AHS
Annual Report

Reporting Period:
April 1, 2023 to March 31, 2024

Alberta Health Services

The *2023-24 Alberta Health Services Annual Report* was prepared in accordance with the *Sustainable Fiscal Planning and Reporting Act* and *Regional Health Authorities Act*. The 2023-24 fiscal year spanned from April 1, 2023, to March 31, 2024. All material economic and fiscal implications known as of June 1, 2024, 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 Board Chair

The 2023-24 AHS Annual Performance Report encapsulates the exceptional work and achievements of Alberta Health Services (AHS) in a transitional year of its existence.

The Government of Alberta announced its plan to refocus the province's healthcare system in November 2023, and these much-needed reforms will ultimately streamline AHS operations, enabling the organization to concentrate on acute care delivery. Once refocusing efforts are complete, AHS will be laser-focused on clinical operations, surgeries and emergency medical services, and on providing outstanding care in our hospital, urgent care and cancer care facilities. AHS will improve performance in key areas identified by Albertans including improving surgical and emergency department wait times and shortening response times for emergency medical services.

As you will see in this report, the staff, physicians and volunteers working within AHS continued to provide safe, high-quality healthcare to the people we serve, as the refocusing efforts began. Our hard-working and dedicated healthcare professionals have our utmost respect and, on behalf of the AHS Board, I wish to thank them for everything they do to provide the best possible care to patients and their families.

We will support our healthcare professionals through these refocusing efforts and ensure that they have a bigger say in healthcare decisions that affect their patients and their teams.

Albertans will be better served by AHS once the refocusing efforts are complete. More surgeries completed within recommended time frames. Improved patient flow in our hospitals. Timely cancer care. Emergency medical services where and when they're needed. Fewer imbalances between access to care in rural and urban communities.

This report represents our first step toward this brighter future.

Original signed by

Dr. Lyle Oberg
Board Chair
Alberta Health Services Board

Message from the President & Chief Executive Officer

During a fiscal year in which work began to refocus the province's healthcare system, I'm pleased to say Alberta Health Services continued to make progress in several areas that matter most to Albertans, as illustrated in this 2023-24 AHS Annual Performance Report.

Albertans expect emergency medical services to arrive where they're needed and when they're needed. As you will see here, performance in three of four response-time measures show improvement over the previous fiscal year, meeting targets in two of them.

AHS also completed more surgeries in 2023-24 than the previous year, and the number of cases on the waitlist outside of clinically recommended wait times at all adult sites continues to drop; in fact, for the first time, we're now at pre-pandemic levels.

This is some of the good news contained in this report.

Of course, more concerted, strategic effort is needed to further improve surgical wait times and Emergency Medical Services (EMS) response times, so that AHS can meet and exceed all performance targets and provide the access to quality care Albertans want. Meanwhile, this report shows emergency department wait times continued to rise in 2023-24. We know we can do better to reduce the time Albertans wait for care they urgently need.

As AHS President and CEO, I am committed to working with government, the AHS Board, and teams across the organization to refocus healthcare in the province. The goals of the refocusing include ensuring there is sufficient capacity to support more timely discharge of individuals for whom a hospital stay can now be rather lengthy, as they wait for suitable space in long-term care or supportive living. As government addresses these capacity issues, and implements other important aspects of the transformation, AHS will be able to focus on improving EMS response times, surgical wait times, emergency department wait times, and patient flow through our hospitals — areas that require more attention and resources for improvement. We have estimated that the ability to discharge patients to more suitable community capacity could reduce our hospital occupancy by as much as 10 per cent – this would have significant positive impacts on flow, the use of hospital resources, and staffing capacity.

These are times of change. In the past year, there has been significant change to the AHS executive team, and we have welcomed a new Board of Directors. With these changes, and more to come in the coming year, I remain confident in the strength and commitment of our people on the front lines and those supporting the front lines. Every day, they go the extra mile for patients and families. I am grateful for everything they do. They deserve the promised changes from the refocusing to ensure their hard work, dedication and ingenuity translate into outstanding patient outcomes and patient experiences.

I am pleased with the progress outlined in this 2023-24 AHS Annual Performance Report, yet I know our transformational improvement efforts are only getting started. The best is still to come.

Original signed by

Athana Mentzelopoulos
President and CEO
Alberta Health Services

About Alberta Health Services

Who We Are

Alberta Health Services (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. 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.

In 2023-24, AHS was recognized as one of Canada's Best Diversity Employers. 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.

Looking forward, AHS is embarking on a new journey as part of the Government of Alberta's refocus initiative in which its workforce, programs, services as well as beds and care spaces will be managed by one of four sector-specific provincial health agencies. The new provincial organizations including primary care, acute care, continuing care, and mental health and addiction, will provide oversight and coordination of service delivery, improve health outcomes and access, provide seamless care between different healthcare providers, improve local decision-making, and prioritize the well-being and expertise of healthcare workers. Throughout this transition, AHS will work to minimize impacts to our workforce and disruptions to service delivery and will continue to provide quality care across the province.

