Alberta Health Services

2022 - 2023

Annual Report

Alberta Health Services

The *2022-23 Alberta Health Services Annual Report* was prepared in accordance with the *Fiscal Planning and Transparency Act (repealed on March 31, 2023)* and *Regional Health Authorities Act*. The 2022-23 fiscal year spanned from April 1, 2022, to March 31, 2023. All material economic and fiscal implications known as of June 1, 2023, have been considered in preparing the Annual Report.

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

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Message from the Official Administrator

It is an honour to serve as Official Administrator (OA) for Alberta Health Services (AHS) — an organization I have had a longstanding connection with and which I hold in the highest regard.

When I was appointed AHS OA in November 2022, my mandate was clear: to deliver immediate, measurable and organization-wide improvements in four key priority areas of healthcare delivery, in alignment with the Government of Alberta's Health Care Action Plan.

The priorities are reducing emergency medical services (EMS) response times; decreasing emergency department wait times; reducing surgery wait times; and empowering frontline workers to deliver health care. I committed to share regular progress updates with Albertans, and this annual report is an important exercise in accountability to the people we serve.

The 2022-23 AHS Annual Report shows AHS has made significant and measurable progress on these four priorities in a short period of time. EMS response times are down across the province, as are emergency department wait times. Our adult surgical waitlist is now shorter than it was before the pandemic. Over the fiscal year, we've added 50 intensive care beds, as well as hundreds of acute care beds and continuing care spaces, in communities across the province.

AHS was facing major challenges at the time of my appointment — challenges stemming from the COVID-19 pandemic and other pressures that have impacted healthcare organizations

across Canada and around the world. The 2022-23 AHS Annual Report shows the organization — bolstered by renewed focus and additional resources — is moving in the right direction and is steadily improving patient outcomes and patient experiences.

Credit goes to our people. Simply put, the frontline healthcare providers at AHS are among the best in the world. They lead the way in innovation, competence and compassion — three important attributes of quality healthcare. We also have a team of corporate and support staff and volunteers who are equally driven

to enable the frontlines to do what they do best. Together, our teams are committed to improvement and transformation. There is a shared sense of urgency in addressing the challenges facing us, and an inspiring willingness across the entire organization to tackle them head on.

The progress does not end with the fiscal year. We will continue to deliver improvement and growth in all four key priority areas into the next year and beyond, to build an AHS that works for all Albertans. I am proud of what we have achieved in 2022-23, and confident our momentum is only going to build.

Original signed by

Dr. John Cowell BSc, MSc, MD, CCBOM, CCFP, FRCPC.

Official Administrator

Message from the President & Chief Executive Officer

The 2022-23 Annual Report tells the story of a milestone year for Alberta Health Services (AHS). For the first time since the start of the COVID-19 pandemic, we have been able to shift our focus to recovery and renewal.

Like all healthcare organizations, AHS continues to face the challenges brought about by this global health crisis. But we have made tremendous progress in the past months.

The latest statistics from the Canadian Institute for Health Information show that AHS leads the country in many areas of healthcare delivery, including fewer patient re-admissions, fewer high users of hospital beds, fewer self-harm hospitalizations and better perceived health.

Moreover, as this report will show, we have taken major strides to address some of the most pressing challenges we have had to contend with in recent years. In November, the Government of Alberta released its Health Care Action Plan and appointed Dr. John Cowell to lead the plan's implementation. This ambitious strategy maps out dozens of concrete actions in four priority areas of healthcare delivery: reducing emergency medical services (EMS) response times; decreasing emergency department wait times; reducing surgery wait times; and empowering frontline workers to deliver health care.

Since November, AHS has made considerable improvement in all four priorities, and this important work will continue into the next year and beyond. Over the past twelve months, we have made significant progress in many other areas of AHS operations as well.

Building on the practices developed during our COVID-19 response, we are expanding virtual healthcare to complement the high-quality frontline care we provide. Examples include our Addiction and Mental Health Line, Rehabilitation Advice Line and Virtual MD. These, and other virtual healthcare services, help take the pressure off the healthcare system and break down barriers for the Albertans we serve.

In the past fiscal year, AHS successfully completed the fourth and fifth launches of Connect Care. Connect Care is a major transformational initiative at AHS, which will improve patient safety and give patients more control over their health information. In 2022-23, more than 75,000 staff, physicians and healthcare

providers made the shift to Connect Care, and this work will continue in the coming year.

This year we have also made progress on the *AHS Indigenous Health Commitments: Roadmap to Wellness*, which focuses on five priority areas, including cultural safety, healthy communities and families, primary healthcare, patient concerns and experience and addiction and mental wellness.

We are especially proud of our work with the Wisdom Council to develop the Patient Access to Indigenous Spiritual Ceremony Policy, which will give Indigenous patients and their families enhanced access to Indigenous spiritual ceremonies in AHS facilities.

We have also made significant progress in addressing our workforce recruitment and retention challenges. This includes launching national and international recruitment campaigns, launching an employer-based healthcare aide program for rural areas and creating the Rural Capacity Investment Fund in partnership with our unions. We also developed the AHS Health Workforce Strategy, which commits us to a checklist of short-, medium- and long-term actions to address our workforce needs and ensure that our organization has the people it needs now and for the future.

These achievements were made possible through the incredible support from our staff, physicians and volunteers. The past few years have challenged our people like never before and yet they've responded with dedication and determination. It has been a privilege to serve alongside such committed and compassionate professionals, and with their continued support, I am certain that our organization has a bright future.

Original signed by

Mauro Chies

AHS President & CEO

About Alberta Health Services

Who We Are

Alberta Health Services (AHS) is proud to be part of Canada's first and largest provincewide, integrated health system. AHS is one of three entities within the Ministry of Health, delivering a broad range of healthcare on behalf of government, and in accordance with the mandate set by government. As Alberta's regional health authority, AHS plays a significant role in delivering healthcare services to more than 4.5 million people living in Alberta as well as occasionally to some residents of other provinces and territories.

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

AHS and its many health service delivery partners, including Covenant Health, physicians practicing in community, allied health professionals, pharmacies, local governments and Indigenous communities, work together to deliver high-quality health care.

In 2022-23, AHS was recognized as one of Alberta's Top Employers and Canada's Best Diversity Employers. This success can be attributed to the dedication, collaboration and hard work of our staff, physicians and volunteers. AHS is proud to be recognized for supporting our people and strives to create workplaces where everyone feels safe, healthy, valued and included, and able to reach their full potential.

Workforce and Volunteers

AHS has more than 111,100 direct AHS employees (excluding Covenant Health and other contracted health service providers) and more than 13,100 staff working in AHS' wholly owned subsidiaries, such as Carewest, CapitalCare Group and Alberta Precision Laboratories.

AHS is also supported by more than 11,100 independently practicing physicians, approximately 8,850 of whom are members of the AHS medical staff.

Similarly, AHS is supported by nearly 160 midwives on the AHS midwifery staff who provide care both in the community and in our facilities.

Volunteers share a commitment to improving the quality of the patient and family experience. AHS' 9,100 volunteers contributed more than 558,000 volunteer hours this past year to help keep Albertans safe and healthy. Volunteers support many areas of AHS' work – in our facilities, at our planning tables and in our communities. Volunteers work in our acute care hospitals, rehabilitation hospitals and home care programs; in cancer care, mental health and addiction, pediatric care, continuing care and public health programs.

Facilities and Beds

AHS programs and services are offered at more than 900 facilities throughout the province, including hospitals, continuing care facilities (including long-term care, designated supportive living, community palliative and hospice, and contracted care sites), cancer centres, addiction and mental health facilities, and community ambulatory care centres. All facilities and programs are operated in compliance with relevant legislation.

Facilities and Beds

106 Acute Care Hospitals

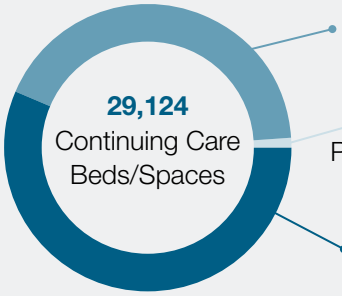
Five Standalone Psychiatric Facilities

41,390 AHS-Operated and Contracted Beds in Service

8,605
Acute Care Beds
(**223** general adult ICU beds;
229 specialty and high intesity beds;
8,153 non-ICU beds (of which,
6,089 beds are respiratory capable))

485
Sub-Acute Care Beds

3,176
Addiction and Mental Health Beds/Spaces

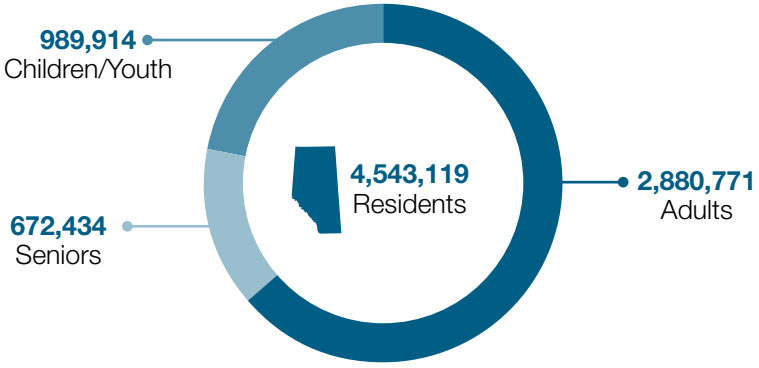


12,864 Designated Supportive Living Beds

261 Community Palliative and Hospice Beds/Spaces

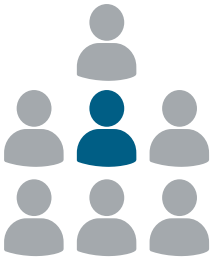
15,999 Long-term Care Beds

Alberta Demographics



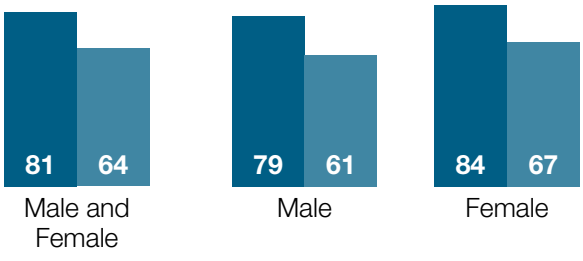
Median Age

Aging Population



1 in 7 Albertans was 65+

Life Expectancy



AHS Health Plan & Business Plan

The AHS 2022-25 Health Plan & 2022-23 Business Plan is a legislated public accountability document that describes, at a strategic level, the actions AHS will take in carrying out its legislated responsibilities with a focus on the delivery of quality healthcare services. The AHS 2022-25 Health Plan & 2022-23 Business Plan reflects direction from Alberta Health and is aligned to the Ministry of Health 2022-25 Business Plan.

This AHS Annual Report reflects progress on priorities and metrics identified in the AHS 2022-25 Health Plan. The AHS Performance section is organized according to the priorities and actions outlined in the AHS 2022-25 Health Plan.

Mission, Vision & Values

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

Governance

On November 17, 2022, Dr. John Cowell was appointed Official Administrator for Alberta Health Services by the Minister of Health. In accordance with Section 11 of the *Regional Health Authorities Act*, the Official Administrator is responsible for the same governance oversight and decision-making functions as the former board.

The Official Administrator has responsibility 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 Official Administrator is accountable to the Minister of Health and the Premier.

AHS Vision Statement

Healthy Albertans.
Healthy Communities.
Together.

AHS Mission

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

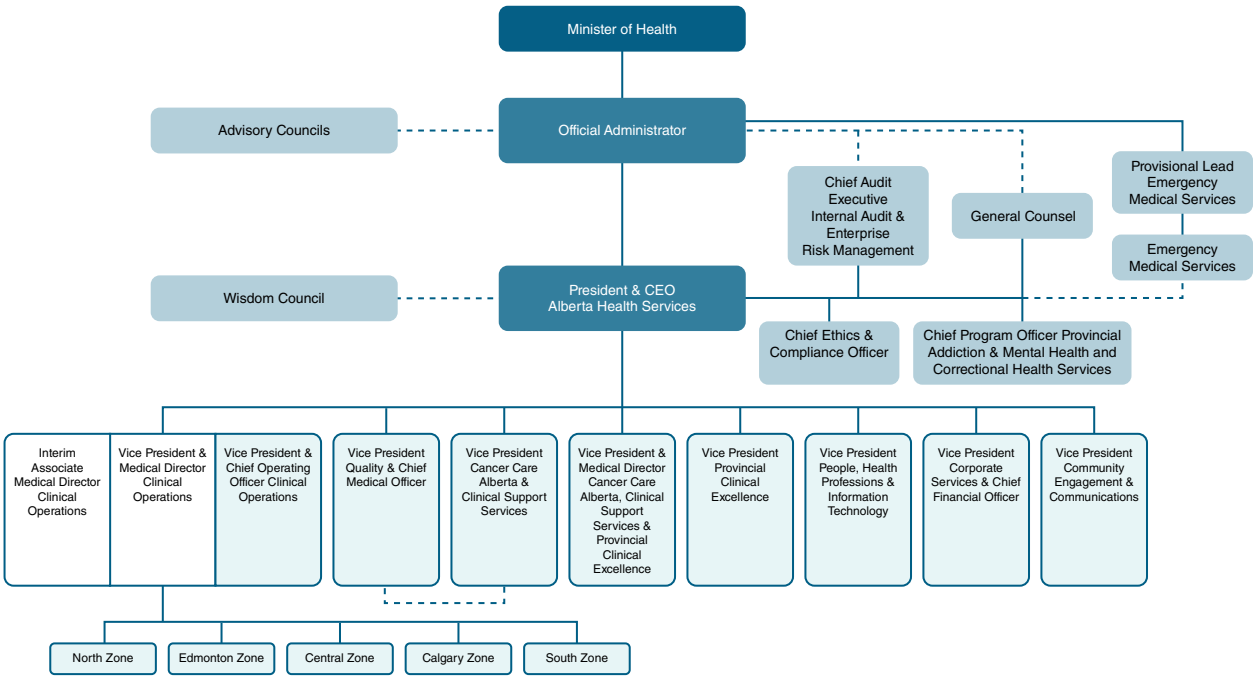
AHS Values

AHS cares

compassion accountability
respect excellence safety

Organizational Structure

Reporting directly to the Official Administrator, the President & Chief Executive Officer (CEO) led more than 111,100 caring and dedicated individuals who made up the AHS workforce. Along with leaders and staff in the organization, AHS is proud to have a culture that exemplifies its values, takes a provincial perspective on issues and ensures good ideas developed locally are shared across the province. AHS' organizational structure is represented below, arranged under the AHS Executive Leadership Team reporting directly to the President & CEO.



Advisory Councils

Advisory Councils help bring the voice of Alberta's communities to healthcare services. To learn more, visit the Councils online at www.ahs.ca/advisorycouncils.

Health Advisory Councils

Health Advisory Councils (HACs) work in partnership with the AHS Community Engagement team and zone leaders to bring local perspectives to the delivery of healthcare services in Alberta. HACs engage members of the public in communities throughout Alberta and provide advice and feedback on what is working well in AHS and where there are areas in need of improvement. The 12 HACs represent different geographical areas within the province. In 2022-23, HACs continued to provide input to high priority initiatives, including participating in the Provincial Health Tour hosted by Alberta Health, zone healthcare planning and *Shared Commitments*.

Wisdom Council

The Wisdom Council and Elder Circle provide guidance and recommendations to AHS on service delivery, program design and evaluation of culturally appropriate services delivered by AHS to Indigenous peoples in Alberta. In 2022-23, the Wisdom Council consulted on initiatives aimed at addressing cultural safety, relationship building and the *AHS Indigenous Health Commitments*, including the Indigenous Support Line pilot in the North Zone which helps Indigenous patients and their families navigate the healthcare system.

Clinician Council

Great decisions are shaped by many viewpoints. The AHS Clinician Council ensures diverse voices and experiences drive decision-making in the organization. Comprised of more than 80 clinicians and leaders, the Council collaborates with those developing and implementing significant plans, projects and programs across AHS. In 2022-23, council members informed several initiatives, including pediatric rehabilitation services, pressure injury prevention, long-COVID, continuous listening strategies, the AHS Violence Prevention Strategy, efforts to grow the talent supply and the AHS Health Workforce Strategy.

Provincial Advisory Councils

The **Addiction and Mental Health Provincial Advisory Council** works in partnership with the AHS Provincial Addiction and Mental Health team on provincewide programs and services. The Council provides recommendations that seek to improve system access, quality of service and patient satisfaction. In 2022-23, Council members provided their expertise to the Provincial Addiction Counselling Practice Group and participated in Partnership for Research and Innovation in the Health System (PRIHS) grant projects.

The **Cancer Provincial Advisory Council** provides advice related to priorities for cancer services, including screening and prevention, diagnosis, treatment and care, and research. Members are experts in cancer-related fields, have a loved one affected by cancer or are cancer survivors. In 2022-23, Council members provided input on several key initiatives including the *Ambulatory Oncology Patient Survey*, the Alberta Cancer Diagnosis Initiative and the lung cancer screening pilot program.

The **Seniors and Continuing Care Provincial Advisory Council** works in partnership with the AHS Provincial Seniors Health and Continuing Care team to improve the delivery of AHS services to seniors and Albertans receiving continuing care services and supports. In 2022-23, Council members provided input on several topics, including development of the AHS *Family Presence Policy* suite in response to the COVID-19 pandemic.

The **Sexual Orientation, Gender Identity and Expression Provincial Advisory Council** aims to create a safer, more inclusive and welcoming healthcare environment for sexual and gender minority (lesbian, gay, bisexual, transgender, queer, and 2 Spirit or LGBTQ2S+) patients and their families. In 2022-23, the Council was consulted on inclusive language for public health messaging related to Monkeypox. Feedback was also provided to the Modernizing Alberta's Primary

Healthcare System (MAPS) initiative, including opportunities to reduce access barriers for the LGBTQ2S+ community.

Provincial Patient and Family Advisory Council

The Provincial Patient and Family Advisory Council is comprised of patients and family members from across Alberta who volunteer their time and experience to improve the quality, safety and experience of healthcare services. Together with senior and executive leaders, physicians, clinicians and clinical support teams, advisors work to enhance the principles of patient- and family-centered care through the design and planning of policies and services within AHS.

In 2022-23, members contributed more than 1,500 volunteer hours and shared what mattered most to patients and families in more than 30 consultations on initiatives including *Shared Commitments*, Connect Care and MyAHS Connect, and patient flow. Work was also done to embed truth and reconciliation commitments into Council practices.

Service Delivery Information

Provincial Quick Facts

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

	2019-20	2020-21	2021-22	2022-23
Primary Care / Population Health				
Ambulatory Care Visits♦	6,137,600	5,175,278	5,455,397	5,021,546
Number of Home Care Clients♦[1]	124,779	117,502	122,084	127,012
Number of People Placed in Continuing Care	8,521	7,427	8,664	9,432
Health Link Calls*	891,931	2,291,243	--	--
Health Link Calls Received – Clinical*	--	--	1,444,868	756,806
Health Link Calls Received – Non-Clinical*	--	--	2,291,770	604,799
Health Link Outbound Calls – Clinical*	--	--	59,775	43,587
Health Link Outbound Calls – Non-Clinical*	--	--	494,208	337,899
Poison Information Calls (PADIS)	39,253	38,718	48,392	49,398
Seasonal Influenza Immunizations♦**	1,438,682	1,650,836	1,207,403	1,276,970
EMS Events	589,498	602,283	672,898	661,177
Food Safety Inspections	48,247	26,171	33,728	48,569
Acute Care				
Emergency Department Visits (all sites)♦•	2,062,528	1,552,096	1,824,366	1,982,246
Urgent Care Visits♦	202,925	148,166	193,948	221,062
Hospital Discharges♦	399,281	358,107	376,019	380,212
Births••	49,981	46,603	47,297	45,753
Total Hospital Days♦	2,852,150	2,505,858	2,614,642	2,825,701
Average Length of Stay (in days)•	7.1	7.0	7.0	7.4
Alternate Level of Care Total Discharges♦	16,175	14,604	15,434	17,291
Ambulatory Care Sensitive Conditions Hospital Discharges♦	12,724	9,660	10,540	12,258
Diagnostic / Specific Procedures				
Total Surgical Volumes (Main OR and CSFs)	295,000	277,000	278,600	292,500
Hip Replacements (scheduled and emergency)♦	6,605	5,802	6,177	7,520
Knee Replacements (scheduled and emergency)♦	6,233	5,125	5,272	7,314
Cataract Surgery♦	45,236	44,289	48,341	40,668
MRI Exams	201,118	205,793	235,241	231,033
CT Exams	427,508	462,443	508,071	520,507
X-rays	1,846,918	1,532,099	1,697,532	1,746,125
Lab Tests	80,528,613	72,491,239	82,149,662	82,905,409
Cancer Care				
Patient Visits to Cancer Care (patients may have multiple visits)	704,191	737,212	794,799	727,567
Number of Patients to Cancer Care	62,513	60,902	64,496	62,937
Addiction and Mental Health				
Mental Health Discharges (acute care sites)♦	22,737	23,347	24,182	22,391
Mental Health Discharges (acute care sites and standalone psychiatric facilities)♦	27,448	28,038	29,246	27,331
Community Treatment Orders (CTOs) Issued♦	757	802	863	781
Addiction Residential Treatment & Detoxification Admissions♦	10,348	8,156	9,250	9,371

Workforce				
AHS Physicians	7,987	8,792	8,697	8,849
AHS Staff	103,340	108,689	112,373	111,159
AHS Volunteers	16,020	12,241	9,186	9,100
AHS Volunteer Hours	1,040,783	410,437	484,838	558,290

Data updated as of May 17, 2023. Definitions can be found at https://www.ahs.ca/about/Page11905.aspx

♦ *Historical data has been restated due to reporting corrections.*
• *Results are calculated based on data available to AHS.*
[1] *The Alberta Health Business Plan refers to this measure as unique home care clients served.*
* *As of 2021-22, the measure "Health Link Calls" was expanded to four separate measures to better represent activity. 'Clinical' refers to calls requiring nursing, addiction and mental health, respiratory illness clinical services, rehabilitation, etc. 'Non-Clinical' refers to calls requiring information and/or referral, respiratory illness non-clinical services, tobacco cessation, immunization booking, etc.*
** *Source: Alberta Health Influenza Immunization Report.*

Bed Numbers Summary

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

AHS increased capacity by opening 1,270 net new community care beds/spaces (764 continuing care, 8 sub-acute in LTC, 119 community addiction and mental health, 159 integrated home living spaces and 220 AMH wrap-around supports). Increasing community capacity means that people are gradually being moved from hospital settings to a more appropriate (and often more cost-effective) community-based setting.

Additional information on bed capacity can be found in the Supplemental Information to the 2022-23 AHS Annual Report.

Number of Beds/Spaces	March 31, 2022	March 31, 2023	Difference	% Change
Acute Care				
Acute Care	8,133	8,153	20	0.2%
General Adult Intensive Care Unit (ICU)	173	223	50	28.9%
Specialty ICU	217	229	12	5.5%
Total Acute Care	**8,523**	**8,605**	**82**	**1.0%**
Addiction and Mental Health				
Psychiatric (standalone facilities)	927	927	0	0.0%
Addiction Treatment	1,243	1,283	40	3.2%
Community Mental Health	887	966	79	8.9%
Total Addiction and Mental Health	**3,057**	**3,176**	**119**	**3.9%**
Community-Based Care				
Continuing Care – Long-Term Care (LTC)				
Auxiliary Hospital	5,569	5,575	6	0.1%
Nursing Home	10,433	10,424	-9	-0.1%
Sub-Total Long-Term Care	**16,002**	**15,999**	**-3**	**0.0%**
Continuing Care – Designated Supportive Living (DSL)				
Designated Supportive Living 3	1,470	1,449	-21	-1.4%
Designated Supportive Living 4	7,052	7,486	434	6.2%
Designated Supportive Living 4 – Dementia	3,579	3,929	350	9.8%
Sub-Total Designated Supportive Living	**12,101**	**12,864**	**763**	**6.3%**
Sub-Total Long-Term Care & Designated Supportive Living	**28,103**	**28,863**	**760**	**2.7%**
Continuing Care – Community Palliative and End of Life Care (PEOLC)				
Community Palliative and End of Life Care *(out-of-hospital)*	257	261	4	1.6%
Sub-Total Continuing Care *(includes LTC, DSL and PEOLC)*	**28,360**	**29,124**	**764**	**2.7%**
Sub-Acute in Long-Term Care				
Sub-Acute in Long-Term Care (Auxiliary Hospital)	477	485	8	1.7%
Total Community-Based Care *(includes LTC, DSL, PEOLC and Sub-Acute in LTC)*	**28,837**	**29,609**	**772**	**2.7%**
Provincial Total *(includes all beds and spaces)*	**40,417**	**41,390**	**973**	**2.4%**

Source: AHS Bed Survey as of March 31, 2023.
Notes:
- Beds may have been restated since previous AHS Annual Reports and AHS Bi-Annual Bed Surveys due to reporting corrections.
- Of the 8,605 acute care beds, 223 are general adult ICU beds, 229 specialty and high intensity beds and 8,153 non-ICU beds (of which, 6,089 beds are respiratory capable).
– Does not include integrated home living spaces (+159) and AMH wrap-around supports (+220).

AHS Performance

Accreditation

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

During the Spring 2022 survey, Accreditation Canada surveyed six North Zone and eleven Central Zone rural hospitals. These 17 sites were assessed for emergency, inpatient, obstetrics, perioperative, medical device reprocessing (where applicable) and long-term care standards. A total of 36 continuing care facilities (LTC and DSL) were surveyed for long-term care standards, as well as community-based mental health, hospice, palliative, end of life, and rehabilitation standards where these services were provided. Performance related to the foundational standards of infection prevention and control, leadership, medication management and service excellence were assessed at all hospitals and continuing care facilities.

During the Fall 2022 survey, three North Zone rural hospitals, five rural continuing care sites, as well as inpatient, perioperative and emergency services at three urban hospitals were surveyed. Adult and pediatric critical care services were assessed at 12 sites. Cancer services were surveyed at 13 sites. Cardiovascular services were surveyed at three urban sites for ambulatory, critical care, inpatient and perioperative standards. In addition, maternal and child health services (with special focus on Indigenous maternal health) were surveyed at 15 sites for critical care, obstetrics and population health standards. Performance related to the foundational standards of infection prevention and control, leadership, medication management and service excellence were also assessed at all sites.

In total, more than 2,100 interviews were conducted. Surveyors reported committed leaders, physicians and teams, with effective use of resources, strong safety and infection control support and commitment to Connect Care.

Leading in Health

According to the latest statistics (2021-22) from the Canadian Institute for Health Information (CIHI), Alberta is a national leader in many areas of healthcare delivery.

In 2021-22, Alberta spent 2.7 per cent of expenses on administrative expenses. This is the lowest of the 10 provinces and 37 per cent lower than the national average.

CIHI has developed indicators to measure the health of Canadians and health system performance in Canada. These indicators help inform AHS and Albertans on how we perform nationally. The indicators below represent where CIHI shows Alberta is performing better than the national average.

- Higher % of hip fracture surgeries within 48 hours
- Fewer self-harm hospitalizations
- Fewer obstetric traumas for instrument-assisted vaginal deliveries
- Fewer patients (medical, surgical, obstetric and pediatric combined) readmitted to hospital
- Fewer surgical patients readmitted to hospital
- Fewer high users of hospital beds
- Lower potentially inappropriate use of antipsychotics in Long-Term Care
- Lower restraint use in Long-Term Care
- Better perceived health
- Fewer hospitalized heart attacks
- Fewer hospitalized strokes
- Higher % of residents with improved physical functioning in Long-Term Care

Source: CIHI Your Health System In Depth Website, May 2023 update.

Alberta Health Services Priority Areas

AHS is committed to making improvements in priority areas that matter most to Albertans: reducing wait times; increasing access to surgeries; keeping ambulances on the road and in their home communities; and working to ensure Albertans receive the right care at the right time and in the right environment. AHS continues to be a national and international leader in many areas of healthcare and, while there is still much more work ahead, significant progress has been made since the Official Administrator was appointed in November 2022.

Improving EMS Response Times

Teams within EMS and across AHS are reducing response times, creating capacity, and ensuring that emergency response is there when Albertans need help.

- EMS **response times are improving**, despite call volume fluctuations of up to 30 per cent at times. Since November 2022, EMS response times for the most urgent calls are shorter.
- The **EMS Return to Service** initiative is now active in five areas of the province. The time paramedics spend in the safe hand over of patient care to emergency department (ED) staff in these areas decreased from 3.6 hours in November 2022 to 2.4 hours in March 2023. AHS continued to see improvement in April 2023 (1.4 hours).
- The **EMS/811 Shared Response** initiative transfers low-acuity EMS callers to Health Link 811 where they are assessed and connected with the type of care and support that is needed. The number of callers who were transferred to Health Link and did not require an EMS response each month increased from 510 in January 2023 to 2,073 in March 2023. AHS continued to see improvement in April 2023 (2,660).

Albertans are waiting less time for an EMS Response in metro and urban areas 90 per cent of the time

21.8 minutes November 2022 → **15.0 minutes** March 2023

31 per cent improvement

AHS continued to see improvement in April 2023 (12.3 mins)

2,000+ people

who called 911 for EMS were transferred to Health Link and were directed to care that did not require an ambulance. This keeps more ambulances available for emergency calls.

Note: Data represents point-in-time and was pulled as of May 2023.

Decreasing Emergency Department Wait Times

AHS is addressing current health system capacity challenges that tend to be most acutely reflected in emergency department wait times.

- In the top 16 sites, **admitted patients** are spending less time in the emergency department 90 per cent of the time from 42 hours in November 2022 to **31 hours** in March 2023. AHS continued to see improvement in April 2023 (29 hours).
- In the top 16 sites, **discharged patients** are spending less time in the emergency department 90 per cent of the time from 11.9 hours in November 2022 to **11.1 hours** in March 2023. AHS continued to see improvement in April 2023 (10.7 hours).

Albertans are waiting less time to see a doctor in an ED 90 per cent of the time

7.1 hours (November 2022) → **5.9** hours (March 2023)

17 per cent reduction

AHS sustained results in April 2023 (5.9 hours)

Reducing Wait Times for Surgeries

AHS is reducing surgical wait lists and ensuring Albertans have their required surgeries within clinically appropriate timelines.

- In 2022-23, **11,000+ fewer patients** were waiting longer than clinically recommended compared to the same time last year.
- In 2022-23, AHS completed about **22,100 cancer surgeries**, compared to about 20,040 pre-pandemic, a **10 per cent increase**.

Patients waiting within the clinically recommended surgical target

75% of pediatric patients April 2023

86% of cardiac patients April 2023

Improving Patient Flow Throughout the Healthcare Continuum

AHS is improving access to acute and community care through effective management of system capacity, deployment of community care and strategies to safely reduce acute care length of stay.

- In 2022-23, AHS opened **1,270** net new **community care spaces**.
- The **Bridge Healing** Transitional Accommodation Program in Edmonton began accepting patients in March to help provide transitional care for people experiencing homelessness or other housing insecurity who have been discharged from EDs.

Fewer Albertans are waiting for continuing care placement at the 14 largest hospitals

253 November 2022 → **240** March 2023

five per cent reduction

AHS continued to see improvement in April 2023 (238)

Note: Data represents point-in-time and was pulled as of May 2023.

Year-Over-Year Performance Results Summary

In 2022-23, the convergence of several factors led to increasing pressures on many parts of health care systems across Canada. These factors included staff shortages due to attrition and burnout related to the pandemic; increases in respiratory viruses; and higher acuity patients requiring EMS, emergency department, hospital and mental health services. As with other provinces, these pressures resulted in a deterioration in many areas when comparing 2022-23 performance to 2021-22 performance levels. Nevertheless, AHS began reversing these trends in December 2022 and significant improvement continues to be seen into 2023-24. With a steady focus on reducing surgical waitlists, AHS has managed to recover to better than our target to pre-pandemic levels and will continue these efforts until there are no patients waiting longer than their clinically recommended wait time. AHS continues to actively hire into vacant positions across the organization to ensure the best outcomes and experience for Albertans seeking care. As of April 2023, EMS response times and the time spent in hospital are better than pre-pandemic levels and continue to improve.

Improving Access to Emergency and Acute Care

In AHS' 16 largest sites for the fiscal year of 2022-23:

Patients waited less than **6.3 hours** to **see a doctor in an emergency department** 90% of the time

Target: 5.5 hours, 2021-22: 4.6 hours

Patients **treated in an emergency department and admitted to hospital** stayed less than **35.3 hours** 90% of the time

Target: 38.0 hours, 2021-22: 26.7 hours

Patients **treated in an emergency department and discharged** stayed less than **11.2 hours** 90% of the time

Target: 10.0 hours, 2021-22: 9.5 hours

Reducing EMS Response Times

For the fiscal year of 2022-23:

People waited less than **17.5 minutes** for EMS to respond to the most urgent calls in **metro and urban communities** 90% of the time

Target: Improve, 2021-22: 14.6 minutes

People waited less than **33.9 minutes** for EMS to respond to the most urgent calls in **rural communities** 90% of the time

Target: Improve, 2021-22: 33.8 minutes

In the top 16 sites, EMS units spent less than **90 minutes at hospital** before being able to respond to another call **60%** of the time

Target: Improve, 2021-22: 64%

People waited less than **18.9 minutes** for EMS to respond to the most urgent calls in **communities with over 3,000 residents** 90% of the time

Target: Improve, 2021-22: 18.6 minutes

People waited less than **61.8 minutes** for EMS to respond to the most urgent calls in **remote communities** 90% of the time

Target: Improve, 2021-22: 55.4 minutes

In the top 16 sites, EMS units spent less than **3.0 hours at hospital** before being able to respond to another call 90% of the time

Target: Improve, 2021-22: 2.5 hours

Reducing Surgical Wait Times

At the end of March 2023, there were **67,186** cases on the **surgery waitlist** at adult sites

Target: <68,000, End of March 2022: 74,637 cases

At the end of March 2023, **48%** of cases were on the waitlist **outside of clinically recommended wait times** at adult sites

Target: <45%, End of March 2022: 58%

At the end of March 2023, there were **32,200** cases on the waitlist **outside of clinically recommended wait times** at adult sites

Target: <30,600, End of March 2022: 43,599

For the fiscal year 2022-23, **60%** of surgeries were completed **within clinically recommended wait times**

Target: 70%, 2021-22: 63%

Continuing Care

At the end of March 2023, there were **127,012 home care clients** served

Target: 126,400, End of March 2022: 122,084 clients

For the fiscal year 2022-23, **64.1%** of clients were placed in **continuing care** within 30 days

Target: 62.0%, 2021-22: 65.6%

Workforce Recruitment & Retention

For the fiscal year 2022-23, **7.1%** of **postings** for staff positions were **open greater than 90 days**

Target: Stabilize/improve, 2021-22: 5.2%

At the end of March 2023, **15.0%** of all AHS **positions were vacant**

Target: Stabilize/improve, End of March 2022: 14.3%

Mental Health and Addiction Recovery

In the first three quarters of fiscal year 2022-23:

Half of children and youth waited less than **21 days** for core **community outpatient AMH** services

Target: Improve, 2021-22: 20 days

11.9% of hospitalizations for AMH issues were **readmitted within 30 days**

Target: Improve, 2021-22: 13.0%

Public Health & Pandemic Response and Recovery

In the calendar year 2022, **70.7%** of children were **immunized against DTaP-IPV-Hib-HB**[1] [2]

2022 Target: ≥76.0%, 2021: 72.5%

In the period ending March 2023, **63.3%** of the eligible population were **screened for breast cancer**

Target: ≥60.0%, Period ending March 2022: 60.5%

In the period ending March 2023, **60.0%** of the eligible population were **screened for cervical cancer**

Target: ≥61.0%, Period ending March 2022: 60.1%

In the calendar year 2022, **82.0%** of children were **immunized against MMR-V**[1] [2]

2022 Target: ≥86.0%, 2021: 83.1%

In the period ending March 2023, **53.5%** of the eligible population were **screened for colorectal cancer**

Target: ≥52.0%, Period ending March 2022: 50.3%

Digital Health Evolution and Innovation

At the end of March 2023, **211,191** users were registered on the **MyAHS Connect patient portal**

Target: >140,000, End of March 2022: 95,101 users

At the end of March 2023, there were **337,401** acute, community and ambulatory **virtual visits**

Target: >450,000, End of March 2022: 433,299 visits

Rural & Indigenous Initiatives and Engagement

At the end of March 2023, **18.8%** of rural/remote **positions were vacant**

Target: Stabilize/improve, End of March 2022: 16.7%

For the fiscal year 2022-23, **5.7%** of employees in rural/remote staff positions **left AHS**

Target: Stabilize/improve, 2021-22: 6.3%

Quality & Patient Outcomes

For the first half of fiscal year 2022-23, **4.26%** of cases developed **infections within 30 days of surgery** at the largest 14 adult sites

Target: 3.12%, 2021-22: 3.91%

For the first three quarters of fiscal year 2022-23, **63.2%** of adults rated their **hospital experience 9 or 10** out of 10

Target: Improve, 2021-22: 65.6%

Sustainability

For the fiscal year 2022-23, the ratio of acute length of stay to the **expected length of stay** was **1.01** at the largest 14 sites

Target: Improve, 2021-22: 0.98

[1] Target represents the AHS organizational target. Alberta Health uses the national target (set by CIHI) for childhood immunizations.

