are based on weighted data.
- Facility level results and All Other Hospitals results presented here are based on unweighted data.

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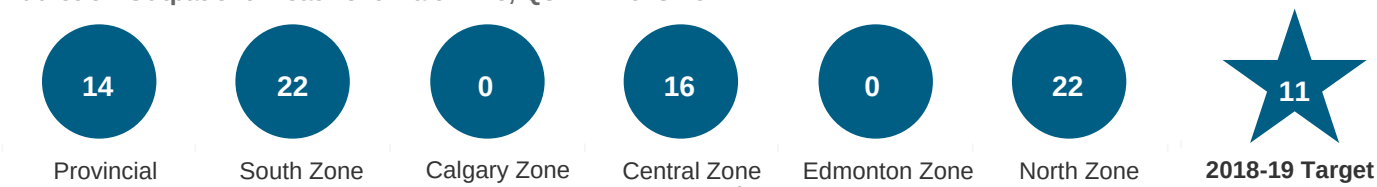
WAIT TIME FOR ADDICTION OUTPATIENT TREATMENT (in days)

This measure represents the time it takes to access adult addiction outpatient treatment services, expressed as the number of days that 9 out of 10 clients have attended their first appointment since referral or first contact (excludes opioid dependency programs). The lower the number the better, as it demonstrates people are waiting for a shorter time to receive adult addiction outpatient services.

Addiction Outpatient Treatment Wait Time, Q3YTD 2018-19



Addiction Outpatient Treatment Wait Time Trend by Zone (90th Percentile)

Wait Time Grouping	Zone Name	2013-14	2014-15	2015-16	2016-17	2017-18	Q3YTD 2017-18	Q3YTD 2018-19	Trend	2018-19 Target
Provincial	**Provincial**	**18**	**15**	**13**	**15**	**13**	**14**	**14**	⇨	**11**
Urban										
	Calgary Zone	21	9	5	6	0	0	0	☆	11
	Edmonton Zone	17	14	0	0	0	0	0	☆	11
Rural										
	South Zone	13	20	21	26	21	21	22	⇩	11
	Central Zone	20	16	14	15	14	14	16	⇩	11
	North Zone	16	16	19	27	23	24	22	⇧	11

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Outpatient Treatment Wait Time Trend by Zone (Average)

Wait Time Grouping	Zone Name	2013-14	2014-15	2015-16	2016-17	2017-18	Q3YTD 2017-18	Q3YTD 2018-19
Provincial	**Provincial**	**6.9**	**6.5**	**5.7**	**7.3**	**6.2**	**6.4**	**5.8**
Urban								
	Calgary Zone	7.7	7.4	7.8	11.4	9.1	9.8	6.9
	Edmonton Zone	6.4	5.1	1.2	0.9	0.4	0.4	0.3
Rural								
	South Zone	5.0	7.8	7.8	8.7	7.5	7.9	8.4
	Central Zone	7.3	6.2	6.0	6.2	5.7	5.5	6.7
	North Zone	7.5	7.3	8.2	11.1	10.5	10.5	9.0

Total Enrollments

Zone	2015-16	2016-17	2017-18	Q3YTD 2017-18	Q3YTD 2018-19
Provincial	**18,329**	**18,033**	**18,039**	**13,479**	**12,896**
South Zone	1,760	1,818	1,747	1,275	1,235
Calgary Zone	4,616	4,454	4,386	3,285	2,894
Central Zone	3,467	3,560	3,814	2,841	3,086
Edmonton Zone	4,957	4,665	4,637	3,471	3,159
North Zone	3,529	3,536	3,455	2,607	2,522

Sources: Addiction System for Information and Service Tracking (ASIST) Data Research View for Treatment Service, Standard Data Product 2. Clinical Activity Reporting Application (CARA), for results since Apr 1, 2013 3. Geriatric Mental Health Information System (GMHIS), for results since Apr 1, 2013 4. eClinician, for results since Jun 22, 2015 (ASE program) and Apr 20, 2015 (YASE program), as of April 30, 2019

Notes:

- The results are reported a quarter later due to requirements to follow-up with patients after end of reporting quarter.

- Average wait time is also provided to provide further context for the interpretation of the wait time performance measure. Trend and target are not applicable.

- Results may change due to data updates in the source information system or revisions to the measure inclusion and exclusion criteria.

- Enrollments have decreased due to higher client acuity and longer program stays resulting in less capacity.

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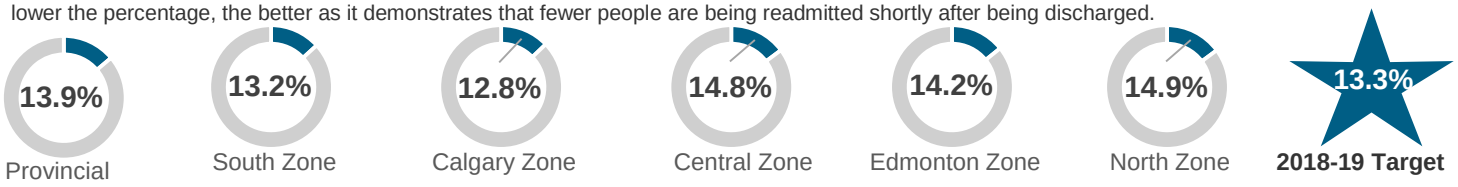
UNPLANNED MEDICAL READMISSIONS

The measure is defined as the percentage of medical patients with unplanned readmission to hospital within 30 days of leaving the hospital. The lower the percentage, the better as it demonstrates that fewer people are being readmitted shortly after being discharged.



Unplanned Medical Readmissions Trend

Zone Name	Site Name	2013-14	2014-15	2015-16	2016-17	2017-18	Q3YTD 2017-18	Q3YTD 2018-19	Trend	2018-19 Target
Provincial	**Provincial**	**13.5%**	**13.6%**	**13.7%**	**13.6%**	**13.6%**	**13.7%**	**13.9%**	⇨	**13.3%**
South Zone	**South Zone**	**14.1%**	**13.4%**	**14.2%**	**13.9%**	**13.9%**	**14.3%**	**13.2%**	☆	**13.3%**
	Chinook Regional Hospital	13.1%	13.4%	14.0%	13.3%	12.7%	13.2%	11.9%	☆	13.3%
	Medicine Hat Regional Hospital	14.4%	12.4%	14.1%	13.8%	13.9%	13.9%	13.1%	☆	13.3%
	Other South Hospitals	15.0%	14.7%	14.5%	14.9%	15.5%	16.0%	15.3%	⇧	13.3%
Calgary Zone	**Calgary Zone**	**12.2%**	**12.2%**	**12.3%**	**12.3%**	**12.5%**	**12.6%**	**12.8%**	☆	**13.3%**
	Foothills Medical Centre	12.2%	12.1%	12.3%	12.3%	12.3%	12.4%	12.6%	☆	13.3%
	Peter Lougheed Centre	12.0%	12.3%	12.8%	13.1%	12.6%	12.7%	12.5%	☆	13.3%
	Rockyview General Hospital	12.0%	11.9%	12.0%	12.1%	12.4%	12.9%	13.1%	☆	13.3%
	South Health Campus	12.3%	12.3%	12.0%	11.4%	12.3%	12.3%	13.7%	⇩	13.3%
	Other Calgary Hospitals	12.8%	13.7%	12.5%	13.0%	13.4%	13.2%	12.0%	☆	13.3%
Central Zone	**Central Zone**	**14.4%**	**14.9%**	**15.0%**	**14.8%**	**14.2%**	**14.5%**	**14.8%**	⇨	**13.3%**
	Red Deer Regional Hospital Centre	14.0%	13.8%	14.0%	13.0%	13.1%	13.2%	14.0%	⇩	13.3%
	Other Central Hospitals	14.6%	15.3%	15.4%	15.6%	14.6%	15.0%	15.2%	⇨	13.3%
Edmonton Zone	**Edmonton Zone**	**13.5%**	**13.8%**	**13.6%**	**13.6%**	**13.9%**	**13.9%**	**14.2%**	⇨	**13.3%**
	Grey Nuns Community Hospital	12.7%	12.3%	13.2%	12.7%	12.7%	13.1%	14.6%	⇩	13.3%
	Misericordia Community Hospital	13.0%	13.7%	13.5%	15.0%	14.2%	14.4%	15.6%	⇩	13.3%
	Royal Alexandra Hospital	13.2%	14.0%	13.7%	13.1%	14.2%	14.2%	13.8%	⇨	13.3%
	Sturgeon Community Hospital	12.3%	13.7%	13.4%	13.1%	13.8%	13.8%	15.3%	⇩	13.3%
	University of Alberta Hospital	14.6%	14.5%	14.2%	14.4%	14.5%	14.5%	14.2%	⇨	13.3%
	Other Edmonton Hospitals	13.4%	12.7%	11.9%	12.9%	12.0%	11.8%	12.4%	☆	13.3%
North Zone	**North Zone**	**15.0%**	**15.3%**	**15.3%**	**15.2%**	**14.8%**	**15.0%**	**14.9%**	⇨	**13.3%**
	Northern Lights Regional Health Centre	13.4%	12.8%	13.3%	14.2%	15.0%	15.2%	13.7%	⇧	13.3%
	Queen Elizabeth II Hospital	12.7%	11.9%	13.3%	13.3%	11.7%	11.5%	11.5%	☆	13.3%
	Other North Hospitals	15.5%	16.1%	15.9%	15.6%	15.3%	15.5%	15.6%	⇨	13.3%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total Discharges

Zone	2015-16	2016-17	2017-18	Q3YTD 2017-18	Q3YTD 2018-19
Provincial	**114,313**	**114,401**	**114,719**	**85,685**	**86,227**
South Zone	9,688	9,885	9,598	7,248	7,057
Calgary Zone	35,594	35,712	36,842	27,617	27,574
Central Zone	16,898	16,811	16,298	12,151	11,744
Edmonton Zone	37,859	37,853	37,829	28,120	29,465
North Zone	14,274	14,140	14,152	10,549	10,387

National Comparison:
Alberta ranks
5 (tied) out of 10

Source(s): AHS Provincial Discharge Abstract Database (DAD), as of May 3, 2019

Notes:

- *This quarter is a quarter later due to requirements to follow up with patients after end of reporting quarter.*
- *This indicator measures the risk-adjusted rate of urgent readmission to hospital for the medical patient group, which is adapted from the CIHI methodology (2016).*
- *Implementation of CIHI's 2018 CMG grouper resulted in minor changes to the number of qualified medical discharges (episodes) for historical fiscal years. This change has had negligible impact on the adjusted medical readmission rates at the zone/province level.*

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PERINATAL MORTALITY RATE AMONG FIRST NATIONS

Number of stillbirths (at 28 or more weeks gestation) plus the number of infants dying under 7 days of age divided by the sum of the number of live births plus the number of stillbirths of 28 or more weeks gestation for a given calendar year; multiplied by 1,000.