Workforce and Volunteers

In 2023-24, AHS had more than 113,000 direct AHS employees (excluding Covenant Health and other contracted health service providers) and more than 14,700 staff working in AHS' wholly owned subsidiaries such as Carewest, CapitalCare Group, and Alberta Precision Laboratories (APL).

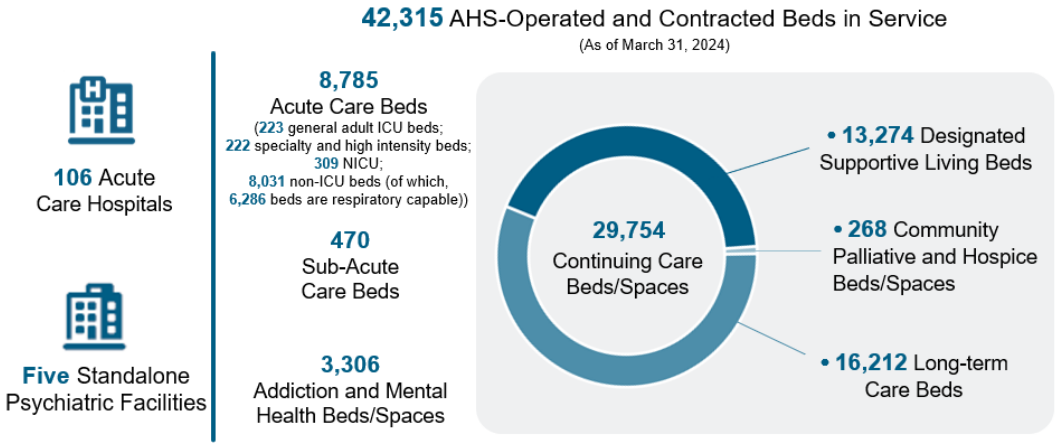
AHS was also supported by more than 11,600 independently practicing physicians, approximately 9,500[1] of whom are members of the AHS medical staff. Similarly, AHS is supported by nearly 170 midwives on the AHS midwifery staff who provide care both in the community and in our facilities.

Volunteers share a commitment to improving the quality of the patient and family experience. AHS' 9,700 volunteers contributed more than 690,000 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.

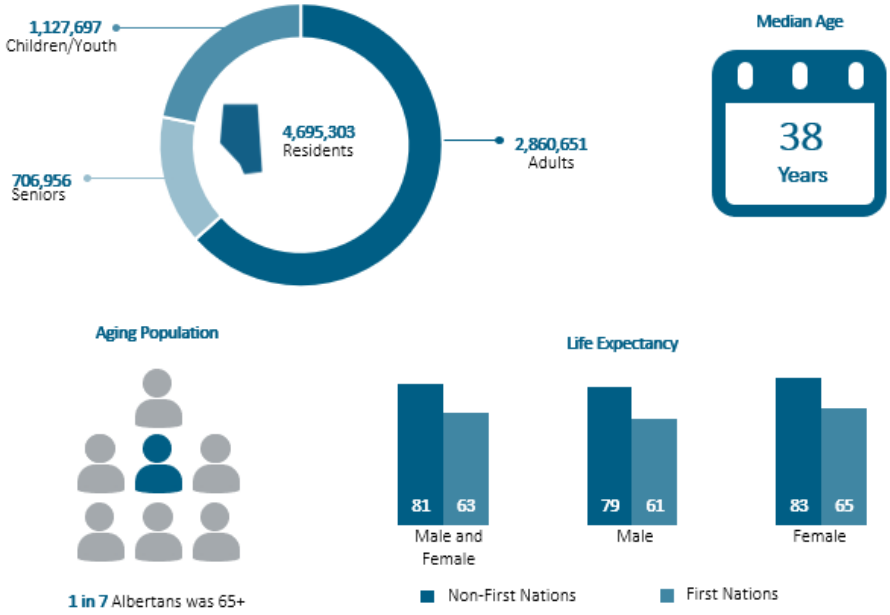
[1] Includes physicians in the Provincial Department of Public Health and the Provincial Department of Laboratory Medicine.

Facilities and Beds

In 2023-24, AHS programs and services were 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 were operated in compliance with relevant legislation.



Alberta Demographics



Source: Alberta Interactive Health Data Application (IHDA); Population estimates for 2023.

AHS Health & Business Plan

The AHS 2023-26 Health Plan & 2023-24 Business Plan was a legislated public accountability document that describes, at a strategic level, the actions AHS were to take in carrying out its legislated responsibilities with a focus on the delivery of quality healthcare services. The AHS 2023-26 Health Plan & 2023-24 Business Plan reflected direction from Alberta Health and was aligned to the Ministry of Health 2023-26 Business Plan.