[2] The Interactive Health Data Application (IHDA) recently restated Childhood Immunization rates to values that now include First Nations coverage. This methodology change resulted in immunization rates that, over the last 2 years, averaged lower than historically reported values

Improving Access to Emergency and Acute Care

Flow, or patient movement, within the health system is complex with multiple interacting and interdependent processes. These elements constantly evolve in response to the dynamic needs of patients and families, and the capacity available across different parts of the health system. AHS is committed to addressing current flow challenges from a systems perspective to understand the impact increased pressure within one part of the system has on other areas.

Desired Outcomes:

- Improve patient flow through emergency departments, acute inpatient wards and out to community to increase patient safety and experience.
- Support care needs through optimization of community services and continuing care to avoid unnecessary visits to emergency departments and/or avoidable bed days in acute care.

Actions and Achievements

In 2022-23, AHS continued to face challenges with COVID-19 and other respiratory illnesses. As of March 31, 2023, there were approximately 500 patients in Alberta hospitals with COVID-19. AHS continues to support the provincial shift from an emergency response to a more sustainable approach by adapting testing and isolation requirements for AHS staff and healthcare workers, and masking requirements at AHS sites. In alignment with direction from Alberta Health, AHS also continues to provide treatment and vaccinations to Albertans.

Expand adult critical care capacity by adding 50 new intensive care unit (ICU) beds.

- In 2022-23, 50 new ICU beds were added, bringing the provincial total for adult ICU to 223 beds.

Implement the Fall and Winter surge plan which includes provision for 300 net new beds and 1,200 repurposed (existing) beds as required.

- In 2022-23, AHS opened 282 net new beds. To reduce the impact to other services and ensure readiness for future respiratory virus seasons, AHS is planning a permanent increase to inpatient beds.

Reduce alternate level of care (ALC) days in acute care by implementing strategies that support expedited discharge.

- In 2022-23, AHS improved flow by enabling patient admissions into continuing care seven days a week. Since implementing the placement strategy in November 2022, 103 clients were placed in designated living options on the weekends. This work contributed to 128 fewer patients waiting in acute care for continuing care placement.
- Bridge Healing, a community-based option for homeless and vulnerable populations requiring medical respite and convalescence, opened in Edmonton Zone on March 16, 2023. Between March 16 and March 31, 2023, 18 patients were admitted into the program.
- AHS is developing solutions to enhance social work support in acute care to address barriers to discharge. This year, 15 new permanent social work resources were added across the province to address current and ongoing barriers to timely patient transitions from acute care to appropriate community living options.

Apply targeted actions and standard metrics to monitor patient flow and identify and act on areas for improvement across the largest emergency departments.

- In 2022-23, standard metrics and targets were developed for the four priority areas (reducing EMS response times, decreasing emergency department wait times, improving access to acute and continuing care, and reducing surgical wait times) as well as for primary care. Targets are in development for continuing care and addiction and mental health. Zones continue to engage in quality improvement work focused on patient flow.

Expand embedded psychiatric emergency teams within the emergency departments in Calgary to ensure rapid assessment and treatment of mental health patients in the right setting.

- In 2022-23, Calgary Zone began recruiting more staff to support the expansion of the psychiatric emergency team. North, Central and South Zones are exploring opportunities to develop similar teams within regional sites. Edmonton Zone continues to operate previously established psychiatric emergency service teams embedded in emergency departments.

Establish a clinic at each of the Alberta Children's and Stollery Children's Hospitals to provide care for lower acuity patients presenting at the emergency departments.

- In 2022-23, AHS established a fast track to rapidly assess and treat lower acuity patients at the Alberta Children's Hospital (Calgary), which joins the program previously implemented at the Stollery Children's Hospital (Edmonton). This year, the programs saw more than 18,500 patients combined.

Provide dedicated allied health supports in the emergency department to decrease length of stay and facilitate safe discharge back to community supports (admission avoidance).

- In 2022-23, AHS began recruiting into additional allied health positions to support decreased ED lengths of stay and safe discharge back to community. Updated workflows have been developed to support the integration of these roles into emergency departments. Global health workforce shortages have impacted recruitment progress.

Implement provincial critical care and medicine load levelling framework to ensure demand is equitably distributed and all available inpatient capacity is maximized across zones and provincially.

- The medicine load levelling framework was implemented in January 2023. In 2022-23, no critical care load levelling was required.

Deploy two additional EMS Mobile Integrated Health Units in each of Edmonton and Calgary to provide care for unscheduled needs within the community, e.g., IV antibiotics, rehydration, transfusions at home.

- In 2022-23, four additional units were operationalized in Edmonton and Calgary, increasing program capacity by 16 patient appointments per day.
- This year, AHS also expanded existing programs that support care in the community, without the need for EMS transport. For example, expanding the Virtual MD program to provide an alternative to ED access for low acuity calls to Health Link and expanding PHC pathways, home rehabilitation programs and virtual hospitals to support timely access to care.

Performance Measure Results

Note: Other metrics related to improving flow including increasing capacity, percentage placed in continuing care within 30 days, and acute length of stay compared to the expected length of stay can be found under other priorities (Continuing Care; Sustainability).

Patients requiring emergent and urgent treatment should be assessed and treated in a timely fashion. Longer waits may result in poorer patient outcomes or reduced patient satisfaction. Wait time measures help evaluate the timeliness and efficiency of care delivery in the emergency department.

Various factors are contributing to longer waits and stays in emergency departments. Compared to the same period last year, more people presented to the emergency department and there were more complex cases, which may require more time to be diagnosed and treated and are more likely to be admitted to the hospital. Hospital occupancy was higher than usual, and more patients were waiting in hospital for placement in continuing care. In addition, there were also workforce shortages throughout the organization which also significantly impacted our emergency departments.

Initiatives to improve patient flow include expanding options in the community to support care outside the emergency department, improving access to continuing care, adding supports to emergency departments, expanding hospital capacity, and implementing strategies in hospitals to streamline patient treatment and discharge. Importantly, the most recent fourth quarter results are trending lower and show improvement for waits and stays from their high point in Q3 2022-23.

ED wait time to see a doctor: Time to see a physician after being triaged on arrival 90% of the time in the 16 largest sites.

2019-20	2020-21	2021-22	2022-23	Target
4.4 hrs	3.4 hrs	4.6 hrs	6.3 hrs	5.5 hrs

- For fiscal year 2022-23, the wait time to see a doctor in the emergency department (6.3 hrs) deteriorated by 37 per cent compared to the same period last year (4.6 hrs). This measure did not achieve the target of 5.5 hours for the 2022-23 fiscal year. The lower the number the better, as it demonstrates patients are receiving timely assessment and treatment in the emergency department.
- While AHS faced significant challenges in the first part of the year, patients were waiting less than 5.9 hours to see a doctor in the emergency department 90 per cent of the time in March 2023, a 17 per cent improvement since November 2022 (7.1 hours).
- In 2021-22, across all hospitals, 90 per cent of Albertans spent less than 3.8 hours waiting to see a doctor in an emergency department, compared to the Canadian average of 4.2 hours *(CIHI)*.

Total time in ED for discharged patients: Time from when a patient is triaged to when they are discharged home 90% of the time in the 16 largest sites.

2019-20	2020-21	2021-22	2022-23	Target
8.4 hrs	8.5 hrs	9.5 hrs	11.2 hrs	10.0 hrs

- For fiscal year 2022-23, the total time in the emergency department for discharged patients (11.2 hours) deteriorated by 18 per cent compared to the same period last year (9.5 hours). This measure did not achieve the target of 10 hours for the 2022-23 fiscal year. The lower the number the better, as it demonstrates patients are receiving timely assessment and treatment in the emergency department.
- While AHS faced significant challenges in the first part of the year, patients treated in an emergency department and discharged stayed less than 11.1 hours 90 per cent of the time in March 2023, a seven per cent improvement since November 2022 (11.9 hours).
- In 2021-22, across all hospitals, 90 per cent of Albertans spent less than 7.5 hours in an emergency department before being discharged, compared to the Canadian average of 8.6 hours *(CIHI)*.

Total time in ED for patients admitted to hospital: Time from when a patient is triaged to when they are transferred to a hospital bed 90% of the time in the 16 largest sites.

2019-20	2020-21	2021-22	2022-23	Target
27.6 hrs	26.2 hrs	26.7 hrs	35.3 hrs	38.0 hrs

- For fiscal year 2022-23, the total time in the emergency department for patients admitted to hospital (35.3 hours) deteriorated by 32 per cent compared to the same period last year (26.7 hours). This measure achieved the target of 38 hours for the 2022-23 fiscal year. The lower the number the better, as it demonstrates patients are receiving timely assessment and treatment in the emergency department, as well as being moved into a hospital bed to receive the right care in the right place.
- While AHS faced significant challenges in the first part of the year, patients treated in an emergency department and admitted to hospital stayed less than 31 hours 90 per cent of the time in March 2023, a 26 per cent improvement since November 2022 (42 hours).
- In 2021-22, across all hospitals, 90 per cent of Albertans spent less than 27.0 hours in an emergency department before being admitted to hospital, compared to the Canadian average of 40.7 hours *(CIHI)*.

Reducing Emergency Medical Services (EMS) Response Times

Developed with Alberta Health, this priority involves improving EMS services and availability by addressing ongoing system pressures and creating capacity within the system. This includes engagement with stakeholders on a Provincial EMS Service Plan, as well as seeking further short- and medium-term solutions to improve EMS responsiveness.

Desired Outcomes:

- Increase EMS capacity to respond to calls by increasing workforce capacity, reducing time spent in hospital, and reducing out-of-community responses.
- Reduce EMS response times for the most urgent calls to improve patient outcomes and safety.

Actions and Achievements

Transfer appropriate non-emergency, low-priority calls to other agencies, such as Health Link 811 and PADIS.

- In January 2023, AHS launched the EMS/811 Shared Response program which transfers low acuity callers to Health Link 811 where registered nurses provide further assessment to determine the type of care and support needed. As of March 31, 2023, more than 2,000 EMS responses were avoided. EMS and Health Link continue to explore options to expand the service requests that can be managed by 811 without an EMS response.

Stop automatic dispatch of ambulances to non-injury motor vehicle collisions.

- AHS EMS ceased the automatic dispatch of ambulances to non-injury motor vehicle collisions. This change assists in freeing ambulances up for urgent patient care needs and allows EMS to better manage sustained high call volumes.

Manage non-emergency inter-facility transfer pilot project.

- In December 2022, the *Inter-facility Transfer or Discharge Transport for Medically Stable Patients Policy* went into effect, including an algorithm that supports decision-making for appropriate patient transportation options to expedite patient flow and minimize wait times for patients. The project aims to transport patients with no clinical needs using means other than ambulances.

Create a new Integrated Operations Centre in Calgary.

- In 2022-23, Calgary opened a new Integrated Operations Centre (IOC), and the Edmonton IOC extended its hours. IOCs help direct EMS crews to the most appropriate care facility for each patient, based on patient need and site capacity.

Hire and retain more paramedics.

- In 2022-23, AHS hired 457 new staff members, including 341 paramedics. As of March 31, 2023, there were 3,555 AHS EMS employees, representing a net increase of 169 EMS staff in 2022-23.

Launch Metro Response Plan to keep more suburban ambulances in communities.

- In conjunction with the EMS Return to Service initiative, the Metro Response Plan has contributed to improvements in

keeping suburban ambulances in their home communities, supporting improved local community coverage and response times. In Calgary and Edmonton, results demonstrated a 91 per cent and 62 per cent improvement in the number of suburban ambulances being used for responses within metro areas respectively.

Roll out fatigue management programs to support ground and air EMS staff at high risk of fatigue.

- In 2022-23, AHS continued to engage with contract service partners to convert more core flex units to full staffing. Considerations for unique needs, such as accommodation for out-of-town staff, continue to be addressed.

Continue to engage stakeholders, communities and EMS front-line staff to support all deliverables.

- In 2022-23, Albertans were invited to participate in the EMS Service Planning survey to help shape EMS in Alberta. Additional input was sought from Indigenous communities, municipal administrators, elected officials and advisory councils.

Complete the Provincial EMS Service Plan and submit to the Minister of Health by September 2022.

- In 2022-23, the Provincial EMS Service Plan was completed and submitted to the Minister of Health for approval.

Performance Measure Results

AHS EMS brings care to people and people to care. Shorter response times contribute to improved patient experience, quality, and safety. Response time measures help evaluate the timeliness of ambulance services.

AHS is committed to addressing ongoing EMS system pressures and creating capacity within the system to ensure patients receive the emergency care they need, where and when they need it. In alignment with Alberta Emergency Medical Services Provincial Advisory Committee (AEPAC) recommendations, several mitigating actions have been taken to help improve response times, including updated processes for managing non-emergency inter-facility transfers and non-injury motor vehicle collisions, implementing additional dispatching and prioritization processes, implementing fatigue management strategies and hiring more paramedics. Results reflect the combined impacts of early year deterioration and later year improvements. The full impact of improvement initiatives will be seen in 2023-24.

EMS response time for the most urgent calls in metro and urban areas: Time in minutes after a call is received at EMS dispatch that patients wait for an EMS crew to arrive on scene for a life-threatening event 90% of the time.

2019-20	2020-21	2021-22	2022-23	Target
11.1 mins	11.7 mins	14.6 mins	17.5 mins	Improve

- For fiscal year 2022-23, the EMS response time for the most urgent calls in metro and urban areas (17.5 minutes) deteriorated by 20 per cent compared to the same period last year (14.6 minutes). This measure did not achieve the target to improve for the 2022-23 fiscal year. The shorter the time the better, as it demonstrates system responsiveness and ability to provide timely medical care to patients in the community.
- While AHS faced significant challenges in the first part of the year, people waited less than 15.0 minutes for EMS to respond to the most urgent calls in metro and urban areas 90 per cent of the time in March 2023, a 31 per cent improvement since November 2022 (21.8 minutes).

EMS response time for the most urgent calls in communities over 3,000 residents: Time in minutes after a call is received at EMS dispatch that patients wait for an EMS crew to arrive on scene for a life-threatening event 90% of the time.

2019-20	2020-21	2021-22	2022-23	Target
15.0 mins	15.7 mins	18.6 mins	18.9 mins	Improve

- For fiscal year 2022-23, the EMS response time for the most urgent calls in communities over 3,000 residents (18.9 minutes) remained stable compared to the same period last year (18.6 minutes). This measure did not achieve the target to improve for the 2022-23 fiscal year. The shorter the time the better, as it demonstrates system responsiveness and ability to provide timely medical care to patients in the community.
- While AHS faced significant challenges in the first part of the year, people waited less than 16.4 minutes for EMS to respond to the most urgent calls in communities over 3,000 residents 90 per cent of the time in March 2023, a 24 per cent improvement since November 2022 (21.5 minutes).

EMS response time for the most urgent calls in rural communities (under 3,000 residents): Time in minutes after a call is received at EMS dispatch that patients wait for an EMS crew to arrive on scene for a life-threatening event 90% of the time.

2019-20	2020-21	2021-22	2022-23	Target
30.4 mins	31.6 mins	33.8 mins	33.9 mins	Improve

- For fiscal year 2022-23, the EMS response time for the most urgent calls in rural communities (33.9 minutes) remained stable compared to the same period last year (33.8 minutes). This measure did not achieve the target to improve for the 2022-23 fiscal year. The shorter the time the better, as it demonstrates system responsiveness and ability to provide timely medical care to patients in the community.

- While AHS faced significant challenges in the first part of the year, people waited less than 33.3 minutes for EMS to respond to the most urgent calls in rural communities 90 per cent of the time in March 2023, an eight per cent improvement since November 2022 (36.0 minutes).

EMS response time for the most urgent calls in remote communities: Time in minutes after a call is received at EMS dispatch that patients wait for an EMS crew to arrive on scene for a life-threatening event 90% of the time.

2019-20	2020-21	2021-22	2022-23	Target
60.5 mins	55.1 mins	55.4 mins	61.8 mins	Improve

- For fiscal year 2022-23, the EMS response time for the most urgent calls in remote communities (61.8 minutes) deteriorated by 12 per cent compared to the same period last year (55.4 minutes). This measure did not achieve the target to improve for the 2022-23 fiscal year. The shorter the time the better, as it demonstrates system responsiveness and ability to provide timely medical care to patients in the community.
- While AHS faced significant challenges in the first part of the year, people waited less than 61.7 minutes for EMS to respond to the most urgent calls in remote communities 90 per cent of the time in March 2023, a three per cent improvement since November 2022 (63.9 minutes).

EMS staff must remain with their patient, providing assessment and treatment, until care is formally transferred to the emergency department. Hospital time measures help evaluate system capacity and flow management.

AHS continues to manage system and capacity pressures that impact EMS performance. Acute care capacity and patient flow management impact the amount of time an ambulance spends at the hospital before it is available to respond to another call. In alignment with AEPAC recommendations, several mitigating actions have been taken to help improve EMS hospital time, including the EMS Return to Service initiative which supports paramedics to safely hand over patient care to ED staff within a 45-minute target. Results reflect the combined impacts of early year deterioration and later year improvements. The full impact of improvement initiatives will be seen in 2023-24.

Percentage of EMS events with hospital time less than 90 minutes: Percentage of time an EMS unit arrives at an Emergency Department and is available to respond to another call in less than 90 minutes.

2019-20	2020-21	2021-22	2022-23	Target
72%	71%	64%	60%	Improve

Note: Historical values were restated from the 2022-25 Health Plan to align to measure definitions used in priority action reporting. (Changed from reporting 27 sites to 16 busiest sites.)

- For fiscal year 2022-23, the percentage of EMS events with hospital time less than 90 minutes (60%) deteriorated by six per cent compared to the same period last year (64%). This measure did not achieve the target to improve for the 2022-23 fiscal year. The higher the percentage the better, as it demonstrates EMS teams are spending less time waiting in hospitals and are freed up to respond to other calls.

EMS hospital time: Time between an EMS unit arrival at an Emergency Department until that EMS unit is available to respond to another call 90% of the time.

2019-20	2020-21	2021-22	2022-23	Target
2.3 hrs	2.2 hrs	2.5 hrs	3.0 hrs	Improve

Note: AHS adopted this measure in November 2022.

- For fiscal year 2022-23, the EMS hospital time (3.0 hours) deteriorated by 20 per cent compared to the same period last year (2.5 hours). This measure did not achieve the target to improve for the 2022-23 fiscal year. The lower the number the better, as it demonstrates EMS teams are spending less time waiting in hospitals and are freed up to respond to other calls.
- While AHS faced significant challenges in the first part of the year, EMS spent less than 2.4 hours at hospital before being able to respond to another call 90 per cent of the time in March 2023, a 33 per cent improvement since November 2022 (3.6 hours).

Reducing Surgical Wait Times

Developed with Alberta Health (AH), the Alberta Surgical Initiative (ASI) will improve timely access to surgical care in Alberta. The goal of the ASI is to ensure Albertans receive their required surgeries within clinically recommended timelines. This will be achieved through a holistic, patient-centred approach to the entire journey, requiring system-wide change.

Desired Outcomes:

- Increase and optimize health system capacity and reduce wait times for surgical procedures to improve health and quality of life.
- Improve surgical and specialty access through central access and intake.
- Enhance ability to measure and monitor the patient surgical access journey.

Actions and Achievements

Perform approximately 306,000 surgeries in both acute care and chartered surgical facilities (CSFs) (representing 3% more surgeries than the 2018-19 surgical baseline).

- In 2022-23, AHS completed approximately 292,500 surgeries, representing 96 per cent of the targeted surgical volume (306,000). No incremental volumes were achieved due to workforce shortages and more complex cases being prioritized, which required longer operating room times. CSF volumes were also lower than expected due to the time required for vendors to ramp-up to full operational capacity, workforce challenges and renovations at vendor sites.
- In 2022-23, AHS made significant improvements to the surgical wait list, and more Albertans are getting their surgeries faster.
    - In 2022-23, AHS reduced the adult surgical waitlist by more than 7,000 patients. As of March 31, 2023, the total number of cases on the adult surgical waitlist (67,186) was less than before the pandemic.
    - In 2022-23, AHS completed approximately 10 per cent more cancer surgeries (~22,100), compared to pre-pandemic (~20,040). Nearly 65 per cent of these were completed within clinically recommended wait times.
- The AHS Provincial Surgery Coordination Centre regularly reviews workforce status and ensures actions are taken to address shortages, such as fast-tracked training and education. AHS is also working closely with all CSFs to optimize surgical capacity and achieve contracted volumes.

Centralize access and intake to improve access to specialty care and referral management and improve operating room efficiency and throughput through the implementation of the FAST (Facilitated Access to Specialized Treatment) model.

- In 2022-23, AHS implemented central access and intake in orthopedics and urology in all zones, and began implementation of gynecology, vascular surgery, general surgery and thoracic surgery in Q4.

- The FAST model includes standardized referral pathways, orientation and training for surgeons and specialist office staff, use of databases for referral management and migration to Netcare e-referral.

Work with and support Alberta Health's independent surgical recovery lead to accelerate surgery recovery.

- To enable surgery recovery work, a Provincial Surgery Steering Committee and zonal structures have been established within AHS to support operational surgery acceleration and monitoring related to key actions.
- Progress in 2022-23 included FAST implementation, surgery wait list validation and cleanup, workforce planning and recruitment, and continued focus on optimization of surgical capacity across the province.
- Rural optimization continues to be a priority for AHS. Surgical activity expansion began at rural sites in South Zone and Central Zone in orthopedics and general surgery.

Implement Anesthesia Care Team (ACT) model using alternate providers to support the anesthesia workforce in Edmonton and Calgary.

- In 2022-23, ACT was implemented in ophthalmology and podiatry services in Calgary and Edmonton, enabling one anesthesiologist to provide supervision for respiratory therapists providing anesthesia care in two to three operating room theatres, whenever safe and suitable.
- In Calgary Zone, the ACT model was used in the completion of approximately 8,440 procedures, releasing approximately 255 days of anesthesiologist time, adding surgical capacity to the system.

Performance Measure Results

Number of cases on the surgical waitlist: Number of cases on the surgical waitlist at end of the fiscal year at all adult surgical sites (does not include Stollery and Alberta Children's Hospitals).

2019-20	2020-21	2021-22	2022-23	Target
--	70,292	74,637	67,186	<68,000

Note: The provincial wait list was established in July 2020, therefore older data is not available.

Note: Results are point-in-time values recorded at the end of the reporting period.

- AHS continues to expand operating space where possible to ensure as many surgeries as possible can be completed. This measure can help evaluate system capacity and barriers to access.
- As of March 31, 2023, the total number of cases on the surgical waitlist at all adult surgical sites (67,186) improved by 10 per cent compared to the same period last year (74,637). This measure achieved the target of fewer than 68,000 cases by March 31, 2023. The lower the number the better, as it demonstrates fewer patients are waiting for scheduled surgery.
- Since November 2022, the number of cases on the surgical waitlist at all adult surgical sites (70,014) has been reduced by more than 2,800 cases when compared to March 2023 (67,186).

Number of cases on waitlist outside clinically recommended wait times at all adult surgical sites: Number of cases on the surgical waitlist outside of clinically recommended wait times at the end of the fiscal year at all adult surgical sites (does not include Stollery and Alberta Children's Hospitals).

2019-20	2020-21	2021-22	2022-23	Target
--	35,660	43,599	32,200	<30,600

Note: The provincial wait list was established in July 2020, therefore older data is not available.

Note: Results are point-in-time values recorded at the end of the reporting period.

- Alberta Coding Access Targets are diagnosis-based wait time clinical recommendations. This measure enables comparison of wait time performance against a clinically acceptable timeframe. A clinically appropriate wait time contributes to improved health outcomes and increased patient satisfaction.
- As of March 31, 2023, the number of cases on the waitlist outside clinically recommended wait times at all adult surgical sites (32,200) improved by 26 per cent compared to the same period last year (43,599). This measure did not achieve the target of fewer than 30,600 cases by March 31, 2023. The lower the number the better, as it demonstrates fewer patients are waiting longer than clinically recommended timeframes.
- Since November 2022, the number of cases on the waitlist outside clinically recommended wait times at all adult surgical sites (38,124) has been reduced by more than 5,900 cases when compared to March 2023 (32,200).

Percentage of cases on waitlist outside clinically recommended wait times at all adult surgical sites: Percentage of cases on the surgical waitlist outside of clinically recommended wait times at the end of the fiscal year at all adult surgical sites (does not include Stollery and Alberta Children's Hospitals).

2019-20	2020-21	2021-22	2022-23	Target
--	51%	58%	48%	<45%

Note: The provincial wait list was established in July 2020, therefore older data is not available.

Note: Results are point-in-time values recorded at the end of the reporting period.

- Alberta Coding Access Targets are diagnosis-based wait time clinical recommendations. This measure enables comparison of wait time performance against a clinically acceptable timeframe. A clinically appropriate wait time contributes to improved health outcomes and increased patient satisfaction.

- As of March 31, 2023, the percentage of cases on the waitlist outside clinically recommended wait times at all adult surgical sites (48%) improved by 17 per cent compared to the same period last year (58%). This measure did not achieve the target of fewer than 45 per cent of cases by March 31, 2023. The lower the percentage the better, as it demonstrates fewer patients are waiting longer than clinically recommended timeframes.

Percentage of surgeries completed within clinically recommended wait times at all surgical sites: Percentage of surgeries completed within clinically recommended wait times throughout the year at all surgical sites.

2019-20	2020-21	2021-22	2022-23	Target
62%	56%	63%	60%	70%

- AHS is committed to ensuring all Albertans receive timely access to surgical services. Performing surgeries within recommended timeframes supports improved health outcomes and patient experience and provides opportunities to ensure operating room time is optimized where possible.
- For fiscal year 2022-23, the percentage of surgeries completed within clinically recommended wait times at all surgical sites (60%) deteriorated by five per cent compared to the same period last year (63%). This measure did not achieve the target of 70 per cent for the 2022-23 fiscal year. The higher the percentage the better, as it demonstrates more procedures are being completed within clinically recommended wait times.
- As AHS continues to focus on surgical recovery and completing surgeries for those waiting the longest, it is expected that the percentage of surgeries completed within target will deteriorate in the short-term, followed by improvement in the long-term.

Continuing Care

To meet the needs of the province's growing and aging population, AHS is strengthening and investing in community-based care options to reduce demand for hospital beds, ease congestion in emergency departments and add capacity to the overall healthcare delivery system. Innovative care models will ensure Albertans have choices as they access care where they want it most: in their homes and communities.

Desired Outcomes:

- Support Alberta Health in modernizing the continuing care system to improve continuing care services for Albertans.
- Reduce wait times for Albertans in community or hospital who need admission into long-term care or designated supportive living.
- Enhance quality of life by supporting clients in their homes through home care and palliative care services and shift reliance away from facility-based models of care.

Actions and Achievements

Increase continuing care capacity by approximately 1,500 spaces.

- In 2022-23, AHS increased capacity by opening 1,270 net new community care beds/spaces (764 continuing care, eight sub-acute in LTC, 119 community addiction and mental health, 159 integrated home living spaces and 220 AMH wrap-around supports).
- AHS worked diligently to meet the provincial target of adding 1,500 net new community-based care spaces in 2022-23. An additional 674 beds/spaces were scheduled to open this year, but were delayed due to vendor supply chain issues, recruitment challenges and/or extended timelines on proposal submissions.

Support the modernization and transformation of Alberta's continuing care system including participating with Alberta Health, Alberta Infrastructure, and the Ministry of Seniors, Community and Social Services to update continuing care design standards and best practices.

- In 2022-23, AHS contributed to work related to the Continuing Care Transformation initiative, including a cost impact study on the draft Continuing Care Design Standards and Best Practices.
- Representatives from AHS Seniors Health also participated in the evaluation of proposals submitted through the Alberta Health capital grant program for facility modernization.

Re-contract all home care services provincially and engage stakeholders in developing new models of care.

- In 2022-23, AHS completed a home care Request for Expression of Interest and Qualification (RFEOIQ) to explore capacity and re-evaluate overall home care service delivery within Alberta. Based on the RFEOIQ outcomes, AHS extended all existing Home Care Agreements for six months and has engaged in rate negotiations with all incumbents.

Increase home care clients by approximately 4% over 2021-22.

- In 2022-23, AHS served 127,012 home care clients, representing a four per cent increase compared to 2021-22 (122,084).

Develop a workforce strategy for continuing care in alignment with the Integrated Workforce Action Plan, a three-year strategy to build out and integrate efforts to attract, retain and optimize the workforce while supporting their wellness.

- This is an Alberta Health-led initiative. In 2022-23, AHS supported this work by identifying supports required to attract and retain workers as part of continuing care transformation. AHS also assisted Alberta Health with the development of a Health Care Aide (HCA) Bursary Program for continuing care.

Support the Office of the Auditor General (OAG) audit of AHS' response to the COVID-19 pandemic in continuing care.

- The OAG Report on the COVID-19 response in continuing care was released publicly in February 2023. AHS will now work on implementing the eight recommendations in the audit. The full report can be found on the Auditor General of Alberta website.

Performance Measure Results

Home care clients served: Total number of individual clients within a Home Care program.

2019-20	2020-21	2021-22	2022-23	Target
124,779	117,502	122,084	127,012	126,400

Note: The Alberta Health Business Plan refers to this measure as unique home care clients served.

Note: Historical values were restated as the data is extracted from a transactional database and subject to ongoing data entry and data remediation.

- AHS strives to provide Albertans with care where they want it most: in their homes and communities. By providing home care services that are responsive to changing needs, Albertans are supported to safely manage their own care while reducing reliance on acute and emergency services. This measure can help evaluate system capacity and barriers to access.
- As of March 31, 2023, the number of home care clients served (127,012) improved by four per cent compared to the same period last year (122,084). This measure achieved the target of 126,400 clients for the 2022-23 fiscal year. The higher the number the better, as it demonstrates improvement in home care services capacity.

Percentage of clients placed in continuing care within 30 days: The number of clients admitted to a continuing care facility (long-term care or supportive living) within 30 days of being assessed and approved for admission, as a percentage of all clients admitted to a long-term care facility.

2019-20	2020-21	2021-22	2022-23	Target
60.0%	61.3%	65.6%	64.1%	62.0%

- Timely and appropriate access to continuing care is important to the healthcare experience of aging Albertans and can reduce the stress and burden on clients and family members. Continuing care placements ensure patients are receiving care in the most appropriate setting. This measure is an indicator of capacity and overall system flow management.
- For fiscal year 2022-23, the percentage of clients placed in continuing care within 30 days (64.1%) remained stable compared to the same period last year (65.6%). This measure achieved the target of 62 per cent for the 2022-23 fiscal year. The higher the percentage the better, as it demonstrates availability of long-term care or designated supportive living beds.

Workforce Recruitment and Retention

AHS has a large, diverse and geographically dispersed workforce, making workforce planning a complex task. AHS continues to experience challenges with recruitment and retention of its health human resources which was exacerbated by the lengthy COVID-19 pandemic. AHS is committed to providing a strong and engaging workplace and continues to work with community partners and organizations to address challenges and optimize the workforce while supporting their wellness.

Desired Outcomes:

- Respond to immediate clinical shortages by recruiting and retaining needed staff and physicians to ensure AHS can continue to provide high-quality services.
- Better anticipate future clinical workforce demand and supply gaps through advanced forecasting models.
- Improve quality and safety of services by implementing new staffing models and new models of care that create more capacity for service delivery.

Actions and Achievements

Participate with Alberta Health in developing a long-term workforce plan that focuses on high-need workforce areas, including physicians, general practice and specialist, nurse practitioners, all nurses and other high-need professions.

- The AHS Health Workforce Strategy (HWS) was approved in March 2023 and focuses on immediate responses to short-term workforce challenges along with activities to support longer term strategies to recruit, retain and optimize the critical workforce, including rural and Indigenous initiatives and engagement.

Physicians

- In 2022-23, AHS expanded the use of strategic recruitment incentives, such as one-time payments to new recruits and relocation expense reimbursement.
- The implementation of anesthesia care teams expanded capacity of the anesthesiology workforce supporting surgical capacity in the province.
- In 2022-23, AHS began developing the Physician Experience portfolio to address physician well-being.

Nursing

- In 2022-23, AHS began developing a comprehensive nursing strategy. The strategy aligns with the HWS and encompasses international recruitment, rural placement opportunities and workforce optimization.

Nurse Practitioners

- In 2022-23, AHS optimized the scope of Nurse Practitioners (NP) to fill the gap between the number of NP graduates and increased demand.

Work with Alberta Health to initiate recruitment initiatives, including establishing national and international recruitment strategies.

- In 2022-23, AHS implemented national and international recruitment campaigns, with a focus on nurse recruitment. As of March 2023, more than 400 internationally educated nurses were being assessed. AHS continues

to explore ways to expedite the ability for internationally educated nurses and medical graduates to practice in Alberta.