Perinatal Mortality Rate Gap, 2018-19

3.25

Provincial

Perinatal Mortality Rate by Population

Population	2013	2014	2015	2016	2017	2018	Trend	2017-18 Target
First Nations	9.46	10.50	10.69	9.64	8.38	8.66	N/A	AHS' focus is to reduce gap between First Nations and Non-First Nations
Non-First Nations	4.98	5.69	5.30	4.62	5.50	5.41	N/A	
Difference (Rate Gap)	**4.48**	**4.81**	**5.39**	**5.02**	**2.88**	**3.25**	⇩	

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

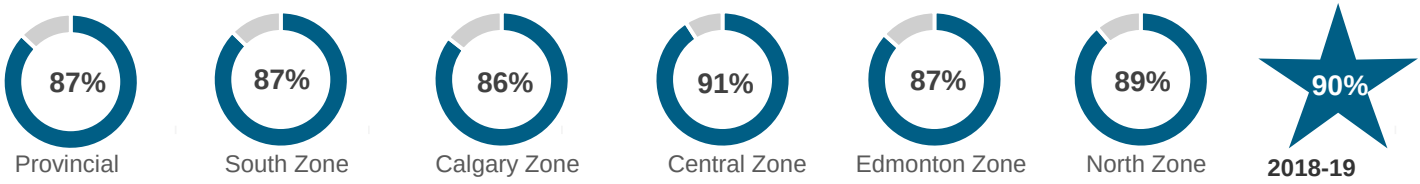
Source(s): Alberta Health, as of April 30, 2019
Note: Perinatal mortality is reported on an annual basis pending the availability of the most recent census data (2017). It is a performance indicator rather than a performance measure, and therefore no target is identified.

AHS Report on Performance FY 2018-19

HAND HYGIENE COMPLIANCE

This measure is defined as the percentage of opportunities in which healthcare workers clean their hands during the course of patient care. Direct observation is recommended to assess hand hygiene compliance rates for healthcare workers. The higher the percentage the better, as it demonstrates more healthcare workers are complying with appropriate hand hygiene practices.

Hand Hygiene Compliance, FY 2018-19



Hand Hygiene Compliance Trend

Zone Name	Site Name	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Trend	2018-19 Target
Provincial	**Provincial**	**66%**	**75%**	**80%**	**82%**	**85%**	**87%**	⇨	**90%**
South Zone	**South Zone**	**78%**	**82%**	**82%**	**84%**	**80%**	**87%**	⇧	**90%**
	Chinook Regional Hospital	81%	85%	82%	83%	78%	87%	⇧	90%
	Medicine Hat Regional Hospital	76%	77%	82%	87%	84%	89%	⇧	90%
	Other South Hospitals	79%	85%	83%	83%	81%	87%	⇧	90%
Calgary Zone	**Calgary Zone**	**59%**	**71%**	**78%**	**81%**	**84%**	**86%**	⇨	**90%**
	Alberta Children's Hospital	57%	74%	77%	80%	79%	81%	⇧	90%
	Foothills Medical Centre	52%	66%	76%	83%	84%	85%	⇨	90%
	Peter Lougheed Centre	62%	77%	85%	79%	80%	85%	⇧	90%
	Rockyview General Hospital	62%	68%	74%	84%	88%	91%	☆	90%
	South Health Campus	59%	59%	69%	76%	77%	76%	⇨	90%
	Other Calgary Hospitals	63%	77%	80%	79%	85%	88%	⇧	90%
Central Zone	**Central Zone**	**64%**	**74%**	**81%**	**78%**	**87%**	**91%**	☆	**90%**
	Red Deer Regional Hospital Centre	75%	69%	78%	78%	85%	88%	⇧	90%
	Other Central Hospitals	57%	77%	82%	78%	87%	92%	☆	90%
Edmonton Zone	**Edmonton Zone**	**57%**	**74%**	**79%**	**83%**	**86%**	**87%**	⇨	**90%**
	Grey Nuns Community Hospital	64%	75%	73%	83%	89%	92%	☆	90%
	Misericordia Community Hospital	71%	77%	75%	80%	86%	88%	⇨	90%
	Royal Alexandra Hospital	62%	75%	81%	84%	86%	85%	⇨	90%
	Stollery Children's Hospital	58%	75%	79%	80%	81%	80%	⇨	90%
	Sturgeon Community Hospital	59%	81%	84%	86%	88%	83%	⇩	90%
	University of Alberta Hospital	43%	70%	74%	85%	88%	89%	⇨	90%
	Other Edmonton Hospitals	58%	73%	79%	82%	86%	89%	⇧	90%
North Zone	**North Zone**	**66%**	**81%**	**87%**	**88%**	**88%**	**89%**	⇨	**90%**
	Northern Lights Regional Health Centre	56%	64%	88%	87%	82%	88%	⇧	90%
	Queen Elizabeth II Hospital	68%	91%	96%	91%	88%	81%	⇩	90%
	Other North Hospitals	66%	74%	85%	88%	89%	90%	☆	90%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total Observations *(excludes Covenant Sites)*

Zone	2015-16	2016-17	2017-18	2018-19
Provincial	**396,272**	**383,975**	**332,578**	**319,199**
South Zone	39,185	38,314	18,270	26,029
Calgary Zone	183,110	162,423	128,616	114,198
Central Zone	45,103	35,952	38,974	41,678
Edmonton Zone	99,795	125,281	117,032	106,473
North Zone	29,079	22,005	29,686	30,821

Source: AHS Infection, Prevention and Control Database, as of April 23, 2019

Notes:

- Covenant sites (including Misericordia Community Hospital and Grey Nuns Hospital) use different methodologies for capturing and computing Hand Hygiene compliance rates. These are available twice a year in spring (Q1 & Q2) and fall (Q3 & Q4). These are not included in the Edmonton Zone and Provincial totals.

- "Other Sites" include any hand hygiene observations performed at an AHS operated program, site, or unit including acute care, continuing care, and ambulatory care settings such as Cancer Control, Corrections, EMS, hemodialysis (e.g., NARP and SARP), home care, and public health.

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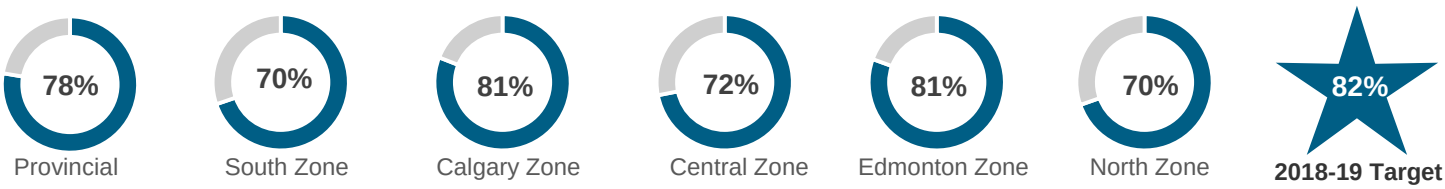
CHILDHOOD IMMUNIZATION RATE

DIPHTHERIA, TETANUS, ACELLULAR PERTUSSIS, POLIO, HAEMOPHILUS INFLUENZAE TYPE B (DTaP-IPV-Hib)

This measure is defined as the percentage of children who have received the required number of vaccine doses by two years of age. A high rate of immunization for a population reduces the incidence of vaccine-preventable childhood diseases, and controls outbreaks. Immunizations protect children and adults from a number of vaccine-preventable diseases, some of which can be fatal or produce permanent disabilities. The higher the percentage the better, as it demonstrates more children are immunized and protected from vaccine-preventable childhood diseases.

Childhood Immunization Rate: DTaP-IPV-Hib, FY 2018-19



Childhood Immunization Rate: DTaP-IPV-Hib Trend

Zone Name	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Trend	2018-19 Target
Provincial	**77.6%**	**78.3%**	**78.0%**	**78.3%**	**77.7%**	**77.7%**	⇨	**82%**
South Zone	64.6%	67.9%	65.7%	67.8%	70.0%	69.8%	⇨	82%
Calgary Zone	81.4%	82.6%	81.5%	81.4%	79.8%	81.0%	*	82%
Central Zone	71.1%	71.1%	70.9%	70.6%	70.7%	71.9%	⇨	82%
Edmonton Zone	84.0%	84.0%	84.6%	84.0%	82.9%	80.5%	*	82%
North Zone	67.2%	66.6%	66.5%	67.7%	68.9%	69.6%	⇨	82%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

*- * 2018-19 rates not comparable to previous years due to change in reporting system. Going forward the new system will provide a more accurate reflection of the rate.*

Total Eligible Population

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

Source: Province-wide Immunization Program, Communicable Disease Control as of April 23, 2019
Notes:
- The target represented is the AHS' 2018-19 Target. Alberta Health has higher targets for both vaccines by two years of age.

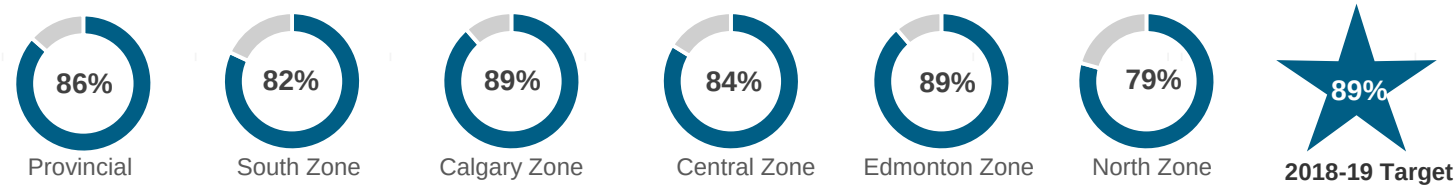
AHS Report on Performance FY 2018-19

CHILDHOOD IMMUNIZATION RATE

MEASLES, MUMPS, RUBELLA (MMR)

This measure is defined as the percentage of children who have received the required number of vaccine doses by two years of age. A high rate of immunization for a population reduces the incidence of vaccine-preventable childhood diseases and controls outbreaks. Immunizations protect children and adults from a number of vaccine-preventable diseases, some of which can be fatal or produce permanent disabilities. The higher the percentage the better, as it demonstrates more children are immunized and protected from vaccine-preventable childhood diseases.