This AHS Annual Report reflects progress on priorities and metrics identified in the AHS 2023-26 Health Plan. The AHS Performance section is organized according to the priorities and actions as outlined in the AHS 2023-26 Health Plan.

Mission, Vision & Values

The mission, vision and values as articulated in the 2023-24 Health Plan 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. Going forward, as part of the refocus initiative, we expect that each of the four sector-specific provincial health agencies will be developing their own, vision, mission and values that are aligned to their organizational mandates.

Board Governance

The AHS Board is responsible for the governance of AHS to ensure all Albertans have access to high quality health services across the province. Led by the Board Chair, Dr. Lyle Oberg, the AHS Board is accountable to the Minister of Health. The AHS Board fulfills their governance role by overseeing and providing direction to the AHS President & Chief Executive Officer or their designate with regards to the conduct of the business of AHS.

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

Board Members:

Dr. Lyle Oberg (Chair)

Sandy Edmonstone (Vice-Chair)

Cynthia Farmer

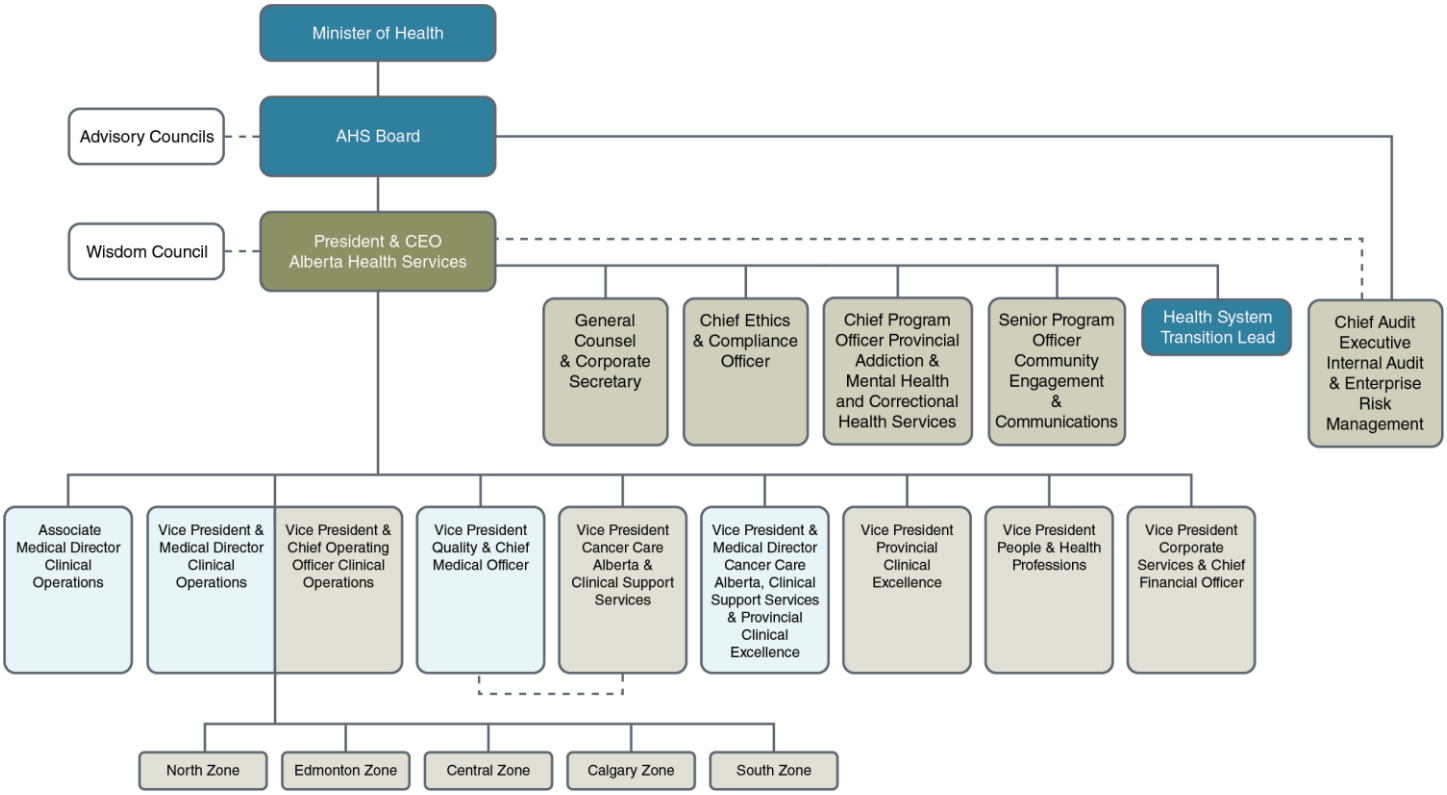
Angela Fong

Paul George Haggis

Evan Romanow

Andre Tremblay

AHS Organizational Structure



Advisory Councils

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

Health Advisory Councils

Health Advisory Councils (HACs) work in partnership with 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 2023-24, HACs continued to provide input to high priority initiatives. This included providing a patient and public voice along with that of a local MLA, mayor, reeve, and the foundation president in the Grande Prairie Regional Hospital Culture Project Guiding Coalition. Some advisory members participated in focus groups for the Cancer Screening Virtual Education Project where they provided input to educational materials for patients who are referred for a colonoscopy or colposcopy. A member of the Greater Edmonton HAC sat on a working group for the Edmonton Zone Primary Care Network Addiction and Mental Health Subcommittee; a member of the Palliser Triangle HAC co-chaired a steering committee leading the development of the AHS Shared Commitments which were launched in mid-April. Participants assisted in the creation of standardized pathways to access psychiatrists and mental health teams in the community. Members were also invited to participate in various online engagement, such as the Alberta Organ and Tissue Donation Program Naming Survey and Hand Hygiene workshops providing input to creative options for promoting handwashing.

In November 2023, the Government of Alberta announced plans to refocus health services in Alberta. As part of this plan, it is replacing AHS HACs with a new model - Regional Advisory Councils (RACs). These Councils will be operated by Alberta Health.

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 2023-24, Council members continued providing 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 2023-24, Council members provided input on several key initiatives including the Ambulatory Oncology Patient Survey, the Future of Cancer Impact in Alberta report, Alberta Cancer Diagnosis Initiative, and a lung cancer screening pilot program.