- In 2022-23, AHS engaged with high schools and educational institutions to increase paramedic student enrollment and enhance career options.
- AHS hosted a national virtual allied health career fair focused on recruiting occupational therapists, physiotherapists, speech language pathologists and therapy assistants.

Work with Alberta Health, Alberta Advanced Education and post-secondary institutions to increase the number of health human resources (HHR) post-secondary seats with a focus on medical and nursing professions, including public health nurses and ensure adequate supply of clinical placements.

- In 2022-23, the Government of Alberta announced an increase of approximately 1,800 new seats in nursing, health care aide and paramedicine programs, and 120 new physician seats over the next three years. AHS continues to work with government and academic partners to support expansion efforts.

Increase internal HHR supply through 'build your own' programs.

- An employer-based HCA training program started in September 2022 with cohorts receiving on-the-job training in rural locations. The program is designed to leverage the workplace setting by providing instruction and support for HCA certification while working on-the-job for AHS.
- In 2022-23, AHS began collaborating with the Métis Settlements Health Board on developing the Medical Response Training on Métis Settlements project which aims to improve emergency medical capability in Métis Settlements of Alberta. Training is expected to begin in 2023-24.

Provide strong retention strategies, including concluding collective bargaining without labour disruption, implementing physician compensation models that align with health service delivery needs and initiating a nursing strategy to increase recruitment, retention, and scope of practice, including public health nursing.

- In 2022-23, AHS developed a Retention Strategy which focuses on creating capacity for managers and supporting leaders, fostering safe and respectful workplaces, addressing the health and well-being of the workforce, and re-engaging the workforce by providing opportunities for growth and fulfillment.
- In 2022-23, AHS released the Psychological Health and Safety in the Workplace Statement to formalize the organization's commitment to the psychological health and safety of employees, medical and midwifery staff, students and volunteers.
- In 2022-23, the Rural Capacity Investment Fund (RCIF) was developed with the United Nurses of Alberta to allocate money toward recruitment and retention strategies in rural and remote areas of the province.

Build a workforce forecasting model that anticipates future demand, including consideration of voluntary termination, turnover, growing needs and forecasted retirements.

- In 2022-23, a preliminary workforce supply and demand forecasting tool was developed to identify potential organizational gaps in the overall physician and registered nursing workforce. The tool will be refined to more detailed levels and expanded to include additional workforce groups.

Expand the availability and usage of strategies, such as crisis-management services, peer support programs, and personal resiliency app (Headversity), to manage workforce burnout and address psychological health and safety.

- In 2022-23, a provincial Peer Support Network project was initiated to create a consistent approach to peer support at AHS, including management structures to ensure sustainability. A pilot was completed with EMS and Protective Services with feedback used to build resources for new and existing networks.

- AHS continues to promote Headversity, a workforce mental health and resilience platform focused on prevention. As of March 31, 2023, there were approximately 3,450 active users, with 94 per cent of respondents reporting being motivated to act positively after completing a lesson.
- In March 2023, more than 1,000 leaders and healthcare providers attended a virtual conference to discuss topics related to personal resiliency and teamwork. Daily one-hour sessions were hosted over five days and covered topics such as Excelling Under Pressure and Nurturing Individual Resilience.
- AHS continues to create and promote various mental health and psychological safety supports and resources. Leadership support is provided through information sessions on trauma-informed leadership, prevention of burnout and supporting psychologically healthy and safe workplace cultures.

Implement Homewood Pathfinder for AHS staff, which features new customized service recommendations, daily check-ins, a personalized dashboard and a new online booking system.

- In 2022-23, the new Pathfinder online tool launched, offering enhanced options for needs assessments, symptom screening and immediate access to a Homewood Health professional in urgent situations.
- Homewood Health also enhanced their virtual cognitive behavioural therapy program, Sentio, to address common barriers to accessing mental health support, such as limited access to counsellors or therapists, hesitancy to disclose mental health concerns or access to clinicians for those with mobility issues or who live in rural or remote areas.

Performance Measure Results

Alberta is experiencing the same challenges as other health systems across Canada and the globe – demand for increased service levels (including adding new positions) combined with a shortage of qualified healthcare workers. This has led to fewer candidate applications and longer times to fill positions. This is especially true in rural locations where applications have decreased considerably since the COVID-19 pandemic. While some workforce metrics are starting to stabilize and trend positively, employee fatigue, burnout and increased desire for employee flexibility are impacting retention and shift availability. AHS is implementing a range of strategies to retain employees and attract new ones within Alberta, and from across Canada and globally.

Percentage of postings open greater than 90 days for staff positions: The number of postings open greater than 90 days as a percentage of the total open postings.

2019-20	2020-21	2021-22	2022-23	Target
3.3%	3.5%	5.2%	7.1%	Stabilize/ Improve

- AHS actively hires into vacant positions across the organization to ensure the best outcomes and experience for Albertans seeking care. Fewer postings open greater than 90 days suggests teams are operating with the optimal number of people to ensure quality and safety. This measure can help identify positions that are harder to fill or have additional barriers.
- For fiscal year 2022-23, the percentage of postings open greater than 90 days for staff positions (7.1%) deteriorated by 37 per cent compared to the same period last year (5.2%). This measure did not achieve the target to stabilize then improve for the 2022-23 fiscal year. The lower the percentage the better, as it demonstrates AHS is able to fill more vacant positions in a timely manner.

Vacancy rate for all AHS positions: The number of AHS vacant positions as a percentage of the total filled and vacant positions.

2019-20	2020-21	2021-22	2022-23	Target
9.9%	13.4%	14.3%	15.0%	Stabilize/ Improve

Note: Results are point-in-time values recorded at the end of the reporting period.

- Albertans expect high-quality care delivered by skilled and compassionate professionals. Vacancy rates help identify areas or positions with the highest staffing needs. This measure supports evidence-based planning to ensure availability of the appropriate health workforce to effectively deliver services.
- As of March 31, 2023, the vacancy rate for all AHS positions (15.0%) deteriorated by five per cent compared to the same period last year (14.3%). This measure did not achieve the target to stabilize then improve for the 2022-23 fiscal year. The lower the rate the better, as it demonstrates AHS is able to fill positions needed to provide and support care to patients and families.

Mental Health and Addiction Recovery

Using a recovery-oriented approach, AHS will continue working with the Ministry of Mental Health and Addiction to offer a range of community-based services, supports and treatments in response to the opioid crisis and other emerging needs, such as addressing the mental well-being of Albertans post-pandemic, and helping those living with mental health or addiction live a satisfying, hopeful and contributing life.

Desired Outcomes:

- Improve access to services and supports in the community for Albertans living with, or at risk of addiction or mental health issues by providing options other than emergency departments to improve health and quality of life.
- Improve access to addiction and mental health (AMH) services and supports through virtual service options.
- Improve access to addiction treatment and recovery services.
- Albertans seeking AMH services and supports enjoy strong continuity of care through warm handoffs between AHS and community services and supports.

Actions and Achievements

Support Alberta Health to develop a response to the recommendations from the Alberta Mental Health & Addiction Advisory Council Report: Toward an Alberta Model of Wellness.

- As of March 31, 2023, implementation was underway on the four recommendations stemming from AHS' 90-day review to improve coordination and outcomes of provincial AMH planning and service delivery. AHS is working with the Ministry of Mental Health and Addiction to further address recommendations from the Toward an Alberta Model of Wellness report.

Work with Alberta Health to prioritize the design and implementation of standardized AMH models of care.

Standardized Models of Care

- A framework has been established to guide the development of a provincial model of care in specific clinical areas, which supports a common approach to the delivery of clinical care and service provision supported by documentation, leadership governance and performance monitoring.

Provincial Protection of Children Abusing Drugs (PChAD)

- In collaboration with Indigenous and community stakeholders, AHS developed a framework for implementing recommendations from Alberta Health's PChAD Program and Legislative Review.
- AHS continues to work with zone partners to develop a standardized, medically supported model of care. In 2022-23, AHS focused on ensuring consistent application of best practices, with documentation standardization occurring within Connect Care.

Residential Addiction Treatment and Detox

- In 2022-23, 71 new medical detoxification and residential recovery beds were established

under the Medical Detoxification and Residential Addiction Treatment Expansion grant, which standardizes public funding for residential addiction treatment.

- In 2022-23, all remaining beds that were closed because of COVID-19 were reopened at both AHS and contracted service provider sites.
- Residential addiction treatment redesign is underway at AHS sites. As of March 31, 2023, occupancy was increased by expanding intake dates, having flexible lengths of stay and reducing service barriers. Work continues on optimizing current programming by advancing evidence-based practices.

Enhance existing virtual AMH tools to improve access to supports and facilitate implementation of a recovery-oriented system of care.

- Access AMH launched in January 2022 to support residents living in South, Central and North Zones by providing a single access point to non-urgent AMH information and services. In 2022-23, 28,652 calls were received by the program. Since referral data became available in May 2022, 5,363 referrals were received.

Initiate the My Recovery Plan (MRP) application in detox and residential addiction treatment settings to facilitate objectives of a recovery-oriented system of care.

- AHS continues to work with the Ministry of Mental Health and Addiction and Last Door Recovery Society to implement the platform. In 2022-23, 14 unique contracted service providers completed training, and the platform was successfully implemented at 9 sites.
- An information session was held in September 2022 with 75 AHS clinicians in attendance. The session enhanced clinicians' understanding of MRP and ways to support implementation.

Expand and standardize collection of AMH data and analytic tools to advance AMH service planning, including outcomes reporting.

- In 2022-23, additional data from the Strata Pathways AMH housing and waitlist management system, Addiction Recovery and Community Health (ARCH) program, supervised consumption services and MRP was integrated into the consolidated AMH database.
- Integration of data from placement (LOCUS) and outcome (HONOS) measurement tools in Connect Care is currently underway.

Implement justice-related AMH virtual tools to support police in responding to mental health needs in the community.

- Since launching in July 2022, the HealthIM application is now available to sections of the Edmonton Police Service and the RCMP Central District, as well as the police agencies of Medicine Hat, Lethbridge and Camrose.
- The provincial Law Enforcement Consultation Line was launched in Q2, providing AMH support to all police agencies, as well as RCMP working in regional police and crisis team partnerships when they require additional support.

Work with Alberta Health to transition supervised consumption site and overdose prevention site grants from AH to AHS.

- In 2022-23, six AHS-operated and community-based supervised consumption and overdose prevention sites transitioned under the AHS master grant. The Ministry of Mental Health and Addiction announced in February 2023 that the AHS-contracted overdose prevention site operated by Turning Point would transition to AHS operations in 2023-24.
- This year, services supported approximately 1,600 individuals and 44,000 visits per month.
- AHS continues to work with sites to align data collection and reporting, improve information security, standardize policy and clinical practice, and support stakeholders to comply with Government of Alberta legislation and regulations.

Expand the use of recovery supports, including opioid agonist therapy (OAT) treatments, in correctional facilities, including expanded access to the Virtual Opioid Dependency Program (VODP).

- Through AHS' Opioid Dependency Program (ODP), Albertans have access to opioid addiction treatment which provides OAT medications and/or Narcotic Transition Services (NTS) and recovery-oriented services and supports to meet the individualized needs of the person, including referral to specialized services, community partners and other recovery supports. In October 2022, AHS enhanced ODP services by sustaining NTS within Edmonton and Calgary ODP clinics. As of February 3, 2023, Grande Prairie ODP clinic services expanded to include NTS, and three new AHS ODP clinics were established in Red Deer, Lethbridge and Medicine Hat. VODP also expanded services this year to support corrections and law enforcement agencies, supervised consumption services, shelters and youth intervention services.
- In 2022-23, the Low Barrier, Urgent Access team initiated 25 urgent starts from shelters, 14 from supervised consumption or overdose prevention services sites and nearly 1,200 from police services and detention.
- In 2022-23, the VODP received more than 2,100 referrals from corrections and law enforcement agencies to enable transitions in treatment and avoid lapses in OAT for clients released from incarceration. The team supported individuals requesting same day starts for OAT at a rate of 15 clients per day, seven days per week.
- This year, the VODP began delivering OAT via store-and-forward telehealth, providing more than 1,200 consultations to individuals in the Edmonton Remand Centre.

Work with Alberta Health to sustain existing COVID-19 supports, such as the addiction and mental health helplines, and domestic abuse response teams, and develop actions to address emerging needs.

- In 2022-23, the AMH Helpline operationalized call flows and referral pathways to support the Operational Stress Injury Clinic, Domestic Abuse Response Team (DART), Safe Healthy Environments Call Centre and Home Care teams.
- This year, AHS expanded the DART team to an additional North Zone community (High Level); the team has now been implemented in 71 AHS and Covenant Health departments.
- A domestic violence screening simulation scenario was developed and initiated to support rural sites in South Zone. Approximately 85% of participants indicated no prior formal training on domestic violence screening, with over half indicating more than 10 years' experience as a healthcare provider.
- Beginning in 2023, AHS Protective Services began implementing the Mental Health Liaison Officer program in partnership with AHS AMH in facilities with inpatient psychiatric units. This model enhances officers' ability to recognize an individual with a mental illness and increases understanding and skills to safely manage emerging situations.

Work with Alberta Health, other Ministries and community partners on strengthening the integration and coordination of child and youth addiction and mental health services.

- In January 2023, the PChAD and VODP Children's Team added new youth services with four facility-based treatment centres and group care settings. As of March 31, 2023, the program had 22 clients.

Performance Measure Results

Child and youth wait times for core community outpatient AMH services (median days): The number of days within which half of the referred cases have their first therapeutic appointment scheduled from the date the referral was received.

2019-20	2020-21	2021-22	2021-22 Q3YTD	2022-23 Q3YTD	Target
15 days	14 days	20 days	20 days	21 days	Improve

- Providing young Albertans with the care they need in a timely manner is essential to improving health outcomes. Long wait times for AMH outpatient services contributes to overreliance on urgent and emergency care services. This measure helps evaluate system capacity to meet patient demand.
- As of Q3YTD, child and youth wait times for core community outpatient AMH services (21 days) deteriorated by five per cent compared to the same period last year (20 days). This measure is not currently on track to achieve the target to improve for the 2022-23 fiscal year. This measure is lagged by one quarter. The lower the number the better, as it demonstrates children and youth are waiting for a shorter time to receive community outpatient AMH services.
- While wait times have increased slightly, Alberta is still performing better than the national average of 25 days, as reported by the Canadian Institute for Health Information (CIHI) *(Your Health System: Wait Times for Community Mental Health)*. Most zones are performing at or near the target of 20 days. Notable progress has been made in Edmonton Zone, where a number of interventions have been implemented (e.g., increasing the number of group sessions, increasing the number of initial appointments completed by therapists). There are recent indications that interventions are having a positive impact on wait times.

30-day hospital readmission rate for AMH issues: The percentage of patients treated in a hospital for mental health disorders who have an unplanned readmission to hospital within 30 days of discharge from hospital.

2019-20	2020-21	2021-22	2021-22 Q3YTD	2022-23 Q3YTD	Target
11.1%	12.6%	13.0%	13.2%	11.9%	Improve

Note: Historical values were restated as of April 2023 to align with recent change with CIHI methodology.

- Hospital care for mental illnesses aims to stabilize acute symptoms with subsequent care and support being provided through outpatient and community programs. Lower readmission rates suggest appropriate discharge planning and follow-up care in the community. This measure helps evaluate care continuity and appropriateness of services and processes.
- As of Q3YTD, the 30-day hospital readmission rate for AMH issues (11.9%) improved by 10 per cent compared to the same period last year (13.2%). This measure is currently on track to achieve the target to improve for the 2022-23 fiscal year. This measure is lagged by one quarter. The lower the percentage the better, as it demonstrates fewer patients are being readmitted after discharge.

Public Health and Pandemic Response and Recovery

AHS remains committed to maintaining readiness to respond to all communicable diseases and viruses, including COVID-19. This includes continued access to treatments and vaccines as well as implementation of strategies to increase immunization rates for all vaccine-preventable diseases. AHS public health teams will also accelerate pre-pandemic work, while continuing to work with First Nations and Métis organizations and communities and respond to the needs of all Albertans.

Desired Outcomes:

- Return to then enhance pre-pandemic capacity for public health follow-up, prevention management, control of routine communicable disease/outbreaks and other public health and prevention programs.
- Maintain foundational capacity to respond to future pandemics or other public safety events.
- Maintain an effective response to the COVID-19 pandemic by supporting access to new vaccines and treatments.

Actions and Achievements

Maintain sufficient capacity for all communicable diseases and viruses including COVID-19 to be ready to ramp up and ramp down according to joint Alberta Health-AHS pandemic and recovery planning.

- The Emergency Coordination Centre was stood down in Q2. A Readiness and Recovery Committee remains in place to monitor and manage any COVID-related matters that require coordination across teams, including rapid reactivation as required.

Refine communicable disease emergency response plans to incorporate lessons learned from responding to COVID-19.

- In 2022-23, a final report on the AHS COVID-19 Pandemic Response was developed based on findings from 39 COVID-19 debrief sessions and the analysis of approximately 60 additional evaluations, audits and reports.
- AHS' Communicable Disease Emergency Response Plan was revised and incorporates approximately 600 COVID-19 related documents.

Resume regular public health activities, such as the oral health program; tobacco, cannabis and vaping reduction; school health promotion; and cancer screening.

Oral Health Program

- In 2022-23, school dental health preventive programs resumed regular activity.
- Both Public Health Dental Clinics in Calgary are back to full scope of practice. In 2022-23, 2,659 patients received dental treatments and 19,052 dental procedures were completed.
- The Public Health Dental Clinic in Red Deer (Central Zone) initiated services one day per week. In 2022-23, 77 patients received dental treatments and 622 dental procedures were done.

Tobacco, Cannabis and Vaping Reduction

- In 2022-23, tobacco, cannabis and vaping reduction programs returned to pre-pandemic activity levels, including offering health professional training, QuitCore sessions, local tobacco cessation and prevention projects, and other prevention and protection activities with vulnerable populations.

- AHS continued to build capacity around addressing nicotine dependence as a standard of care in health settings and offer Albertans support to quit smoking. In 2022-23, nearly 200 participants completed the QuitCore course. In addition, health professionals completed more than 1,250 online learning courses.

School Health Promotion

- In 2022-23, AHS continued to re-engage with school authorities and other partners across the province to support and enhance student and staff wellness. AHS facilitated 29 professional learning sessions with a total of 951 participants on topics such as nature, mental health and staff wellness.
- Evidence-based content continues to be developed for the Healthier Together Schools website to support implementation of health promotion strategies, such as action cards on tobacco/vaping prevention, Alberta-based success stories and articles for families with children in grades K-12.

Cancer Screening

- AHS Breast Cancer Screening Programs continue to engage underserved populations to promote screening uptake, including collaborating with Indigenous partners to address screening needs and working with primary care providers to increase knowledge and awareness of updated breast cancer screening clinical practice guidelines.
- The new Alberta Lung Cancer Screening Program pilot launched on September 1, 2022. This year, 975 referrals were received, 445 low dose computed tomography (CT) scans were completed and 549 patients were referred to tobacco cessation services.
- In 2022-23, the HPV Test of Cure clinical pathway was adopted across the province, supporting safe discharge from specialty care. In the first five months, 567 patients were discharged to community care, diverting up to three years of specialty care.
- In 2022-23, a new fecal immunochemical test (FIT) online ordering system was developed to increase access to colorectal cancer screening. In the first year, more than 2,960 FIT kits were mailed.

Return to pre-pandemic capacity for routine in-school immunization.

- In 2022-23, the routine in-school immunization program resumed pre-pandemic offerings for grades 6 and 9, administering approximately 93,500 doses of vaccine.
- In 2022-23, approximately 63,600 doses of vaccine were administered to students in grades 7-12 to complete outstanding school immunizations caused by pandemic service disruptions during the 2019-20 and 2020-21 school years.

Continue ongoing support for access to vaccines and treatments for COVID-19. Vaccine reporting will be based on the number of vaccines administered and aligned with Alberta Health's Immunization Policy for COVID-19 and eligibility criteria.

- As of March 31, 2023, two COVID-19 outpatient therapies were available, and AHS continued to work with partners, including primary care, to ensure timely access for all eligible Albertans. In 2022-23, Health Link completed eligibility screening for more than 29,200 individuals for these programs.
- In 2022-23, AHS administered more than 254,000 COVID-19 vaccine doses (including initial series and booster doses). Alberta Health continues to expand COVID-19 vaccine eligibility for adults and children.

Performance Measure Results

Immunizations protect Albertans from vaccine-preventable diseases, some of which can be fatal or produce permanent disabilities. Immunization rate measures help identify groups or areas that may be experiencing barriers to access.

Immunization rates for most programs fell steadily during the pandemic due to workforce pressures in public health as well as some public loss of confidence in immunization programs related to concerns about the COVID-19 immunization program. AHS has begun developing a multi-year strategy which outlines actions aimed at improving immunization rates across Alberta.

Childhood immunization rate at 2 years – DTaP-IPV-Hib-HB: The number of children that turned 2 years of age and had received four doses of diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b, and hepatitis B containing vaccine as a percentage of all children who turned 2 years of age.

2019	2020	2021	2022	Target
77.0%	75.8%	72.5%	70.7%	≥76%

Note: Historical values were restated as of June 2023.

Note: The target represents the 2022 AHS organizational target. Alberta Health uses the national target (set by CIHI) for childhood immunization by two years of age.

Note: The Interactive Health Data Application (IHDA) recently restated Childhood Immunization rates to values that now include First Nations coverage. This methodology change resulted in immunization rates that, over the last 2 years, averaged lower than historically reported values.

- In 2022, the childhood DTaP-IPV-Hib immunization rate (70.7%) remained stable compared to the same period last year (72.5%). This measure did not achieve the AHS target of at least 76 per cent for 2022. The higher the percentage the better, as it demonstrates more children are immunized and protected from vaccine-preventable childhood diseases.

Childhood immunization rate at 2 years – MMR-V: The number of children that turned 2 years of age and had one dose of mumps, measles, rubella, and varicella containing vaccine as a percentage of all children who turned 2 years of age.

2019	2020	2021	2022	Target
86.8%	86.5%	83.1%	82.0%	≥86%

Note: Historical values were restated as of June 2023.

Note: The target represents the 2022 AHS organizational target. Alberta Health uses the national target (set by CIHI) for childhood immunization by two years of age.

Note: The IHDA recently restated Childhood Immunization rates to values that now include First Nations coverage. This methodology change resulted in immunization rates that, over the last 2 years, averaged lower than historically reported values.

- In 2022, the childhood MMR immunization rate (82.0%) remained stable compared to the same period last year (83.1%). This measure did not achieve the AHS target of at least 86 per cent for 2022. The higher the percentage the better, as it demonstrates more children are immunized and protected from vaccine-preventable childhood diseases.

Cancer has a large impact on Albertans and the healthcare system. A high rate of screening participation for a population increases the likelihood of detecting cancer early when it is more treatable. Screening participation measures help identify groups or areas that may be experiencing barriers to access.

Breast cancer screening participation rate: The percentage of eligible Alberta women, 50-74 years old, who completed at least one screening mammogram within 30 months prior to the end of the reporting period.

2019-20	2020-21	2021-22	2022-23	Target
65.5%	61.1%	60.5%	63.3%	≥60%

- As of March 31, 2023, the breast cancer screening participation rate (63.3%) improved by five per cent compared to the same period last year (60.5%). This measure achieved the target of at least 60 per cent for the 2022-23 fiscal year. The higher the rate the better, as it demonstrates more eligible Albertans are being screened for breast cancer, increasing the chances of early detection which may mean less treatment and less time spent recovering.

Cervical cancer screening participation rate: The percentage of Alberta screen-eligible women, 25-69 years old, who completed at least one screening Pap test within 42 months prior to the end of the reporting period.

2019-20	2020-21	2021-22	2022-23	Target
63.8%	60.8%	60.1%	60.0%	≥61%

- As of March 31, 2023, the cervical cancer screening participation rate (60.0%) remained stable compared to the same period last year (60.1%). This measure did not achieve the target of at least 61 per cent for the 2022-23 fiscal year. The higher the rate the better, as it demonstrates more eligible Albertans are being screened for cervical cancer, increasing the chances of early detection which may mean less treatment and less time spent recovering.
- Due to service interruptions and public risk perception during the pandemic, many eligible people didn't get screened. Therefore, the number of people who were due for screening gradually accumulated over the last few years. While cervical screening service volumes were higher in 2022-23 than previous years, the number of people due for screening was even higher.

Colorectal cancer screening participation rate: The percentage of screen-eligible individuals, 50-74 years of age, who had a Fecal Immunochemical Test in the past two years or a sigmoidoscopy or colonoscopy in the past five years.

2019-20	2020-21	2021-22	2022-23	Target
55.4%	50.0%	50.3%	53.5%	≥52%

- As of March 31, 2023, the colorectal cancer screening participation rate (53.5%) improved by six per cent compared to the same period last year (50.3%). This measure achieved the target of at least 52 per cent for the 2022-23 fiscal year. The higher the rate the better, as it demonstrates more eligible Albertans are being screened for colorectal cancer, increasing the chances of early detection which may mean less treatment and less time spent recovering.

Digital Health Evolution and Innovation

Albertans need the proper tools and technologies to actively manage their health and well-being. AHS is committed to enabling more timely communication and decision-making between patients, families and healthcare providers through virtual care initiatives, smart devices and Connect Care software. As a learning organization, AHS will engage providers, researchers and industry partners to bring innovative solutions that advance the application of virtual technologies to support healthcare delivery.

Desired Outcomes:

- Improve patient safety and quality through enhanced decision-making information being provided at point of care.
- Improve patient-centred care through access to the Connect Care patient portal.
- Benefits realized through Connect Care implementation continue to fund the program.
- Improve patient access to services through virtual care options.

Actions and Achievements

Deploy Connect Care Launches 4 and 5 (approximately 50,000 clinicians).

- Connect Care successfully completed its fourth launch on May 28, 2022, in both Calgary and Edmonton, and its fifth launch on November 6, 2022, in acute and long-term care sites in Calgary, North and Central Zones, and in Cancer Care Alberta and Alberta Kidney Care sites. There are now more than 75,000 staff, physicians and other healthcare providers using Connect Care and more than 211,000 patients using the MyAHS Connect patient portal.

With Alberta Innovates, invest in digital health solutions through the Alberta Partnership for Research and Innovation in the Health System (PRIHS) program.

- In February 2023, Alberta Innovates awarded funding to eight PRIHS digital health projects. In collaboration with Strategic Clinical Networks and Integrated Provincial Programs, AHS will be able to leverage digital and data-enabled technologies to deliver innovative models of care for patients in Alberta.

Collaborate with Alberta's innovation accelerators to test emerging digital technologies of relevance to the care needs of Albertans.

- In 2022-23, the Accelerating Innovation into Care (AICE) grant was awarded to AHS, enabling EMS to assess the feasibility of diagnosing strokes remotely. The artificial intelligence electroencephalography (EEG) device was tested in Calgary Zone in ambulances and in the Foothills Medical Centre Emergency Department to detect a stroke. The project will launch a clinical trial in 2023-24.
- In 2022-23, AHS initiated a project to test augmented reality technology and 5G networking capabilities in the Stroke Ambulance at the U of A Hospital to improve the delivery of acute stroke care in the field. Equipment and cable installation is underway.

- With funding from the Canadian Early Adopter Health Network, AHS initiated trials to assess three innovations: testing a new closure device following abdominal surgery to improve outcomes; exploring the use of robotics in training children with disabilities; and trialing a self-management app for patients at high risk of developing post-surgical chronic pain. Trials will conclude in Q1 2023-24.

Build on virtual care deployed during the pandemic.

Addiction and Mental Health Line

- In 2022-23, the AMH Line received more than 56,400 calls. Call flow integration and referral pathways were completed between the AMH Line and Access AMH teams in North, Central and South Zones.
- In April, Alberta Health provided grant funding for a provincial Law Enforcement Consultation Line where law enforcement workers can consult with a mental health clinician, 24 hours a day. The line is now available provincially and received more than 100 calls in 2022-23.

Virtual MD Line

- Since launching in January 2022, more than 24,000 Albertans have been referred to the Virtual MD Line. Data shows the line is diverting Albertans from emergency departments (EDs) and urgent care clinics, with only 12% of referred patients advised to proceed to an ED.
- Beginning in January 2023, EMS/811 shared response calls that did not require an ED visit were referred to the Virtual MD Line. This year, 184 patients were transferred and assessed.

Rehabilitation Advice Line (RAL)

- In 2022-23, the RAL addressed more than 20,400 calls, approximately half of which were related to musculoskeletal concerns. Since September 2022, Therapy Assistants have screened more than 5,700 callers for low-income eligibility for physiotherapy.
- On March 6, 2023, RAL launched a pediatric service, to support parents, guardians and caregivers with concerns about their child's development and well-being. In the first two weeks of service, the team received 23 calls. In 2022-23, the Virtual Rehabilitation Team provided virtual occupational and physical therapy to rural communities in Central and North Zones. More than 50 patients were assessed and treated in the Rimbey area (Central Zone) in the first six months of service.

Launch Health Link 1-800 Indigenous Support Line pilot project.

- Since launching in North Zone on May 30, 2022, the 1-800 Indigenous Support Line has received more than 800 calls. The support line will expand into the South and Central Zones in Q1 2023-24.

Expand Virtual Physician Triage criteria to offer this service to more Albertans.

- In 2022-23, the program's inclusion criteria were expanded to include all non-active-labor pregnancy-related issues; all influenza-like symptoms, rashes, nausea/vomiting, diarrhea; and all EMS/811 shared response calls that do not require an ED visit.

Performance Measure Results

Users registered on MyAHS Connect patient portal: The number of Connect Care health accounts being accessed via MyAHS Connect.

2019-20	2020-21	2021-22	2022-23	Target
9,461	38,017	95,101	211,191	>140,000

Note: Values are cumulative across all years and recorded at the end of the reporting period.

- MyAHS Connect is a patient portal that offers secure online access to a person's AHS record of care, allowing Albertans to be active participants in their care, leading to improved health and well-being and supporting informed use of healthcare resources.
- For fiscal year 2022-23, the cumulative number of users registered on the MyAHS Connect patient portal (211,191) increased by 122 per cent compared to the same period last year (95,101). This measure achieved the target of greater than 140,000 users for the 2022-23 fiscal year. The higher the number the better, as it demonstrates more Albertans have access to the portal and can be more involved in their care and decision making.

Number of virtual visits (acute, community and ambulatory): The number of scheduled and completed video visits using Telehealth, AHS Zoom Enterprise, and MyAHS Connect Video Visit technologies.

2019-20	2020-21	2021-22	2022-23	Target
32,425	369,847	433,299	337,401	>450,000

- AHS supports virtual care encounters when clinically appropriate and for those whom a virtual visit can effectively and safely replace an in-person visit. This measure can be used to assess patient access to care and monitor virtual care use within AHS.
- As of March 31, 2023, the number of virtual visits (337,401) deteriorated by 22 per cent compared to the same period last year (433,299). This measure did not achieve the target of greater than 450,000 visits for the 2022-23 fiscal year. The higher the number the better, as it demonstrates higher uptake of video and telephone visits to deliver virtual care and may suggest improved patient access to healthcare.
- Virtual visit numbers increased exponentially during the COVID-19 pandemic for several reasons, including pandemic-related restrictions, availability of new technology platforms and patient preference for virtual visits. AHS is seeing virtual visits decline due to the removal of restrictions and patients' clinical need to be seen in-person after a prolonged period of virtual visits. Nonetheless, the use of virtual platforms remains strong when compared to pre-pandemic time periods and is anticipated to remain at this level moving forward.

Rural & Indigenous Initiatives and Engagement

To address the unique healthcare needs of Albertans living in rural, remote and Indigenous communities, AHS is engaging in work that strengthens partnerships in non-urban communities, supports the rural workforce and enables more locally responsive decision-making. These actions will support improved health outcomes among these diverse communities and will span the continuum of care and focus on community-based care.

Desired Outcomes:

- Better reflect the needs of diverse communities and populations by increasing the opportunity for Albertans to inform the future of healthcare delivery.
- Improve attraction, recruitment and retention of clinical staff in rural and remote areas of the province.
- Improve quality and access to care in rural and remote communities through virtual care options.
- Develop approaches to better meet the needs of First Nations, Métis and Inuit communities.

Actions and Achievements

Ensure communities and all Albertans can participate in 'multi-directional engagement' — a model in which information flows in every direction by using best practice engagement strategies and tactics that are accessible and ensuring Albertans understand how their feedback was utilized.

- In 2022-23, AHS supported direct engagement with more than 10,000 Albertans, including through events held in 21 communities across the province in partnership with Alberta Health. Activities ranged from large in-person sessions to discuss recruitment challenges and service disruptions, to small online sessions to seek input on healthcare planning and patient education materials. A summary document is shared with participants to validate their input.
- The online engagement platform Together4Health hosted 75 projects in 2022-23 and recorded participation by more than 97,200 internal and external stakeholders.

Improve effectiveness/engagement of existing advisory councils: Health Advisory Councils, Provincial Advisory Councils, and the Wisdom Council.

- Health and Provincial Advisory Council members participated in the annual Spring Forum in May 2022. More than 70 members attended in person and 40 joined three virtual sessions offered during the event.
- Health Advisory Councils (HACs) host public meetings and engagement events across Alberta. In 2022-23, more than 1,400 Albertans attended a HAC-hosted session. Discussion topics included palliative care, suicide prevention, understanding grief and loss, and Connect Care.
- In 2022-23, the Wisdom Council worked with AHS Senior Leadership to develop the *Patient Access to Indigenous Spiritual Ceremony Policy* which aims to enhance the availability of Indigenous spiritual ceremonies for Indigenous patients and their families.

- In 2022-23, more than 90 new members joined councils, reducing the vacancy rate by more than half.

Sustain engagement of regional community leaders on health service delivery planning, issues and opportunities, and relationship-building.

- In 2022-23, AHS Community Engagement and Communications teams supported more than 500 instances of engagement with zone leadership and elected officials to provide notification of pending service disruptions or changes in service delivery.
- This year, South Zone launched zone healthcare planning, hosting 13 virtual and in-person engagement events that reached more than 350 participants.

Further build Culture of Engagement across AHS and strengthen local relationships; ensure foundational stakeholder engagement supports are in place for local leadership.

- In 2022-23, a taskforce was established to identify short- and medium-term actions which will support local decision-making while reducing administrative burden and increasing leader capacity to respond to daily demands. The taskforce will also look at opportunities for local engagement and support leaders to build capability in decision-making.
- AHS continues to revise processes across the organization to support decision-making at the appropriate authority level, including those related to corporate purchasing, travel and financial authority approval limits, human resources escalation, and recruitment and hiring.
- AHS continues to make regular connections across the province. Important updates are provided in the bi-weekly Together4Health Headlines e-newsletter, which has more than 4,600 subscribers.
- In 2022-23, the AHS Protective Services Safety Ambassador Program enabled non-uniform security personnel to assist in the de-escalation and prevention of emotional behaviour. The program has been warmly received by individuals and communities who have experienced trauma with people in uniform, allowing for enhanced engagement and safety in the care environment.