Childhood Immunization Rate: MMR, FY 2018-19



Childhood Immunization Rate: MMR Trend

Zone Name	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Trend	2018-19 Target
Provincial	**86.7%**	**87.6%**	**86.9%**	**87.4%**	**86.9%**	**86.5%**	⇨	**89%**
South Zone	81.1%	83.9%	78.8%	81.0%	82.1%	82.0%	⇨	89%
Calgary Zone	88.3%	89.6%	89.2%	89.6%	87.9%	88.6%	☆*	89%
Central Zone	81.2%	80.8%	81.1%	82.3%	84.2%	83.8%	⇨	89%
Edmonton Zone	91.7%	92.2%	91.9%	91.8%	90.5%	88.7%	☆*	89%
North Zone	79.6%	80.3%	78.5%	77.8%	79.6%	79.3%	⇨	89%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

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Source: Province-wide Immunization Program, Communicable Disease Control as of April 23, 2019
Notes:
- The target represented is the AHS' 2018-19 Target. Alberta Health has higher targets for both vaccines by two years of age

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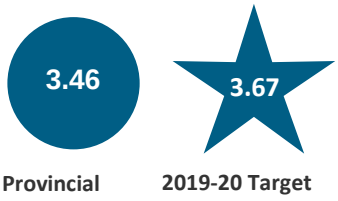
AHS WORKFORCE ENGAGEMENT

Engagement refers to how committed an employee is to the organization, their role, their manager, and co-workers. High engagement correlates with higher productivity, safe patient care and willingness to give discretionary effort at work. Monitoring workforce engagement enables us to determine the effectiveness of processes/programs that support employee engagement and strengthen a patient safety culture.

The Engagement Rate is the mean score of the responses to the AHS' 'Our People Survey' which utilized a five-point scale, with one being 'strongly disagree' and five being 'strongly agree'. More than 46,000 individuals – including nurses, emergency medical services, support staff, midwives, physicians and volunteers – participated in the Our People Survey in 2016-17.

Our People Survey Results



AHS' workforce engagement was 3.46 on a five-point scale (5 indicates highly engaged). Based on a question asking how satisfied people are with AHS as a place to work: 57% of respondents felt positively, 40% felt neutral, and 3% felt negatively. The next survey is planned for 2019-20 with a target of 3.67.

Employees	Volunteers	Physicians
57% were positive about the work they do at AHS and chose a 4 or 5 for overall satisfaction.	**90%** were positive about the work they do at AHS and chose a 4 or 5 for overall satisfaction.	**48%** were positive about the work they do at AHS and chose a 4 or 5 for overall satisfaction.

Source(s): AHS People, Legal, Privacy. http://insite.albertahealthservices.ca/2305.asp

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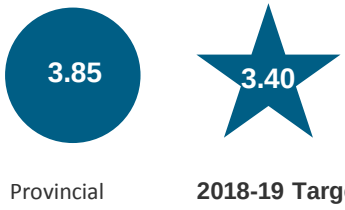
DISABLING INJURIES IN AHS WORKFORCE

This measure is defined as the number of injured AHS workers requiring modified work or time loss from work per 200,000 paid hours (approximately 100 full-time equivalent workers. Our disabling injury rate enables us to identify Workplace Health & Safety (WHS) programs that provide AHS employees, volunteers and physicians with a safe and healthy work environment and keep them free from injury. The lower the rate, the fewer disabling injuries are occurring at work.

Disabling Injury Rate: Q3YTD 2018-19



Provincial **2018-19 Target**

Level of Portfolio	Portfolio or Departments	2015-16	2016-17	2017-18	Q3YTD 2017-18	Q3YTD 2018-19	Trend	2018-19 Target
Province	**Provincial**	**3.57**	**3.85**	**4.11**	**3.97**	**3.85**	⇧	**3.40**
Zone	South Zone Clinical Operations	3.57	3.50	3.75	3.63	3.83	⇩	3.40
	Calgary Zone Clinical Operations	3.56	3.88	4.57	4.24	4.32	⇨	3.40
	Central Zone Clinical Operations	3.88	4.12	4.91	5.16	3.91	⇧	3.40
	Edmonton Zone Clinical Operations	3.48	3.73	4.11	3.94	4.00	⇨	3.40
	North Zone Clinical Operations	4.35	3.75	4.09	3.71	4.14	⇩	3.40
Provincial Portfolios	Cancer Control	1.68	1.47	1.04	0.80	1.30	☆	3.40
	Capital Management	2.15	2.74	2.24	2.09	2.20	☆	3.40
	Community Engagement and Communications	0.00	0.00	0.00	0.00	0.00	☆	3.40
	Contracting, Procurement & Supply Management	2.61	3.85	3.24	3.33	3.20	☆	3.40
	Diagnostic Imaging Services	1.85	2.86	3.57	3.94	3.63	⇧	3.40
	Emergency Medical Services	12.94	15.09	15.02	15.06	12.60	⇧	3.40
	Finance	0.16	0.33	0.50	0.67	0.46	☆	3.40
	Health Information Management	1.25	2.19	1.80	1.50	1.23	☆	3.40
	Health Professions & Practice	7.47	6.58	7.73	8.20	7.15	⇧	3.40
	Information Technology (IT)	0.26	0.17	0.21	0.14	0.13	☆	3.40
	Internal Audit and Enterprise Risk Management	0.00	0.00	0.00	0.00	0.00	☆	3.40
	Laboratory Services	1.26	1.63	2.30	1.75	2.25	☆	3.40
	Nutrition Food, Linen & Environmental Services	6.95	6.89	6.35	6.39	6.12	⇧	3.40
	People, Legal, and Privacy	1.51	2.89	2.69	2.78	2.76	☆	3.40
	Pharmacy Services	1.05	1.69	1.22	1.18	1.01	☆	3.40
	Population Public & Indigenous Health	1.31	1.13	0.82	0.82	1.08	☆	3.40
	System Innovations and Programs	0.27	0.25	0.47	0.47	0.60	☆	3.40

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Source: WCB Alberta and e-Manager Payroll Analytics (EPA). EPA 2017-19 YTD data as of June, 2018. WCB data April-June, 2018 as of January 17, 2019; Data retrieval May 1, 2019

Notes:

- This measure is reported one quarter later as data continues to accumulate as individual employee cases are closed.

- Reporting of "0.00" is accurate and reflects these portfolios having very safe and healthy work environments.

- Starting Q2 2018-19, the Nutrition, Food, Linen & Environmental Services departments have been merged into one department.

- Accurate mapping of historical data is not possible as functional centre hierarchies have been recently revised. As a result, data in fiscal years 2014-15 to 2016-17 were not refreshed in this update to guarantee reporting consistency.

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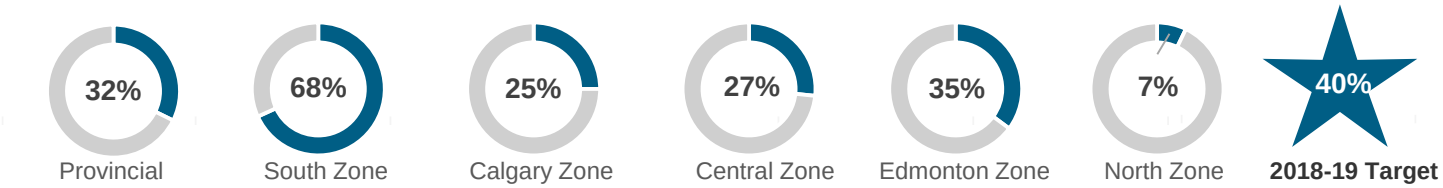
NURSING UNITS ACHIEVING BEST PRACTICE EFFICIENCY TARGETS

This measure is defined as the percentage of nursing units at the 16 busiest sites meeting Operational Best Practice (OBP) labour efficiency targets. A higher percentage means more efficiencies have been achieved across AHS.

Percentage of Nursing Units Achieving Best Practice Efficiency Targets, FY 2018-19



Percentage of Nursing Units Achieving Best Practice Efficiency Targets

Zone Name	2015-16	2016-17	2017-18	2018-19	Trend	2018-19 Target
Provincial	**20%**	**28%**	**38%**	**32%**	⇩	**40%**
South Zone	63%	58%	61%	68%	☆	40%
Calgary Zone	15%	20%	25%	25%	⇨	40%
Central Zone	7%	14%	47%	27%	⇩	40%
Edmonton Zone	14%	29%	42%	35%	⇩	40%
North Zone	33%	33%	36%	7%	⇩	40%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Source: AHS General Ledger (no allocations); Worked Hours - Finance consolidated trial balance, Patient Days – Adult & Child - Finance statistical General Ledger, as of May 2, 2019
Notes:
- Data quality issues were identified in historical data which potentially overstated efficiencies. While improvements to data quality continue to be made, historical data cannot be retroactively corrected.

Monitoring Measures

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

The National Comparison column is based on the most recent data available, released May 2019. Parts of this material are based on data and information provided by the Canadian Institute for Health Information (CIHI). However, the analyses, conclusions, opinions and statements expressed herein are those of the author, and not necessarily those of CIHI.

AHS has seen improvements to the measure results over the last five years in:

- Reducing acute care length of stay relative to expected acute care length of stay. This measure helps healthcare teams ensure appropriate and efficient care. Improvement in this measure enables the ability to treat more patients with the existing beds and other resources.
- Reducing hospital acquired *Clostridium difficile* infection (CDI) rate. CDI is one common cause of hospital acquired infections and prolongs hospital stays.
- Reducing Hospital Standardized Mortality Ratio (HSMR). This measures how successful hospitals have been reducing patient death and improving patient care.
- Reducing heart attack in-hospital mortality rate. This is a good indicator that care for patients within our hospitals is improving.
- Access to radiation therapy. This measures how quickly we are able to care for patients who need radiation therapy.

Data updated as of May 30, 2019. Definitions can be found at https://www.albertahealthservices.ca/about/Page12640.aspx.

LIFE EXPECTANCY	2014	2015	2016	2017	2018	National Comparison
The number of years a person would be expected to live, starting at birth, on the basis of mortality statistics.						
Provincial	81.7	81.7	81.8	81.7	81.9	5 out of 10
Females	83.8	84.0	84.1	84.0	84.3	5 out of 10
Males	79.6	79.5	79.7	79.5	79.6	5 out of 10
First Nations	70.9	69.7	70.8	70.6	70.4	n/a
Non-First Nations	82.1	82.2	82.2	82.1	82.4	n/a

POTENTIAL YEARS OF LIFE LOST	2014	2015	2016	2017	2018	National Comparison
The total number of years not lived (per 1,000 population) by an individual who died before their 75th birthday.						
Both	49.9	50.7	49.8	50.9	50.4	5 out of 10
Females	38.9	38.3	38.0	38.2	36.9	6 out of 10
Males	60.4	62.6	61.1	63.2	63.6	5 out of 10

CANCER SCREENING	2014-15	2015-16	2016-17	2017-18	2018-19	National Comparison
Breast Cancer Participating Rate	62.7%	63.4%	64.1%	63.9%	n/a	4 out of 10
Colorectal Cancer Participating Rate	39.2%	38.0%	37.7%	38.6%	n/a	2 out of 6
Cervical Cancer Participating Rate	66.9% (2012-14)	65.9% (2013-15)	65.7% (2014-16)	65.1% (2015-17)	64.3% (2016-18)	4 out of 9
Early Detection of Cancers	69.0% (2014)	69.9% (2015)	69.8% (2016)	71.4% (2017)	n/a	n/a

Note: n/a = not available
Modified wording; no changes to data June 19, 2019

Monitoring Measures (Cont'd)