The Seniors & Continuing Care (SCC) 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 2023-24, Council members provided input on the Request for Expressions of Interest and Qualifiers for Home Care Services in Alberta, influencing parameters of new contracts developed for future use with operators who are considered pre-qualified for home and community care service delivery. Members received information and provided feedback on Continuing Care key topic areas including shift to care in the community; enhance workforce capacity; increase choice and innovation; and improve quality. Council received information about AHS Connect Care and Continuing Care and discussed challenges for those requiring third-party access.

The Sexual Orientation, Gender Identity & Expression (SOGIE) Provincial Advisory Council provides advice on healthcare matters and aims to create a safer, more inclusive, and welcoming healthcare environment for sexual and gender minority (Two Spirit, lesbian, gay, bisexual, transgender, queer, and Inclusivity & Identity Acknowledgement or 2SLGBTQI+) patients and their families. In 2023-24, the Council provided feedback to the Health Quality Council of Alberta (HQCA) on the refresh of the Alberta Quality Matrix Health tool. They also provided input into the new AHS Practice Support Tool titled Nutrition Assessment for Transgender and Gender Diverse Patients. SOGIE also provided recommendations to the AHS Indigenous Wellness Core and Diversity & Inclusion on changes of the AHS acronym from LGBTQ2S+ to a more inclusive and representative acronym.

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 2023-24, the Wisdom Council continued to reflect Indigenous voices to inform advancements in Indigenous health and re-iterated the need to address anti-Indigenous racism in AHS facilities and across the healthcare system. In addition, the Wisdom Council provided guidance on the expansion of the Indigenous Support Line in the North Zone to other AHS zones, the update to the Indigenous Awareness and Sensitivity Certification Program (as part of Required Organizational Learning), and Indigenous mental health and addiction priorities.

Clinician Council

The AHS Clinician Council exists to work, listen and learn from others, and provide feedback that is straightforward and steeped in knowledge and insight. The AHS Clinician Council ensures diverse voices and experiences propel decision-making throughout the organization. More than 80 clinicians and leaders from all levels and areas of AHS are part of the Council's multidisciplinary forums. Gathering quarterly, the Council exchanges knowledge and collaborates with those developing and implementing significant AHS plans, projects and programs. In the past year, members informed 15 initiatives, including the AHS Workforce Strategy, Allied Health Career Pathways, Peer Support Program, Psychological Health & Safety Action Plan, Organizational Learning Module Patient Experience 101, The Incident Reporting and Investigation Project, Wait List Reduction Alberta Surgical Initiative, MyAHS Connect, Microsoft Technologies Program, Staff Readiness, Connect Care Action Plan, Addressing Malnutrition in Alberta and the Cancer Diagnosis Program.

Provincial Patient and Family Advisory Council (PFAC)

The Provincial Patient and Family Advisory Council is comprised of patients and family members from across Alberta who are registered AHS volunteers. They 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, the council works to advance the principles of Patient and Family-Centered Care and improve patient outcomes through the design and planning of health services. Consulting with PFAC helps meet Accreditation Standards, fulfill program objectives, and improve patient and family experiences. In 2023-24, members contributed more than 1,500 volunteer hours and shared what mattered most to patients and families in more than 30 initiatives including Shared Commitments, Connect Care, Patient Concerns Competencies, and provincial policies such as Family Presence.