Work with the Indigenous Wellness Core and Alberta Health to ensure Indigenous engagement opportunities are increased and sustained.

- In 2022-23, progress was made on the *AHS Indigenous Health Commitments: Roadmap to Wellness*, which focuses on five priority areas: cultural safety, healthy communities and families, primary healthcare, patient concerns and experience, and addiction and mental wellness.
- Community engagement and co-design work is underway in all zones to support the development of an *Indigenous Health Action Plan* that addresses local needs by leveraging evidence-based tools such as care coordination, pathways, and culturally safe and accessible care options.

Refine internal review processes to rural foundations to ensure they are receiving requests that demonstrate a larger strategy and impact on local and rural health.

- In 2022-23, AHS leadership and foundations met to discuss a priority-setting framework. Feedback will help AHS further improve processes to ensure foundations are aware of priorities at the site, zone and system level.

Led by Alberta Health, participate in the development of a long-term workforce plan particularly for rural workforce, to build a more sustainable supply of key roles and skills.

- The AHS Health Workforce Strategy (HWS) was approved in March 2023 and focuses on immediate responses to short-term workforce challenges along with activities to support longer-term strategies to recruit, retain and optimize the critical workforce, including rural initiatives and engagement.

Collaborate with post-secondary institutions to establish rural-based nursing programs and pathways for rural placements.

- In 2022-23, AHS collaborated with post-secondary institutions to establish rural-

based training programs and pathways for rural placements. The first cohort of nursing students was in Wainwright (Central Zone).

- In 2022-23, registered midwives were enabled to provide urgent assistance in rural areas to support continued labour and delivery services.
- AHS has partnered with the *Rural Health Professions Action Plan* to support worker placement and community integration of internationally educated nurses recruited for rural positions.

Work with appropriate post-secondary institutions to deliver a health care aide (HCA) program at the workplace to expand the HCA workforce and increase the number of HCAs in rural and remote areas, with a focus on continuing care sites and home care.

- This is an Alberta Health-led initiative that allocates funding toward an HCA Bursary Program with a focus on recruiting into the continuing care workforce. In 2022-23, AHS actively participated in monthly working group meetings and provided input on bursary parameters.

Develop an operating room utilization plan for rural sites with Alberta Surgical Initiative targeted volume increases to explore further opportunities for expansion.

- AHS continued to engage in rural optimization planning, such as enhancing surgical capacity for low acuity procedures in orthopedics, general surgery and plastic surgery. There have been delays in planning and implementation due to workforce shortages which are being addressed through the Alberta Surgical Initiative.
- In 2022-23, North Zone achieved surgical targets for volumes and for those waiting the longest.

Performance Measure Results

Vacancy rates for rural/remote staff positions: The number of AHS vacant positions in rural and remote areas of Alberta as a percentage of the total filled and vacant positions in rural and remote areas.

2019-20	2020-21	2021-22	2022-23	Target
10.4%	13.2%	16.7%	18.8%	Stabilize/ Improve

Note: Results are point-in-time values recorded at the end of the reporting period.

- All Albertans, regardless of where they live, expect high-quality care delivered by skilled and compassionate professionals. Vacancy rates help identify areas or positions with the highest staffing needs. This measure supports evidence-based planning to ensure availability of the appropriate health workforce to effectively deliver services.
- As of March 31, 2023, the vacancy rate for rural/remote staff positions (18.8%) deteriorated by 13 per cent compared to the same period last year (16.7%). This measure did not achieve the target to stabilize then improve by March 31, 2023. The lower the rate the better, as it demonstrates AHS is able to fill positions needed to provide and support care to patients and families.
- Alberta is experiencing the same challenges as other health systems across Canada and the globe – demand for increased service levels (including adding new positions) combined with a shortage of qualified healthcare workers. This has led to fewer candidate applications and longer times to fill positions. This is especially true in rural locations where applications have decreased considerably since the COVID-19 pandemic. While some workforce metrics are starting to stabilize and trend positively, employee fatigue, burnout and increased desire for employee flexibility are impacting retention and shift availability. AHS is implementing a range of strategies to retain employees and attract new ones within Alberta, and from across Canada and globally.

Turnover rates for rural/remote staff positions: The number of employees in rural and remote areas who have left AHS voluntarily as a percentage of the total number of employees in rural and remote areas.

2019-20	2020-21	2021-22	2022-23	Target
4.3%	4.5%	6.3%	5.7%	Stabilize/ Improve

- Grounded in our values, AHS is committed to ensuring the health workforce has the supports and resources they need to thrive in the workplace. This measure can help identify areas that are experiencing workforce challenges and may be an indicator of workplace satisfaction.
- As of March 31, 2023, the turnover rate for rural/remote staff positions (5.7%) improved by 10 per cent compared to the same period last year (6.3%). This measure achieved the target to stabilize then improve by March 31, 2023. The lower the rate the better, as it demonstrates strong staff retention which provides continuity of knowledge and patient care, as well as controls expenses and time associated with recruiting and training new employees.

Quality and Patient Outcomes

AHS has a responsibility to deliver high-quality, accessible healthcare services. By incorporating elements of quality planning, quality assurance, quality control and quality improvement into the delivery of healthcare services, AHS will be able to continue providing Albertans the best possible health outcomes and experiences.

Desired Outcomes:

- Reduce unwarranted variation in testing and treatment through initiative prioritization and implementation.
- Increase patient safety, experience and quality of service through quality improvement initiative prioritization and implementation.
- Enhance the staff/physician culture of patient safety and quality through training and other experiential opportunities.
- Focus on the *CT and MRI Action Plan* to decrease costs, manage wait times and increase appropriateness of diagnostic imaging.

Actions and Achievements

Identify Right Care Alberta clinical appropriateness initiatives focused on unwarranted variation working with the Health Quality Council of Alberta and in collaboration with others, such as the Physician Learning Program and the Alberta Medical Association.

- In 2022-23, six clinical appropriateness initiatives were approved and began implementation:
    - Appropriateness and Stewardship in Asymptomatic Bacteriuria.
    - Appropriateness of Pre-Operative Chest X-rays for Low-Risk Procedures.
    - Optimizing Chronic Shoulder Magnetic Resonance Imaging Utilization for Surgical Decision Making.
    - Optimizing Knee Magnetic Resonance Imaging in Patients Aged 55 and Older with Known Osteoarthritis.
    - Bronchiolitis Appropriate Care.
    - HPV Test of Cure.
- Topics have been identified for the first Alberta Atlas of Variation, with an anticipated publishing date of October 2023.

Continue development and implementation of AHS' Academy of Quality Improvement Sciences (AQuIS).

- In 2022-23, the two foundational curriculum streams of AQUiS were completed, encompassing patient safety and quality improvement. Learner feedback was gathered and incorporated into the course outline.

Designate Culture of Patient Safety course as required organizational learning.

- In 2022-23, the Royal College of Physicians and Surgeons of Canada granted accredited status to the Provincial Patient Safety course. Work is ongoing to designate the course as required learning. Accredited status was also granted for all courses in both foundational streams of AQuIS.

Revise Quality Assurance Review education and training materials to improve and standardize systems review methodology and develop certified trainers.

- The new Systematic Systems Analysis curriculum was piloted in 2022-23 to improve how quality assurance reviews are conducted in Alberta. An in-person and virtual course was

offered, reaching 31 participants from AHS. Course evaluations are underway and will inform future implementation. An AHS-specific companion document was also developed and is undergoing stakeholder review.

Develop Patient Rights and Responsibilities approach and deliverables that will lead to improved patient experience and partnerships, health ownership and health outcomes.

- In 2022-23, a *Shared Commitments* resource was developed to enhance mutually respectful and satisfying relationships between patients/families and healthcare providers. In addition to patient and family advisors, stakeholders represented all areas of AHS, including quality improvement, patient relations, accreditation, community engagement, clinical ethics, health workforce, allied health, Indigenous wellness, legal services and zone operations. Implementation is expected to occur in 2023-24.

Implement a provincewide quality improvement initiative to reduce surgical site infections (SSI) at the 14 adult sites that have adopted the National Surgical Quality Improvement Program (NSQIP).

- In 2022-23, site teams were established to focus on implementing SSI reduction best practices. Each site identified key areas of opportunity, including pre-operative patient education, optimizing prophylactic antibiotic timing, pre-operative skin preparation and cleansing, monitoring and maintenance of optimal patient body temperature, and increasing the use of established care pathways to standardize and improve patient care. Alignment with the Acute Care Length of Stay Improvement Bundle (ACB) initiative is ongoing.

Work with Alberta Health to implement targeted improvements to improve patient concerns management process.

- In 2022-23, a competency framework for Patient Relations staff was developed based on an extensive literature review, national best practices and through a survey of AHS staff.
- A review of the concern and commendation categories used to classify the feedback received by patients and families was initiated. The goal is to produce more meaningful and accurate summary reports and to determine if changes are needed to the categories, titles or their definitions.

Achieve wait time targets for MRI and CT imaging.

- Although current wait times for MRI and CT imaging are better than the pre-pandemic period, a rise in demand has contributed to increased wait times over the last two years, along with Alberta performing fewer CT and MRI scans per capita when compared to Canadian averages. Wait time targets were not achieved in 2022-23 and progress was impacted by pandemic recovery, increased demand, a global shortage of radiographic iodinated contrast material, equipment downtime and staffing shortages. Efforts are focused on managing growing demand through clinical decision support, appropriateness initiatives and increasing imaging volumes where appropriate.

Performance Measure Results

Surgical site infection rate (14 large volume adult acute care sites): The percentage of cases that developed infections in a surgical site within 30 days after surgery.

2019-20	2020-21	2021-22	2021-22 Q2YTD	2022-23 Q2YTD	Target
4.15%	4.49%	3.91%	4.16%	4.26%	3.12%

- AHS is committed to delivering high-quality care while ensuring patient safety by reducing preventable harm. Lower rates of surgical site infections contribute to improved health outcomes and lower readmission rates. This measure is an indicator of care quality and supports evidence-based process improvements.
- As of Q2YTD, the surgical site infection (SSI) rate at the 14 large volume adult acute care sites (4.26%) remained stable compared to same period last year (4.16%). This measure is not currently on track to achieve the target of 3.12 per cent for the 2022-23 fiscal year. This measure is lagged by two quarters. The lower the rate the better, as it demonstrates fewer infections are occurring as a result of surgical procedures.
- Site teams continue to work on SSI reduction activities with common areas of focus including optimizing prophylactic antibiotic timing, pre-operative skin preparation and cleansing, monitoring and maintenance of optimal patient body temperature, and increasing the use of established surgical care pathways such as Enhanced Recovery After Surgery. The provincial target was an aggressive goal and is unlikely to be met. Factors including patient acuity and complexity coming out of the COVID-19 pandemic, site capacity for implementing change activities, and overall surgical services staffing capacity affect the success of local and provincial SSI reduction strategies. The SSI rate variance between the 14 adult sites across AHS impacts the provincial metric and revised provincial targets have been set to better align with patient complexity and SSI reduction activities. The provincial collaborative, including all 14 adult NSQIP sites, will continue in 2023-24 to build local and system level best practice-based care.

Adult patient satisfaction with hospital experience: The percentage of patients rating hospital care as 9 or 10 on a scale from 0-10, where 10 is the best possible rating.

2019-20	2020-21	2021-22	2021-22 Q3YTD	2022-23 Q3YTD	Target
66.3%	66.8%	65.6%	65.7%	63.2%	Improve

Note: Historical values for fiscal year 2019-20 were restated to be consistent with a small change in methodology in 2020-21.

- Gathering feedback from individuals using hospital services is a critical part of improving the care and services AHS provides. Effective communication and care coordination is linked to higher patient satisfaction ratings. This measure is an indicator of system performance from the patient's perspective. This measure monitors patients' overall perceptions associated with the hospital where they received care, based on survey ratings, using a scale from 0-10, where 10 is the best possible rating.
- As of Q3YTD, the percentage of patients rating hospital care as 9 or 10 (63.2%) deteriorated by four per cent compared to the same period last year (65.7%). This measure is not currently on track to achieve the target to improve for the 2022-23 fiscal year. This measure is lagged by one quarter. The higher the number the better, as it demonstrates more patients are satisfied with their care in hospital.
- Ongoing staffing pressures and service demands continued to impact patient and family experiences in acute and emergency care through Q3 2022-23. Strategies aimed at addressing priority issues were not fully implemented during the reporting period. Additionally, satisfaction ratings are impacted, in part, by provider-patient communications. Fluctuations in communication ratings throughout the pandemic response have prompted communications and process improvements across the organization.
- In 2021-22, across all hospitals, 66% of Albertans rated their overall hospital experience as 9 or 10 out of 10, compared to the Canadian average of 63% *(CIHI).*

Sustainability

To ensure our services, our people and the environment are sustainable for current and future generations, AHS will aim to deliver on innovative initiatives that enable systemic transformation while reinvesting cost savings back into the health system. This includes actions aimed at increasing operational efficiency and reducing greenhouse gas emissions, as well as the continued implementation of recommendations identified by the AHS Sustainability Program Office.

Desired Outcomes:

- Increase value in the healthcare delivery system by reducing or avoiding unnecessary costs that can be re-invested into delivering quality patient care and adding system capacity.
- Adopt and embed new models and innovations into the care system and supporting infrastructure that helps AHS meet its sustainability goals and improve patient outcomes.
- Reduce AHS' electricity, natural gas, water and emissions environmental footprint.

Actions and Achievements

Continue to work with Alberta Health on the AHS Sustainability Program.

- AHS continues to work with Alberta Health on advancing the priorities of the AHS Sustainability Program. Currently, AHS is working towards a three-year plan with progress updates shared in routine and transparent reporting through regular reporting cycles supported by the AHS Sustainability Program.

Continue to work with Alberta Health and Alberta Infrastructure in utilizing existing committee structures to steer sustainability efforts related to capital infrastructure projects and energy-efficient health facilities.

- AHS continues to collaborate with Alberta Health and Alberta Infrastructure to support major infrastructure projects, including the Calgary Cancer Centre, renovations at multiple sites and equipment purchases to support the Alberta Surgical Initiative. The Calgary Cancer Centre was transferred to AHS ownership on November 28, 2022.

Continue to work with Alberta Health to refine service planning approach to support government equity policy decisions.

- In 2022-23, the joint AH/AHS Provincial Service Planning Committee provided oversight to service plans in development, including Provincial EMS, the *Provincial Strategic Capital Plan* and the development of a joint *Health Service Planning Framework* which aims to refine planning processes and standardize documentation.
- In 2022-23, joint AH/AHS work was initiated on the development of Edmonton and South Zone Healthcare Plans (ZHCP). ZHCPs are long-range plans that consider current and anticipated future needs and align with Ministry of Health priorities.

Implement savings and investment initiatives to improve value and transform care with a focus on priority initiatives.

- The AHS Sustainability Program continues to support various system priorities. As of March 31, 2023, year-to-date cumulative savings was $203M.

Increase automation in back-office functions by expanding the adoption of Robotic Process Automation across the organization.

- As of March 31, 2023, the program has freed the equivalent of 51.8 full-time employee's worth of capacity with 25 automations in production.
- In 2022-23, the team won two global awards and initiated the use of Process Mining technology on the Oracle Financials purchase requisition, purchase order and invoice processes. They also won an AHS CARES Award in Quality Improvement.

Implement the Urban Acute Care Length of Stay Improvement Bundle (ACB) in sequence with Connect Care launches to support the creation of new capacity through efficiencies over three years.

- In 2022-23, the ACB was rolled-out in alignment with Launches 4 and 5 of Connect Care at the Royal Alexandra Hospital (Edmonton), Peter Lougheed Centre (Calgary), Foothills Medical Centre (Calgary), and Red Deer Regional Hospital Centre (Central Zone). The ACB initiative standardizes Connect Care-based activities for admission, daily care routines and discharge back to the community, and is expected to reduce hospital length of stay and readmissions.

Complete an AHS Environmental Sustainability Action Plan including implementing energy and water reduction projects to reduce energy and utility costs, reduce greenhouse gases and develop waste and recycling programs (e.g., cardboard, paper and plastics).

- In 2022-23, AHS initiated utility reduction strategies, including installing LED lighting systems and low flow plumbing fixtures, recommissioning mechanical systems, and ventilation and building management system upgrades. Prototype solar power installations have also been initiated at two rural sites.
- In September 2022, the International Federation of Healthcare Engineering (IFHE) recognized 22 AHS hospitals for reducing their energy use by at least five per cent, and nine facilities were recognized for reducing energy use by more than 10 per cent.

Performance Measure Results

Ratio of acute length of stay to expected length of stay (ALOS/ELOS) in 14 highest volume adult sites: The ratio of the total number of days patients spent in inpatient hospital acute care compared to the total length of stay that would be expected based on factors such as patient age, diagnoses and required interventions.

2019-20	2020-21	2021-22	2022-23	Target
1.03	0.98	0.98	1.01	Improve

- To improve service delivery, it is important to manage the length of time patients remain in hospital to ensure the most efficient utilization of hospital beds. This measure can help evaluate care outcomes, discharge planning and care transitions from acute to primary and community care.
- For fiscal year 2022-23, the ratio of acute length of stay to the expected length of stay in the 14 highest volume adult sites (1.01) remained stable compared to the same period last year (0.98). This measure did not achieve the target to improve by March 31, 2023. A ratio of 1.0 represents a patient stay equal to the expected length of stay. A ratio less than one indicates the acute stay was shorter than expected, and vice versa.
- The length of stay in hospital measure continues to be impacted by many factors. In 2020-21 and 2021-22, case mix and patient treatments were substantially changed by pandemic procedures and discharges were expedited, when safe to do so, to reduce risk of COVID-19 exposure in hospital which reduced lengths of stay. In 2022-23, services and treatments began to return to normal, but a sharp rise in demand and ongoing workforce shortages contributed to longer lengths of stay. It will take more time for data results to normalize post-pandemic, and initiatives like the Acute Care Bundle are expected to contribute to sustained improvement in the longer-term.
- In 2021-22, hospitals across Alberta had an ALOS/ELOS ratio of 0.98, compared to the Canadian average of 0.97 *(CIHI)*.

Financial Summary

Financial Statement Discussion and Analysis

For the year ended March 31, 2023

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, 2023. The FSD&A reports to stakeholders how financial resources are being utilized to provide patient-focused, quality health services that are accessible and sustainable for all Albertans. It serves as an opportunity to communicate with stakeholders about AHS' 2022-23 financial performance as well as cost drivers, strategies and plans to address financial risk and financial sustainability.

This FSD&A has been prepared by and is the responsibility of AHS management and should be read in conjunction with the March 31, 2023 audited consolidated financial statements, notes and schedules.

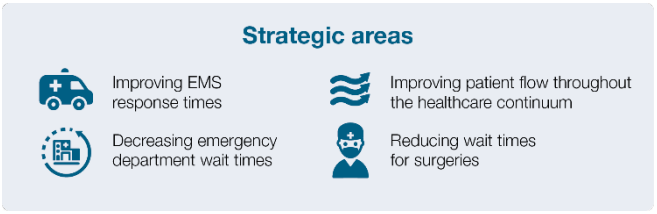
Additional information about AHS is available at www.albertahealthservices.ca

Highlights

During the fiscal year AHS advanced many key initiatives and priorities. AHS finished the year with an $84 million annual operating surplus, representing 0.5 per cent of total expenses.

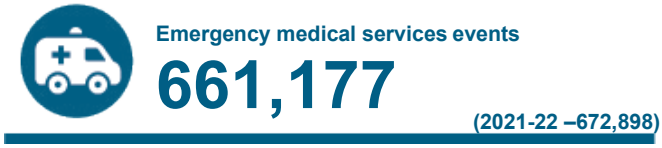
The demands on healthcare and AHS' operations continued to be impacted by the response to and recovery from COVID-19. Additional pressure was also experienced from an increased volume of other respiratory illnesses during the fall and winter virus season, further impacted by workforce recruitment challenges.

Total incremental expenses associated with the COVID-19 response and recovery amounted to $1.1 billion in fiscal 2022-23 ($1.6 billion in 2021-22). Significant costs continued to be incurred related to staffing in acute care settings, additional funding for contracted health service providers, the utilization of personal protective equipment and various operational costs associated with assessment centres, contract tracing, vaccine deployment, entry screening and Health Link services.



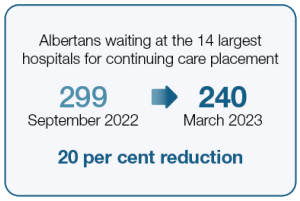
Under the guidance of the Official Administrator, AHS focused on making fast, effective improvements to four clinical priority areas: improving emergency medical response times, decreasing emergency department wait times, improving patient flow throughout the healthcare continuum, and reducing wait times for surgeries.

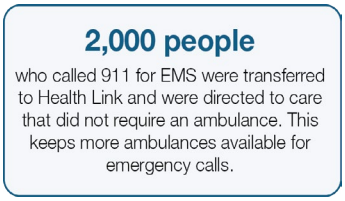
AHS spent an additional $42 million in **emergency medical services** in 2022-23, including activities related to recruiting frontline staff, such as paramedics, emergency communications officers and other frontline staff and supervisors, increased capacity by adding 19 new ground ambulances, increased ambulance unit hours and reduced paramedic time spent in hospitals. AHS also launched EMS/811 Shared Response, which helped reduce emergency medical services events by transferring low-acuity callers to 811, where appropriate, and by utilizing more non-clinical transports.



During the year, AHS focused on **reducing surgical wait times** by continuing to implement strategies and initiatives in the Alberta Surgical Initiative, which was developed in partnership with Alberta Health to ensure more Albertans receive scheduled surgeries within clinically appropriate targets. In 2022-23, 292,500 surgeries were performed which is a 5-per-cent increase from the prior year.

AHS also continued to invest in decreasing **emergency department wait times** by adding additional nursing, allied health and pharmacy staff to emergency department teams and expanding use of emergency liaison physicians to support emergency department flow and shorten transfer times. Pediatric fast-track clinics were also implemented in Edmonton and Calgary to provide care for lower-acuity patients presenting at the emergency departments.





To improve **patient flow**, AHS invested in hospital capacity during the respiratory virus season, including the opening of 93 net new acute care beds including 50 new intensive care unit beds. AHS also continued to expand continuing care, community and home care options to ease pressures on hospitals and ensure sufficient capacity for the flow of patients.

AHS' continuing, community and home care expenses increased $139 million from the prior year, representing 22.7 per cent of total expenses. AHS increased capacity by opening 1,270 new designated supportive living beds, long-term care beds and community mental health beds. The number of people placed in continuing care facilities has increased 8.9 per cent from the prior year. AHS also added hours of home care to support patients at home and increased unique home care clients. The number of unique home care clients increased by 4,928, as part of the ongoing initiative.

Net New Continuing Care Beds Opened Since 2010

9,424

(2021-22 –8,660)

In addition to the four clinical priorities, progress was also made in other key areas, including commencing operations of the recently completed Calgary Cancer Centre, implementation of the new Emergency Medical Services and Intensive Care Unit Capacity initiatives and continued progress on the Continuing Care Capacity Plan, and MRI and CT Implementation Plan.

AHS also expanded its transformative provincial clinical information system, Connect Care, investing $260 million in operating and capital expenditures in 2022-23. Connect Care will provide better care for Albertans, ensuring the whole healthcare team, including patients, have the best possible information throughout their care journey.

Key Financial Trending

Annual Operating Surplus (Deficit)

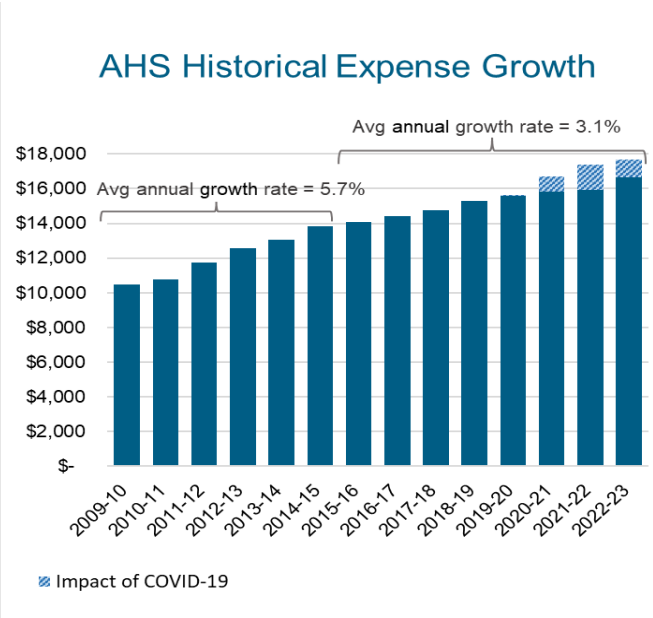
AHS' annual operating surpluses and deficits have averaged less than one per cent of total expenses in each of the past five fiscal years.

(in $ millions)	2023	2022*	2021*	2020*	2019*
Revenues	17,749	17,499	16,789	15,468	15,274
Expenses	17,665	17,368	16,697	15,626	15,325
Annual operating surplus (deficit)	**84**	**131**	**92**	**(158)**	**(51)**
Accumulated Surplus	1,121	1,037	906	814	972

** Select prior year information has been restated for the adoption of PS 3280 Asset Retirement Obligations (AHS Consolidated Financial Statements March 31, 2023 - Note 2(m)).*

Expense Growth

As Alberta's population grows and ages, the demand for healthcare services continues to increase. Alberta's inflation rate during all of fiscal 2022-23 was also at its highest rate in more than 30 years. This resulted in AHS experiencing higher costs related to utilities, drugs and gases, medical supplies, leases, insurance, and food and dietary supplies.



Through various initiatives to contain costs while maintaining quality, AHS has slowed the rate of expense growth. AHS' expenses have increased by an average of 3.1 per cent per year over the past seven years. However, AHS' average expense growth rate was lower than Alberta's inflation and population growth during this period.

The largest cost for AHS is workforce compensation (51.8 per cent of total expenses). In 2022-23, unionized employees ratified their collective bargaining agreements, the Alberta Medical Association ratified its agreement with Alberta Health, and after an eight-year freeze, AHS provided a one-step increment to eligible non-union employees.

As salaries and benefit costs increased for AHS employees, they also increased for those employed by contracted providers including Covenant Health, continuing care, home care, mental health and addiction, emergency medical services, housekeeping services and protective services.

Workforce

Calculated Full-Time Equivalents (FTEs) measure the total workload required to address the demands placed on AHS compared to the workload of a full-time employee. FTE is the total number of paid hours (including regular hours, overtime, relief and paid time off), divided by the annual hours of a full-time employee (2,022.75).

Calculated FTE	2022-23	2021-22	Increase (Decrease)	
			FTE	%
Clinical staff'[1]	54,243	54,214	29	0.1
Other staff[2]	29,191	30,285	(1,094)	(3.6)
Management – includes both clinical and other management	3,234	3,187	47	1.5
Total Calculated FTEs	**86,668**	**87,686**	**(1,018)**	**(1.2)**

The decrease was mainly due to temporary COVID-19 positions coming to an end in the year and the transfer of employees to a third party related to the lab transition. AHS continued to adjust to a more sustainable approach to managing staffing for health-service capacity and recovery. Voluntary termination rates stabilized, while vacancy rates and overtime continued to rise as the global healthcare worker shortage continued.

[1] Clinical staff comprise AHS' medical doctors, regulated nurses, health technical and professional staff and unregulated health service providers.

[2] Other staff include support services employees such as food services, facilities and maintenance, clerical and administrative support staff.

Despite the overall decrease in FTEs, overtime hours were above the AHS five-year average and increased 21 per cent in 2022-23 compared to the prior year. The increase was primarily due to higher vacancy rates, increased vacation time taken, higher sick leave utilized by staff, and reduced relief workforce available. Sick-leave hours continued to remain higher than average in 2022-23, increasing 3.9 per cent from the prior year which was influenced by the impact of influenza, COVID-19 and other respiratory viruses, as well as employee fatigue.

Alberta's health workforce is facing considerable challenges with higher demand for healthcare workers and services, increased fatigue and burnout, and lower external applicants and internal supply of workers. These challenges are not unique to Alberta and are being seen nationally and globally.

The *AHS Health Workforce Strategy* has been developed to act on the immediate response to short-term challenges and coordinate planning under four strategic pillars to meet medium and long-term workforce needs:

1. Integrate workforce planning to drive data- and evidence-informed decision-making.
2. Grow our talent supply through recruitment, education and training.
3. Optimize the workforce with healthcare teams working to their full scope of practice.
4. Improve retention through a multi-faceted, focused action plan.

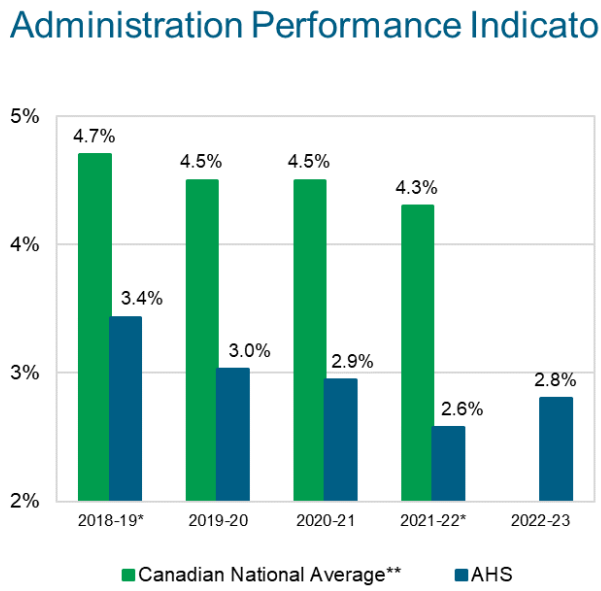
This strategy aligns with the Alberta Health Provincial Health Workforce Strategy, as partnerships will be critical to sustaining a robust, sustainable and engaged workforce that delivers quality healthcare services to Albertans now and into the future. Key performance indicators will measure success as we evolve this important work to build a more resilient healthcare authority.

AHS continues to be one of the most efficiently managed public sector organizations in Canada, with clinical and other managers overseeing an average of 33 employees. The average ratio for Canadian public administration agencies, according to the most recent Conference Board of Canada report was eight employees per manager[3].

[3] Conference Board of Canada. (2021). Human Resources Metrics Survey: https://www.conferenceboard.ca

Administration

The Canadian Institute of Health Information (CIHI) reports the corporate services expense ratio as a financial performance indicator based on administration expense as a percentage of total expenses[4]. Last year, AHS' indicator was 2.6 per cent, which was the lowest across the country. For 2022-23 AHS' indicator was 2.8 per cent.



** Certain amounts have been reclassified to conform to subsequent years presentation*
***CIHI Canadian national average for the administration indicator for 2022-23 was not available at the time of publication of this report.*

AHS continues to have one of the lowest administrative ratios in Canadian healthcare and continues to look for ways to ensure administrative systems and processes are as efficient and effective as possible, while investing in areas such as quality initiatives, research and innovation.

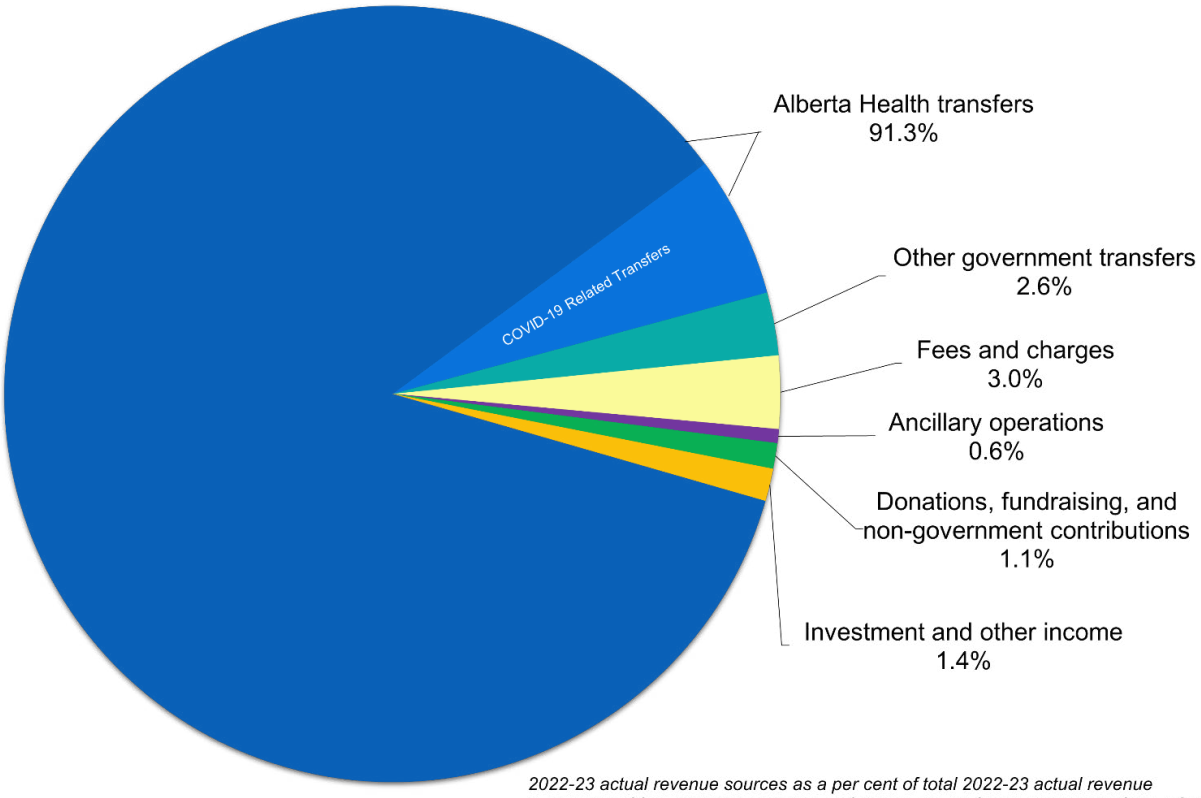
[4] Canadian Institute for Health Information. (n.d.). Your Health System. Retrieved from Interactive Map: Corporate Services Expense Ratio (Percentage), 2021-22: https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en&_ga=2.159018553.2003620571.1683215781-806221219.1682440829#/indicator/041/2/C20018/

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 2022-23 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 the prior year is also discussed in this section.

Operations

Revenues



2022-23 actual revenue sources as a per cent of total 2022-23 actual revenue
A glossary of financial statement line definitions can be found at the end of this FSD&A

Alberta Health transfers accounted for 91.3 per cent of AHS' total revenues in 2022-23 (2021-22 – 92.2 per cent). The decrease in the proportion of Alberta Health revenues to total revenues is a result of lower transfers in the current year required for the response to and recovery from COVID-19. AHS' total revenues amounted to $17,749 million, which was $1,252 million or 7.6 per cent higher than the budget of $16,497 million due to unbudgeted Alberta Health COVID-19 response and recovery-related transfers.