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INFLUENZA IMMUNIZATION	2014-15	2015-16	2016-17	2017-18	2018-19	National Comparison
Seasonal Influenza Immunizations	**1,254,950**	**1,146,569**	**1,171,825**	**1,229,350**	**1,317,659**	n/a
Rates of seasonal influenza immunization by age group.						
Adults 65+ years	60.5%	62.7%	60.2%	60.1%	61.2%	5 out of 10
Children 6 to 23 months	35.6%	35.9%	35.3%	34.6%	40.7%	n/a
AHS healthcare workers	63.9%	60.9%	62.5%	66.0%	67.6%	n/a

PRIMARY HEALTH CARE	2014-15	2015-16	2016-17	2017-18	2018-19	National Comparison
Albertans enrolled in a Primary Care Network	78%	79%	80%	82%	82%	n/a
Ambulatory care sensitive conditions: rate of hospital admissions for health conditions that may be prevented or managed by appropriate primary healthcare.	378 (2014)	361 (2015)	362 (2016)	349 (2017)	340 (2018)	5 out of 10
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.	24.4%	23.1%	22.2%	21.3%	20.2%	n/a
# of Health Link calls	813,471	755,334	744,278	706,280	694,313	n/a
Percentage of Health Link calls answered within two minutes	77%	76%	74%	73%	74%	n/a

CHILDREN'S MENTAL HEALTH SERVICES	2014-15	2015-16	2016-17	2017-18	2018-19	National Comparison
Percentage of children aged 0 to 17 years *offered* scheduled mental health treatment	89%	85%	81%	74%	82%*	n/a
Percentage of children aged 0 to 17 years *receiving* scheduled mental health treatment	82%	73%	73%	67%	73%*	n/a

* Child mental health measures for 2018-19 do not include North Zone and Red Deer Clinic due to data quality issues.

EMERGENCY DEPARTMENT (ED)*	2014-15	2015-16	2016-17	2017-18	2018-19	National Comparison
Total Number of ED Visits (all sites)	2,181,369	2,134,945	2,079,688	2,101,629	2,055,864	n/a
Percentage of patients treated and admitted to hospital within 8 hours (all sites)	46.0%	46.9%	46.1%	43.9%	45.4%	n/a
Percentage of patients treated and admitted to hospital within 8 hours (busiest sites)	36.1%	37.9%	37.3%	35.5%	37.9%	n/a
Percentage of patients treated and discharged within 4 hours (all sites)	78.5%	78.3%	77.8%	76.0%	74.4%	n/a
Percentage of patients treated and discharged within 4 hours (busiest sites)	63.3%	62.9%	62.6%	60.1%	58.7%	n/a
ED time to Physician Initial Assessment (median in hours at busiest sites)	1.4	1.3	1.3	1.4	1.4	n/a
Percentage of patients left without being seen and left against medical advice	4.3%	3.9%	3.9%	4.3%	4.5%	n/a

* ED historical values were restated to ensure consistent information over time based on the NACRS database.

Note: n/a = not available
Modified wording; no changes to data June 19, 2019

Monitoring Measures (Cont'd)

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ACUTE CARE	2014-15	2015-16	2016-17	2017-18	2018-19	National Comparison
Hospital Discharges	401,331	404,514	403,958	400,909	401,179	n/a
Acute Care Occupancy: Percentage of patient days in hospital compared to available bed days in the reporting period for top 16 AHS sites.	97.4%	96.1%	96.9%	98.0%	96.3%	n/a
Acute Length of Stay to Expected Length of Stay Ratio	1.06	1.04	1.02	1.00	1.00	2 (tied) of 9
Hospital-Acquired *Clostridium difficile* Infection Rate (per 10,000 patient days)	3.5	3.6	3.4	3.0	2.5	Better than national average
Hospital Standardized Mortality Ratio (HSMR)	93	93	93	93	89	5 out of 10
Mental Health Readmissions within 30 days (risk adjusted)	8.8%	8.6%	8.8%	8.8%	9.8% (Q3YTD)	1 (tied) of 10
Surgical Readmissions within 30 days (risk adjusted)	6.5%	6.5%	6.7%	6.5%	6.6% (Q3YTD)	7 out of 10
Heart Attack (AMI) in Hospital Mortality within 30 days (risk adjusted)	5.9%	6.1%	5.5%	5.4%	5.5% (Q3YTD)	3 (tied) of 10
Stroke in Hospital Mortality within 30 days (risk adjusted)	13.8%	14.0%	12.5%	12.8%	12.7% (Q3YTD)	5 out of 10

CANCER CARE WAIT TIMES in weeks, 90th percentile	2014-15	2015-16	2016-17	2017-18	2018-19	National Comparison
Radiation oncology access: referral to first consult (from referral to the time of their first appointment with a radiation oncologist).	4.9	5.0	5.0	5.3	7.0	n/a
Medical oncology access: referral to first consult (from referral to the time of their first appointment with a medical oncologist).	5.6	5.6	5.1	5.7	6.4	n/a
Radiation therapy access: ready to treat to first therapy.	3.1	2.9	2.7	2.7	2.7	1 (tied) of 10

SURGERY WAIT TIMES in weeks		2014-15	2015-16	2016-17	2017-18	2018-19	National Comparison
Coronary Artery Bypass Graft (CABG) Urgency III – Scheduled (excludes Urgent and Emergent cases)	Average (Median)	5.7	4.4	5.1	6.6	7.0	6 (tied) of 8
	90th Percentile	14.9	12.1	10.7	22.2	19.4	6 out of 8
	Volume	479	404	423	355	403	n/a
Cataract Surgery	Average (Median)	10.6	13.0	13.9	14.9	16.9	8 out of 10
	90th Percentile	29.9	33.0	34.0	38.6	48.1	8 out of 10
	Volume	36,582	36,806	38,053	39,340	40,140	n/a
Hip Replacement	Average (Median)	13.1	13.7	14.6	18.1	18.9	6 out of 10
	90th Percentile	28.7	31.4	32.9	36.7	38.0	4 out of 10
	Volume	5,397	5,564	6,004	6,191	6,278	n/a
Knee Replacement	Average (Median)	14.7	15.9	16.3	20.7	19.1	3 out of 10
	90th Percentile	33.0	34.7	36.9	40.7	43.7	4 out of 10
	Volume	6,377	6,645	6,692	6,556	6,613	n/a
Hip Fracture Repair: Percentage within 48 hours		86.2%	90.1%	91.8%	92.8%	94.1%	1 out of 9

Note: n/a = not available
Modified wording; no changes to data June 19, 2019

Monitoring Measures (Cont'd)

The National Comparison column is based on the most recent data available, released May 2019. Parts of this material are based on data and information provided by the Canadian Institute for Health Information (CIHI). However, the analyses, conclusions, opinions and statements expressed herein are those of the author, and not necessarily those of CIHI.

Data updated as of May 30, 2019. Definitions can be found at https://www.albertahealthservices.ca/about/Page12640.aspx.

CONTINUING CARE	2014-15	2015-16	2016-17	2017-18	2018-19	National Comparison
Total number of people placed into continuing care	7,810	7,879	7,963	7,927	8,098	n/a
Number of patients placed from acute/ sub-acute hospital bed into continuing care	5,548	5,405	5,395	5,218	5,005	n/a
Number of clients placed from community (at home) into continuing care	2,262	2,474	2,568	2,709	3,093	n/a
Average wait time for continuing care placement (in days)	51	53	59	62	61	n/a
Average wait time in acute/ sub-acute care hospital bed for continuing care placement (in days)	42	44	46	51	46	n/a
Average wait time for long-term care placement (in days)	45	37	38	46	39	n/a
Average wait time for designated supportive living placement (in days)	62	79	91	86	95	n/a
Total number waiting for continuing care placement	1,544	1,411	1,873	1,937	1,508	n/a
Number of persons waiting in acute/ sub-acute hospital bed for continuing care placement	690	628	846	676	474	n/a
Number of persons waiting in community (at home) for continuing care placement	854	783	1,027	1,261	1,034	n/a
Number of unique/individual home care clients	114,813	117,505	119,749	121,929	127,214	n/a

Note: n/a = not available
Modified wording; no changes to data June 19, 2019

Public Interest Disclosure (Whistleblower Protection) Act (PIDA)

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

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

Over the past year, AHS has:

- Monitored legislative amendments to PIDA that came into force on March 1, 2018.
- Updated resources for managers and staff about PIDA and the internal disclosure process.

In compliance with legislated reporting requirements, from April 1, 2018 to March 31, 2019, AHS reports as follows:

- No disclosures were received by or referred to the Designated Officer
- No 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

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

Non-Hospital Surgical Facility Contracts under the Health Care Protection Act (Alberta)

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

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

A provincial framework was developed including governance, quality measurement, incident reporting, and monitoring. Contracts with NHSFs provide increased choice of service provider for patients and supplement the resources available in hospitals, while providing good value for public dollars. There's no discernable difference (<1%) between the total number of procedures performed in 2018-19 (40,344) as compared to 2017-18 (40,705).

The table below summarizes non-hospital surgical contracts by service area for 2018-19:

2018-19 NON-HOSPITAL SURGICAL FACILITIES ACTIVITY		
Contracted Service Area	# of Contracted Operators	# of Contracted Procedures Performed
Dermatology – Edmonton Zone	1	24
Ophthalmology – Calgary Zone**	5	17,363
Ophthalmology – Edmonton Zone	6	3,257
Ophthalmology – North Zone	1	965
Oral and Maxillofacial Surgery – Calgary Zone	8	851
Oral and Maxillofacial Surgery – Edmonton Zone	9	3,184
Otolaryngology (ENT) – Edmonton Zone	2	221
Plastic Surgery – Edmonton Zone	3	306
Pregnancy Termination – Calgary	1	5,315
Pregnancy Termination – Edmonton	1	5,946
Restorative Dental – South Zone	4	633
Dental Contract Surgical Service – Calgary*	1	400
Dermatology (Non-HCPA) - Edmonton Zone	2	344
Dermatology (Non-HCPA) - Calgary Zone	3	179
Restorative Dental – Edmonton	3	377
Podiatry Contract Surgical Service – Calgary*	1	979

There are no surgical contracts with NHSF in the Central Zone that fall under the *Health Care Protection Act (HCPA).*
*based on activity generated May 2, 2019.
**Calgary Zone contracts more ophthalmology procedures outside AHS hospitals compared to Edmonton Zone, which performs more ophthalmology procedures within AHS hospitals.