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.

	2020-21	2021-22	2022-23	2023-24
Primary and Continuing Care / Population Health				
Ambulatory Care Visits[1]	5,175,278	5,455,397	5,159,906	5,321,435
EMS Events	602,283	672,898	661,177	724,783
Food Safety Inspections	26,171	33,728	48,569	55,009
Health Link Calls*	2,291,243	--	--	--
Health Link Calls Received – Clinical*	--	1,444,868	756,806	719,929
Health Link Calls Received – Non-Clinical*	--	2,291,770	604,799	394,883
Health Link Outbound Calls – Clinical*	--	59,775	43,587	95,046
Health Link Outbound Calls – Non-Clinical*	--	494,208	337,899	150,259
Poison Information Calls (PADIS)	38,718	48,392	49,398	49,621
Seasonal Influenza Immunizations**	1,650,836	1,207,403	1,276,970	Pending
Number of Clients Placed from Acute / Subacute Hospital	4,663	5,193	5,814	NA
Number of Clients Placed from Community (home)	2,764	3,471	3,618	NA
Number of Unique Home Care Clients[1,2]	117,502	122,084	126,539	130,111
Acute Care				
Emergency Department Visits (all sites)[1]	1,552,096	1,824,366	1,983,852	2,028,196
Urgent Care Visits[1]	148,166	193,948	221,066	233,785
Hospital Discharges[1]	358,107	376,019	380,268	392,805
Births[1]	46,603	47,297	45,755	47,603
Total Hospital Days[1]	2,505,858	2,614,642	2,826,571	2,965,496
Average Length of Stay (in days)	7.0	7.0	7.4	7.5
Alternate Level of Care Total Discharges[1]	14,604	15,434	17,303	18,191
Ambulatory Care Sensitive Conditions Hospital Discharges[1]	9,660	10,540	12,311	12,502
Diagnostic / Specific Procedures				
Hip Replacements (scheduled and emergency)[5]	5,802	6,177	7,434	8,075
Knee Replacements (scheduled and emergency)[5]	5,125	5,272	7,504	9,421
Cataract Surgery[5]	44,289	48,341	40,290	47,621
Total Surgical Volumes (Main OR and CSF)[5, 6]	277,000	278,600	294,300	304,595
MRI Exams	205,793	235,241	231,033	255,200
CT Exams	462,443	508,071	520,507	595,817
X-rays	1,532,099	1,697,532	1,746,125	1,780,812
Lab Tests[1]	72,491,239	82,149,662	82,410,198	87,980,881
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)[3]	737,212	794,799	727,567	680,976
Unique/Individual Cancer Patients	60,902	64,496	62,937	63,941
Mental Health and Addiction				
Mental Health Discharges (acute care sites)[1]	23,347	24,182	22,395	23,983
Mental Health Discharges (acute care sites and standalone psychiatric facilities)[1]	28,038	29,246	27,335	28,825
Community Treatment Orders (CTOs) Issued[1]	802	863	792	804

Addiction Residential Treatment & Detoxification Admissions[1]	8,156	9,250	9,367	10,193
Workforce				
AHS Physicians	8,792	8,697	8,849	9,171[4]
AHS Staff	108,689	112,373	111,159	113,897
AHS Volunteers	12,241	9,186	9,100	9,729
AHS Volunteer Hours[1]	410,437	484,838	558,289	690,672

Data updated as of May 23, 2024. Definitions can be found at https://www.ahs.ca/about/Page11905.aspx

[1]Historical data has been restated for 2021-22 due to reporting updates.

[2]The Alberta Health Business Plan refers to this measure as unique home care clients served.

[3]The transition from the Aria MO Electronic Medical Record (EMR) to the Connect Care EMR impacted the Cancer Care Alberta (CCA) workflows and appointment scheduling. As a result of different workflows in Connect Care, many activities are no longer scheduled as attending appointments (which is what CCA has always reported) but the work continues with CCA resources. The two EMRs are not comparable when viewing volume changes.

[4]Does not include physicians in the Provincial Department of Public Health or physicians in the Provincial Department of Laboratory Medicine.

[5] Historic surgical values have been restated due to the reconciliation of CSF data and improvements in methodology. As AHS continues to optimize methods for improved reporting, these numbers may be subject to further changes.

[6] Surgical volume data was extracted June 5, 2024.

* 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 866 net new community care beds/spaces (Includes 623 community-based care - long-term care and designated supportive living), 7 community palliative and end of life care, 148 community mental health and addiction, 96 integrated home living/other spaces, 7 mental health and addiction wrap-around services, and a decrease of 15 sub-acute in long-term care). 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.