(in $ millions)	Budget 2022-23	Actual 2022-23	Actual to Budget Variance	Actual 2021-22 (Restated)*	Year over Year Increase (Decrease)
Alberta Health transfers	15,220	16,204	984	16,045	159
Other government transfers	305	476	171	463	13
Fees and charges	491	537	46	478	59
Ancillary operations	114	103	(11)	91	12
Donations, fundraising and non-government contributions	181	189	8	186	3
Investment and other income	186	240	54	236	4
Total revenues	**16,497**	**17,749**	**1,252**	**17,499**	**250**

** AHS Consolidated Financial Statements March 31, 2023, Schedule 4 – Consolidated Schedule of Adjustments*

Actual to Budget

Alberta Health transfers were higher than budget due to unbudgeted transfers for the COVID-19 response and recovery, as well as funding for union settlements and children's pain medication. The overall variance was partially offset by the transition of mental health and addiction grants from Alberta Health to the new Ministry of Mental Health and Addiction, which is now included in other government transfers.

Other government transfers were higher than budget mainly due to the transition of mental health and addiction grants from Alberta Health to the new Ministry of Mental Health and Addiction, higher than anticipated transfers for various infrastructure maintenance projects and the unbudgeted receipt of drugs and supplies from the federal government to support the COVID-19 response and recovery.

Fees and charges were higher than budget due to the continued easing of public health restrictions, which resulted in a higher than anticipated number of patients who were provided care that is billable to other provinces, non-residents of Canada and the Workers Compensation Board.

Ancillary operations were lower than budget mainly due to lower revenues from retail food services, which have not yet fully normalized to budgeted levels after the easing of public health restrictions.

Investment and other income was higher than budget due to higher-than-expected recoveries from external entities, interest earned and dividends received as a result of market-rate fluctuations. The overall variance was partially offset by realized losses from the ongoing active management and resulting sale of bonds in response to market conditions.

Year over Year

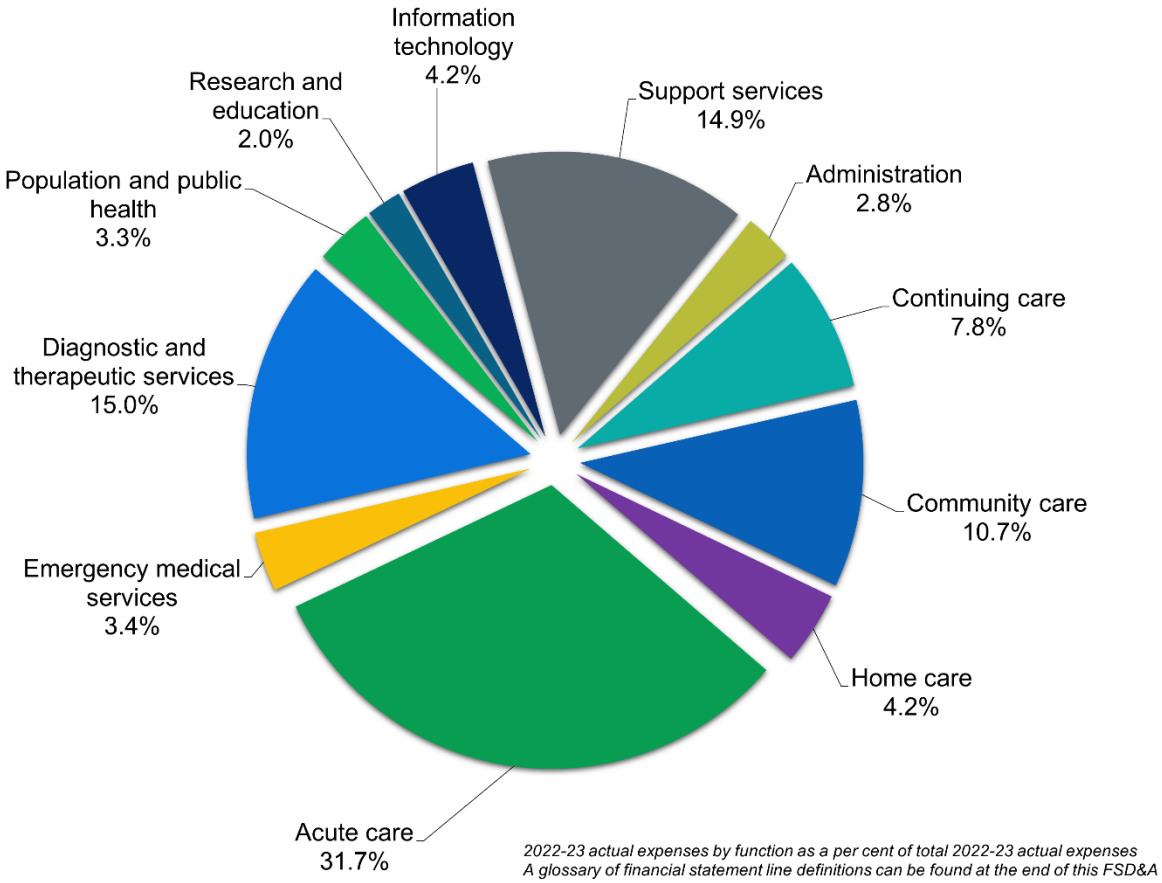
Alberta Health transfers were higher than the prior year due to an increase in base operating funding and funding received for union settlements and children's pain medication. Lower transfers related to the COVID-19 response and recovery partially offset the overall increase.

Other government transfers were higher than the prior year mainly due to increased activity in infrastructure maintenance projects and mental health and addiction programs, and higher recognition of externally-funded capital revenue related to tangible capital asset additions. Decreased federal contributions of drugs and supplies to support the COVID-19 response and recovery partially offset this increase.

Fees and charges were higher than the prior year due to further easing of public health restrictions, which resulted in an increased number of patients who were provided healthcare services that is billable to other provinces, non-residents of Canada, other responsible parties, and the Workers Compensation Board.

Ancillary operations were higher than the prior year due to increased revenue from parking and retail food services due to the continued easing of public health restrictions.

Expenses by Function



2022-23 actual expenses by function as a per cent of total 2022-23 actual expenses
A glossary of financial statement line definitions can be found at the end of this FSD&A

Expenses by function represent AHS' major distinguishable activities and services. The overall distribution of expenses by function changed slightly from the prior year due to a decrease in COVID-19 response and recovery-related costs which decreased expenses in population and public health and diagnostic and therapeutic services. Acute care, which comprises mainly inpatient, outpatient and emergency services, continued to be the largest function, making up 31.7 per cent of total expenses (2021-22 – 30.8 per cent).

(in $ millions)	Budget 2022-23	Actual 2022-23	Actual to Budget Variance	Actual 2021-22 (Restated)*	Year over Year Increase (Decrease)
Continuing care	1,239	1,382	(143)	1,357	25
Community care	1,792	1,888	(96)	1,804	84
Home care	765	740	25	710	30
Acute care	5,271	5,595	(324)	5,344	251
Emergency medical services	605	600	5	558	42
Diagnostic and therapeutic services	2,620	2,646	(26)	2,758	(112)
Population and public health	360	589	(229)	876	(287)
Research and education	355	342	13	351	(9)
Information technology	726	749	(23)	674	75
Support services	2,267	2,639	(372)	2,489	150
Administration	497	495	2	447	48
Total expenses by function	**16,497**	**17,665**	**(1,168)**	**17,368**	**297**

** AHS Consolidated Financial Statements March 31, 2023, Schedule 4 – Consolidated Schedule of Adjustments*

The costs incurred by AHS related to the response to and recovery from COVID-19 and the impacts of asset retirement obligations were not included in the 2022-23 budget. COVID-19 response and recovery costs were primarily funded by unbudgeted Alberta Health transfers.

Actual to Budget

Continuing care was higher than budget due to funding provided to support long-term care providers and utilization of personal protective equipment related to the COVID-19 response and recovery. Delayed continuing care capacity plan bed openings due to facility construction partially offset the variance.

Community care was higher than budget due to funding provided to supportive living facilities and other community health providers, increased services provided by Health Link and utilization of personal protective equipment related to the COVID-19 response and recovery. Delayed continuing care capacity plan bed openings and vacancies partially offset the variance.

Total Surgical Volumes

292,500

(2021-22 –278,600)

Home care was lower than budget due to delays in implementing home-care initiatives, including client-directed care, recruitment of health care aides and vacancies. Additional funding to support contracted home-care providers related to the COVID-19 response and recovery partially offset the variance.

Emergency Department Visits

1,982,246

(2021-22 – 1,824,366)

Acute care was higher than budget due to costs related to caring for COVID-19 and other respiratory virus patients in hospitals, including increased personal protective equipment utilization, staffing levels and overtime. Higher compensation costs — including increased use of overtime throughout the organization due to higher vacancy rates, recruitment challenges, and increased sick leave and vacation taken, as well as increased patient acuity resulting in higher staffing and volume of procedures performed — also contributed to the variance. The overall variance is partially offset by the cost of beds opening under the intensive care unit capacity initiative being lower than planned and vacancies.

Diagnostic and therapeutic services were higher than budget due to costs associated with COVID-19 lab testing, including the utilization of reagents and other laboratory supplies, and personal protective equipment. Increased compensation costs, including overtime, further contributed to the overall variance.

Population and public health was higher than budget due to COVID-19 and other respiratory viruses' response and recovery, including operating COVID-19 vaccination and

assessment centres, entry screening, contact tracing, and the distribution of rapid-test kits and personal protective equipment.

Research and education was lower than budget primarily due to vacancies and lower activity in various research programs including Cancer Care Clinical Trials and other research in participation with University institutions.

Information technology was higher than budget due to the need to use contracted staff to train and support Connect Care launches four and five in rural centres, due to staffing challenges. Information technology licenses and equipment required for the COVID-19 response and recovery further contributed to the increase.

Support services were higher than budget due to higher utility costs resulting from inflation and carbon tax, delays in outsourcing initiatives and increased costs in infrastructure maintenance projects, as well as new costs for biomedical waste disposals at Swan Hills Treatment Centre. Higher costs related to the COVID-19 response and recovery, including increased protective and housekeeping services, and a valuation adjustment for inventory further contributed to the variance.

Year over Year

Continuing care was higher than the prior year due to contract inflation and the opening of long-term care beds related to the Continuing Care Capacity Plan.

Community care was higher than the prior year due to opening of new supportive living beds related to the Continuing Care Capacity Plan, contract inflation, and higher compensation costs due to vacancies being filled in the year.

Home care was higher than the prior year due to increased home-care activity as AHS continued to work towards providing home-care services at pre-pandemic levels and increased compensation costs.

Unique Home Care Clients

127,012

(2021-22 –122,084)

Acute care was higher than the prior year due to increased activity and patient acuity, including more emergency room visits, surgeries performed, inpatient days, utilization of rare and high cost drugs, and 50 new adult intensive care unit beds added to meet demand. Compensation costs were higher due to union settlements and increased overtime in the year.

Emergency medical services were higher than the prior year due to increased costs associated with implementing emergency medical services initiatives, including additional staff and ambulance equipment.

Diagnostic and therapeutic services were lower than the prior year due to reduced COVID-19 testing this year, resulting in the lower utilization of reagents, other lab supplies and personal protective equipment.

CT & MRI Exams

751,540

(2021-22- 743,312)

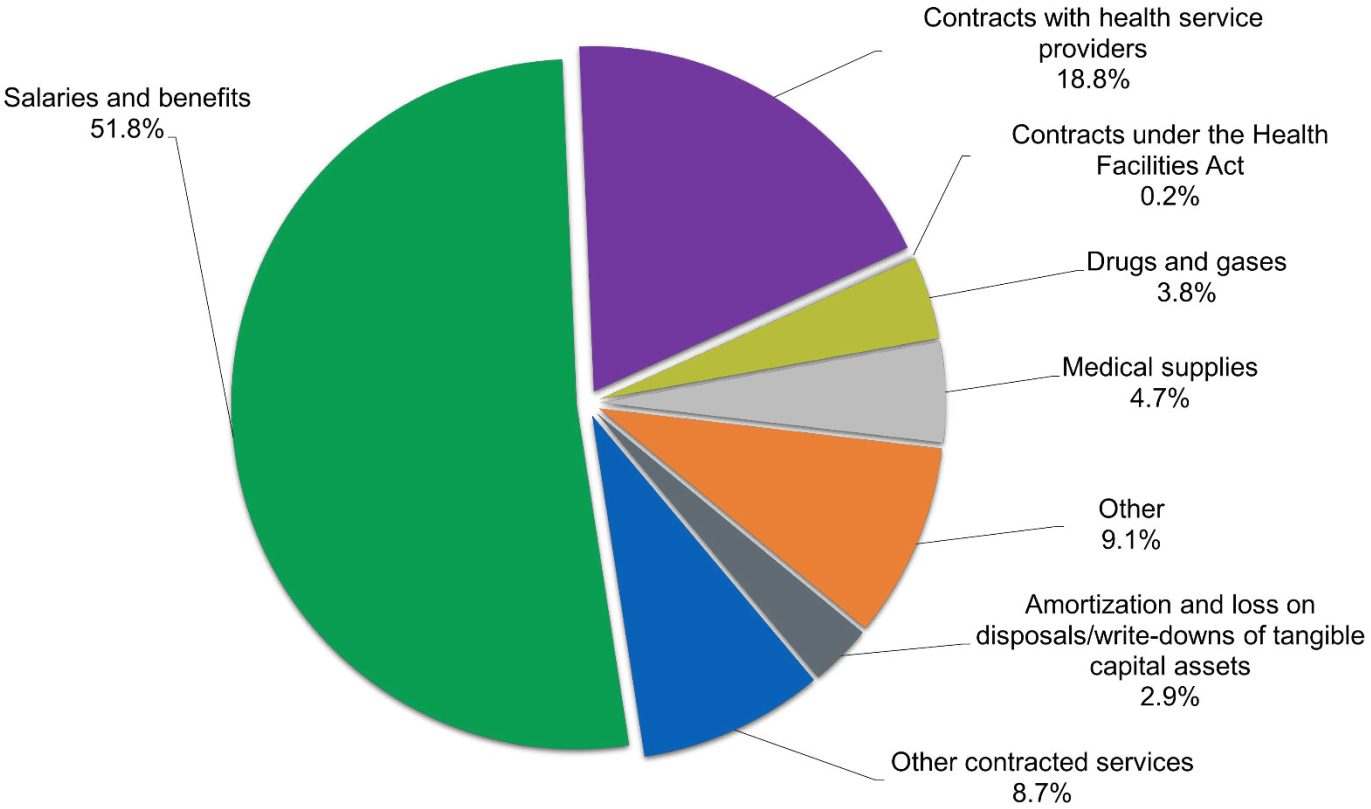
Population and public health was lower than the prior year due to decreased costs associated with COVID-19 contact tracing, vaccination and assessment centres, entry screening, and fewer rapid-test kits distributed due to reduced demand.

Information technology was higher than the prior year due to the ongoing implementation of Connect Care which included launches four and five and preparations for launch six. Connect Care implementation costs included increased contracted trainers and launch readiness resources. Software maintenance, licensing and equipment costs further contributed to the increase as the technology footprint expands across the province.

Support services were higher than the prior year due to increased utility costs resulting from inflation and carbon tax, and increased infrastructure maintenance and equipment project costs. New costs for biomedical waste disposals at Swan Hills Treatment Centre further contributed to the increase.

Administration was higher than the prior year due to additional staff hired to fill vacancies, union settlements, increased activity related to recruitment and insurance premium increases.

Expenses by Object



2022-23 actual expenses by object as a per cent of total 2022-23 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 the prior years, with salaries and benefits making up 51.8 per cent of total expenses (2021-22 – 52.6 per cent). This does not include employees who work for contract providers.

(in $ millions)	Budget 2022-23	Actual 2022-23	Actual to Budget Variance	Actual 2021-22	Year over Year Increase (Decrease)
Salaries and benefits	8,707	9,139	(432)	9,136	3
Contracts with health service providers	3,182	3,328	(146)	3,210	118
Contracts under the *Health Facilities Act*	22	30	(8)	28	2
Drugs and gases	681	679	2	651	28
Medical supplies	594	828	(234)	748	80
Other contracted services	1,415	1,534	(119)	1,477	57
Other	1,397	1,612	(215)	1,641	(29)
Amortization and loss on disposals/write-downs of tangible capital assets	499	515	(16)	477	38
Total expenses by object	**16,497**	**17,665**	**(1,168)**	**17,368**	**297**

The costs incurred by AHS related to the response to and recovery from COVID-19 and the impacts of asset retirement obligations were not included in the 2022-23 budget. COVID-19 response and recovery costs were primarily funded by unbudgeted Alberta Health transfers.

Actual to Budget

Salaries and benefits were higher than budget due to higher staffing levels to support the response to COVID-19, other respiratory viruses and higher than budgeted overtime. Delays in the timing of lab and retail food outsourcing initiatives and higher compensation costs, including union settlements and salary increments for non-unionized employees, and increased use of overtime further contributed to the increase. Vacancies throughout the organization partially offset the variance.

Contracts with health service providers were higher than budget due to funding provided to support long-term care providers, designated supportive living facilities, full spectrum health services providers, lab services, and other community health programs related to the response to COVID-19 and other respiratory viruses. Delayed Continuing Care Capacity Plan bed openings and outsourcing of lab and retail foods initiatives partially offset the variance.

Lab Tests

82,905,409

(2021-22 – 82,149,662)

Medical supplies were higher than budget due to increased use of personal protective equipment, lab testing supplies, distribution of rapid-test kits and an inventory-valuation adjustment related to the COVID-19 response and recovery. Increased patient acuity and higher volumes of surgical procedures performed further contributed to the variance.

Other contracted services were higher than budget due to the COVID-19 response and recovery, including costs related to physician services, on-site protective services and housekeeping services, and increased utilization of contracted healthcare workers in continuing care and acute care settings due to vacancies.

Other was higher than budget due to increased use of personal protective equipment related to the COVID-19 response and recovery, and the increased cost of utilities due to inflation and carbon tax.

Amortization and loss on disposals/write-downs of tangible capital assets were over budget due to unbudgeted amortization recognized from asset retirement obligations and amortization of equipment received at no cost and recorded at fair market value related to consumable supplies contracts.

Year over Year

Contracts with health service providers were higher than the prior year due to contract inflation, opening of long-term care beds related to the *Continuing Care Capacity Plan* and implementation of emergency medical services initiatives.

Drugs and gases were higher than the prior year due to increased utilization of rare disease and high cost cancer drugs.

Medical supplies were higher than the prior year due to increased operating-room volumes, emergency-room visits and higher complex cases, including increased orthopedic procedures.

Other contracted services were higher than the prior year due to the increased use of contracted workers in continuing care and acute-care settings, increased physician costs, and the ongoing implementation of Connect Care to support launches four and five and launch-six preparations.

Other was lower than the prior year due to reduced usage of personal protective equipment, and other supplies related to the COVID-19 response and recovery. This was partially offset by increased utility costs.

Amortization and loss on disposals/write-downs of tangible capital assets were higher than the prior year due to the capitalization of Connect Care launches four and five, and assets transferred into use in the year, including the Calgary Cancer Centre.

Financial Position

(in $ millions)	2022-23	2021-22 (Restated)*	Change
Financial assets	3,269	3,399	(130)
Liabilities	4,328	4,408	(80)
Net debt	**(1,059)**	**(1,009)**	**(50)**
Non-financial assets	10,842	10,687	155
Expended deferred revenue	8,642	8,616	26
Net assets	**1,141**	**1,062**	**79**

** AHS Consolidated Financial Statements March 31, 2023, Schedule 4 – Consolidated Schedule of Adjustments*

Financial Assets

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

At year-end, AHS' consolidated **cash and cash equivalents** balances were $335 million, which is sufficient cash on hand to meet cash-flow requirements.

In accordance with AHS' ***Investment*** *Policy* and *Investment Bylaw*, AHS invests in a diversified mix of assets, including high-quality instruments, such as government and corporate bonds and lower-volatility equities. This strategy is meant to preserve AHS' capital while providing a reasonable investment return. The portfolio is sufficiently liquid in nature to enable AHS to respond to cash-flow requirements quickly and efficiently. AHS' investments portfolio decreased by $419 million primarily due to the transfer of funds to support current and future operating requirements. Cash and cash equivalents required for operations increased $134 million over the prior year. Receivables for Alberta Health restricted grants increased by $120 million year over year, an amount that would have been contributed to investments if they had been received. Finally, there was a general downturn in financial markets which were impacted by rising inflation and interest-rate increases, supply-chain issues, and overall economic uncertainty. These factors contributed to a decrease in both fixed income and equity values.

Accounts receivable increased by $156 million primarily due to increased Alberta Health operating grants, other operating and capital grants from non-Alberta Health sources and patient receivables. The overall increase was partially offset by decreased Alberta Health capital grants and nonpatient receivables.

Liabilities

Liabilities represent AHS' existing financial obligations at year end.

Accounts payable and accrued liabilities decreased by $179 million mainly due to lower payroll accruals including union settlements that were ratified and paid during the year, as well as a decrease in provisions for unpaid liability claims and the timing of payments related to various trades accounts payable.

Unexpended deferred operating revenue increased $42 million mainly due to unspent Alberta Health funding received for the outpatient cancer drug benefit program, intensive care unit baseline initiatives, various research grants and increased foundation donations. Recognition of previous years COVID-19 pandemic response funding from Alberta Health and unrealized losses on investments during the year partially offset the increase.

AHS' **debt** is primarily comprised of debentures issued to the Government of Alberta to finance the construction of parking facilities. AHS pledges the revenue derived from all parking facilities as security for the debentures. As at March 31, 2023, AHS' debt balance was $434 million (2021-22 – $455 million). Repayments of $33 million during the year, were offset by loan proceeds of $12 million received to support the purchase of new emergency medical services ambulances and vehicles.

Asset retirement obligations represent AHS' legal obligation associated with the retirement of tangible capital assets. The liability was recorded due to the initial adoption of *PSAS 3280 Asset Retirement Obligations* in 2022-23 using a modified retroactive approach. The liability increased $39 million during the year primarily from an increase in estimated asbestos-abatement rates used in calculating the liability. There was also a slight increase due to additional asset retirement obligations arising from buildings acquired in 2022-23. The overall increase was partially offset by asbestos-abatement projects undertaken during the year.

Non-Financial Assets

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

Tangible Capital Assets			
(in $ millions)	2022-23	2021-22 (Restated)	Increase (Decrease)
Cost	20,199	19,469	730
Accumulated amortization	9,895	9,471	424
Net book value	**10,304**	**9,998**	**306**

** AHS Consolidated Financial Statements March 31, 2023, Schedule 4 – Consolidated Schedule of Adjustments*

AHS receives significant external funding for **tangible capital asset** expenditures, primarily from Government of Alberta ministries. Capital asset additions amounted to $822 million, of which 85 per cent were externally funded (2021-22 – 81 per cent). Several capital projects totaling $1,823 million were completed during the year, including the Calgary Cancer Centre and parkade, Norwood Care Centre (Phase 1), Connect Care launches four and five, the installation of building service equipment, and facility initiatives. Capital equipment additions included equipment acquired to support, diagnostic services, information technology and emergency medical services.

The Work-in-Progress balance of $665 million includes facilities construction and improvements, and information technology initiatives that include:

- Connect Care
- Misericordia Community Hospital Modernization
- Norwood Care Centre (Phase 2)

AHS maintains **inventories of supplies** to ensure goods, such as pharmaceuticals, medical and surgical supplies, are available for operational needs. During the pandemic, AHS increased inventory holdings to ensure adequate levels of supplies were readily available. Over the past year, AHS' inventory balance decreased by $205 million primarily due to the drawdown of personal protective equipment, lab-testing supplies and rapid-test kits. As the market continues to stabilize, there is no longer a need to stockpile these supplies as much, reducing overall inventory levels. The decrease was partially offset by the children's pain medication procurement initiative and increased volume of pharmaceutical drugs to treat cancer patients.

Prepaid expenses increased by $55 million primarily due to inventory not yet received including children's pain medication and building-premises deposits related to the emergency medical services initiative.

Expended Deferred Revenue

Expended deferred capital revenue represents external resources spent on the acquisition of capital assets, stipulated for use in the provision of services. These balances are recognized as revenue over the useful lives of the related tangible capital assets acquired. The assets include hospitals and other facilities, equipment and information technology systems. The increase from the prior year is the result of externally-funded tangible capital asset additions to support the development of several major capital projects. Funding from Government of Alberta ministries represented $8,297 million, or 97 per cent of the $8,525 million total balance (2021-22 – 97 per cent).

Expended deferred operating revenue represents external resources spent on the acquisition of certain inventories. These balances are recognized as revenue as the related inventories are consumed. This balance decreased by $220 million from the prior year due to the drawdown of funded pandemic inventory such as personal protective equipment, rapid-test kits and other testing supplies.

Net Assets

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

(in $ millions)	2022-23	2021-22 (Restated)*	Increase (Decrease)
Unrestricted Surplus	262	236	26
Invested in tangible capital assets	1,000	944	56
Endowments	77	77	-
Internally restricted surplus for insurance equity requirements and foundations	132	122	10
Asset retirement obligations	(350)	(342)	(8)
Accumulated Surplus	**1,121**	**1,037**	**84**
Accumulated Remeasurement Gains	20	25	(5)
Total Net Assets	**1,141**	**1,062**	**79**

** AHS Consolidated Financial Statements March 31, 2023, Schedule 4 – Consolidated Schedule of Adjustments*

The **unrestricted surplus** grew $26 million as a result of the $84 million operating surplus, offset by net internal investment in tangible capital assets and an increase to internally restricted surplus for insurance equity requirements and foundations.

Outlook

AHS operations are broad and complex. Through the course of the pandemic, AHS has learned the importance of being adaptable, innovative and proactive. While AHS has managed its expense growth over the past seven years, it has become evident that continued work is needed to enhance and transform the delivery of health care to meet the changing needs of Albertans.

AHS continues to focus on financial sustainability while also making efforts to improve capacity and patient flow through acute-care, emergency medical services and care in the community. Over the next few years, AHS will allow for increased choice for patients in continuing care to align with patient- and family-centred care. AHS will also ensure preparedness for future communicable diseases. AHS is committed to listening to staff, addressing burnout and reducing high volumes of turnover, to build a workforce model that anticipates future demand.

AHS will continue to increase the value that Albertans receive from each health dollar without compromising care. AHS compares healthcare delivery costs with those outside of Alberta — and where AHS can do better, it is making changes, improving practices and reducing costs without impacting quality.

To support health care transformation and increase sustainability, AHS encourages teams to deliver on innovative projects and implement additional savings strategies.

AHS can only succeed with the collaboration and engagement of stakeholders including Albertans, employees, physicians, other healthcare providers and the Government of Alberta.

Financial Reporting, Control and Accountability

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

An effective and integrated governance model is an essential component to improving the delivery of care services to Albertans and the way the organization operates.

The Official Administrator Advisory Committee is a governance-advisory committee established by the Official Administrator of AHS. The purpose of the Committee is to assist the **Official Administrator** in fulfilling their oversight and governance responsibilities with respect to the following areas: finance & audit; governance & risk; community engagement; human resources; and quality & safety.

The **Committee** fulfils 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. In addition, the Committee assists the Official Administrator in fulfilling financial oversight responsibilities, including those pertaining to the *Health Plan* and *Business Plan,* the budget, and the investment portfolio.

AHS has an established **Internal Audit** function with the mandate of providing independent advisory and assurance services to management and the Official Administrator on the operations of AHS and its subsidiaries. Internal Audit's work takes a risk-based approach to evaluating and advising on the efficiency and effectiveness of AHS' governance, risk-management practices, and financial and management controls and processes. The Chief Audit Executive is responsible for coordinating AHS' Enterprise Risk Management function, including the development and implementation of policies and processes for identifying, monitoring and reporting on key organizational risks, as well as working with management to better understand and

manage risk. In addition, the Chief Audit Executive is responsible for the oversight of the Compliance function which conducts compliance audits of contracting, procurement, inventory and asset-management business processes and controls.

As a component of the Internal Audit function, AHS has the **Internal Controls over Financial Reporting** 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, Internal Controls over Financial Reporting team provides assurance on the design and operational effectiveness of financial reporting controls using a risk-based approach.

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

Glossary of Financial Statement Line Definitions

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

Revenues

Alberta Health transfers comprise funding received from Alberta Health which may be unrestricted or restricted for operating or capital purposes. Unrestricted Alberta Health transfers are the main source of operating funding for the provision of healthcare 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 comprise contributions from federal, provincial (other than Alberta Health and including those under other jurisdictions), municipal, and foreign 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 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, such as parking services, AHS-operated non-patient food services, gift shops and rental of television and cable to patients and residents. This excludes revenue from activities that support the provision of health services, promote and protect the health of the population, or work toward the prevention of disease and injury.

Donations, fundraising, and non-government contributions comprise contributions from donors and non-government entities 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 comprises interest income, dividends, net realized gains and losses on disposal of investments, recoveries from external sources other than ancillary operations, and miscellaneous revenues that cannot be classified elsewhere.

Expenses by Function

Continuing care comprises long-term care, including chronic and psychiatric care in facilities operated by AHS and contracted providers.

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

Home care comprises home nursing and support.

Acute care comprises predominantly patient-care units such as medical, surgical, intensive care, respirology intensive care, palliative care, obstetrics, pediatrics, addiction and mental health, emergency, day/night care, clinics, day surgery, communicable diseases, and contracted surgical services. This category also includes operating and recovery rooms.

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

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

Population and public health comprises primarily health promotion, disease and injury prevention and health protection. This category also includes immunizations, travellers' health clinics, outbreaks, screening programs, and disease surveillance. It excludes activities associated with treatment of communicable diseases.

Research and education comprises primarily costs pertaining to health research and graduate medical education, primarily funded by donations, and third-party contributions.

Information technology comprises costs pertaining to the provision of service and consultation in the design, development and implementation of information-technology services and systems.

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

Administration comprises 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, quality assurance, patient safety, insurance, privacy, public relations, risk management, internal audit and legal.

Expenses by Object

Salaries and benefits comprises 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 Facilities Act* relates to contracts with surgical facilities pursuant to the *Health Facilities 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, anesthetic gas, oxygen, and other medical gases used for patient treatment. Drugs used for purposes other than patient treatment such as diagnostic reagents, are not included in this category, and are reported in other expenses.

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

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

Other expenses relate to those expenses not classified elsewhere, including personal protective equipment.

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

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2023

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the year ended March 31, 2023 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 include certain disclosures required by 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 funds;
- safeguard the assets and properties of the "Province of Alberta" that are the responsibility of Alberta Health Services.

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Official Administrator Advisory 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 Official Administrator 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]

Mauro Chies
President and Chief Executive Officer
Alberta Health Services

[Original signed by]

Colleen Purdy, FCPA, FCMA
Vice President Corporate Services and Chief Financial Officer
Alberta Health Services

June 1, 2023

Auditor General OF ALBERTA

Independent Auditor's Report

To the Official Administrator of Alberta Health Services

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, 2023, 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, 2023, and the results of its operations, its remeasurement gains and losses, its changes in net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for opinion

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

Other information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Original signed by]

W. Doug Wylie FCPA, FCMA, ICD.D
Auditor General

June 1, 2023
Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS YEAR ENDED MARCH 31			
	2023		2022
	Budget (Note 3)	Actual	Actual (Restated – Schedule 4)
Revenues:			
Alberta Health transfers			
Base operating	$ 13,446,516	$ 13,446,558	$ 13,097,557
One-time base operating	-	185,146	71,003
Other operating	1,663,027	2,467,695	2,779,853
Recognition of expended deferred capital revenue	111,500	104,165	95,636
Other government transfers (Note 4)	304,700	475,512	462,844
Fees and charges	491,200	536,774	478,313
Ancillary operations	114,000	103,324	91,369
Donations, fundraising, and non-government contributions (Note 5)	181,000	189,244	185,893
Investment and other income (Note 6)	185,525	240,285	236,292
TOTAL REVENUES	**16,497,468**	**17,748,703**	**17,498,760**
Expenses:			
Continuing care	1,239,000	1,381,494	1,357,126
Community care	1,792,400	1,888,404	1,803,896
Home care	765,100	740,152	709,715
Acute care	5,271,168	5,594,950	5,343,935
Emergency medical services	605,600	599,476	557,720
Diagnostic and therapeutic services	2,619,700	2,645,702	2,757,593
Population and public health	359,600	589,216	876,457
Research and education	354,900	341,797	351,106
Information technology	726,300	749,085	674,214
Support services (Note 7)	2,266,900	2,639,431	2,489,173
Administration (Note 8)	496,800	495,326	446,932
TOTAL EXPENSES (Schedules 1 and 3)	**16,497,468**	**17,665,033**	**17,367,867**
ANNUAL OPERATING SURPLUS	**-**	**83,670**	**130,893**
Accumulated surplus, beginning of year	1,037,157	1,037,157	906,264
Accumulated surplus, end of year (Note 21)	**$ 1,037,157**	**$ 1,120,827**	**$ 1,037,157**

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

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31		
	2023 Actual	2022 Actual (Restated – Schedule 4)
Financial Assets:		
Cash and cash equivalents	$ 334,649	$ 200,691
Portfolio investments (Note 10)	2,184,694	2,603,605
Accounts receivable (Note 11)	750,083	594,429
	3,269,426	3,398,725
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,773,424	1,951,855
Employee future benefits (Note 13)	787,643	777,878
Unexpended deferred operating revenue (Note 14)	572,628	529,707
Unexpended deferred capital revenue (Note 15)	177,901	149,516
Debt (Note 17)	434,088	454,993
Asset retirement obligations (Note 18)	583,172	544,416
	4,328,856	4,408,365
NET DEBT	**(1,059,430)**	**(1,009,640)**
Non-Financial Assets:		
Tangible capital assets (Note 19)	10,303,649	9,998,035
Inventories of supplies (Note 20)	307,725	513,019
Prepaid expenses, deposits, and other non-financial assets	231,254	176,570
	10,842,628	10,687,624
NET ASSETS BEFORE EXPENDED DEFERRED REVENUE	9,783,198	9,677,984
Expended deferred revenue (Note 16)	8,642,101	8,615,941
NET ASSETS	**1,141,097**	**1,062,043**
Net Assets is comprised of:		
Accumulated surplus (Note 21)	1,120,827	1,037,157
Accumulated remeasurement gains	20,270	24,886
	$ 1,141,097	**$ 1,062,043**

Contractual Obligations and Contingent Liabilities (Note 22)
Impact of COVID-19 Pandemic (Note 27)

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

Approved by:

[Original signed by]

Dr. John Cowell
Official Administrator
Alberta Health Services

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT YEAR ENDED MARCH 31			
	2023		2022
	Budget (Note 3)	Actual	Actual (Restated – Schedule 4)
Annual operating surplus	$ -	$ 83,670	$ 130,893
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets:			
Purchased	(498,000)	(497,852)	(463,646)
Leased	-	(19,031)	(15,646)
Constructed by Alberta Infrastructure on behalf of AHS	(660,000)	(262,429)	(425,337)
Contributed	-	(35)	(522)
Capitalized asset retirement costs	-	(41,164)	(9,811)
Amortization and loss on disposals/write-downs of tangible capital assets	499,000	514,897	476,786
Effect of other changes:			
Net increase in expended deferred capital revenue	554,200	246,496	452,077
Net (decrease) increase in expended deferred operating revenue	-	(220,336)	(90,473)
Net decrease (increase) in inventories of supplies	(20,000)	205,294	50,909
Net (increase) decrease in prepaid expenses, deposits and other non-financial assets	9,000	(54,684)	32,796
Net remeasurement (losses) gains for the year	49,900	(4,616)	(30,891)
(Increase) decrease in net debt for the year	**(65,900)**	(49,790)	**107,135**
Net debt, beginning of year	(1,009,640)	(1,009,640)	(1,116,775)
Net debt, end of year	**$ (1,075,540)**	**$ (1,059,430)**	**$ (1,009,640)**

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

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31	2023 Actual	2022 Actual
Unrestricted unrealized gains (losses) attributable to:		
Derivatives	$ 2,572	$ (24)
Portfolio investments	(39,600)	(29,270)
Amounts reclassified to the Consolidated Statement of Operations:		
Derivatives	(1,710)	-
Portfolio investments	34,122	(1,597)
Net remeasurement losses for the year	**(4,616)**	**(30,891)**
Accumulated remeasurement gains, beginning of year	24,886	55,777
Accumulated remeasurement gains, end of year (Note 10)	**$ 20,270**	**$ 24,886**

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

CONSOLIDATED STATEMENT OF CASH FLOWS YEAR ENDED MARCH 31		
	2023 Actual	2022 Actual (Restated – Schedule 4)
Operating transactions:		
Annual operating surplus	$ 83,670	$ 130,893
Non-cash items:		
Amortization and loss on disposals/write-downs of tangible capital assets	514,897	476,786
Revenue recognized for acquisition of land	(3,934)	(987)
Recognition of expended deferred capital revenue	(328,651)	(298,774)
Recognition of expended deferred operating revenue	(289,853)	(453,686)
Loss (gain) on disposal of portfolio investments	32,218	(36,100)
Change in employee future benefits	9,765	17,092
(Increase) decrease in:		
Accounts receivable related to operating transactions	(155,654)	70,986
Inventories of supplies	205,294	50,909
Prepaid expenses, deposits, and other non-financial assets	(54,684)	32,796
(Decrease) increase in:		
Accounts payable and accrued liabilities	(171,577)	35,567
Unexpended deferred operating revenue	59,541	(111,762)
Asset retirement obligations	(2,409)	-
Cash applied to operating transactions	(101,377)	(86,280)
Capital transactions:		
Purchased tangible capital assets	(497,852)	(463,646)
Cash applied to capital transactions	(497,852)	(463,646)
Investing transactions:		
Purchase of portfolio investments	(4,110,544)	(3,806,735)
Proceeds on disposals of portfolio investments	4,476,003	3,439,408
Cash provided by (applied to) investing transactions	365,459	(367,327)
Financing transactions:		
Restricted operating contributions received	69,517	363,213
Restricted capital contributions received	345,074	310,803
Unexpended deferred capital revenue returned	(73)	(419)
Proceeds from debt	11,500	26,000
Principal payments on debt	(32,405)	(26,666)
Payments on obligations under capital leases	(25,639)	(30,642)
Net repayment of life lease deposits	(246)	(1,493)
Cash provided by financing transactions	367,728	640,796
Increase (decrease) in cash and cash equivalents	**133,958**	**(276,457)**
Cash and cash equivalents, beginning of year	200,691	477,148
Cash and cash equivalents, end of year	**$ 334,649**	**$ 200,691**

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS FOR THE YEAR ENDED MARCH 31, 2023

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 assets, liabilities, revenues and expenses associated with its responsibilities.