AHS Facilities and Beds

AHS Facilities

Facility Definitions

Facility	Definition
Addiction	Addiction treatment facilities with beds and mats for clients with substance use and gambling problems. Includes detoxification, nursing care, assessment, counselling and treatment. Direct services provided by AHS as well as funded and contracted services. This also includes beds for Protection of Children Abusing Drugs (PChAD) program clients and residential beds funded through the Safe Communities Initiative.
Comm. MH	Community Mental Health (CMH) supports home programs, community beds and other mental health community beds/spaces that deliver both transitional and permanent/long-term services to clients with varying mental health issues. In addition, CMH treats the clients behavioral, social, physical and medical needs.
Standalone Psych	Standalone psychiatric facilities: Claresholm Centre for Mental Health and Addictions (Claresholm), Southern Alberta Forensic Psychiatric Centre (Calgary), Centennial Centre for Mental Health and Brain Injury (CCMHBI) (Ponoka), Alberta Hospital Edmonton (Edmonton) and Villa Caritas (Edmonton)
Hospital	Acute Care Hospitals are where active treatment is provided. They include medical, surgery, obstetrics, pediatrics, acute care psychiatric, NICU (neonatal intensive care level 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, for example, 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, outpatient and specialty clinics. They do not have acute care beds or inpatient services. ***Ambulatory Endoscopy / Surgical Centre Hospitals (OP)*** reflect facilities providing ambulatory services including endoscopy and outpatient specialty clinics.
Sub-acute Care (SAC)	Sub-acute care is provided in an auxiliary hospital for the purpose of receiving convalescent and/or rehabilitation services, where it is anticipated that the patient will achieve functional potential to enable them to improve their health status and to successfully return to the community.
Palliative (PEOLC)	Palliative and End-of-Life Care (PEOLC) facilities are where a designated program or bed for the purpose of receiving palliative care services, including end-of-life and symptom alleviation, but are not located in an acute care facility. This includes community hospice beds.
Long-Term Care (LTC)	Long-term care is provided in nursing homes and auxiliary hospitals. It is reserved for those with unpredictable and complex health needs, usually multiple chronic and/or unstable medical conditions. Long-term care includes health and personal care services, such as 24-hour nursing care provided by registered nurses or licensed practical nurses.
Designated Supportive Living (DSL)	Designated supportive living includes comprehensive services, such as the availability of 24-hour nursing care (levels 3 or 4). Designated Supportive Living 4-Dementia and Designated Supportive Living Mental Health is also available for those individuals living with moderate to severe dementia or cognitive impairment. Albertans accessing designated supportive living services generally reside in lodges, retirement communities, or designated supportive living centres.
Cancer (Ca)	Cancer Care Services include assessments and examinations, supportive care, pain management, prescription of cancer- related medications, education, resource and support counselling and referrals to other cancer centres.
Ambulatory	***Urgent Care Centre (UCC)*** is a community-based service delivery site (non-hospital setting) where higher level assessment, diagnostic and treatment services are provided for unscheduled clients who require immediate medical attention for injuries /illnesses that require human and technical resources more intensive than what is available in a physicians' office or AACC unit. ***Advanced Ambulatory Care Services (AACS)*** is a community-based service delivery site (non-hospital setting) where assessment, diagnostic and treatment services are provided for unscheduled patients seeking immediate medical attention for non-life threatening illnesses, typically patients of lower acuity than those treated in a UCC or ED. ***Community Ambulatory Care Centre (CACC)*** is a community-based service delivery site (non-hospital setting) primarily engaged in the provision of ambulatory care diagnostic and treatment services. This includes typically scheduled primary care for clients who do not require hospital outpatient emergency care or inpatient treatment. ***Family Care Clinic (FCC)*** provides primary healthcare to people and their families in under-serviced areas of Alberta. ***Public Health Centres*** include community health centres, community health clinics, district offices, public health, and public health centres. They provide services that are offered by public health nurses, including immunization, health education/counselling/support for parents, health assessment and screening to identify health concerns, and referral to appropriate healthcare providers such as physicians, and community resources.

Facilities by Zone

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

Number of Facilities	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
Community Ambulatory Care						
Urgent Care Centres		5		1		**6**
Ambulatory Care Centres	2	1	2		2	**7**
Family Care Clinics		1		1	1	**3**
Primary Care Networks	2	7	12	9	11	**41**
Public Health Centres	17	23	34	22	45	**141**
Addiction and Mental Health						
Addiction	6	12	5	10	6	**39**
Community Mental Health	6	14	2	21	1	**44**
** The number of facilities for Community Mental Health does not include contracted sites with multiple locations. These facilities are noted in Zone Beds by Facility.*		2		3		
Standalone Psychiatric		2	1	2		**5**
Hospital Acute Care						
Urban		5		5		**10**
Regional	2		1		2	**5**
Community	10	8	29	7	31	**85**
Standalone Emergency Departments	1			2	1	**4**
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	70	80	88	58	**347**
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	1	6	4	**21**

Source: AHS Bi-Annual Bed Survey as of March 31, 2019.
Note: Refer to definition and explanation of facilities on previous page.
Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

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, 7,463 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**
Total Net New Beds	1,168	6,228	7,396	7,396	67	7,463

Source: AHS Bi-Annual Bed Survey as of March 31, 2019.
Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

The number of beds above reflects AHS new capacity which has been staffed and in operation (patient placed into beds) during 2018-19. AHS is working with Alberta Health on a number of projects for additional capacity that did not open in 2018-19 but are planned to open in 2019-20. AHS does not include future capacity in any bed reporting.

Continuing Care – New Facilities

In 2018-19, new continuing care capacity was added at existing facilities in all zones including new facilities (1,093 beds). All new capacity was built to accommodate clients needing long-term care and dementia care. The table below reflects where clients were placed from the AHS waitlists into the new facilities that opened.

New Facilities Opened in 2018-19	Zone	Location	Date Opened	Long-Term Care	Dementia Designated Supportive Living 4	Designated Supportive Living 4	Designated Supportive Living 3	Total
Kainai Continuing Care Centre (federal partnership with AHS)	South	Stand Off	April 1, 2018	25				**25**
Chartwell Heritage Valley	Edmonton	Edmonton	April 9, 2019		18			**18**
Benevolence Care Centre	Edmonton	Edmonton	April 17, 2018	99				**99**
AgeCare SkyPointe	Calgary	Calgary	June 4, 2018	128	64	160		**352**
Points West Living Lac La Biche	North	Lac La Biche	June 11, 2018		24	16		**40**
Pioneer Lodge (re-opened)	South	Fort Macleod	July 23, 2018				10	**10**
Bar V Nook Supportive Living	North	Smoky Lake	August 8, 2018		20	21		**41**
Points West Living Wetaskiwin	Central	Wetaskiwin	September 17, 2018		53	29		**82**
Bethany Riverview	Calgary	Calgary	September 24, 2018	210				**210**
Edmonton People in Need – Bridgeway 2 (replacement facility)	Edmonton	Edmonton	October 10, 2018		13	84		**97**
Kahkiyow Keyhanow Elders Care Home	North	Fort Chipewyan	October 15, 2018				11	**11**
The Hamlets at Red Deer	Central	Red Deer	February 4, 2019		54	54		**108**
TOTAL				462	246	364	21	1093

Source: AHS Bi-Annual Bed Survey as of March 31, 2019.

Number of Continuing Care Facilities by Provider

As of March 31, 2019, there were 26,914 Designated Long Term Care (LTC) and Designated Supportive Living (DSL) spaces staffed and in operation in the province in over 300 facilities. These facilities encompass AHS, AHS subsidiaries (Carewest and CapitalCare), private (Extendicare, Agecare, etc.), not-for-profit/non-profit (non-profit includes Covenant, Good Samaritan, etc.) and Saskatchewan Health Authority (Lloydminster) ownership. AHS will continue to improve the system and access to care and supports in the community. Collaboration with our valued service providers is integral to this effort.

Continuing Care Facilities by Operator	Number of Facilities as of March 31, 2019								
	LTC (Facilities)	LTC (Spaces)	DSL (Facilities)	DSL (Spaces)	Campus of Care (Facilities)	Campus of Care (LTC Spaces)	Campus of Care (DSL Spaces)	Total Facilities	Total Spaces
AHS Operated	**81**	**4,341**	**17**	**612**	**4**	**263**	**127**	**102**	**5,343**
South	12	239	1	10				13	249
Calgary	5	216	1	38				6	254
Calgary Subsidiary (CareWest)	9	901	1	10	1	175	30	11	1,116
Central	24	1,154	2	32	1	23	19	27	1,228
Edmonton	2	54	1	72				3	126
Edmonton Subsidiary (CapitalCare)	6	997	5	208				11	1,205
North	23	780	6	242	2	65	78	31	1,165
Private	**37**	**4,730**	**70**	**4,880**	**13**	**977**	**1,156**	**120**	**11,743**
South	3	288	9	563	3	130	91	15	1,072
Calgary	14	2,389	15	1,040	5	415	800	34	4,644
Central	2	133	20	1,175	1	220	60	23	1,588
Edmonton	14	1,694	21	1,918	1	80	15	36	3,707
North	4	226	5	184	3	132	190	12	732
Non-Profit	**35**	**4,252**	**76**	**3,873**	**12**	**924**	**669**	**123**	**9,718**
South	2	35	18	1,084	3	276	144	23	1,539
Calgary	10	1,603	6	734	3	248	213	19	2,798
Central	9	519	15	415	4	205	196	28	1,335
Edmonton	13	2,065	23	1,348	2	195	116	38	3,724
North	1	30	14	292				15	322
Saskatchewan Health Authority - Lloydminster	**2**	**110**	**0**	**0**	**0**	**0**	**0**	**2**	**110**
Total	**155**	**13,433**	**163**	**9,365**	**29**	**2,164**	**1,952**	**347**	**26,914**

Source: AHS Bi-Annual Bed Survey as of March 31, 2019.
Note: The number of facilities does not include the over 100 Personal Care Homes which are considered Private Supportive Living. The beds for these facilities are included in the spaces total. The table also does not include beds in standalone palliative/hospice facilities.

Revised August 8, 2019

Addiction and Mental Health

The Addiction and Mental Health (AMH) portfolio coordinates, plans, delivers and evaluates a province wide network of AHS programs and contracted services. AMH works with a common purpose: to promote understanding and compassion, to encourage healthy behaviour and attitudes, and to help all Albertans achieve well-being throughout their lives. The tables below reflect the AHS addiction and mental health bed provincial capacity by zone and care stream. These represent AHS contracted facilities and do not include privately funded facilities.

AHS-operated and contracted Addiction and Mental Health beds, as of March 31, 2019

Zone	Addiction			Community Mental Health			Standalone Psychiatric			Acute Care Psychiatric (included in Acute Care)			Mental Health DSL 3	Mental Health DSL 4	Total Beds
	< 18	≥ 18	Total	< 18	≥ 18	Total	< 18	≥ 18	Total	< 18	≥ 18	Total	(included in Continuing Care DSL)		
South	8	74	82	5	37	42	0	0	0	0	72	72	0	0	196
Calgary	25	276	301	22	437	459	0	153	153	49	238	287	0	0	1,200
Central	5	61	66	0	31	31	0	330	330	8	42	50	0	0	477
Edmonton	21	388	409	20	311	331	18	427	445	54	182	236	363	50	1,834
North	4	114	118	0	5	5	0	0	0	0	40	40	0	0	163
Provincial Total	**63**	**913**	**976**	**47**	**821**	**868**	**18**	**910**	**928**	**111**	**574**	**685**	**363**	**50**	**3,870**

Note: This table includes Acute Care Psychiatric located in hospitals as well as Mental Health Designated Supportive Living included in continuing care.