Number of Beds/Spaces	March 31, 2023	March 31, 2024	Difference	% Change
Acute Care				
Acute Care	7,844	8,031	187	2.4%
General Adult Intensive Care Unit (ICU)	223	223	0	0.0%
Specialty ICU	229	222	-7	-3.1%
Neonatal ICU	309	309	0	0.0%
Total Acute Care	**8,605**	**8,785**	**180**	**2.1%**
Addiction and Mental Health				
Psychiatric (Standalone facilities)	927	936	9	1.0%
Addiction Treatment	1,280	1,323	43	3.4%
Community Mental Health	951	1,047	96	10.1%
Total Addiction and Mental Health	**3,158**	**3,306**	**148**	**4.7%**
Community-Based Care				
Continuing Care – Long-Term Care (LTC)				
Auxiliary Hospital	5,575	5,611	36	0.6%
Nursing Home	10,424	10,601	177	1.7%
Sub-Total Long-Term Care	**15,999**	**16,212**	**213**	**1.3%**
Continuing Care – Designated Supportive Living (DSL)				
Designated Supportive Living 3	1,449	1,427	-22	-1.5%
Designated Supportive Living 4	7,486	7,809	323	4.3%
Designated Supportive Living 4 – Dementia	3,929	4,038	109	2.8%
Sub-Total Designated Supportive Living	**12,864**	**13,274**	**410**	**3.2%**
Sub-Total Long-Term Care & Designated Supportive Living	**28,863**	**29,486**	**623**	**2.2%**
Continuing Care – Community Palliative and End of Life Care (PEOLC)				
Community Palliative and End of Life Care *(out-of-hospital)*	261	268	7	2.7%
Sub-Total Continuing Care *(includes LTC, DSL and PEOLC)*	**29,124**	**29,754**	**630**	**2.2%**
Sub-Acute in Long-Term Care				
Sub-Acute in Long-Term Care (Auxiliary Hospital)	485	470	-15	-3.1%
Total Community-Based Care *(includes LTC, DSL, PEOLC and Sub-Acute in LTC)*	**29,609**	**30,224**	**615**	**2.1%**
Provincial Total *(includes all beds and spaces)* **Provincial Total** *(includes all beds and spaces)*	**41,372**	**42,315**	**943**	**2.3%**

Source: AHS Bed Survey as of March 31, 2024

Notes:

- Beds may have been restated since previous AHS Annual Reports and AHS Bi-Annual Bed Surveys due to reporting corrections.
- 2023-24 community care capacity does not include Integrated Home Living Spaces (96) and MHA wrap-around services (7).
- 2022-23 added General Adult Intensive Care Unit (ICU) and Specialty ICU under Acute Care.

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. A new accreditation decision of 'Accredited' was awarded by Accreditation Canada in 2023, valid until 2027. AHS continues to maintain accredited status with the College of Physicians and Surgeons of Alberta for diagnostic facilities. AHS-funded partners, Alberta Precision Laboratories, 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 2023 survey, Accreditation Canada surveyed 51 sites across the province. These sites were assessed for addiction treatment services, community-based mental health, home care, hospice, palliative and end-of-life, inpatient mental health, public health, and rehabilitation services including acquired brain injury, and spinal cord injury. Performance related to the foundational standards of infection prevention and control, leadership, medication management and service excellence were also assessed.

During the fall 2023 survey, governance and leadership were assessed at the corporate/provincial and zone levels, with validation at eight clinical service sites. Infection prevention and control, medication management and medical device reprocessing were assessed at 26 sites. Perioperative services and invasive procedures were surveyed at seven sites. Surveyors reported teams of strong professionals who work collaboratively to provide safe, quality care, are committed to quality improvement, and offering compassionate care.

Leading in Health

In 2021-22, the most recent year with national data, 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 of 4.3 per cent.

According to the latest statistics (2022-23) from the Canadian Institute for Health Information (CIHI), Alberta is a national leader in many areas of healthcare delivery.