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. In addition, the consolidated financial statements include certain disclosures required by 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 wholly owned subsidiaries:

- Alberta Precision Laboratories Ltd. - provides medical diagnostic services throughout Alberta.
- CapitalCare Group Inc. - manages continuing care programs and facilities in the Edmonton area.
- Carewest - manages continuing care programs and facilities in the Calgary area.

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

- Foundations and other organizations:

  The largest foundations controlled by AHS are the Alberta Cancer Foundation and the Calgary Health Foundation. AHS also controls 32 other foundations to facilitate fundraising for various initiatives including enhancements to healthcare delivery (including equipment), programs, renovations, and research and education.

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

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

  The LPIP has a fiscal year end of December 31, 2022. Significant transactions occurring between this date and March 31, 2023 have been recorded in these consolidated financial statements.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

(ii) Government Partnerships

AHS proportionately consolidates its 50% ownership interests in 40 (2022 – 40) Primary Care Network (PCN) partnerships with physician groups, its 50% ownership interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta, and its 33.33% ownership interest in the Institute for Reconstructive Sciences in Medicine (iRSM) partnership with the University of Alberta and Covenant Health (Note 24).

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.

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 25).

(iv) Other

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

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

(b) Revenue Recognition

Revenue is recognized in the year in which the transactions or events that give rise to the revenue as described below occur. All revenue is recorded on an accrual basis, except when the accrual cannot be determined within a reasonable degree of certainty or when estimation is impracticable. Unallocated costs comprising of materials and services contributed by related parties in support of AHS' operations, are not recognized in these consolidated financial statements.

(i) Government Transfers

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

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

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

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

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

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

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

(iii) Transfers and Donations related to Land

Transfers and donations for the purchase of land are recorded as deferred revenue when received and as revenue when the land is purchased. In-kind donations of land from non-related entities are recorded as revenue at the fair value of the land. When AHS cannot determine the fair value, it records such donations at nominal value. In-kind donations of land from related entities are recorded as revenue at the net book value of the transferring entity.

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

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

(v) Investment Income

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

(c) Expenses

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

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

(d) Financial Instruments

Financial instruments comprise financial assets and financial liabilities. Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations. Financial liabilities are contractual obligations to deliver cash or another financial asset to another entity or to exchange financial instruments with another entity under conditions that are potentially unfavourable to AHS.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

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

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

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

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

All financial assets are assessed for impairment on an annual basis. When a decline is determined to be other than temporary, the amount of the loss is reported as a realized loss on the Consolidated Statement of Operations. A write-down of a portfolio investment to reflect a loss in value is not reversed for a subsequent increase in value.

Contractual obligations are evaluated for the existence of embedded derivatives. An election can be made to either measure the entire contract at fair value or measure the value of the derivative component separately when characteristics of the derivative are not closely related to the economic characteristics and risks of the contract itself. Contracts to buy or sell non-financial items for AHS' normal course of business are not recognized as financial assets or liabilities. AHS does not have any embedded derivatives.

A financial liability or a part thereof is derecognized when it is extinguished.

Transaction costs associated with the acquisition and disposal of portfolio investments are expensed as incurred. Investment management fees are expensed as incurred. The purchase and disposition of portfolio investments are recognized on the trade date.

(e) Cash and Cash Equivalents

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(f) Inventories of Supplies

Purchased inventories of supplies are valued at lower of cost (defined as moving average cost) and replacement cost. Contributed inventories of supplies are recorded at fair value when such value can reasonably be determined.

(g) Tangible Capital Assets

Tangible capital assets 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, and asset retirement cost. Costs incurred by Alberta Infrastructure (AI) to construct tangible capital assets on behalf of AHS are recorded by AHS as work in progress as AI incurs costs.

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

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

	Useful Life
Facilities and improvements	10-70 years
Equipment	3-20 years
Information systems	3-15 years
Building service equipment	5-40 years
Land improvements	5-40 years

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

Leases of tangible capital assets which transfer substantially all benefits and risks of ownership to AHS are accounted for as leased tangible capital assets and leasehold improvements and are amortized over the shorter of the term of the lease or their estimated useful lives. Obligations under capital leases are recorded at the present value of the minimum lease payments excluding executory costs (e.g. insurance, maintenance costs, etc.). The discount rate used to determine the present value of the lease payments is the lower of AHS' rate for incremental borrowing and the interest rate implicit in the lease.

Tangible capital assets are written down to their net recoverable amount when conditions indicate that they no longer contribute to AHS' ability to provide goods and services or when the value of future economic benefits associated with the tangible capital assets are less than their net book value. Write-downs are recorded as part of amortization and loss on disposals / write-downs of tangible capital assets.

Intangibles and other assets inherited by right and that have not been purchased are not recognized in these consolidated financial statements. Similarly, works of art, historical treasures, and collections are not recognized as tangible capital assets.

(h) Employee Future Benefits

(i) Defined Benefit Pension Plans

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

AHS participates in the LAPP and MEPP which are multi-employer registered defined benefit pension plans. AHS accounts for these plans on a defined contribution basis. Accordingly, the pension expense recorded for these plans in these consolidated financial statements is comprised of the employer contributions that AHS is required to pay for its employees during the fiscal year. LAPP and MEPP set the employer contribution rates on an annual basis based on actuarially pre-determined amounts that are expected to provide the plans' future benefits.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Supplemental Executive Retirement Plan (SERP)

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

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

(ii) Defined Contribution Pension Plans

Group Registered Retirement Savings Plans (GRRSPs)

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

Supplemental Pension Plan (SPP)

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

(iii) Other Benefit Plans

Accumulating Non-Vesting Sick Leave

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

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

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

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.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(i) Asset Retirement Obligations

Asset retirement obligations are legal obligations associated with the retirement of tangible capital assets. A liability for an asset retirement obligation is recognized when, as at the financial reporting date:

(i) there is a legal obligation to incur retirement costs in relation to a tangible capital asset;
(ii) the past transaction or event giving rise to the liability has occurred;
(iii) it is expected that future economic benefits will be given up; and
(iv) a reasonable estimate of the amount can be made.

Asset retirement obligations are initially measured as of the date the legal obligation was incurred, based on management's best estimate of the amount required to retire tangible capital assets.

When a liability for asset retirement obligation is recognized, asset retirement costs related to recognized tangible capital assets in productive use are capitalized by increasing the carrying amount of the related asset and are amortized over the estimated useful life of the underlying tangible capital asset. Asset retirement costs related to unrecognized tangible capital assets and those not in productive use are expensed. Revisions in estimates are recognized as a change to both the liability and related tangible capital asset in the Consolidated Statement of Financial Position.

(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 denominated in foreign currencies included in the fair value category reflect the exchange rates at the Consolidated Statement of Financial Position date. Unrealized foreign exchange gains and losses are recognized in the Consolidated Statement of Remeasurement Gains and Losses.

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

(k) Reserves

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

(l) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a difference between the recognized or disclosed amount and another reasonably possible amount. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences could require adjustment in subsequent reporting years.

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

There is measurement uncertainty related to asset retirement obligations as it involves estimates in determining settlement amount and timing of settlement. Changes to any of these estimates and assumptions may result in change to the obligation.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(m) Changes in Accounting Policy

Effective April 1, 2022, AHS adopted the new accounting standard PS 3280 Asset Retirement Obligations and applied the standard using the modified retroactive approach with restatement of prior year comparative information.

On the effective date, AHS recognized the following to conform to the new standard;

(i) asset retirement obligations;
(ii) asset retirement cost capitalized as an increase to the carrying amount of the related tangible capital assets in productive use;
(iii) accumulated amortization on the capitalized cost; and
(iv) adjustment to the opening balance of the accumulated surplus.

Amounts are measured using information and assumptions where applicable, that are current on the effective date of the standard. The amount recognized as an asset retirement cost is measured as of the date the asset retirement obligation was incurred. Accumulated amortization is measured for the period from the date the liability would have been recognized had the provisions of this standard been in effect to the date as of which this standard is first applied. Impacts on the prior year's financial statements as a result of the change in accounting policy are presented in Schedule 4.

(n) Future Accounting Changes

On April 1, 2023, AHS will adopt the following new accounting standards and guideline approved by the Public Sector Accounting Board:

- **PS 3400 – Revenue**
  PS 3400 provides guidance on how to account for and report revenue, and specifically, it differentiates between revenue arising from exchange and non-exchange transactions.

- **PSG-8 – Purchased Intangibles**
  PSG-8 provides guidance on the recognition, accounting, and classification of purchased intangible assets.

- **PS 3160 – Public Private Partnerships**
  PS 3160 provides guidance on how to account for public private partnerships between public and private sector entities, where the public sector entity procures infrastructure using a private sector partner.

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

Note 3 Budget

The 2022-23 annual budget was approved by the AHS Board on March 17, 2022 for submission to the Minister who approved it on July 4, 2022. The budget excludes COVID-19 revenues and expenses and the impacts of asset retirement obligations.

Note 4 Other Government Transfers

	Budget	2023	2022 (Note 28)
Recognition of expended deferred capital revenue (Note 16 (a))	$ 191,600	$ 192,079	$ 170,119
Restricted operating (Note 14 (a))	82,900	218,460	175,590
Unrestricted operating	30,200	64,973	117,135
	$ 304,700	**$ 475,512**	**$ 462,844**

Other government transfers include $433,722 (2022 – $364,457) transferred from the Province of Alberta, $41,790 (2022 – $98,387) from government entities outside the Province of Alberta and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

Note 5 Donations, Fundraising, and Non-Government Contributions

	Budget	2023	2022
Recognition of expended deferred capital revenue (Note 16 (a))	$ 36,000	$ 32,407	$ 33,020
Restricted operating (Note 14(a))	142,000	150,190	123,946
Unrestricted operating	3,000	6,537	27,213
Endowment contributions (Note 21)	-	110	1,714
	$ 181,000	**$ 189,244**	**$ 185,893**

Note 6 Investment and Other Income

	Budget	2023	2022
Investment income	$ 55,000	$ 39,658	$ 75,643
Other income:			
AH	10,525	12,883	11,817
Other Province of Alberta Ministries (Note 23)	30,800	31,307	24,646
Other [(i)]	89,200	156,437	124,186
	$ 185,525	**$ 240,285**	**$ 236,292**

[(i)] Other mainly relates to recoveries for services provided to third parties.

Note 7 Support Services

	Budget	2023	2022 (Restated – Schedule 4)
Facilities operations	$ 889,100	$ 994,103	$ 895,991
Patient health records, food services, and transportation	405,800	492,530	446,921
Housekeeping, laundry, and linen	193,500	260,404	233,797
Materials management [(i)]	175,500	243,399	221,805
Support services expense of full-spectrum contracted health service providers	152,500	166,462	159,647
Ancillary operations	85,300	73,236	76,291
Fundraising expenses and grants awarded	46,900	51,705	44,296
Other [(i)]	318,300	357,592	410,425
	$ 2,266,900	**$ 2,639,431**	**$ 2,489,173**

[(i)] Materials management and other include valuation adjustments of $71,419 (2022 – $109,034) relating primarily to COVID-19 Inventory (Note 20).

Note 8 Administration

	Budget	2023	2022 (Restated – Schedule 4)
General administration	$ 224,300	$ 219,583	$ 192,610
Human resources	124,200	127,969	118,230
Finance	78,200	80,565	73,758
Communications	25,600	26,496	22,972
Administration expense of full-spectrum contracted health service providers	44,500	40,713	39,362
	$ 496,800	**$ 495,326**	**$ 446,932**

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 accordance with the AHS investment bylaw and policy, AHS manages market risk by maintaining a conservative and diversified portfolio, and engages Alberta Investment Management Corporation, a related party, to manage the portfolio. Compliance with the bylaw and policy is monitored and reported to the Official Administrator on a quarterly basis.

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

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

AHS assesses the sensitivity of its portfolio to market risk based on historical volatility of equity and fixed income markets. Volatility is determined using a ten-year average based on fixed income and equity market fluctuations and is applied to the total portfolio. Based on the volatility average of 3.79% (2022 – 3.60%) increase or decrease, with all other variables held constant, the portfolio could expect an increase or decrease in unrealized net gains and losses attributable to unexpended deferred operating revenue of $60,549 (2022 – $71,795).

(i) Price Risk

Price risk relates to the possibility that equity portfolio investments will change in fair value due to future fluctuations in market prices caused by factors specific to an individual equity investment or other factors affecting all equities traded in the market. AHS is exposed to price risk associated with the underlying equity portfolio investments held in pooled funds. If equity market indices (S&P/TSX, S&P1500 and MSCI ACWI and their sectors) declined by 10%, and all other variables are held constant, the potential loss in fair value to AHS would be approximately $49,936 or 2.27% of total portfolio investments (March 31, 2022 – $58,868 or 2.25%).

(ii) Interest Rate Risk

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

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

Note 9 Financial Risk Management (continued)

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

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $62,550 (March 31, 2022 – $66,742).

Interest bearing securities have the following average maturity structure:

	2023	2022
Less than one year	27%	30%
1 – 5 years	52%	51%
6 – 10 years	8%	11%
Over 10 years	13%	8%

	Average Effective Market Yield	
Asset Class	2023	2022
Money market instruments	4.45%	0.89%
Fixed income securities	4.21%	2.62%

(iii) Foreign Currency Risk

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

Foreign currency risk is managed by the investment policies which limit non-Canadian equities to a maximum of 10% to 45% of the total investment portfolio, depending on the policy. At March 31, 2023, investments in non-Canadian equities represented 12.5% (March 31, 2022 – 13.6%) of total portfolio investments.

Foreign exchange fluctuations on cash balances are mitigated by derivatives and holding minimal foreign currency cash balances. AHS holds US dollar forward contracts to manage currency fluctuations relating to its US dollar accounts payable requirements. As at March 31, 2023, AHS held derivatives in the form of forward contracts for future settlement of $18,000 (2022 – $24,000). The fair value of these forward contracts as at March 31, 2023 was $846 (2022 – ($16)) and is included in portfolio investments (Note 10).

(b) Credit Risk

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

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

The carrying amounts of financial assets represent the maximum credit exposure.

Under the investment bylaw and policies governing the consolidated investment portfolio, money market securities are limited to a rating of R1 or equivalent or higher, and no more than 10% may be invested in any one issuer unless guaranteed by the Government of Canada or a Canadian province. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total investment portfolio. Not more than 20% of the investment portfolio may be BBB or equivalent rated bonds. AHS holds unrated mortgage fund investments which are classified as part of AHS' fixed income securities.

Note 9 Financial Risk Management (continued)

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

Credit Rating	2023	2022
AAA	51%	50%
AA	19%	23%
A	14%	17%
BBB	12%	7%
Unrated	4%	3%
	100%	**100%**

(c) Liquidity Risk

Liquidity risk is the risk that AHS will encounter difficulty under both normal and stressed conditions in meeting obligations associated with financial liabilities that are settled by delivery of cash and cash equivalents or another financial asset. Liquidity requirements of AHS are met through funding provided by AH, income generated from portfolio investments, and by investing in liquid assets, such as money market securities, fixed income securities and equities traded in an active market that are easily sold and converted to cash. Short-term borrowing to meet financial obligations would be available through established credit facilities, which have not been drawn upon, as described in Note 17(c).

AHS issued debenture maturities are described in Note 17(d). The following are contractual maturities of the remaining financial liabilities as at March 31, 2023, based on expected undiscounted cash flows.

	Due in less than 1 year	Due in 1-5 years	Due after 5 years
Payroll payable and related accrued liabilities	$ 697,925	$ -	$ -
Trade payable and accrued liabilities	749,089	-	-
Other liabilities	6,615	13,227	6,952
	$ 1,453,629	**$ 13,227**	**$ 6,952**

Note 10 Portfolio Investments

	2023		2022	
	Fair Value	Cost	Fair Value	Cost
Cash held for investing purposes	**$ 122,940**	**$ 122,940**	**$ 126,002**	**$ 126,002**
Interest bearing securities:				
Money market securities	367,815	367,775	530,043	530,210
Fixed income securities	1,194,576	1,228,624	1,358,881	1,403,265
	1,562,391	**1,596,399**	**1,888,924**	**1,933,475**
Equities:				
Canadian equity investments and funds	177,151	171,926	189,136	163,447
Global equity investments and funds	273,522	228,896	354,516	294,912
	450,673	**400,822**	**543,652**	**458,359**
Real estate pooled funds	**48,690**	**40,371**	**45,027**	**40,371**
	$ 2,184,694	**$ 2,160,532**	**$ 2,603,605**	**$ 2,558,207**

	2023	2022
Items at fair value		
Portfolio investments designated to the fair value category	$ 2,121,012	$ 2,577,860
Portfolio investments in equity instruments that are quoted in an active market	62,836	25,761
Derivatives	846	(16)
	$ 2,184,694	**$ 2,603,605**

As at March 31, 2023, included in portfolio investments is $187,959 (2022 – $215,299) that is restricted for use as per the requirements in Sections 99 and 100 of the *Insurance Act* (Alberta). Endowment principal included in portfolio investments amounts to $77,492 (2022 – $77,382).

Note 10 Portfolio Investments (continued)

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

	2023	2022
Accumulated remeasurement gains	$ 20,270	$ 24,886
Restricted unrealized net gains attributable to unexpended deferred operating revenue (Note 14(b))	3,892	20,512
	$ 24,162	**$ 45,398**

Fair Value Hierarchy

	2023			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ -	$ 122,940	$ -	$ 122,940
Interest bearing securities:				
Money market securities	-	367,815	-	367,815
Fixed income securities	-	1,143,251	51,325	1,194,576
Equities:				
Canadian equity investments and funds	62,836	114,315	-	177,151
Global equity investments and funds	-	273,522	-	273,522
Real estate pooled funds	-	-	48,690	48,690
	$ 62,836	**$ 2,021,843**	**$ 100,015**	**$ 2,184,694**
Percent of total	3%	93%	4%	100%

	2022			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ -	$ 126,002	$ -	$ 126,002
Interest bearing securities:				
Money market securities	-	530,043	-	530,043
Fixed income securities	-	1,307,828	51,053	1,358,881
Equities:				
Canadian equity investments and funds	25,761	163,375	-	189,136
Global equity funds	-	354,516	-	354,516
Real estate pooled funds	-	-	45,027	45,027
	$ 25,761	**$ 2,481,764**	**$ 96,080**	**$ 2,603,605**
Percent of total	1%	95%	4%	100%

Reconciliation of Investments classified as level 3

	2023		
	Fixed income securities	Real estate pooled funds	Total
Beginning of year	$ 51,053	$ 45,027	$ 96,080
Purchases	2,266	-	2,266
Sales	(857)	-	(857)
(Loss) gain included in the Consolidated Statement of Remeasurement Gains and Losses	(1,999)	3,663	1,664
Transfers in	862	-	862
End of year	**$ 51,325**	**$ 48,690**	**$ 100,015**

Note 10 Portfolio Investments (continued)

	2022		
	Fixed income securities	Real estate pooled funds	Total
Beginning of year	$ 51,585	$ 40,623	$ 92,208
Purchases	1,192	29	1,221
Sales	-	-	-
Gain (loss) included in the Consolidated Statement of Remeasurement Gains and Losses	(1,663)	4,375	2,712
Transfers out	(61)	-	(61)
End of year	**$ 51,053**	**$ 45,027**	**$ 96,080**

Note 11 Accounts Receivable

	2023			2022
	Gross	Allowance for Doubtful Accounts	Net	Net
AH operating transfers receivable	$ 324,146	$ -	$ 324,146	$ 194,000
Other capital transfers receivable	108,535	-	108,535	96,127
Patient accounts receivable	134,813	48,229	86,584	74,495
Drugs rebates receivable	87,031	-	87,031	83,982
AH capital transfers receivable	10,922	-	10,922	21,400
Other operating transfers receivable	38,117	-	38,117	20,334
Other accounts receivable	104,310	9,562	94,748	104,091
	$ 807,874	**$ 57,791**	**$ 750,083**	**$ 594,429**

Accounts receivable are unsecured and non-interest bearing. At March 31, 2022, the total allowance for doubtful accounts was $51,767 of which $42,081 related to patient accounts receivable.

Note 12 Accounts Payable and Accrued Liabilities

	2023	2022
Payroll payable and related accrued liabilities	$ 697,925	$ 807,029
Trade accounts payable and accrued liabilities	749,089	756,193
Provision for unpaid claims[(a)]	164,312	191,618
Obligations under capital leases[(b)]	122,977	129,882
Other liabilities	39,121	67,133
	$ 1,773,424	**$ 1,951,855**

As at March 31, 2023, accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $237,507 (2022 – $250,754). Of these amounts, $9,779 (2022 – $10,025) comprise life lease deposits received from tenants of certain AHS' long term care facilities, amounts payable to AI of $nil (2022 – $23,550) related to a project funded by debt, and obligations under capital leases of $122,977 (2022 – $129,882).

(a) Provision for unpaid claims is an actuarial estimate of liability claims against AHS. It is influenced by factors such as historical trends involving claim payment patterns, loss payments, number of unpaid claims, claims severity and claim frequency patterns.

Note 12 Accounts Payable and Accrued Liabilities (continued)

The provision has been estimated using the discounted value of claim liabilities using a discount rate of 3.80% (2022 – 3.00%) plus a provision for adverse deviation, based on actuarial estimates.

(b) Obligations under capital leases include site leases with the University of Calgary, vehicle and equipment leases, site leases for ambulance services and a community care service facility.

The obligations will be settled between 2024 and 2041 and have an implicit interest rate payable ranging from 2.53% to 5.07% (2022 – 2.53% to 5.07%).

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

Year ended March 31	Minimum Contract Payments
2024	$ 16,904
2025	16,120
2026	14,944
2027	13,003
2028	9,729
Thereafter	74,187
	144,887
Less: interest	(21,910)
	$ 122,977

Note 13 Employee Future Benefits

	2023	2022
Accrued vacation pay	$ 646,664	$ 640,004
Accumulating non-vesting sick leave[(a)]	140,592	135,445
SERP pension plans	387	2,429
	$ 787,643	**$ 777,878**

(a) Accumulating Non-Vesting Sick Leave

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

	2023	2022
Funded status – deficit	$ 91,650	$ 145,281
Unamortized net actuarial gain (loss)	48,942	(9,836)
Accrued benefit liability	**$ 140,592**	**$ 135,445**

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

	2023	2022
Estimated average remaining service life	10 years	13 years
Draw down rate of accumulated non-vesting sick leave bank	18.30%	18.30%
Discount rate – beginning of year	2.50%	1.77%
Discount rate – end of year	5.60%	2.50%
Rate of compensation increase per year	2022-23	2021-22
	1.60%	1.25%
	2023-24	2022-23
	2.25%	1.25%
	2024-25	Thereafter
	2.00%	2.75%
	Thereafter	
	2.75%	

Note 13 Employee Future Benefits (continued)

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP. AHS' employees comprise approximately 47% (2022 - 47%) of the total membership in LAPP. AHS is not responsible for future funding of the plan deficit other than through contribution increases. As AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

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

(ii) LAPP Surplus

The LAPP carried out an actuarial valuation as at December 31, 2021 and these results were then extrapolated to December 31, 2022.

	December 31, 2022	December 31, 2021
LAPP net assets available for benefits	$ 58,747,000	$ 61,715,000
LAPP pension obligation	46,076,000	49,792,629
LAPP surplus	**$ 12,671,000**	**$ 11,922,371**

The 2023 and 2022 LAPP contribution rates are as follows:

Calendar 2023		Calendar 2022	
Employer	**Employees**	**Employer**	**Employees**
8.45% of pensionable earnings up to the YMPE and 12.23% of the excess	7.45% of pensionable earnings up to the YMPE and 11.23% of the excess	8.45% of pensionable earnings up to the YMPE and 12.80% of the excess	7.45% of pensionable earnings up to the YMPE and 11.80% of the excess

(c) Pension Expense

	2023	2022
Local Authorities Pension Plan	$ 462,649	$ 555,331
Defined contribution pension plans and group RRSPs	39,651	42,545
Other pension plans	(253)	1,012
	$ 502,047	**$ 598,888**

Note 14 Unexpended Deferred Operating Revenue

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

	2023				2022
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 203,407	$ 30,347	$ 295,953	$ 529,707	$ 641,469
Adjustment related to Ministry of Mental Health and Addiction[(ii)]	(70,048)	70,048	-	-	-
Balance, beginning of year (reclassified)	**$ 133,359**	**$ 100,395**	**$ 295,953**	**$ 529,707**	**$ 641,469**
Received or receivable during the year	2,295,676	137,599	163,087	2,596,362	2,969,275
Unexpended deferred operating revenue returned	(1,037)	(2,363)	(1,185)	(4,585)	(97,699)
Restricted investment income	549	402	1,512	2,463	36,329
Transferred from (to) unexpended deferred capital revenue [(iii)]	9,942	81,990	(8,497)	83,435	90,524
Transferred to expended deferred operating revenue	(69,517)	-	-	(69,517)	(363,213)
Recognized as revenue	(2,177,842)	(218,460)	(150,190)	(2,546,492)	(2,665,233)
Miscellaneous other revenue recognized	(548)	(3)	(1,574)	(2,125)	(33,873)
	190,582	**99,560**	**299,106**	**589,248**	**577,579**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	(339)	(830)	(15,451)	(16,620)	(47,872)
Balance, end of year	**$ 190,243**	**$ 98,730**	**$ 283,655**	**$ 572,628**	**$ 529,707**

(i) The balance for other government includes $2,512 (2022 – $535) of unexpended deferred operating revenue received from government entities outside the Province of Alberta. The remaining balance in other government all relates to the Province of Alberta (Note 23).

(ii) On November 14, 2022, the Premier of Alberta announced the new Ministry of Mental Health and Addiction. A reclassification has been made to the consolidated financial statements for the year ended March 31, 2022 to reclassify the related mental health & addiction amount from Alberta Health transfers to other government transfers to conform with 2023 presentation.

(iii) The transfer is mainly comprised of restricted capital funding that was used for approved expenditures that did not meet the definition of a tangible capital asset.

Note 14 Unexpended Deferred Operating Revenue (continued)

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

	2023				2022
	AH	Other Government	Donors and Non-Government	Total	Total
Research and education	$ 4,732	$ 2,494	$ 194,499	$ 201,725	$ 203,806
Cancer prevention, screening and treatment	71,224	-	3,582	74,806	32,423
Support services	1,081	4,213	63,628	68,922	66,959
Addiction and mental health	-	46,926	1,791	48,717	50,115
Physician revenue and alternate relationship plans	46,050	341	-	46,391	28,771
Primary Care Networks	23,150	-	-	23,150	20,299
Diagnostic and therapeutic services	20,415	613	1,563	22,591	16,222
Promotion, prevention and community	5,102	16,064	697	21,863	18,254
Long term care partnerships	-	19,508	-	19,508	19,109
COVID-19 pandemic response and support	6,163	6,717	51	12,931	30,535
Inpatient acute nursing services	8,603	-	2,880	11,483	4,022
Others individually less than $10,000	3,243	1,034	12,372	16,649	18,680
	189,763	**97,910**	**281,063**	**568,736**	**509,195**
Unrealized net gain attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 10)	480	820	2,592	3,892	20,512
	$ 190,243	**$ 98,730**	**$ 283,655**	**$ 572,628**	**$ 529,707**

Note 15 Unexpended Deferred Capital Revenue

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

	2023				2022
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 52,128	$ 3,734	$ 93,654	$ 149,516	$ 165,111
Adjustment related to Ministry of Mental Health and Addiction[(ii)]	(801)	801	-	-	-
Balance, beginning of year (reclassified)	**$ 51,327**	**$ 4,535**	**$ 93,654**	**$ 149,516**	**$ 165,111**
Received or receivable during the year	98,436	282,052	49,182	429,670	401,327
Used for the acquisition of land	(22)	-	(3,912)	(3,934)	(987)
Unexpended deferred capital revenue returned	-	(31)	(42)	(73)	(419)
Transferred to expended deferred capital revenue	(68,783)	(195,032)	(48,868)	(312,683)	(324,992)
Transferred to (from) unexpended deferred operating revenue[(iii)]	(9,942)	(81,990)	8,497	(83,435)	(90,524)
Revenue recognized on settlement of asset retirement obligations (Note 18)	(43)	(1,092)	(25)	(1,160)	-
Balance, end of year	**$ 70,973**	**$ 8,442**	**$ 98,486**	**$ 177,901**	**$ 149,516**

[(i)] The balance for other government all relates to the Province of Alberta (Note 23).
[(ii)] On November 14, 2022, the Premier of Alberta announced the new Ministry of Mental Health and Addiction. A reclassification has been made to the consolidated financial statements for the year ended March 31, 2022 to reclassify the related mental health & addiction amount from Alberta Health transfers to other government transfers to conform with 2023 presentation.
[(iii)] The transfer is mainly comprised of restricted capital funding of approved expenditures that did not meet the definition of a tangible capital asset.

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

	2023	2022 [(i)]
AH		
COVID-19 related projects and equipment	$ 5,061	$ 2,086
Continuing Care Beds	12,714	18,844
Information systems	5,505	2,946
Medical Equipment Replacement Upgrade Program	2,367	-
Diagnostic equipment	3,612	9,560
Alberta Surgical Initiative Capital Program	15,560	-
Rural Health Facilities Revitalization Program	22,119	17,697
Other equipment	4,035	194
Total AH	**70,973**	**51,327**
Other government		
Facilities and improvements	2,489	3,734
COVID-19 related projects and equipment	392	390
Equipment	5,561	411
Total other government	**8,442**	**4,535**
Donors and non-government		
Equipment	88,792	81,336
Facilities and improvements	9,694	12,282
COVID-19 related projects and equipment	-	36
Total donors and non-government	**98,486**	**93,654**
	$ 177,901	**$ 149,516**

Note 15 Unexpended Deferred Capital Revenue (continued)

(i) On November 14, 2022, the Premier of Alberta announced the new Ministry of Mental Health and Addiction. The following adjustments have been made related to the Ministry of Mental Health and Addiction: AH COVID-19 related projects and equipment reclassified from $2,476 to $2,086, AH Other Equipment reclassified from $605 to $194, Other Government COVID-19 related projects and equipment reclassified from $nil to $390, and Other Government Equipment reclassified from $nil to $411.

Note 16 Expended Deferred Revenue

	2023	2022
Expended deferred capital revenue[a]	$ 8,525,465	$ 8,278,969
Expended deferred operating revenue[b]	116,636	336,972
	$ 8,642,101	**$ 8,615,941**

(a) Expended deferred capital revenue

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

	2023				2022
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 632,388	$ 7,435,085	$ 211,496	$ 8,278,969	$ 7,826,892
Adjustment related to Ministry of Mental Health and Addiction[(ii)]	(5,138)	5,138	-	-	-
Balance, beginning of year (reclassified)	**$ 627,250**	**$ 7,440,223**	**$ 211,496**	**$ 8,278,969**	**$ 7,826,892**
Transferred from unexpended deferred capital revenue	68,783	195,032	48,868	312,683	324,992
Constructed tangible capital assets on behalf of AHS	-	262,429	-	262,429	425,337
Contributed tangible capital assets	-	-	35	35	522
Recognized as revenue	(104,165)	(192,079)	(32,407)	(328,651)	(298,774)
Balance, end of year	**$ 591,868**	**$ 7,705,605**	**$ 227,992**	**$ 8,525,465**	**$ 8,278,969**

(i) The entire balance in other government all relates to the Province of Alberta (Note 23).

(ii) On November 14, 2022, the Premier of Alberta announced the new Ministry of Mental Health and Addiction. A reclassification has been made to the consolidated financial statements for the year ended March 31, 2022 to reclassify the related mental health & addiction amounts from Alberta Health transfers to other government transfers to conform with 2023 presentation.