AHS Addiction Beds

Pertains to beds and mats for clients with substance use and gambling problems. Includes detoxification, shelter mats, residential (short and long term), problem gambling, and transitional beds. Also includes beds for Protection of Children Abusing Drugs (PChAD) program clients and residential beds funded through the Safe Communities Initiative (Safe Comm). Direct services provided by AHS as well as funded and contracted services. Excludes: Beds that are not funded by AHS (privately funded beds).

PChAD offers 25 residential detoxification and stabilization beds for high risk youth throughout the province. The 25 PChAD beds are included in the 239 publicly-funded child and youth mental health and addictions beds across the province (Calgary- 9; Red Deer- 5; Edmonton- 9; and Grande Prairie- 2).

Addiction Beds: AHS Operated and Contracted as of March 31	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	Net Change Since 2015
South Zone	64	64	74	74	82	18
Calgary Zone	296	293	296	301	301	5
Central Zone	66	66	66	66	66	0
Edmonton Zone	389	389	389	409	409	20
North Zone	127	143	143	131	118*	-9
Provincial	**942**	**955**	**968**	**981**	**976**	**41**

*North Zone decrease a result of Action North Recovery Centre in High Level closure in November 2018.
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.

Community Mental Health Beds: AHS Operated and Contracted as of March 31	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	Net Change Since 2015
South Zone	37	42	42	42	42	5
Calgary Zone	336	352	418	423	459	123
Central Zone	31	31	31	31	31	0
Edmonton Zone	192	200	245	296	331	139
North Zone	5	5	5	5	5	0
Provincial	**601**	**630**	**741**	**797**	**868**	**267**

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, 2019	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
Hospital Acute & Sub-Acute Care						
Hospital Acute Care	517	2,181	933	2,414	839	6,884
Psychiatric in Acute Care	72	287	50	236	40	685
Neonatal Intensive Care (NICU Levels II and III)	23	126	17	130	10	306
Intensive Care (includes ICU, SCU, CCU, CVICU and PICU)	24	136	21	198	19	398
Sub-acute in Acute Care	9	32	32	22	0	95
Palliative beds in Acute Care	0	29	45	20	21	115
Total Hospital Acute & Sub-Acute Care	**645**	**2,791**	**1,098**	**3,020**	**929**	**8,483**
COMMUNITY BASED CARE						
Continuing Care - Long Term Care (LTC)						
Auxiliary Hospital	286	1,042	1,413	2,209	657	5,607
Nursing Home	682	4,905	951	2,876	576	9,990
Sub-Total Long Term Care (LTC)	**968**	**5,947**	**2,364**	**5,085**	**1,233**	**15,597**
Designated Supportive Living Level 4 - Dementia	548	796	557	1,149	271	3,321
Designated Supportive Living Level 4	1,035	1,836	955	2,130	506	6,462
Designated Supportive Living Level 3	309	233	385	398	209	1,534
Sub-Total Designated Supportive Living (DSL)	**1,892**	**2,865**	**1,897**	**3,677**	**986**	**11,317**
SUB-TOTAL LTC & DSL	**2,860**	**8,812**	**4,261**	**8,762**	**2,219**	**26,914**
Community Palliative and Hospice (out of hospital) PEOLC	20	121	10	85	13	249
TOTAL CONTINUING CARE (includes LTC, DSL and Palliative Care)	**2,880**	**8,933**	**4,271**	**8,847**	**2,232**	**27,163**
Sub-acute in Auxiliary Hospital (includes transition, rehab, community support beds, etc.)*	24	280	0	168	0	472
TOTAL COMMUNITY BASED CARE (includes LTC, DSL, Palliative Care and Sub-Acute in Auxiliary Hospital)	**2,904**	**9,213**	**4,271**	**9,015**	**2,232**	**27,635**
Addiction and Mental Health						
Psychiatric (standalone facilities)	0	153	330	445	0	928
Addiction Treatment	82	301	66	409	118	976
Community Mental Health	42	459	31	331	5	868
TOTAL ADDICTION & MENTAL HEALTH	**124**	**913**	**427**	**1,185**	**123**	**2,772**
Alberta Total	**3,673**	**12,917**	**5,796**	**13,220**	**3,284**	**38,890**

Source: AHS Bi-Annual Bed Survey as of March 31, 2019.
*Note: This includes restorative beds located in long term care. Restorative beds are reported where they are located (auxiliary hospital, nursing home and designated supportive living).

CONSOLIDATED SCHEDULE OF FACILITIES AND SITES

MARCH 31, 2019

The operation of the following facilities and sites are included in the financial statements.

SOUTH ZONE – Beds by Facility (refer to definition page)

South Zone													
Facility Name	Operated by AHS	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		
Brooks Health Centre	X	Brooks				37			15		52		
Sunrise Gardens		Brooks								84	84		
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								53	53		
Extendicare Fort Macleod		Fort Macleod							50		50		
Foothills Detox Centre		Fort Macleod	14								14		
Fort MacLeod Health Centre	X	Fort Macleod				4			6		10		
Pioneer Lodge		Fort Macleod								10	10		
Chinook Regional Hospital	X	Lethbridge	8	5		288					301		
Jack Ady Cancer Centre	X	Lethbridge	Co-located on same campus as Chinook Regional Hospital									CA	
CMHA Crisis Beds		Lethbridge		5							5		
CMHA Laura House		Lethbridge		7							7		
Columbia Care Centre		Lethbridge								50	50		
Edith Cavell Care Centre		Lethbridge							120	-	120		
Extendicare Fairmont Park		Lethbridge								140	140		
Golden Acres Lodge		Lethbridge								45	45		
Good Samaritan Park Meadows Village		Lethbridge								121	121		
Good Samaritan West Highlands		Lethbridge								100	100		
Legacy Lodge		Lethbridge								104	104		
SASHA Group Home #1		Lethbridge		9							9		
SASHA Group Home #2		Lethbridge		8							8		
SASHA Group Home #3		Lethbridge		8							8		
South Country Treatment Centre		Lethbridge	21								21		
Southern Alcare Manor		Lethbridge	13								13		
St. Michael's Health Centre		Lethbridge					24	10	96	72	202		
St. Therese Villa		Lethbridge								200	200		
Youth Residential Services	X	Lethbridge	8								8		
Good Samaritan Garden Vista		Magrath								35	35		
Magrath Health Centre	X	Magrath											CACC
AgeCare Valleyview		Medicine Hat							30	5	35		
Cypress View		Medicine Hat								45	45		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

South Zone (Cont'd)

Facility Name	Operated by AHS	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	50	100		
Meadow Ridge Seniors Village		Medicine Hat								84	84		
Meadowlands Retirement Residence		Medicine Hat								10	10		
Medicine Hat Recovery Centre	X	Medicine Hat	18								18		
Medicine Hat Regional Hospital	X	Medicine Hat				210					210		
Margery E. Yuill Cancer Centre	X	Medicine Hat	Co-located same campus as Medicine Hat Regional Hospital									CA	
River Ridge Seniors Village		Medicine Hat							50	36	86		
Riverview Care Centre		Medicine Hat							118		118		
St. Joseph's Home		Medicine Hat						10	10		20		
Sunnyside Care Centre		Medicine Hat							100	24	124		
The Wellington Retirement Residence		Medicine Hat								50	50		
Milk River Health Centre	X	Milk River				ED			26		26		
Prairie Rose Lodge	X	Milk River								10	10		
Big Country Hospital	X	Oyen				10			30		40		
Piyami Health Centre	X	Picture Butte											CACC
Piyami Lodge		Picture Butte								20	20		
Piyami Place		Picture Butte								15	15		
Good Samaritan Vista Village		Pincher Creek								75	75		
Pincher Creek Health Centre	X	Pincher Creek				16			3		19		
Good Samaritan Prairie Ridge		Raymond								85	85		
Raymond Health Centre	X	Raymond				12			5		17		
Kainai Continuing Care Centre		Stand Off							25		25		
Clearview Lodge		Taber								20	20		
Good Samaritan Linden View		Taber								105	105		
Taber Health Centre	X	Taber				19			10		29		
Total South Zone			**82**	**42**	**0**	**645**	**24**	**20**	**968**	**1,892**	**3,673**		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

CALGARY ZONE – Beds by Facility (refer to definition page)