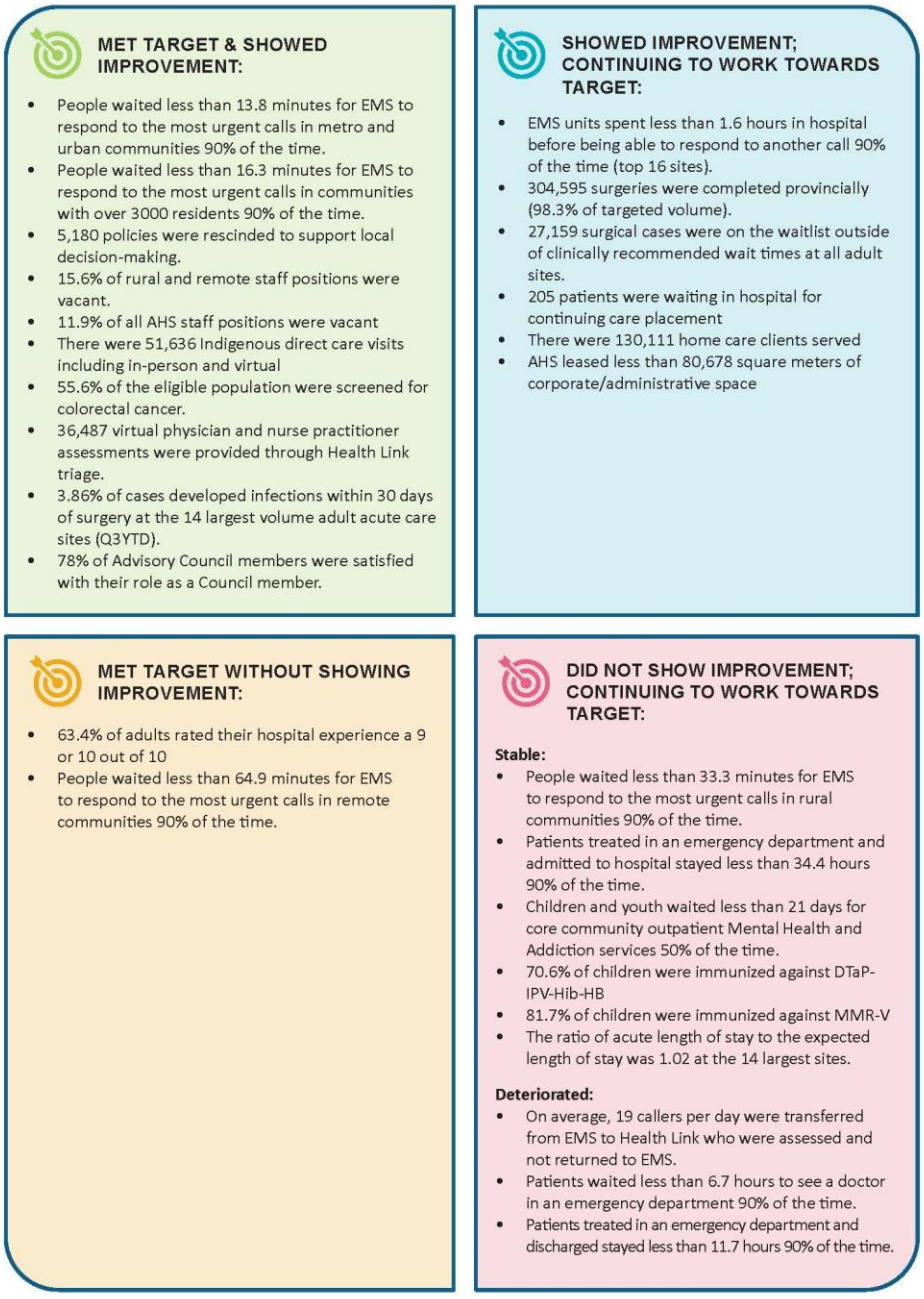
CIHI has developed indicators to measure the health of Canadians and health system performance in Canada. These indicators help inform AHS and Albertans on how Alberta's health authority performs nationally. The indicators below represent where CIHI shows Alberta is performing better than the national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

- Fewer self-harm hospitalizations
- Fewer repeat stays for Mental Health and Substance Use
- Fewer obstetric traumas for instrument-assisted vaginal deliveries
- Fewer patients (medical, surgical, obstetric, pediatric combined) readmitted to hospital
- Fewer surgical patients readmitted to hospital
- Fewer medical patients readmitted to hospital
- Fewer obstetric patients readmitted to hospital
- Lower potentially inappropriate use of anti-psychotics in long-term care
- Lower restraint use in Long-Term Care
- Fewer hospitalized heart attacks

Summary of Performance Results

In 2023-24, AHS saw improvement on many of its 28 performance metrics. For one measure, *workforce experience with local decision-making*, a performance trend could not be determined as initial baseline was established in 2023-24. Of the remaining 27 performance measures, 18 (67 per cent) have either shown improvement, met target or both. Of the nine measures that did not show improvement or meet target, six remained stable. Additional information for each measure can be found under the corresponding priority areas of this report.

Year-end results for AHS' performance metrics are summarized below:



Note: Results are reported as improved if there is a 3% or greater relative change in a desirable direction when compared to the same time period last year. Measures that did not show improvement are those that remained stable (within +/- 2.9%) or deteriorated (3% or greater relative change in an undesirable direction) compared to the same period last year.

Reducing Emergency Medical Services Response Times

AHS Emergency Medical Services (EMS) strives to enhance patient care by improving ambulance response times. Focused improvement initiatives include the reduction in EMS response times to 911 calls and the elimination of delays when patients arrive at the emergency department (ED). From the moment a call is made to 911 to the arrival of an ambulance and the subsequent care of a patient in the hospital, improving the care of patients is a top priority. By implementing EMS initiatives across the province, AHS aims to improve patient flow and the broader healthcare environment.