(b) Expended deferred operating revenue

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

	2023	2022
	Total	Total
Balance, beginning of year	$ 336,972	$ 427,445
Transferred from unexpended deferred operating revenue	69,517	363,213
Recognized as unrestricted revenue	-	(39,530)
Recognized as restricted revenue	(289,853)	(414,156)
Balance, end of year	**$ 116,636**	**$ 336,972**

The balance of expended deferred operating revenue pertains to unused COVID-19 supplies purchased with AH funding.

Note 17 Debt

	2023	2022
Debentures [a]:		
Parkade loan #1	$ 13,446	$ 16,925
Parkade loan #2	14,677	17,567
Parkade loan #3	22,372	25,507
Parkade loan #4	98,549	107,687
Parkade loan #5	24,473	26,528
Parkade loan #6	18,411	19,504
Parkade loan #7	41,037	43,240
Parkade loan #8	151,400	153,334
Energy savings initiative loan	16,817	18,701
EMS support vehicle loan[b]	32,906	37,500
	434,088	466,493
Loan proceeds to be received[b]	-	(11,500)
	$ 434,088	**$ 454,993**

(a) Alberta Treasury Board and Finance (TBF) is responsible for the administration of the Province's lending program.

AHS issued debentures to TBF, a related party, to finance the construction of parkades. AHS has pledged revenue derived directly or indirectly from the operations of all parking facilities being constructed, renovated, owned, and operated by AHS as security for these debentures.

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

AHS is in compliance with all performance requirements relating to its debentures as at March 31, 2023.

(b) AHS issued a debenture to TBF relating to EMS support vehicles. AHS has pledged the vehicles as security for this debenture. In the 2022-23 fiscal year, AHS received the remaining $11,500 in loan proceeds from TBF.

Note 17 Debt (continued)

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

	Maturity Date	Fixed Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Parkade loan #6	December 2035	3.6090%
Parkade loan #7	March 2038	2.6400%
Parkade loan #8	December 2059	3.6010%
Energy savings initiative loan	December 2030	2.4160%
EMS support vehicle loan	September 2026	1.1500%

(c) As at March 31, 2023, AHS has access to a $220,000 (2022 – $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, 2023, AHS has $nil (2022 – $nil) draws against this facility.

AHS also has access to a $33,000 (2022 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2023, AHS has $3,353 (2022 – $3,626) in a letter of credit outstanding against this facility. AHS is in compliance with the terms of the agreement relating to the letter of credit as at March 31, 2023.

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

Year Ended March 31	Principal	Interest	Total
2024	$ 38,275	$ 15,876	$ 54,151
2025	39,633	14,519	54,152
2026	41,047	13,104	54,151
2027	35,618	11,630	47,248
2028	28,214	10,316	38,530
Thereafter	251,301	109,987	361,288
	$ 434,088	**$ 175,432**	**$ 609,520**

During the year, the total interest related to debt was $16,960 (2022 – $17,903), comprised of capitalized interest of $3,631 (2022 – $5,553) (Note 19a) and interest expense of $13,329 (2022 – $12,350). Accrued interest at March 31, 2023 amounted to $2,767 (2022 – $2,893).

Note 18 Asset Retirement Obligations

	2023	2022 (Restated – Schedule 4)
Asset retirement obligations, beginning of year	$ 544,416	$ -
Adjustment related to changes in accounting policy (Note 2(m))	-	534,527
Balance, beginning of year (Restated)	**$ 544,416**	**$ 534,527**
Liability incurred	1,144	-
Liability settled	(2,780)	-
Revision in estimates	40,392	9,889
Asset retirement obligations, end of year	**$ 583,172**	**$ 544,416**

AHS has asset retirement obligations to remove hazardous asbestos fibre containing materials from its buildings. Regulations require AHS to handle and dispose of the asbestos in a prescribed manner when it is disturbed, such as when the building undergoes renovations or is demolished. Although timing of the asbestos removal is conditional on the building undergoing renovations or being demolished, regulations create an existing obligation for AHS to remove the asbestos when asset retirement activities occur.

The estimate of the liability is based primarily on asbestos abatement rates calculated using the current costs incurred as part of AHS renovation and demolition projects. Third party engineering reports, building schematics, and professional judgments were used in determining the square meters containing asbestos.

The timing of settlement of asset retirement obligations is currently unknown. For the year ended March 31, 2023, a recovery of $1,160 (2022 - $nil) was recognized (Note 15(a)).

Note 19 Tangible Capital Assets

Cost	2022 (Restated – Schedule 4)	Additions[a]	Transfers	Disposals/write-downs	2023
Facilities and improvements	$ 11,129,930	$ 41,164	$ 1,564,511	$ (17,954)	$ 12,717,651
Work in progress	1,934,048	557,785	(1,822,697)	(4,042)	665,094
Equipment	2,823,434	208,700	(2,107)	(55,517)	2,974,510
Information systems	2,106,767	10,124	165,939	(14,126)	2,268,704
Building service equipment	978,574	-	47,300	-	1,025,874
Land[b]	117,804	3,966	-	(21)	121,749
Leased facilities and improvements	262,878	-	55,496	(631)	317,743
Land improvements	116,010	-	(8,442)	-	107,568
	$ 19,469,445	**$ 821,739**	**$ -**	**$ (92,291)**	**$ 20,198,893**

Accumulated Amortization	2022 (Restated – Schedule 4)	Amortization Expense	Effect of Transfers	Disposals/write-downs	2023
Facilities and improvements	$ 4,866,614	$ 142,844	$ -	$ (15,168)	$ 4,994,290
Work in progress	-	-	-	-	-
Equipment	2,190,700	160,272	-	(52,809)	2,298,163
Information systems	1,556,079	140,274	-	(14,110)	1,682,243
Building service equipment	574,139	51,966	-	-	626,105
Land[b]	-	-	-	-	-
Leased facilities and improvements	205,500	9,123	-	(307)	214,316
Land improvements	78,378	1,749	-	-	80,127
	$ 9,471,410	**$ 506,228**	**$ -**	**$ (82,394)**	**$ 9,895,244**

Cost	2021	Changes in Accounting Policy (Note 2(m))	Additions	Transfers	Disposals/write-downs	2022 Restated
Facilities and improvements	$ 10,517,852	$ 536,774	$ 106	$ 86,342	$ (11,144)	$ 11,129,930
Work in progress	1,492,842	-	672,654	(229,305)	(2,143)	1,934,048
Equipment	2,724,823	-	195,508	1,160	(98,057)	2,823,434
Information systems	2,014,793	-	35,708	71,953	(15,687)	2,106,767
Building service equipment	918,156	3,360	188	57,664	(794)	978,574
Land[b]	116,840	-	987	-	(23)	117,804
Leased facilities and improvements	256,700	-	-	6,178	-	262,878
Land improvements	110,023	-	-	6,008	(21)	116,010
	$ 18,152,029	**$ 540,134**	**$ 905,151**	**$ -**	**$ (127,869)**	**$ 19,469,445**

Accumulated Amortization	2021	Changes in Accounting Policy (Note 2(m))	Amortization Expense	Effect of Transfers	Disposals/write-downs	2022 Restated
Facilities and improvements	$ 4,420,368	$ 323,673	$ 133,408	$ -	$ (10,835)	$ 4,866,614
Work in progress	-	-	-	-	-	-
Equipment	2,131,296	-	155,655	-	(96,251)	2,190,700
Information systems	1,449,602	-	121,835	-	(15,358)	1,556,079
Building service equipment	524,346	2,054	48,446	-	(707)	574,139
Land[b]	-	-	-	-	-	-
Leased facilities and improvements	196,225	-	9,275	-	-	205,500
Land improvements	74,929	-	3,470	-	(21)	78,378
	$ 8,796,766	**$ 325,727**	**$ 472,089**	**$ -**	**$ (123,172)**	**$ 9,471,410**

Note 19 Tangible Capital Assets (continued)

	Net Book Value	
	2023	2022 (Restated – Schedule 4)
Facilities and improvements	$ 7,723,361	$ 6,263,316
Work in progress	665,094	1,934,048
Equipment	676,347	632,734
Information systems	586,461	550,688
Building service equipment	399,769	404,435
Land[(b)]	121,749	117,804
Leased facilities and improvements	103,427	57,378
Land improvements	27,441	37,632
	$ 10,303,649	**$ 9,998,035**

(a) Additions

Additions include tangible capital assets constructed by AI on behalf of AHS of $262,429 (2022 – $425,337) and $35 contributed from other sources (2022 – $522). During the year, AHS capitalized interest of $3,631 (2022 – $5,553) (Note 17(d)) within work in progress. Capital lease additions amounted to $19,031 (2022 – $15,646).

(b) Leased Land

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

Site	Leased from	Lease Expiry
Laneway adjacent to Queen Elizabeth II Hospital	Town of Grande Prairie	December 2023
Evansburg Community Health Centre	Yellowhead County	April 2031
Bethany Care Centre	Red Deer College	April 2034
Myrnam Land	Eagle Hill Foundation	May 2038
Helipad Land at Two Hills	Stella Stefiuk	August 2041
McConnell Place North	City of Edmonton	September 2044
Northeast Community Health Centre	City of Edmonton	February 2047
Jasper Healthcare Centre	Parks Canada	March 2049
Foothills Medical Centre Parkade	University of Calgary	July 2054
Alberta Children's Hospital	University of Calgary	December 2103
Kaye Edmonton Clinic (Parcel H)	The University of Alberta	February 2109

(c) Leased Tangible Capital Assets

Tangible capital assets acquired through capital leases includes vehicle leases, equipment, information systems and facilities with a cost of $487,324 (2022 – $397,498) and accumulated amortization of $269,475 (2022 – $240,358).

(d) Asset Retirement Costs

Included in tangible capital assets are $581,299 (2022 - $540,134) of asset retirement costs and $348,944 of related accumulated amortization (2022 - $337,329).

Note 20 Inventories of Supplies

	2023	2022
Pharmaceuticals	$ 114,334	$ 93,018
Medical and surgical supplies	42,864	49,450
Personal protective equipment	116,156	246,440
COVID-19 laboratory testing supplies	1,288	13,048
COVID-19 rapid test kits	15,343	93,826
Other	17,740	17,237
	$ 307,725	**$ 513,019**

The easing of health restrictions has reduced the demand for masks and rapid test kits while the resolution of global shortages for personal protective equipment (PPEs) has reduced its costs. As a result, a valuation adjustment of $71,419 (2022 – $109,034) has been recorded to write down the cost of PPEs to its current replacement cost and to provide for inventories that no longer meet clinical standards and requirements (Note 7).

AHS holds and distributes COVID-19 rapid test kits, provided at no cost by the Federal Government, on behalf of AH. These inventories are excluded from these consolidated financial statements. AHS is holding $223,542 (2022 – $117,429) on behalf of AH as at March 31, 2023.

Note 21 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2023					2022
	Unrestricted Surplus	Invested in Tangible Capital Assets [a]	Endowments[b]	Internally Restricted Surplus for Insurance Equity Requirements and Foundations[c]	Total	Total (Restated – Schedule 4)
Balance, beginning of year	$ 235,623	$ 602,562	$ 77,382	$ 121,590	$ 1,037,157	$ 1,236,273
Adjustment related to changes in accounting policy (Note 2(m))	-	-	-	-	-	(330,009)
Balance, beginning of year (Restated)	**$ 235,623**	**$ 602,562**	**$ 77,382**	**$ 121,590**	**$ 1,037,157**	**$ 906,264**
Annual operating surplus	83,670	-	-	-	83,670	130,893
Net investment in tangible capital assets	(55,811)	55,811	-	-	-	-
Transfer of insurance equity requirements and foundations surpluses	(10,087)	-	-	10,087	-	-
Transfer of net deficits related to asset retirement obligations	9,206	(9,206)	-	-	-	-
Transfer of endowment contributions (note 5)	(110)	-	110	-	-	-
Balance, end of year	**$ 262,491**	**$ 649,167**	**$ 77,492**	**$ 131,677**	**$ 1,120,827**	**$ 1,037,157**

Note 21 Accumulated Surplus (continued)

(a) Invested in Tangible Capital Assets

Invested In tangible capital assets represents the portion of accumulated surpluses that has been invested in the acquisition or construction of AHS' assets. The balance is offset by asset retirement costs recognized in accumulated surplus net of related liability settlements.

Reconciliation of invested in tangible capital assets:

	2023	2022 (Restated)
Tangible capital assets (Note 19)	$ 10,303,649	$ 9,998,035
Net Book Value of Asset Retirement Costs capitalized (Note 19(d))	(232,355)	(202,805)
Less funded by:		
Expended deferred capital revenue (Note 16(a))	(8,525,465)	(8,278,969)
Debt (Note 17)	(434,088)	(454,993)
Unexpended debt	20,999	22,812
Obligations under capital leases (Note 12(b))	(122,977)	(129,882)
Life lease deposits (Note 12)	(9,779)	(10,025)
	$ 999,984	**$ 944,173**
Asset retirement costs recognized net of related liability settlements	(350,817)	(341,611)
	$ 649,167	**$ 602,562**

(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 $110 (2022 – $1,714) of contributions received in the year (Note 5).

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

Insurance equity requirements comprise surpluses of $39,359 (2022 – $33,239) related to equity of the LPIP mainly relating to legislative requirements per the Insurance Act. Foundations comprise surpluses amounting to $92,318 (2022 – $88,351) related to donations received by AHS' Controlled Foundations without external restrictions attached.

Note 22 Contractual Obligations and Contingent Liabilities

(a) Contractual Obligations

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

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

Year ended March 31	Services[(i)]	Other[(ii)]	Operating Lease	Capital Projects	Total
2024	$ 3,696,209	$ 487,358	$ 59,888	$ 231,950	$ 4,475,405
2025	1,943,504	281,145	51,792	33,747	2,310,188
2026	1,660,454	163,460	40,364	2,870	1,867,148
2027	1,234,301	94,610	36,397	-	1,365,308
2028	1,105,678	59,340	30,248	-	1,195,266
Thereafter	10,481,598	40,354	94,146	-	10,616,098
March 31, 2023	**$ 20,121,744**	**$ 1,126,267**	**$ 312,835**	**$ 268,567**	**$ 21,829,413**
March 31, 2022	$ 15,791,980	$ 1,102,318	$ 299,788	$ 259,965	$ 17,454,051

(i) Service obligations mainly relate to contracts with third parties for the provision of long-term care services, home care services, and community laboratory services (Note 22 (b)).

(ii) Other obligations mainly relate to contracts with third parties for maintenance, information technology services, software, equipment, and procurement of medical supplies and food.

(b) Outsourcing of Community Laboratory Services

On May 30, 2022, AHS and a third party service provider finalized and executed a Services Agreement and Ancillary Agreements (the Agreements) that resulted in the transition of community laboratory services from AHS to the third party service provider, commencing December 5, 2022. As part of the Agreements, a portion of the workforce was transitioned to the third-party service provider. The Agreements extend over an initial term of 14 years and four months with an estimated commitment of $4.8 billion. This transfer of service does not change AHS' mandate to provide laboratory services within Alberta. AHS plans to continue with the delivery of acute care hospital laboratory, urgent care laboratory, and public health laboratory services and specialty complex and esoteric testing services.

(c) Contingent Liabilities

(i) Legal Claims

AHS is subject to legal claims during its normal course of business. AHS recognizes a liability when the assessment of a claim indicates that a future event is likely to confirm that a liability has been 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, 2023, accruals have been recorded as part of the provision for unpaid claims and other liabilities (Note 12). Included in this accrual are claims in which AHS has been jointly named with the Minister. The accrual provided for these claims under the provision for unpaid claims represents AHS' portion of the liability.

AHS has been named in 292 legal claims (2022 – 283 claims) related to conditions in existence at March 31, 2023 where the likelihood of the occurrence of a future event confirming a contingent loss is not determinable. Of these, 256 claims have $777,051 in specified amounts and 36 have no specified amounts (2022 – 247 claims with $759,551 of specified claims and 36 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that is different than the claimed amount.

(ii) Collective Agreements

AHS currently has 7 (2022 – 18) collective agreements that have expired and are currently under negotiation as at March 31, 2023. Given that negotiations are ongoing, no additional disclosures have been made.

Note 23 Related Parties

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

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

Related parties also include key management personnel of AHS. AHS has defined key management personnel to include those disclosed in Schedules 2A and 2B of these consolidated financial statements, except management reporting to CEO direct reports. Related party transactions with key management personnel primarily consist of compensation related payments and are undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length.

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

	Revenues[a]		Expenses	
	2023	2022 (Restated[b])	2023	2022
Alberta Advanced Education[c]	$ 59,994	$ 54,214	$ 181,312	$ 191,646
Alberta Infrastructure[d]	289,460	235,899	17,310	314
Alberta Mental Health and Addiction[e]	90,695	79,957	-	-
Other ministries	29,113	23,791	33,112	76,418
Total for the year	**$ 469,262**	**$ 393,861**	**$ 231,734**	**$ 268,378**

	Receivable from		Payable to	
	2023	2022 (Restated[b])	2023	2022 (Restated[b])
Alberta Advanced Education[c]	$ 7,597	$ 4,983	$ 45,006	$ 38,066
Alberta Infrastructure[d]	67,236	62,504	1,000	23,550
Alberta Mental Health and Addiction[e]	22,641	21,899	-	205
Other ministries[f]	3,635	8,078	437,593	458,768
Balance, end of year	**$ 101,109**	**$ 97,464**	**$ 483,599**	**$ 520,589**

(a) Revenues with Province of Alberta ministries include other government transfers of $433,722 (2022 – $364,457), (Note 4), other income of $31,307 (2022 – $24,646) (Note 6), and fees and charges of $4,233 (2022 – $4,758).

(b) On November 14, 2022, the Premier of Alberta announced the new Ministry of Mental Health and Addiction. A reclassification has been made to the consolidated financial statements for the year ended March 31, 2022 to reclassify the related mental health & addiction amount from Alberta Health transfers to other government transfers to conform with 2023 presentation.

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

Note 23 Related Parties (continued)

(d) The transactions with AI relate to the construction of tangible capital assets on behalf of AHS. These transactions include operating transfers of $99,542 (2022 – $66,983) and recognition of expended deferred capital revenue of $189,918 (2022 – $168,916) 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 19(a) is tangible capital assets constructed by AI on behalf of AHS of $262,429 (2022 – $425,337).

(e) The transactions with Alberta Mental Health and Addiction relate to initiatives to support Albertans experiencing addiction and mental health challenges.

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

At March 31, 2023, AHS has recorded deferred revenue from other ministries within the Province of Alberta, excluding AH, of $96,218 (2022 – $99,860) related to unexpended deferred operating revenue (Note 14), $8,442 (2022 – $4,535) related to unexpended deferred capital revenue (Note 15) and $7,705,605 (2022 – $7,440,223) related to expended deferred capital revenue (Note 16(a)).

Contingent liabilities in which AHS has been jointly named with other government entities within the Province of Alberta are disclosed in Note 22.

Note 24 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.

	2023	2022
Financial assets (portfolio investments, accounts receivable, other assets)	$ 67,995	$ 63,639
Liabilities (trade accounts payable, unexpended deferred operating revenue)	67,995	63,639
Accumulated surplus	**$ -**	**$ -**
Total revenues	$ 263,082	$ 260,700
Total expenses	263,082	260,700
Annual surplus	**$ -**	**$ -**

Note 25 Trusts under Administration

(a) Health Benefit Trust of Alberta (HBTA)

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

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

	2023	2022
Financial assets	$ 125,630	$ 113,003
Liabilities	34,644	31,927
Net financial assets	90,986	81,076
Non-financial assets	5	4
Net assets	**$ 90,991**	**$ 81,080**

AHS has included in prepaid expenses $59,712 (2022 – $49,749) representing in substance a prepayment of future premiums to the HBTA. For the fiscal year ended March 31, 2023, AHS paid premiums of $552,232 (2022 – $494,645) which is approximately 98% (2022 – 98%) of the total premiums received by the HBTA.

Note 25 Trusts under Administration (continued)

(b) Other Trust Funds

AHS holds funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to appropriate the funds or to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2023, the balance of funds held in trust by AHS for research and development is $100 (2022 – $100).

AHS holds funds in trust from continuing care residents for personal expenses. As at March 31, 2023, the balance of these funds is $1,855 (2022 – $1,832). 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, 2023, there are $26,547 in plan assets (2022 – $29,429). These amounts are not included in the consolidated financial statements.

Note 26 Segment Disclosure

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

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

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

Segments include:

(a) Continuing care

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

(b) Community care

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

(c) Home care

Home care is comprised of home nursing and support.

(d) Acute care

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

(e) Emergency medical services

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

Note 26 Segment Disclosure (continued)

(f) Diagnostic and therapeutic services

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

(g) Population and public health

Population and public health is comprised primarily of health promotion, disease and injury prevention, and health protection. This segment also includes immunizations, traveler's health clinics, screening programs, and disease surveillance. This segment excludes activities associated with treatment of communicable diseases.

(h) Research and education

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

(i) Information technology

Information technology is comprised of costs pertaining to the provision of service and consultation in the design, development, implementation of technology services and systems.

(j) Support services

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

(k) Administration

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

Note 27 Impact of COVID-19 Pandemic

Included within the consolidated statement of operations are incremental expenses of $1,097,744 (2022 - $1,621,619) associated with AHS' pandemic response and recovery activities. AHS has recorded $1,096,062 (2022 - $1,606,515) of revenue to partially offset these expenses. In addition, AHS has recognized $2,681 (2022 - $71,003) of revenue related to lost fees and charges.

Note 28 Corresponding Amounts

Certain other corresponding amounts have been reclassified to conform to 2023 presentation. See Schedule 4 for a detailed disclosure of the reclassifications.

Note 29 Subsequent Events

In early May, wildfires seriously affected many communities across the province. In response, AHS has evacuated some of its impacted facilities. Preparation for re-entry in some of the communities is underway including restoring AHS health care facilities for service. AHS continues to closely monitor the wildfires. Overall, as the response is on-going, the related financial impacts of the wildfires cannot be reliably estimated at this time.

Note 30 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the Official Administrator on June 1, 2023 and submitted to the Minister for approval.

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

	2023		2022
	Budget (Note 3)	Actual	Actual (Restated – Schedule 4)
Salaries and benefits	$ 8,707,260	$ 9,139,165	$ 9,136,225
Contracts with health service providers	3,181,900	3,328,374	3,210,555
Contracts under the Health Facilities Act	22,500	28,587	27,695
Drugs and gases	680,600	679,210	651,495
Medical supplies	593,700	828,438	747,809
Other contracted services	1,415,508	1,533,975	1,476,530
Other[a]	1,397,000	1,612,387	1,640,772
Amortization and loss on disposals/write-downs of tangible capital assets (Note 19)	499,000	514,897	476,786
	$ 16,497,468	**$ 17,665,033**	**$ 17,367,867**
(a) Significant amounts included in Other are:			
Equipment expense	278,200	272,979	253,690
Housekeeping, laundry and linen, staff wearing apparel, plant maintenance and biomedical engineering supplies[i][ii]	$ 85,100	$ 222,813	$ 378,838
Utilities	164,300	209,283	163,234
Building and ground expenses	122,700	164,886	134,362
Building rent	136,000	128,547	133,268
Food and dietary supplies	82,400	86,604	75,929
Minor equipment purchases	70,000	75,540	75,498
Office supplies	67,000	68,685	67,017
Fundraising and grants awarded	52,000	56,600	50,573
Insurance and liability claims	48,000	35,860	31,383
Travel	37,500	35,486	30,011
Telecommunications	37,400	30,936	32,520
Licenses, fees and memberships	30,600	27,390	28,310
Education	12,000	11,802	9,389
Other	173,800	184,976	176,750
	$ 1,397,000	**$ 1,612,387**	**$ 1,640,772**

[i] Includes PPE, such as procedural masks, N95s, gowns, face shields and goggles, as well as other COVID-19 supplies such as hand sanitizers, disinfecting wipes and other cleaning supplies.

[ii] The easing of health restrictions has reduced the demand for masks and rapid test kits while the resolution of global shortages for personal protective equipment (PPEs) has reduced its costs. As a result, a valuation adjustment of $71,419 (2022 – $109,034) has been recorded to write down the cost of PPEs to its current replacement cost and to provide for inventories that no longer meet clinical standards and requirements (Note 7).

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

SCHEDULE 2A – OFFICIAL ADMINISTRATOR/OFFICIAL ADMINISTRATOR COMMITTEES REMUNERATION FOR THE YEAR ENDED MARCH 31, 2023

	Term	2023 Committees	2023 Remuneration	2022 Remuneration
Official Administrator				
Dr. John Cowell	Since Nov 17, 2022	OAAC, CSC	$ 267	$ -
Official Administrator Committee Participants[f]				
Tara Lockyer	Since Nov 24, 2022	OAAC, CSC	4	-
Gregory Turnbull	Since Nov 24, 2022	OAAC, CSC	4	-
Gord Winkel	Since Nov 24, 2022	OAAC, CSC	4	-
Total Official Administrator/Official Administrator Committee			**$ 279**	**$ -**

Dr. John Cowell was appointed to the position of Official Administrator effective November 17, 2022 per Ministerial Order 319/2022.

Official administrator committees were established by the Official Administrator to aid in governing AHS and overseeing the management of AHS' business and affairs. Official administrator committee participants are eligible to receive honoraria for meetings attended.

Committee legend: OAAC = Official Administrator Advisory Committee, CSC = CEO Selection Committee

SCHEDULE 2B – FORMER BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2023

	Term	2023 Committees	2023 Remuneration	2022 Remuneration
Former Board Chairs[g]				
Gregory Turnbull	Dec 8, 2021 to Nov 17, 2022	AOC, ARC, CEC, CSC, FC, GC, HRC, QSC	$ 43	$ 22
David Weyant	Aug 20, 2019 to Dec 7, 2021	-	-	45
Former Board Members				
Dr. Sayeh Zielke (Vice Chair)	Sep 28, 2020 to Nov 17, 2022	ARC, CEC, CSC, FC, HRC, QSC (Chair)	31	49
Deborah Apps	Jan 19, 2021 to Oct 7, 2022	CEC, CSC, FC, HRC, QSC	18	32
David Carpenter	Nov 27, 2015 to Jun 1, 2021	-	-	8
Tony Dagnone	Jan 19, 2021 to Nov 17, 2022	CSC, FC, HRC, QSC	21	32
Sherri Fountain	Jan 19, 2021 to Nov 17, 2022	AOC, CSC, FC, GC (Chair), HRC	23	35
Hartley Harris	Aug 9, 2021 to Nov 17, 2022	AOC, CSC, FC, GC, HRC	21	20
Tara Lockyer	Aug 17, 2022 to Nov 17, 2022	CEC, FC, HRC	7	-
Stephen Mandel	Sep 25, 2019 to Sep 27, 2021	-	-	18
Jack Mintz	Jun 3, 2021 to Nov 17, 2022	ARC (Chair), FC, GC	17	26
Heidi Overguard	Sep 25, 2019 to Nov 17, 2022	AOC, CEC, CSC, FC, GC, HRC (Chair), QSC	23	36
Natalia Reiman	Jan 19, 2021 to Nov 17, 2022	ARC, CEC, FC, GC	18	33
Brian Vaasjo	Aug 20, 2019 to Nov 17, 2022	AOC (Chair), ARC, CSC, FC (Chair), GC	19	35
Glenda Yeates	Nov 27, 2015 to Jun 1, 2021	-	-	6
Vicki Yellow Old Woman	Sep 28, 2020 to Nov 17, 2022	ARC, CEC (Chair), FC, GC, HRC	19	36
Former Board Committee Participants[h,i]				
Dr. William Ghali	Oct 1, 2021 to Nov 17, 2022	QSC	1	2
Irv Kipnes	Apr 9, 2021 to Dec 3, 2021	-	-	3
Stephen Livergant	Apr 9, 2021 to Sep 15, 2022	AOC	-	2
Dr. Brian Postl	Jan 1, 2018 to Jul 2, 2021	-	-	1
Gord Winkel	Nov 27, 2015 to Nov 17, 2022	QSC	1	3
Total Former Board			**$ 262**	**$ 444**

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

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

SCHEDULE 2C - EXECUTIVE REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2023

	2023						
For the Current Fiscal Year	FTE [a]	Base Salary [b,k]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board/Official Administrator Direct Reports							
President and Chief Executive Officer[k,z]	0.99	$ 490	$ 13	$ 143	$ 646	$ -	$ 646
President and Chief Executive Officer[l,aa]	0.01	4	-	4	8	660	668
Chief Audit Executive[m,z]	1.00	291	1	45	337	-	337
Official Administrator Advisor/ Provisional Lead, Emergency Medical Services[n,bb]	0.37	139	-	57	196	-	196
CEO Direct Reports							
VP and Chief Operating Officer, Clinical Operations[z]	1.00	389	-	51	440	-	440
VP and Medical Director, Clinical Operations[z]	0.90	415	22	110	547	-	547
VP, Quality and Chief Medical Officer[o,z]	1.00	477	-	59	536	-	536
VP, People, Health Professions and Information Technology[p,z]	1.00	365	1	81	447	-	447
Interim VP, Cancer Care Alberta and Clinical Support Services[q,z]	0.98	255	3	63	321	-	321
VP, Cancer Care Alberta and Clinical Support Services[k,z]	0.01	4	-	1	5	-	5
Interim VP, Provincial Clinical Excellence[r,cc]	0.83	454	6	34	494	-	494
VP, Provincial Clinical Excellence[s]	0.08	24	5	5	34	-	34
VP and Medical Director, Cancer Care Alberta, Clinical Support Services and Provincial Clinical Excellence[t,u,dd]	0.62	288	20	29	337	-	337
Chief Program Officer, Addictions and Mental Health and Correctional Health Services[v,z]	0.79	242	-	57	299	-	299
VP, Community Engagement and Communications[z]	1.00	356	-	88	444	-	444
VP, Corporate Services and Chief Financial Officer[z]	1.00	412	3	78	493	-	493
General Counsel[w,z]	1.00	257	3	41	301	-	301
Total Executive	**12.58**	**$ 4,862**	**$ 77**	**$ 946**	**$ 5,885**	**$ 660**	**$ 6,545**
Management Reporting to CEO Direct Reports	**56.91**	**$ 13,828**	**$ 459**	**$ 1,608**	**$ 15,895**	**$ 457**	**$ 16,352**

SCHEDULE 2C - EXECUTIVE REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2023 (CONTINUED)

	2022						
For the Prior Fiscal Year	FTE [a]	Base Salary [b,k]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board Direct Reports							
President and Chief Executive Officer	1.00	$ 574	$ -	$ 117	$ 691	$ -	$ 691
Chief Audit Executive	1.00	277	1	34	312	-	312
CEO Direct Reports							
VP and Chief Operating Officer, Clinical Operations	1.00	370	-	72	442	-	442
VP and Medical Director, Clinical Operations[x]	0.51	229	11	58	298	-	298
VP and Medical Director, Clinical Operations[y]	0.37	147	-	18	165	-	165
VP, Quality and Chief Medical Officer	1.00	464	-	48	512	-	512
VP, People, Health Professions and Information Technology	1.00	330	1	40	371	-	371
VP, Cancer Care Alberta and Clinical Support Services	1.00	330	-	66	396	-	396
VP, Provincial Clinical Excellence	1.00	289	13	48	350	-	350
VP and Medical Director, Cancer Care Alberta, Clinical Support Services and Provincial Clinical Excellence	1.00	450	32	46	528	-	528
VP, Community Engagement and Communications	1.00	330	-	79	409	-	409
VP, Corporate Services and Chief Financial Officer	1.00	400	1	88	489	-	489
General Counsel	1.00	255	4	65	324	-	324
Total Executive	**11.88**	**$ 4,445**	**$ 63**	**$ 779**	**$ 5,287**	**$ -**	**$ 5,287**
Management Reporting to CEO Direct Reports	**54.24**	**$ 13,023**	**$ 520**	**$ 2,011**	**$ 15,554**	**$ 221**	**$ 15,775**

SCHEDULE 2D - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

Certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service. The Supplemental Pension Plan (SPP) is a defined contribution plan and the Supplemental Executive Retirement Plan (SERP) is a defined benefit plan. The amounts in this table represent the total SPP and SERP benefits earned by the individual during the fiscal year. The current period benefit costs for SPP and the other costs for SERP included in other non-cash benefits disclosed in Schedule 2C 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/Official Administrator or President and Chief Executive Officer during the current fiscal year are disclosed.

	2023			2022			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2022	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2023
President and Chief Executive Officer/ VP, Cancer Care Alberta and Clinical Support Services	$ 36	$ -	$ 36	$ 17	$ 197	$ 20	$ 217
President and Chief Executive Officer	-	-	-	47	336	(336)	-
Chief Audit Executive	12	-	12	11	164	(5)	159
Official Administrator Advisor/ Provisional Lead, Emergency Medical Services[cc]	-	-	-	-	-	-	-
VP and Chief Operating Officer, Clinical Operations							
SERP	-	(42)	(42)	(20)	671	(111)	560
SPP	23	-	23	22	290	17	307
VP and Medical Director, Clinical Operations	29	-	29	25	134	18	152
VP, Quality and Chief Medical Officer	34	-	34	34	458	11	469
VP, People, Health Professions and Information Technology	21	-	21	17	266	(1)	265
Interim VP, Cancer Care Alberta and Clinical Support Services	8	-	8	2	44	4	48
Interim VP, Provincial Clinical Excellence[cc]	-	-	-	-	-	-	-
VP, Provincial Clinical Excellence	-	-	-	-	-	-	-
VP and Medical Director, Cancer Care Alberta, Clinical Support Services and Provincial Clinical Excellence[dd]	-	-	-	-	-	-	-
Chief Program Officer, Addictions and Mental Health and Correctional Health Services	13	-	13	13	221	(10)	211
VP, Community Engagement and Communications	20	-	20	17	215	5	220
VP, Corporate Services and Chief Financial Officer	26	-	26	26	46	28	74
General Counsel	8	-	8	8	94	(3)	91

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

FOOTNOTES TO THE SCHEDULES OF REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2023

Definitions

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

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

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

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

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

Official Administrator, Former Board and their respective committees

f. These individuals are participants of the Official Administrator committees, but are not AHS employees.

g. The former Board Chairs were Ex-Officio member on all former Board committees.

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

i. Participation by these individuals on former Board committees ceased on November 17, 2022.

Executive

j. Base salary reported for executives are the actual payments earned during the year, and is therefore contingent on the number of AHS' work days in the year. For the year ended March 31, 2023, the number of work days at AHS was 261 (2022 – 261 work days).

k. The incumbent held the position of Vice President, Cancer Care Alberta and Clinical Support Services until April 4, 2022 at which time the incumbent was appointed to Interim President and Chief Executive Officer. The incumbent held the position of Interim President and Chief Executive Officer until March 20, 2023 at which time the incumbent was appointed to President and Chief Executive Officer. In addition, the incumbent received a vacation payout of $29 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 was engaged in an employment agreement with AHS while on leave of absence from the University of Alberta. The incumbent held the position until April 4, 2022, at which time the incumbent left AHS. The incumbent received salary and other accrued entitlements to the date of departure, followed by a lump sum severance of $660. In addition, the incumbent received a vacation payout of $147 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

m. The incumbent received vacation payouts totaling $27 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

n. The incumbent was appointed to an advisory role to the Official Administrator effective November 17, 2022. Effective January 30, 2023, the incumbent took on the additional role and duties of Provisional Lead, Emergency Medical Services. The incumbent is on temporary secondment from the Government of Alberta, and AHS reimburses the Government of Alberta for the incumbent's base salary and benefits.

o. The incumbent received a vacation payout of $37 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.

p. The incumbent received vacation payouts totaling $21 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.

q. The incumbent held the position of Senior Operating Officer, Pharmacy Services until April 7, 2022 at which time the incumbent was appointed to Interim Vice President, Cancer Care Alberta and Clinical Support Services and became a direct report to the President and Chief Executive Officer.