Calgary Zone													
Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Airdrie Regional Community Health Centre	X	Airdrie											UCC
Bethany Airdrie		Airdrie							74		74		
Mineral Springs Hospital		Banff				22			25		47		
Oilfields General Hospital	X	Black Diamond				15			30		45		
Agape Hospice		Calgary						20			20		
AgeCare Glenmore		Calgary							208		208		
AgeCare Midnapore		Calgary							270		270		
AgeCare Seton		Calgary							59	252	311		
AgeCare SkyPointe		Calgary							192	160	352		
AgeCare Walden Heights		Calgary							58	238	296		
Alberta Children's Hospital	X	Calgary				141					141		
Alcove Addictions Recovery for Women		Calgary	1								1		
Alpha House		Calgary	48								48		
Approved Homes - Mental Health		Calgary		117							117		
Aspen Family and Community Network		Calgary		3							3		
Aventa Addiction Treatment for Women		Calgary	48								48		
Bethany Calgary		Calgary							416		416		
Bethany Harvest Hills		Calgary							60		60		
Bethany Riverview		Calgary							210		210		
Bow Crest Care Centre		Calgary							150		150		
Bow View Manor		Calgary							231		231		
Calgary Community Rehabilitation Program (Lighthouse NCR Group Home)	X	Calgary		6							6		
Calgary Homeless Foundation - Bridgeland	X	Calgary		10							10		
Calgary Homeless Foundation - Ophelia	X	Calgary		16							16		
Canadian Mental Health Association		Calgary		123							123		
Canadian Mental Health Association - Glamorgan Building		Calgary		23							23		
Canadian Mental Health Association - Hamilton House		Calgary		9							9		
Canadian Mental Health Association - Robert's House		Calgary		9							9		
Carewest Colonel Belcher	X	Calgary							175	30	205		
Carewest Dr. Vernon Fanning Centre	X	Calgary					98		191		289		
Carewest Garrison Green	X	Calgary							200		200		
Carewest George Boyack	X	Calgary							221		221		
Carewest Glenmore Park	X	Calgary					147				147		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Calgary Zone (Cont'd)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Carewest Nickle House	X	Calgary								10	10		
Carewest Rouleau Manor	X	Calgary							77		77		
Carewest Royal Park	X	Calgary							50		50		
Carewest Sarcee	X	Calgary					35	15	85		135		
Carewest Signal Pointe	X	Calgary							54		54		
Centre of Hope - Salvation Army		Calgary	30								30		
Clifton Manor		Calgary							250		250		
CBI- Complex Needs Client		Calgary		1							1		
Community Living Alternatives for the Mentally Disabled Association (Community LAMDA)- LAMA Kilarney		Calgary		34							34		
Community Living Alternatives for the Mentally Disabled Association (Community LAMDA) - LAMDA Mission		Calgary		28							28		
East Calgary Health Centre	X	Calgary											FCC
Eau Claire Retirement Residence		Calgary								73	73		
Edgemont Retirement Residence		Calgary								31	31		
Enviros Wilderness School Association		Calgary	10								10		
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				1,093					1,093		
Fresh Start Recovery Centre		Calgary	1								1		
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	179		193		
Intercare Southwood Care Centre		Calgary						24	222		246		
Kingsland Terrace		Calgary								24	24		
Mayfair Care Centre		Calgary							142		142		
McKenzie Towne Continuing Care Centre		Calgary							150		150		
McKenzie Towne Retirement Residence		Calgary								42	42		
Millrise Place		Calgary							51	40	91		
Monterey Place		Calgary								107	107		
Mount Royal Care Centre		Calgary							93		93		
Newport Harbour Care Centre		Calgary							127		127		
Oxford House		Calgary	23								23		
Personal Care Homes - Continuing Care		Calgary								223	223		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Calgary Zone (Cont'd)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Peter Lougheed Centre	X	Calgary				522					522		
Prince of Peace Harbour		Calgary								32	32		
Prince of Peace Manor		Calgary								30	30		
Providence Care Centre		Calgary							94	56	150		
Recovery Acres		Calgary	13								13		
Renfrew Recovery Centre	X	Calgary	40								40		
Richmond Road Diagnostic & Treatment Centre	X	Calgary				OP							
Rocky Ridge Retirement Community		Calgary								29	29		
Rockyview General Hospital	X	Calgary				615					615		
Rosedale Hospice		Calgary						7			7		
Rotary Flames House	X	Calgary						7			7		
Sage Hill Retirement Residence		Calgary								72	72		
Scenic Acres Retirement Residence		Calgary								26	26		
SCOPE Hunterview House		Calgary		2							2		
Secura Bright Harbour I	X	Calgary		4							4		
Sheldon M. Chumir Health Centre	X	Calgary											UCC
South Calgary Health Centre	X	Calgary											UCC
South Health Campus	X	Calgary				272					272		
Southern Alberta Forensic Psychiatric Centre	X	Calgary			33						33		
St. Marguerite Manor		Calgary						26		102	128		
St. Teresa Place		Calgary								250	250		
Sunridge Medical Gallery	X	Calgary											CACC
Sunrise Native Addiction Services Society		Calgary	24								24		
Swan Evergreen Village		Calgary								48	48		
Thorncliff - Home Space Partnership		Calgary		22							22		
Trinity Foundation		Calgary		30							30		
Tom Baker Cancer Centre	X	Calgary										CA	
Wentworth Manor/The Residence and The Court		Calgary							74	62	136		
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		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Calgary Zone (Cont'd)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Willow Creek Continuing Care Centre	X	Claresholm							100		100		
Bethany Cochrane		Cochrane							78		78		
Cochrane Community Health Centre	X	Cochrane											UCC
Aspen Ridge Lodge		Didsbury								30	30		
Bethany Didsbury		Didsbury								100	100		
Didsbury District Health Services	X	Didsbury				16			21		37		
High River General Hospital	X	High River				27			50		77		
High River Community Cancer Centre	X	High River	Co-located on same campus as High River General Hospital									CA	
Sunrise Village 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			**301**	**459**	**153**	**2,791**	**280**	**121**	**5,947**	**2,865**	12,917		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

CENTRAL ZONE – Beds by Facility (refer to definition page)

Central Zone													
Facility Name	Operated by AHS	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	6								6		
Breton Health Centre	X	Breton							23		23		
Bethany Meadows		Camrose							65	30	95		
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		
Camrose Community Cancer Centre		Camrose	Co-located on same campus as St. Mary's Hospital									CA	
Sunrise Village 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 Hospital and Care Centre	X	Drayton Valley				32			50		82		
Drayton Valley Community Cancer Centre	X	Drayton Valley	Co-located on same campus as Drayton Valley Hospital and Care Centre									CA	
Serenity House	X	Drayton Valley								12	12		
Sunrise Village Drayton Valley		Drayton Valley								16	16		
Drumheller Health Centre	X	Drumheller				37			96		133		
Drumheller Community Cancer Centre	X	Drumheller	Co-located on same campus as Drumheller Health Centre									CA	
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			45		50		
Lacombe Hospital and Care Centre	X	Lacombe				35			75		110		
Royal Oak Manor		Lacombe								111	111		
Lamont Health Care Centre		Lamont				15			105		120		
Westview Care Community		Linden							37		37		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Central Zone (Cont'd)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Dr Cooke Extended Care Centre		Lloydminster							50		50		
Lloydminster Continuing Care Centre		Lloydminster							60		60		
Lloydminster Hospital		Lloydminster				39					39		
Lloydminster Community Cancer Centre		Lloydminster	Co-located on same campus as Lloydminster Hospital									CA	
Pioneer House		Lloydminster								44	44		
Points West Living Lloydminster		Lloydminister								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		
Sunrise Encore Olds		Olds								60	60		
Sunrise Village 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		
Sunrise Village Ponoka		Ponoka								20	20		
Provost Health Centre	X	Provost				15			47		62		
Addiction Counselling & Prevention Services	X	Red Deer	5								5		
Bethany CollegeSide		Red Deer							112		112		
Extendicare Michener Hill		Red Deer							220	60	280		
Kentwood Place	X	Red Deer		25							25		
Pines Lodge		Red Deer								10	10		
Points West Living Red Deer		Red Deer								114	114		
Red Deer Hospice		Red Deer						10			10		
Red Deer Regional Hospital Centre	X	Red Deer				370					370		
Central Alberta Cancer Centre	X	Red Deer	Co-located on same campus as Red Deer Regional Hospital									CA	
Safe Harbour Society		Red Deer	40								40		
The Hamlets at Red Deer		Red Deer								108	108		
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							40	39	79		
Park Avenue at Creekside		Rocky Mtn House								40	40		
Rocky Mountain House Health Centre	X	Rocky Mtn House				31					31		
Points West Living Stettler		Stettler								88	88		
Stettler Hospital and Care Centre	X	Stettler				26			50		76		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Central Zone (Cont'd)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Sundre Hospital and Care Centre	X	Sundre				14			9		23		
Sundre Seniors Supportive Living		Sundre								40	40		
Bethany Sylvan Lake		Sylvan Lake							40	21	61		
Sylvan Lake Community Health Centre	X	Sylvan Lake											AACS
Chateau Three Hills		Three Hills								15	15		
Three Hills Health Centre	X	Three Hills				21			24		45		
Tofield Health Centre	X	Tofield				16			50		66		
St. Mary's Health Care Centre		Trochu							28		28		
Two Hills Health Centre	X	Two Hills				27			56		83		
Century Park		Vegreville								40	40		
Heritage House		Vegreville								42	42		
St Joseph's General Hospital		Vegreville				23					23		
Vegreville Care Centre	X	Vegreville							60		60		
Vegreville Manor		Vegreville								15	15		
Vermilion Health Centre	X	Vermilion				25			48		73		
Vermilion Valley Lodge		Vermilion								40	40		
Extendicare Viking		Viking							60		60		
Viking Health Centre	X	Viking				16					16		
Points West Living Wainwright		Wainwright								59	59		
Wainwright Health Centre	X	Wainwright				25			69		94		
Good Samaritan Good Shepherd Lutheran Home		Wetaskiwin								69	69		
Points West Living Wetaskiwin		Wetaskiwin								82	82		
Sunrise Village 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			**66**	**31**	**330**	**1,098**	**0**	**10**	**2,364**	**1,897**	5,796		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

EDMONTON ZONE – Beds by Facility (refer to definition page)

Edmonton Zone													
Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Kipohtakawmik Elders Lodge		Alexander Reserve								17	17		
Chateau Vitaline		Beaumont								46	46		
Devon General Hospital	X	Devon				10			14		24		
Addiction Recovery Centre	X	Edmonton	42								42		
Alberta Hospital Edmonton	X	Edmonton			295						295		
Allen Gray Continuing Care Centre		Edmonton							156		156		
Allendale House (House Next Door #4)		Edmonton		10							10		
Ambrose Place		Edmonton		42							42		
Anderson Hall	X	Edmonton		14							14		
Approved Mental Health Care Homes		Edmonton		26							26		
Aspire Homes - Newton	X	Edmonton		5							5		
Aspire Homes - Mount Rose	X	Edmonton		5							5		
Aspire Homes - Elmwood Park	X	Edmonton		5							5		
Balwin Place		Edmonton		25							25		
Balwin Villa		Edmonton								104	104		
Benevolence Care Centre		Edmonton							99		99		
CapitalCare Dickinsfield	X	Edmonton							275		275		
CapitalCare Adult Duplexes (Dickinsfield)	X	Edmonton								14	14		
CapitalCare Grandview	X	Edmonton					34		147		181		
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								165	165		
Chartwell Heritage Valley		Edmonton								18	18		
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		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Edmonton Zone (Cont'd)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
E4C Meadows Place		Edmonton		16							16		
E4C Our Place		Edmonton		10							10		
East Edmonton Health Centre	X	Edmonton											FCC /UCC
Edmonton Chinatown Care Centre		Edmonton							80	15	95		
Edmonton General Continuing Care Centre		Edmonton					20	26	449		495		
Edmonton People in Need #2 (SCH)		Edmonton		4						34	38		
Edmonton People In Need - Bridgeway 2		Edmonton								97	97		
Elizabeth House Harm Reduction Lodge Living		Edmonton		20							20		
Emmanuel Home		Edmonton								15	15		
Extendicare Eaux Claires		Edmonton							204		204		
Extendicare Holyrood		Edmonton							74		74		
Family Care Homes		Edmonton								2	2		
Garneau Hall		Edmonton								37	37		
George Spady Centre Society		Edmonton	73								73		
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				348					348		
Hardisty Care Centre		Edmonton							175		175		
Henwood Treatment Centre	X	Edmonton	72								72		
House Next Door #1, 2, 3		Edmonton		24							24		
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								17	17		
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		
Misericordia Community Hospital		Edmonton				318					318		
Northeast Community Health Centre	X	Edmonton				ED					-		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Edmonton Zone (Cont'd)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Ottewell Lodge		Edmonton		38							38		
Our House		Edmonton	70								70		
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								50	50		
Royal Alexandra Hospital	X	Edmonton				894					894		
Rutherford Heights Retirement Residence		Edmonton								89	89		
Saint Thomas Assisted Living Centre		Edmonton								138	138		
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		
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				694			-		694		
Venta Care Centre		Edmonton							148		148		
Villa Caritas		Edmonton			150						150		
Villa Marguerite		Edmonton								239	239		
Wedman Village Homes		Edmonton								30	30		
Wild Rose Cottage		Edmonton								27	27		
Youth Stabilization and Residential Services	X	Edmonton	21								21		
Good Samaritan Pembina Village		Evansburg							40		40		
Fort Saskatchewan Community Hospital	X	Fort Saskatchewan				36					36		
Rivercrest Care Centre		Fort Saskatchewan						6	74		80		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Edmonton Zone (Cont'd)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
Extendicare Leduc		Leduc							79		79		
Leduc Community Hospital	X	Leduc				74					74		
Lifestyle Options Leduc		Leduc								74	74		
Salem Manor Nursing Home		Leduc							102		102		
Chartwell Aspen House	X	Morinville								72	72		
CapitalCare Laurier House Strathcona	X	Sherwood Park								42	42		
CapitalCare Strathcona	X	Sherwood Park							111		111		
CASA House		Sherwood Park		20							20		
Chartwell Country Cottage Retirement Residence		Sherwood Park								26	26		
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								67	67		
Foyer Lacombe		St. Albert						10	12		22		
Poundmaker's Lodge Treatment Center - Youth Addiction (Safe-Com)		St. Albert	51								51		
St. Albert Retirement Residence		St. Albert								92	92		
Sturgeon Community Hospital	X	St. Albert				161					161		
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								92	92		
West Country Hearth		Villeneuve								32	32		
Cloverleaf Manor		Warburg		13							13		
Total Edmonton Zone			**409**	**331**	**445**	**3,020**	**168**	**85**	**5,085**	**3,677**	13,220		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