FOOTNOTES TO THE SCHEDULES OF REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2023 (CONTINUED)

r. The incumbent held the position of Associate Chief Medical Officer, Strategic Clinical Networks until June 2, 2022 at which time the incumbent was appointed to Interim Vice President, Provincial Clinical Excellence and became a direct report to the President and Chief Executive Officer. The incumbent is a participant in the Alberta Academic Medicine and Health Services Program (South Sector), and their remuneration is as per the terms of that agreement. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary, and AHS reimburses the University for the incumbent's base salary and benefits.

s. The incumbent was on secondment from the University of Alberta until April 30, 2022, at which time the secondment agreement ended. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Alberta, and AHS reimbursed 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.

t. The incumbent was appointed to the position of Interim Chief Medical Officer of Health for the Government of Alberta on a temporary basis effective November 14, 2022. During this temporary appointment, the incumbent is on leave from all duties at AHS and ceases to be a direct report to the President and Chief Executive Officer at AHS. During this tenure, the Government of Alberta will reimburse AHS for the incumbent's remuneration.

u. 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.

v. The incumbent held the position of Senior Program Officer, Enhancing Care in the Community until June 20, 2022 at which time the incumbent was appointed to Chief Program Officer, Addictions and Mental Health and Correctional Health Services and became a direct report to the President and Chief Operating Officer.

w. The incumbent received vacation payouts totaling $35 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

x. The incumbent held the position of Zone Medical Director, Calgary Zone until September 7, 2021 at which time the incumbent was appointed to Vice President and Medical Director, Clinical Operations and became a direct report to the President and Chief Executive Officer.

y. The incumbent held the position until August 13, 2021 at which time the incumbent left AHS.

Termination Obligations

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

aa. Based on the provision of the applicable SPP, the following outlines the benefits received by the incumbent who terminated employment with AHS within the 2022-23 fiscal period. As a result of this termination, the incumbent is entitled to the benefits accrued to them up to the date of termination. For participants of SPP, the benefit includes the account balances as at March 31, 2022 and the current period benefit costs and investment gains or losses related to the account that were incurred during the current year.

Supplemental Plan	Supplemental Plan Commencement Date	Benefit (not in thousands)	Frequency	Payment Terms
SPP	June 3, 2016	$336,756	Once	June 2022

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

cc. There is no severance associated with the Alberta Academic Medicine and Health Services Program (South Sector).

dd. 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

	2023								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Facilities Act	Drugs and gases	Medical supplies	Other contracted services	Other	Amortization and loss on disposals/ write-downs of tangible capital assets	Total
Continuing care	$ 328,893	$ 975,288	$ -	$ 7,711	$ 9,567	$ 35,968	$ 21,563	$ 2,504	$ 1,381,494
Community care	835,405	925,158	-	15,238	5,156	47,831	59,167	449	1,888,404
Home care	350,859	275,690	-	198	11,290	81,146	20,920	49	740,152
Acute care	3,169,349	427,606	28,587	617,230	427,485	657,759	197,273	69,661	5,594,950
Emergency medical services	325,073	207,542	-	2,855	5,570	3,032	42,150	13,254	599,476
Diagnostic and therapeutic services	1,617,433	288,896	-	24,932	229,445	325,160	105,588	54,248	2,645,702
Population and public health	393,365	21,732	-	6,898	90,858	17,126	58,913	324	589,216
Research and education	190,860	3,182	-	91	1,097	121,689	24,812	66	341,797
Information technology	350,583	1,644	-	-	(31)	43,605	214,845	138,439	749,085
Support services	1,208,134	166,678	-	4,037	47,215	156,836	828,509	228,022	2,639,431
Administration	369,211	34,958	-	20	786	43,823	38,647	7,881	495,326
Total	$ 9,139,165	$ 3,328,374	$ 28,587	$ 679,210	$ 828,438	$ 1,533,975	$ 1,612,387	$ 514,897	$ 17,665,033

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

	2022								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Facilities Act	Drugs and gases	Medical supplies	Other contracted services	Other	Amortization and loss on disposals/ write-downs of tangible capital assets[a]	Total (Restated)
Continuing care	$ 331,304	$ 957,042	$ -	$ 7,482	$ 8,808	$ 21,345	$ 28,545	$ 2,600	$ 1,357,126
Community care	790,868	861,783	-	14,310	4,643	62,097	69,490	705	1,803,896
Home care	345,575	241,528	-	192	11,306	89,492	21,538	84	709,715
Acute care	3,106,056	434,549	27,695	593,905	374,673	562,321	181,195	63,541	5,343,935
Emergency medical services	322,248	169,603	-	2,600	5,469	2,505	39,074	16,221	557,720
Diagnostic and therapeutic services	1,638,491	322,681	-	26,366	256,530	338,966	119,709	54,850	2,757,593
Population and public health	587,502	25,323	-	5,068	73,958	65,299	119,027	280	876,457
Research and education	186,288	3,021	-	79	1,182	123,751	36,662	123	351,106
Information technology	315,783	18,244	-	-	37	32,215	187,367	120,568	674,214
Support services[a]	1,152,500	162,770	-	1,480	10,816	145,495	800,712	215,400	2,489,173
Administration	359,610	14,011	-	13	387	33,044	37,453	2,414	446,932
Total	$ 9,136,225	$ 3,210,555	$ 27,695	$ 651,495	$ 747,809	$ 1,476,530	$ 1,640,772	$ 476,786	$ 17,367,867

(a) Support services and Amortization and loss on disposals / write-downs of tangible capital assets are restated for the year ended March 31, 2022 to reflect the adoption of PS 3280 – Asset Retirement Obligations as discussed in Note 2(m).

SCHEDULE 4 – CONSOLIDATED SCHEDULE OF ADJUSTMENTS

Reconciliation of the Prior Year Comparative for the Consolidated Statement of Operations
FOR THE YEAR ENDED MARCH 31, 2022

	2022 as Previously Presented	Changes in Accounting Policy (Note 2(m))	Ministry of Mental Health and Addiction Reclassification[a]	Other Reclassifications[b]	2022 Restated
Revenues:					
Alberta Health transfers					
Base operating	$ 13,097,557	$ -	$ -	$ -	$ 13,097,557
One-time base operating	71,003	-	-	-	71,003
Other operating	2,859,669	-	(79,816)	-	2,779,853
Recognition of expended deferred capital revenue	95,777	-	(141)	-	95,636
Other government transfers	382,887	-	79,957	-	462,844
Fees and charges	478,313	-	-	-	478,313
Ancillary operations	91,369	-	-	-	91,369
Donations, fundraising, and non-government contributions	185,893	-	-	-	185,893
Investment and other income	236,292	-	-	-	236,292
TOTAL REVENUES	**17,498,760**	**-**	**-**	**-**	**17,498,760**
Expenses:					
Continuing care	1,357,126	-	-	-	1,357,126
Community care	1,731,760	-	-	72,136	1,803,896
Home care	709,715	-	-	-	709,715
Acute care	5,423,320	-	-	(79,385)	5,343,935
Emergency medical services	557,720	-	-	-	557,720
Diagnostic and therapeutic services	2,757,593	-	-	-	2,757,593
Population and public health	876,457	-	-	-	876,457
Research and education	351,106	-	-	-	351,106
Information technology	677,737	-	-	(3,523)	674,214
Support services	2,447,719	11,602	-	29,852	2,489,173
Administration	466,012	-	-	(19,080)	446,932
TOTAL EXPENSES	**17,356,265**	**11,602**	**-**	**-**	**17,367,867**
ANNUAL OPERATING SURPLUS	**142,495**	**(11,602)**	**-**	**-**	**130,893**
Accumulated surplus, beginning of year	1,236,273	(330,009)	-	-	906,264
Accumulated surplus, end of year	**$ 1,378,768**	**$ (341,611)**	**$ -**	**$ -**	**$ 1,037,157**

(a) On November 14, 2022, the Premier of Alberta announced the new Ministry of Mental Health and Addiction. A reclassification has been made to the consolidated statement of operations for the year ended March 31, 2022 to reclassify the related mental health & addiction amount from Alberta Health transfers to other government transfers to conform with 2023 presentation.

(b) Shows the effect of all Management Information Systems (MIS) related reclassification adjustments to align with Canadian Institute for Health Information MIS standards.

SCHEDULE 4 – CONSOLIDATED SCHEDULE OF ADJUSTMENTS CONTINUED

Reconciliation of the Prior Year Comparative for the Consolidated Schedule of Expenses by Object
FOR THE YEAR ENDED MARCH 31, 2022

	2022 as Previously Presented	Changes in Accounting Policy (Note 2(m))	2022 Restated
Salaries and benefits	$ 9,136,225	$ -	$ 9,136,225
Contracts with health service providers	3,210,555	-	3,210,555
Contracts under the Health Facilities Act	27,695	-	27,695
Drugs and gases	651,495	-	651,495
Medical supplies	747,809	-	747,809
Other contracted services	1,476,530	-	1,476,530
Other[(a)]	1,640,772	-	1,640,772
Amortization and loss on disposals/write-downs of tangible capital assets	465,184	11,602	476,786
	$ 17,356,265	**$ 11,602**	**$ 17,367,867**
(a) Significant amounts included in Other are:			
Housekeeping, laundry and linen, staff wearing apparel, plant maintenance and biomedical engineering supplies	$ 378,838	$ -	$ 378,838
Equipment expense	253,690	-	253,690
Utilities	163,234	-	163,234
Building and ground expenses	134,362	-	134,362
Building rent	133,268	-	133,268
Food and dietary supplies	75,929	-	75,929
Minor equipment purchases	75,498	-	75,498
Office supplies	67,017	-	67,017
Fundraising and grants awarded	50,573	-	50,573
Telecommunications	32,520	-	32,520
Insurance and liability claims	31,383	-	31,383
Travel	30,011	-	30,011
Licenses, fees and memberships	28,310	-	28,310
Education	9,389	-	9,389
Other	176,750	-	176,750
	$ 1,640,772	**$ -**	**$ 1,640,772**

SCHEDULE 4 – CONSOLIDATED SCHEDULE OF ADJUSTMENTS CONTINUED

Reconciliation of the Prior Year Comparative for the Consolidated Statement of Financial Position AS AT MARCH 31			
	2022 as Previously Presented	Changes in Accounting Policy (Note 2(m))	2022 Restated
Financial Assets:			
Cash and cash equivalents	$ 200,691	$ -	$ 200,691
Portfolio investments	2,603,605	-	2,603,605
Accounts receivable	594,429	-	594,429
	3,398,725	-	3,398,725
Liabilities:			
Accounts payable and accrued liabilities	1,951,855	-	1,951,855
Employee future benefits	777,878	-	777,878
Unexpended deferred operating revenue	529,707	-	529,707
Unexpended deferred capital revenue	149,516	-	149,516
Debt	454,993	-	454,993
Asset retirement obligations	-	544,416	544,416
	3,863,949	544,416	4,408,365
NET DEBT	**(465,224)**	**(544,416)**	**(1,009,640)**
Non-Financial Assets:			
Tangible capital assets [(a)]	9,795,230	202,805	9,998,035
Inventories of supplies	513,019	-	513,019
Prepaid expenses, deposits, and other non-financial assets	176,570	-	176,570
	10,484,819	202,805	10,687,624
NET ASSETS BEFORE EXPENDED DEFERRED REVENUE	10,019,595	(341,611)	9,677,984
Expended deferred revenue	8,615,941	-	8,615,941
NET ASSETS	**1,403,654**	**(341,611)**	**1,062,043**
Net Assets is comprised of:			
Accumulated surplus	1,378,768	(341,611)	1,037,157
Accumulated remeasurement gains	24,886		24,886
	$ 1,403,654	**$ (341,611)**	**$ 1,062,043**

(a) Breakdown of Tangible Capital Assets:

	Net Book Value		
	2022 as Previously Presented	Changes in Accounting Policy (Note 2(m))	2022 Restated
Facilities and improvements	$ 6,061,640	$ 201,676	$ 6,263,316
Work in progress	1,934,048	-	1,934,048
Equipment	632,734	-	632,734
Information systems	550,688	-	550,688
Building service equipment	403,306	1,129	404,435
Land[(b)]	117,804	-	117,804
Leased facilities and improvements	57,378	-	57,378
Land improvements	37,632	-	37,632
	$ 9,795,230	**$ 202,805**	**$ 9,998,035**

SCHEDULE 4 – CONSOLIDATED SCHEDULE OF ADJUSTMENTS CONTINUED

Reconciliation of the Prior Year Comparative for the Consolidated Statement of Change in Net Debt YEAR ENDED MARCH 31	2022 as Previously Presented	Changes in Accounting Policy (Note 2(m))	2022 Restated
Annual operating surplus	$ 142,495	$ (11,602)	$ 130,893
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets:			
Purchased	(463,646)	-	(463,646)
Leased	(15,646)	-	(15,646)
Constructed by Alberta Infrastructure on behalf of AHS	(425,337)	-	(425,337)
Contributed	(522)	-	(522)
Capitalized asset retirement costs	-	(9,811)	(9,811)
Amortization and loss on disposals/write-downs of tangible capital assets	465,184	11,602	476,786
Effect of other changes:			
Net increase in expended deferred capital revenue	452,077	-	452,077
Net (decrease) increase in expended deferred operating revenue	(90,473)	-	(90,473)
Net (increase) decrease in inventories of supplies	50,909	-	50,909
Net (increase) decrease in prepaid expenses, deposits and other non-financial assets	32,796	-	32,796
Net remeasurement gains (losses) for the year	(30,891)	-	(30,891)
(Increase) decrease in net debt for the year	**116,946**	**(9,811)**	**107,135**
Net debt, beginning of year	(582,170)	(534,605)	(1,116,775)
Net debt, end of year	**$ (465,224)**	**$ (544,416)**	**$ (1,009,640)**

SCHEDULE 4 – CONSOLIDATED SCHEDULE OF ADJUSTMENTS CONTINUED

Reconciliation of the Prior Year Comparative for the Consolidated Statement of Cash Flows YEAR ENDED MARCH 31	2022 as Previously Presented	Changes in Accounting Policy (Note 2(m))	2022 Restated
Operating transactions:			
Annual operating surplus	$ 142,495	$ (11,602)	$ 130,893
Non-cash items:			
Amortization and loss on disposals/write-downs of tangible capital assets	465,184	11,602	476,786
Revenue recognized for acquisition of land	(987)	-	(987)
Recognition of expended deferred capital revenue	(298,774)	-	(298,774)
Recognition of expended deferred operating revenue	(453,686)	-	(453,686)
Gain on disposal of portfolio investments	(36,100)	-	(36,100)
Change in employee future benefits	17,092	-	17,092
Decrease (increase) in:			
Accounts receivable related to operating transactions	70,986	-	70,986
Inventories of supplies	50,909	-	50,909
Prepaid expenses, deposits, and other non-financial assets	32,796	-	32,796
Increase (decrease) in:			
Accounts payable and accrued liabilities	35,567	-	35,567
Unexpended deferred operating revenue	(111,762)	-	(111,762)
Asset retirement obligations	-	-	-
Cash applied to operating transactions	(86,280)	-	(86,280)
Capital transactions:			
Purchased tangible capital assets	(463,646)		(463,646)
Cash applied to capital transactions	(463,646)		(463,646)
Investing transactions:			
Purchase of portfolio investments	(3,806,735)	-	(3,806,735)
Proceeds on disposals of portfolio investments	3,439,408	-	3,439,408
Cash applied to investing transactions	(367,327)	-	(367,327)
Financing transactions:			
Restricted operating contributions received	363,213	-	363,213
Restricted capital contributions received	310,803	-	310,803
Unexpended deferred capital revenue returned	(419)	-	(419)
Proceeds from debt	26,000	-	26,000
Principal payments on debt	(26,666)	-	(26,666)
Payments on obligations under capital leases	(30,642)	-	(30,642)
Net repayment of life lease deposits	(1,493)	-	(1,493)
Cash provided by financing transactions	640,796	-	640,796
Decrease in cash and cash equivalents	**(276,457)**	**-**	**(276,457)**
Cash and cash equivalents, beginning of year	477,148	-	477,148
Cash and cash equivalents, end of year	**$ 200,691**	**$ -**	**$ 200,691**

Compensation Analysis and Discussion

Non-Union Exempt Employees

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

Total Compensation Philosophy

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

Total Compensation Strategy

AHS ensures the process used to set total compensation, establish and maintain good governance, and incorporate best practices is transparent. AHS Non-Union Exempt Employees are currently subject to an interim approach that applies to all government agencies, boards, and commissions until March 31, 2024. The job rates for executive, senior leadership, and other non-union exempt salary ranges are intended to be representative of the median of the national healthcare and Alberta public sector markets. To ensure total compensation remains market competitive, AHS monitors its market positioning on a regular basis. Due to the salary freeze, AHS has not adjusted its pay bands since the 2013-14 fiscal year. Adjustments to the pay bands will be implemented in 2023-24. AHS' total compensation programs and practices encourage behaviours that will promote a patient-focused, quality system that is sustainable and accessible for all Albertans.

Total Compensation Plan Structure

AHS is committed to providing a comprehensive total compensation package including salary, benefits, pension, and other programs and services to attract, retain and engage talented and committed employees. AHS' total compensation is comprised of direct, indirect and nonfinancial compensation. Elements within direct and indirect compensation fit the overall total compensation strategy by driving accountability and performance, demonstrating sound fiscal management, and promoting a sense of integrity and equity. Non-financial compensation includes employee appreciation initiatives that support the health and well-being of employees.

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

Indirect Compensation includes benefits (life insurance, long-term disability, dental, and various health and wellness options) and terms and conditions.

All AHS employees are eligible to participate in the Local Authorities Pension Plan (LAPP). LAPP is a defined benefit plan where enrollment is mandatory for anyone working in a regular position of 30 hours or more per week. Benefits under this plan are capped at the maximum

pension benefit limit allowed under the federal *Income Tax Act*, a salary of $190,470 in 2022. All employees over the salary cap are eligible for a Supplemental Pension Plan (SPP) benefit. Unlike the LAPP, the SPP is a defined contribution plan that provides annual notional contributions that are allocated to, and invested as directed, by each member. The SPP helps AHS to compete in its market at lower cost and minimizes risk to the organization. AHS does not provide car allowances or perquisite allowances to its executives or employees.

Total Compensation Governance

The Official Administrator monitors, oversees and advises on total compensation matters related to AHS including:

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

Total Compensation Reporting

The *Schedule 2 – Consolidated Schedule of Remuneration and Benefits* in the annual audited consolidated financial statements for the year ended March 31, 2023, provides complete disclosure of salary, benefits and all other compensation earned by the direct reports to the Official Administrator and the direct reports to the President & CEO for years ended March 31, 2022, and March 31, 2023. The Official Administrator's compensation is also disclosed in *Schedule 2 – Consolidated Schedule of Remuneration and Benefits* in the annual audited consolidated financial statements for the year ended March 31, 2023. The *Schedule 2* information on total compensation philosophy and practices can be found on the AHS website.

Total Compensation 2022-23 Information Updates

The *Public Service Compensation Transparency Act* requires compensation disclosure from Alberta agencies, boards, and commissions, including AHS. As required, AHS disclosed the names and compensation of employees whose annual earnings were over $136,805 in the 2021 calendar year on AHS' external website and the Alberta Government compensation disclosure database by June 30, 2022. AHS will continue this process by disclosing the names and compensation of employees whose earnings are over $141,183 for the 2022 calendar year.

Effective July 1, 2022, the Government of Alberta introduced an interim approach to non-union compensation for public agencies covered by *Alberta Public Agencies Governance Act* (APAGA). This approach permits salary adjustments within specified parameters to maintain fiscal prudence while enabling public agencies to make adjustments necessary for the management of the workforce. In March 2023, the Government of Alberta extended the interim approach without interruption and with the same key provisions to March 31, 2024. The interim approach replaced the Salary Restraint Regulation, which was in effect from April 1, 2018, to June 30, 2022.

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

Appendix

Patient Concerns

Patients and families are at the heart of everything we do. AHS has a robust Patient Concerns Resolution Process (PCRP) to review and respond to feedback, commendations and concerns from patients and families.

When a concern is received, a Patient Concerns Consultant gathers information and works with Program Leadership and Senior Leadership to resolve the concern. If the complainant is not satisfied with the response received, the concern will be escalated to higher levels of AHS leadership. If the complainant remains unsatisfied following internal escalation, the concern will be forwarded to the Patient Concerns Officer (PCO) who will determine if the PCRP has been followed and whether other options exist to resolve the concern. If the complainant believes the decision of the PCO to be unfair, they have the right to contact the Alberta Ombudsman to request an external review regarding administrative fairness. For more information, visit us online at www.ahs.ca/about/patientfeedback.aspx.

All reported concerns and commendations are tracked and monitored to identify areas for broader improvement. The table below summarizes the volume and type of feedback received, and the concerns that required escalation to the PCO.

Concerns and Commendations	2019-20	2020-21	2021-22	2022-23
Total Number of Commendations	1,526	1,495	2,142	2,138
Total Number of Concerns	10,773	11,602	12,728	12,689
Total Number of Concerns reviewed by PCO	20	18	19	14
Percent of Actions Arising from Concerns Resolved in 30 Days or Less	72%	76%	74%	71%

Notes:

- Data includes Covenant Health.

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

Public Interest Disclosure Act (PIDA)

Whistleblower Protection

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

PIDA's purpose is to:

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

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

Consistent with direction from the Alberta Public Interest Commissioner, reports to the Designated Officer of non-compliance with orders issued by the Chief Medical Officer of Health to support Alberta's response to the COVID-19 public health emergency were not considered as disclosures under PIDA.

In compliance with legislated reporting requirements, from April 1, 2022, to March 31, 2023, AHS reports that four disclosures were received by or referred to AHS' Designated Officer:

- Four disclosures were acted on by the Designated Officer.
- No disclosures were not acted on by the Designated Officer.
- Two investigations were commenced by the Designated Officer. For the two investigations commenced, one was concluded as of March 31, 2023, and one remained ongoing as of that date.
- Not applicable - for any investigation that results in a finding of wrongdoing, a description of wrongdoing, recommendations made or corrective measures taken, and if no corrective action has been taken, the reasons for that.

AHS counts the reporting or referral of a matter to the Designated Officer as a disclosure under PIDA if the allegation(s), if founded, would constitute wrongdoing by AHS or by a member of the AHS workforce, where wrongdoing is defined in PIDA and the AHS *Whistleblower Policy*.

Common reasons for not commencing an investigation under PIDA and the AHS *Whistleblower Policy* are:

- The subject matter of the concern does not have a public interest component and/or is based solely on a perceived wrong perpetrated against the person reporting the concern.
- After collecting and reviewing records and meeting with officials who have knowledge of the matter, a determination is made that the allegation, if founded, will not meet the definition of "wrongdoing" under PIDA and the AHS *Whistleblower Policy*.
- The allegation pertains to an individual who is not a member of the AHS workforce or other circumstances outside the authority of AHS to investigate.
- The allegation is anonymous without contact information and the disclosure does not contain sufficient particulars to form the basis of an investigation.

Common actions taken by the Designated Officer to manage a disclosure that is not subject to an investigation include:

- Referring the matter to another AHS department for action.
- Referring the matter to an external agency for action.
- Providing the reporting person with contact information for a more appropriate organization to receive their concern.

Chartered Surgical Facility Contracts under the *Health Facilities Act* (Alberta)

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

Maintaining quality of services in CSFs will require deliberate, targeted and significant effort. AHS works with Alberta Health and the College of Physicians and Surgeons of Alberta to coordinate activities addressing CSF accreditation, patient safety, quality, and compliance with the *Health Facilities Act* and regulations.

The table below summarizes chartered surgical facility contracts by service area for 2022-23.

Contracted Service Area	# of Contracted Operators Covered Under HFA	# of HFA Contracted Procedures Performed
Dermatology – Edmonton Zone	1	0
General Surgery – Edmonton Zone	1	38
Ophthalmology – Calgary Zone*	2	19,536
Ophthalmology – Edmonton Zone*	3	6,422
Oral and Maxillofacial (OMF) – Calgary Zone	8	1,786
Oral and Maxillofacial (OMF) – Edmonton Zone	10	5,055
Orthopedic – Calgary Zone	1	411
Orthopedic – Edmonton Zone	3	608
Otolaryngology (ENT) – Calgary Zone	1	598
Otolaryngology (ENT) – Edmonton Zone	2	441
Plastic Surgery – Edmonton Zone	3	1,121
Plastic Surgery – South Zone	2	14
Pregnancy Termination – Calgary Zone	1	5,426
Pregnancy Termination – Edmonton Zone	1	5,911

Note: There are no surgical contracts with CSFs in the Central and North Zones that fall under the Health Facilities Act (HFA).

Note: The # of Contracted Procedures Performed may be amended as final submissions and AHS audit occurs for the CSF sites. Audit continues through to June 30, 2023.

** There is an Ophthalmology operator that has one contract but operates in both Edmonton and Calgary Zones. Therefore, it is counted once in each Zone.*

Glossary

A

Academy of Quality Improvement Sciences (AquIS) – A series of quality and patient safety learning modules that are available to all AHS employees and contracted providers.

Access AMH – A telephone information line that provides a single point of access for non-urgent addiction and mental health information and services in South, Central and North Zones.

Addiction Recovery and Community Health (ARCH) – A program that delivers specialty consult services to emergency department patients and hospital inpatients to improve health outcomes and healthcare access for patients with substance use disorders.

Accelerating Innovation into Care (AICE) – Part of Alberta Innovates, this program serves to accelerate early-stage health research and innovation that demonstrates high commercial potential in priority areas.

Alberta Atlas of Variation – A document that aims to highlight geographical variation in the delivery of health services and associated health outcomes.

Alberta Surgical Initiative (ASI) – A plan that strives to ensure that all Albertans will receive their required surgeries within clinically appropriate timelines. More information can be found online: www.ahs.ca/aop/Page13999.aspx.

AMH Wrap-Around Supports – Integrated Addiction and Mental Health services that support clients living in permanent supportive housing units.

Anesthesia Care Team (ACT) model – A model in which one Anesthesiologist provides supervision for a qualified Respiratory Therapist II providing anesthesia care in two or more operating room (OR) theatres when appropriate.

C

Chartered Surgical Facilities (CSFs) – Surgical facilities contracted with AHS that provide insured surgical services for dermatology, ophthalmology, oral maxillofacial, otolaryngology, plastic surgery, pregnancy terminations and podiatry. More information can be found online: www.ahs.ca/about/Page3172.aspx.

Community Treatment Order (CTO) – A tool intended to assist patients in maintaining compliance with treatment while in the community, thereby breaking the cycle of involuntary hospitalization, decompensation and re-hospitalization. There are criteria set out in the Mental Health Act that describe the conditions under which a CTO can be written.

Connect Care – Connect Care provides a single AHS health record for care provided by AHS and AHS-affiliated healthcare providers. It provides access to personal health information which improves communication with care teams, standardizes care and improves health outcomes. More information can be found online: www.ahs.ca/cis/cis.aspx.

Continuing Care – Refers to various levels of healthcare services to support the health and well-being of individuals. Continuing Care is comprised of community palliative and end of life, long-term care (auxiliary hospital and nursing home), designated supportive living, and home care.

Core community outpatient AMH services – Refers to general treatment often provided by multi-disciplinary teams of trained addiction and mental health professionals, with no focus on specific problems or disorders.

D

DTaP-IPV-Hib – A combination vaccine that protects against diphtheria, tetanus, pertussis (whooping cough), polio, and Haemophilus influenzae type B.

E

Employee and Family Assistance Program (EFAP) – A confidential service available 24/7 to AHS staff and their immediate family members, offering counselling, lifestyle and specialty coaching, online learning and more.

Enhanced Recovery After Surgery (ERAS) – A provincial initiative, based on international best practices and evidence, that standardizes care before, during and after surgery to help patients stay strong, improve outcomes, reduce complications and create a better patient experience.

F

Facilitated Access to Specialized Treatment (FAST) model – A new central access and intake program for managing referrals in orthopedic surgery and urology. Other specialties will be added over time. More information can be found online: www.ahs.ca/aop/Page14050.aspx.

H

Health human resources (HHR) – Also referred to as the 'health workforce', it is the human capital needed to design healthcare systems and to implement health service delivery models that are cost effective.

Health Link 811 – A telephone line for health advice and information. More information can be found online: www.ahs.ca/info/Page12630.aspx.

Health Quality Council of Alberta (HQCA) – One of three entities within the Ministry of Health that brings together patients, families and partners from across healthcare and academia to inspire improvement in patient safety, person-centred care and health service quality.

HealthIM – A software support for first responders during emergency mental health crisis calls. The app is designed to promote safety for both the responder and the person in crisis, improve outcomes for individuals suffering from unmanaged mental health challenges and promote effective oversight.

Homewood Pathfinder – The new digital platform by Homewood Health, AHS' employee and family assistance program provider (EFAP).

I

Independent surgical recovery lead – A role established by Alberta Health to oversee, track and provide dedicated focus and rigour to surgical recovery. The lead keeps government and AHS on task and accountable to ensure people get better surgical care faster, based on recommended wait times.

Integrated Home Living – A service type established by AHS to provide health and personal care services to residents of private supportive living units through integrated contracts with health service providers. In many cases, other contracted designated supportive living services are co-located in the building. Residents of non-designated units are eligible to receive publicly funded home care services, based on unmet assessed needs.

Integrated Workforce Action Plan – Part of the AHS Health Workforce Strategy, the workforce action plan helps determine current and future staffing needs, and the strategies to address them.

L

Low Barrier, Urgent Access – Part of the Virtual Opioid Dependency Program, this team facilitates rapid assessment and treatment initiation in police detention units, supervised consumption services sites and shelters.

M

MMR – A vaccine against measles, mumps and rubella.

My Recovery Plan (MRP) – An evidence-based platform that provides a predetermined, measurable recovery plan paired with an accurate assessment. The application supports a recovery-oriented approach to addiction and aims to deliver measurably improved outcomes through the use of technology.

MyAHS Connect – A service offered through Alberta Health's MyHealth Records that allows users to manage appointments, access test results and communicate directly with AHS care teams.

N

National Surgical Quality Improvement Program (NSQIP) – A surgical program that uses clinical and patient experience data to identify opportunities for improvement. NSQIP teams support and prioritize improvement plans.

Netcare – The provincial electronic health record, which is a secure and confidential electronic system that enables health professionals to access real-time health information about patients and clients.

Netcare e-referral – Leverages existing information from Alberta Netcare (such as demographics, labs, and diagnostic imaging) into a referral form that can be saved as a draft, checked for completeness and tracked in real time as it is submitted, received, triaged and scheduled for an appointment.

O

Office of the Auditor General (OAG) – The auditors of every ministry, department, regulated fund and most provincial agencies, providing independent assurance to the people of Alberta that public money is spent properly and provides value.

Opioid Agonist Treatment (OAT) – A treatment for opioid use disorder that involves taking medications like oral buprenorphine/naloxone, methadone or injectable extended-release buprenorphine.

P

Poison & Drug Information Service (PADIS) – A telephone line that provides confidential, 24/7 expertise and advice on the health effects of poisons, chemicals, medications and herbal preparations.

Partnership for Research and Innovation in the Health System (PRIHS) – Part of Alberta Innovates, this program strengthens health research capacity in Alberta by encouraging collaboration and partnerships between academic institutions, health and clinician researchers, patients, and AHS operations to impact the health system.

Provincial Protection of Children Abusing Drugs (PChAD) – The *Protection of Children Abusing Drugs Act* (PChAD) is an Alberta law that helps children under the age of 18 whose use of alcohol or drugs will likely cause significant psychological or physical harm to themselves or others. The AHS PChAD program provides a 10-day inpatient program aimed at detoxifying, stabilizing and assessing each patient to ensure appropriate supports are in place to facilitate a successful discharge.

Q

Quarterly – A three-month interval. For AHS, these intervals coincide with the fiscal year (Q1: April – June) (Q2: July – September) (Q3: October – December) (Q4: January – March).

Quarterly year-to-date (YTD) – A cumulative total of three-month intervals. For AHS, these intervals coincide with the fiscal year (Q1YTD: April – June) (Q2YTD: April – September) (Q3YTD: April – December) (Q4YTD: April – March).

R

Referral, Access, Advice, Placement, Information & Destination (RAAPID) – An AHS call center that serves as a single point of contact for care providers which facilitates the return of patients to a healthcare facility closest to their home address that will best meet the patient's healthcare needs (repatriation).

Request for Expression of Interest and Qualification (RFEOIQ) – A process that allows contracted providers to submit proposals to AHS, which are then evaluated and considered for contracts in the future.

Right Care Alberta – A care philosophy that aims to support patients and care providers to collaboratively choose the best evidence-based care that is appropriate, effective and sustainable.

Robotic Process Automation – The use of software to automate manual processes such as data entry.

S

Shared Commitments – A resource to enhance mutually respectful and satisfying relationships between patients/families and healthcare providers. More information can be found on the AHS Together4Health online engagement platform: https://together4health.albertahealthservices.ca/shared_commitments.

Strata Pathways – An information system that matches patients with available and appropriate housing resources in order to transition them between AMH services and AHS-funded housing options. It allows the management of waitlists and transparent transition for clients with AMH conditions who require supported housing in the community. Housing options include both transition and long-term placement options.

T

Together4Health – AHS' online platform, where Albertans can have their say on various healthcare topics. More information can be found online: https://together4health.ahs.ca/.

U

Urban Acute Care Length of Stay Improvement Bundle (ACB) – A provincially coordinated quality improvement project that integrates evidence-based initiatives aimed at simplifying and standardizing steps that a care provider performs for each patient. More information can be found online: www.ahs.ca/assets/about/scn/ahs-scn-acbi-faq.pdf.

V

Virtual Opioid Dependency Program (VODP) – A program that uses technology to serve clients in smaller communities, providing same-day access to medication starts and transition supports for moves between care settings.

Virtual Physician Triage – Part of the Health Link Virtual Health Physician program, Albertans assessed by a Health Link clinician with a triage recommendation to seek care in the next four hours will be referred to Health Link's own Virtual MD first, instead of presenting for care in emergency, urgent, or community care settings. The physician will consult, assess and provide care recommendations to the patient via phone or Zoom.

W

Warm handoff – A process that establishes an initial face-to-face contact between the person and the new care provider and confers the trust and rapport the individual has developed with the previous provider to the new one. More information can be found online: www.ahs.ca/assets/info/amh/if-amh-ecc-warm-handoffs.pdf.

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