NORTH ZONE – Beds by Facility (refer to definition page)

North Zone													
Facility Name	Operated by AHS	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 Healthcare Centre	X	Barrhead				34					34		
Barrhead Community Cancer Centre	X	Barrhead	Co-located on same campus as Barrhead Healthcare Centre									CA	
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 Healthcare Centre		Bonnyville				33			30		63		
Bonnyville Community Cancer Centre		Bonnyville	Co-located same campus as Bonnyville Healthcare Centre									CA	
Bonnyville Indian Metis Rehabilitation Centre		Bonnyville	20								20		
Extendicare Bonnyville		Bonnyville							50		50		
Boyle Healthcare Centre	X	Boyle				20					20		
Wild Rose Assisted Living	X	Boyle								22	22		
Cold Lake Healthcare Centre	X	Cold Lake				24			31		55		
Points West Living Cold Lake		Cold Lake								42	42		
Ridgevalley Seniors Home		Crooked Creek								15	15		
Wabasca/Desmarais Healthcare Centre	X	Desmarais				10					10		
Edson Healthcare Centre	X	Edson				24			38	38	100		
Parkland Lodge		Edson								10	10		
Elk Point Healthcare Centre	X	Elk Point				12			30		42		
Elk Point Heritage Lodge	X	Elk Point								10	10		
Fairview Health Complex	X	Fairview				25		1	66		92		
Kahkiyow Keykanow Elders Care Home		Fort Chipewyan								11	11		
Fort McMurray Recovery Centre	X	Fort McMurray	16								16		
Northern Lights Regional Health Centre	X	Fort McMurray				105			41		146		
Fort McMurray Community Cancer Centre	X	Fort McMurray	Co-located same campus as Northern Lights Regional Health Centre									CA	
Pastew Place Detox Centre		Fort McMurray	11								11		
St. Theresa General Hospital	X	Fort Vermilion				26			8		34		
Fox Creek Healthcare Centre	X	Fox Creek				4					4		
Grande Cache Community Health Complex	X	Grande Cache				12					12		
Whispering Pines Seniors Lodge		Grande Cache								15	15		
Grande Prairie Care Centre		Grande Prairie							60	60	120		
Northern Addiction Centre	X	Grande Prairie	51								51		
Prairie Lake Seniors Community		Grande Prairie						10	50	95	155		
Queen Elizabeth II Hospital	X	Grande Prairie				165				71	236		
Grande Prairie Care Centre	X	Grande Prairie	Co-located same campus as QEII Hospital									CA	

Note: Beds have been restated since previous AHS Annual Reports due to reporting corrections.

North Zone (Cont'd)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
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		
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 Continuing Care Centre	X	Hinton								52	52		
Hinton Healthcare Centre	X	Hinton				23					23		
Hinton Community Cancer Centre	X	Hinton	Colocated same campus as Hinton Healthcare Centre									CA	
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				24			30		54		
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 Health Centre	X	Peace River				31			40		71		
Peace River Community Cancer Centre	X	Peace River	Colocated same campus as Peace River Comm. Health Centre									CA	
Points West Living Peace River		Peace River								42	42		
Radway Continuing Care Centre	X	Radway							30		30		
Rainbow Lake Health Centre		Rainbow Lake											CACC
Redwater Health Centre	X	Redwater				14			7		21		
Points West Living Slave Lake		Slave Lake								45	45		
Slave Lake Family Care Clinic	X	Slave Lake											FCC
Slave Lake Healthcare Centre	X	Slave Lake				24			20		44		
Vanderwell Heritage Place		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		

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North Zone (Cont'd)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	DSL	Total	Cancer	Ambulatory
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				4					4		
Valleyview Health Centre	X	Valleyview				20			25		45		
Vilna Lodge		Vilna								12	12		
Smithfield Lodge	X	Westlock								46	46		
Westlock Healthcare Centre	X	Westlock				46			120		166		
Spruce View Lodge		Whitecourt								15	15		
Whitecourt Healthcare Centre	X	Whitecourt				22					22		
Total North Zone			**118**	**5**	**0**	**929**	**0**	**13**	**1,233**	**986**	3,284		

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Change in Bed Numbers by Zone from 2017-18 to 2018-19

Reported Beds Staffed & In Operation Summary as of March 31, 2019:

ZONE	ADDICTION AND MENTAL HEALTH			ACUTE CARE		CONTINUING CARE – FACILITY LIVING				DESIGNATED SUPPORTIVE LIVING (DSL)				TOTAL CONTINUING CARE (LTC + DSL)	TOTAL COMMUNITY BASED CARE (includes PEOLC)	TOTAL BEDS
	Addiction	Community Mental Health	Psychiatric (Standalone	Acute Care	Sub-Acute (Non Acute Care	Community Palliative & End of	Auxiliary Hospital	Nursing Home	Long Term Care Subtotal (Auxiliary + Nursing home)	Level 3 (includes mental health)	Level 4 (includes mental health)	Level 4 Dementia	DSL Subtotal (DSL 3 + DSL 4 + DSL4D)			
South Zone	82	42	0	645	24	20	286	682	968	309	1,035	548	1,892	2,860	2,880	**3,673**
Calgary Zone	301	459	153	2,791	280	121	1,042	4,905	5,947	233	1,836	796	2,865	8,812	8,933	**12,917**
Central Zone	66	31	330	1,098	0	10	1,413	951	2,364	385	955	557	1,897	4,261	4,271	**5,796**
Edmonton Zone	409	331	445	3,020	168	85	2,209	2,876	5,085	398	2,130	1,149	3,677	8,762	8,847	**13,220**
North Zone	118	5	0	929	0	13	657	576	1,233	209	506	271	986	2,219	2,232	**3,284**
PROVINCIAL TOTAL	**976**	**868**	**928**	**8,483**	**472**	**249**	**5,607**	**9,990**	**15,597**	**1,534**	**6,462**	**3,321**	**11,317**	**26,914**	**27,163**	**38,890**

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, 2018:

ZONE	ADDICTION AND MENTAL HEALTH			ACUTE CARE		CONTINUING CARE – FACILITY LIVING				DESIGNATED SUPPORTIVE LIVING (DSL)				TOTAL CONTINUING CARE (LTC + DSL)	TOTAL COMMUNITY BASED CARE (includes PEOLC)	TOTAL BEDS
	Addiction	Community Mental Health	Psychiatric (Standalone	Acute Care	Sub-Acute (Non Acute Care	Community Palliative & End of	Auxiliary Hospital	Nursing Home	Long Term Care Subtotal (Auxiliary + Nursing home)	Level 3 (includes mental health)	Level 4 (includes mental health)	Level 4 Dementia	DSL Subtotal (DSL 3 + DSL 4 + DSL4D)			
South Zone	74	42	0	645	24	20	258	651	909	299	1,027	548	1,874	2,783	2,803	**3,588**
Calgary Zone	301	423	153	2,779	280	121	1,072	4,313	5,385	233	1,737	730	2,700	8,085	8,206	**12,142**
Central Zone	66	31	330	1,098	0	10	1,413	891	2,304	385	872	444	1,701	4,005	4,015	**5,540**
Edmonton Zone	409	296	445	3,012	168	79	2,234	2,771	5,005	399	2,123	1,118	3,640	8,645	8,724	**13,054**
North Zone	131	5	0	923	18	13	639	604	1,243	198	478	216	892	2,135	2,148	**3,225**
PROVINCIAL TOTAL	**981**	**797**	**928**	**8,457**	**490**	**243**	**5,616**	**9,230**	**14,846**	**1,514**	**6,237**	**3,056**	**10,807**	**25,653**	**25,896**	**37,549**

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

Change from March 31, 2018 to March 31, 2019:

ZONE	ADDICTION AND MENTAL HEALTH			ACUTE CARE		CONTINUING CARE – FACILITY LIVING				DESIGNATED SUPPORTIVE LIVING (DSL)				TOTAL CONTINUING CARE (LTC + DSL)	TOTAL COMMUNITY BASED CARE (includes PEOLC)	TOTAL BEDS
	Addiction	Community Mental Health	Psychiatric (Standalone	Acute Care	Sub-Acute (Non Acute Care	Community Palliative & End of	Auxiliary Hospital	Nursing Home	Long Term Care Subtotal (Auxiliary + Nursing home)	Level 3 (includes mental health)	Level 4 (includes mental health)	Level 4 Dementia	DSL Subtotal (DSL 3 + DSL 4 + DSL4D)			
South Zone	8	-	-	-	-	-	28	31	59	10	8	-	18	77	77	**85**
Calgary Zone	-	36	-	12	-	-	(30)	592	562	-	99	66	165	727	727	**775**
Central Zone	-	-	-	-	-	-	-	60	60	-	83	113	196	256	256	**256**
Edmonton Zone	-	35	-	8	-	6	(25)	105	80	(1)	7	31	37	117	123	**166**
North Zone	(13)	-	-	6	-18	-	18	(28)	(10)	11	28	55	94	84	84	**59**
PROVINCIAL TOTAL	**(5)**	**71**	**-**	**26**	**(18)**	**6**	**(9)**	**760**	**751**	**20**	**225**	**265**	**510**	**1,261**	**1,267**	**1,341**

Note: Beds may have been restated since previous AHS Annual Reports due to reporting corrections.

The 2018-19 Annual Report was prepared by
AHS Planning and Performance.

Financial information in the 2018-19 Annual Report was prepared by
AHS Financial Services.

Alberta Health Services

Our appreciation and gratitude to all those who contributed to the 2018-19 Annual Report.