Desired Outcomes:

- Reduction in EMS response times to improve patient outcomes and safety.
- Eliminate EMS offload (EMS Park) in emergency departments across the province.

Actions & Achievements

Increasing EMS System Capacity

- Work continues with acute care sites to reduce EMS offload delays and reduce EMS hospital time. Results in 2023-24 show a sustained time of 1.4 hours across all zones. While this did not meet the target of 45 minutes, this measure has improved from the baseline of 3.0 hours in 2022-23. EMS is conducting time and motion studies to understand accurate time intervals and determine which steps in the total EMS hospital time can be most impacted through further process improvement activities.
- Site-specific action plans and ongoing staffing of ED Park 24/7 have been implemented throughout the zones to support capacity flow, minimize offload delays, and improve return to service time.
- Resources were added to increase ambulance units per hour from an average of 357 to 377 ambulance units per hour. Provincially, staffed shifts as a percentage of scheduled shifts increased from 82 per cent in Q2 to 85 per cent in Q4.
- AHS EMS is working under the AHS Workforce Planning Strategy to target recruitment in hard-to-staff locations, particularly in the North Zone. Contract negotiations for dedicated interfacility transfer (IFT) resources in Calgary and Edmonton were completed and slated to begin in 2024-25.
- Dedicated IFT resources based out of Red Deer were implemented in 2023-24 and are now operational seven days a week on a staggered schedule to correspond with data-supported peak demand times. These new resources support patient movement throughout the Central zone and are being used for non-urgent, low-priority patient transfers, taking the pressure off local EMS. An impact analysis is underway and will inform future opportunities for improvement.
- A comprehensive review of resource allocation and deployment policies was completed by PricewaterhouseCoopers (PwC) to ensure efficient use of resources in EMS. The review included ground and air interfacility transfer, non-clinical transports, Mobile Integrated Health (MIH), ground ambulance resourcing, and System Status Management. It identified 12 opportunities for improvement including reducing lights and siren responses and clarifying the role of MIH which have specifically been included in the EMS Operating Plan for 2024-25. The additional 10 opportunities have been noted for evaluation and prioritized in operating plan initiatives.
- It was determined through the external PWC review that the scope of the Mobile Integrated Health (MIH) program has grown beyond its original focus of alleviating EMS pressures. Recommendations to define the purpose and scope of MIH has been incorporated into the 2024-25 EMS Operating Plan.
- As part of the Ambulance Readiness Project, the two largest EMS stations (one in Calgary, one in Edmonton) have been staffed with Ambulance Readiness Technicians to facilitate the preparation and clean-up of ambulances at the start and end of shifts. Ambulance readiness will be incorporated into the planning of all future EMS facilities.
- AHS EMS continues to meet with communities to address ambulance availability concerns and has committed to regular service planning meetings as part of negotiations with contracted service providers. The EMS Return to Service initiative has increased ambulance availability resulting in improved response times particularly in metro/urban areas.

Managing EMS Event Demand

- Since the launch of the EMS/811 Shared Response Line in January 2023, over 8,900 calls have been assessed without an EMS response. Efforts to improve and evolve 811 in mitigating EMS responses are part of regular operations.
- 811 and Mobile Integrated Health (MIH) have implemented a new care pathway to allow some 811 patients to move to the MIH team for assistance. Since the inception of the pilot, the numbers of calls diverted to MIH has increased from three calls in August 2023 to 53 calls in March 2024.
- AHS EMS collaborated with clinical operations on policy development and rollout to ensure IFTs are conducted with appropriate resources in a timely and effective manner. In addition, a Request for Expression of Interest and Qualification was used to procure contracted low-acuity inter-facility transport resources for Calgary and Edmonton.
- AHS has developed and implemented the General Assess, Treat, and Refer Protocol for paramedics to provide for patients who need care other than care provided in an emergency department.
- Development of a public information campaign with respect to appropriate use of EMS is ongoing. This includes promotional information under the *Know Your Options* banner on the AHS website.
- EMS participated in a joint initiative with the Edmonton Police Service on a Community Safety Team. This team engages the community in reversing overdoses before calling 911 and subsequently activating an EMS response. This team also supports the navigation of social services and addictions services for vulnerable populations.
- AHS engaged in educational opportunities across the zones, particularly in rural areas regarding appropriate use of EMS services. This included participation in engagement sessions with town councils in 13 communities, as well as meetings with the Alberta Municipalities Board and Rural Municipalities Association Board. In the North Zone, EMS along with the Indigenous Wellness Core provided updates to three Tribal Councils. EMS Operations have also engaged in 10 meetings with fire departments, fire chiefs and Fire Chief Associations across the province, and have partnered with Indigenous Talent Acquisition to develop an Emergency Medical Response training program for the Metis community through the Rupertsland Institute.
- A non-clinical transport (NCT) policy for patients who do not require EMS medical support has been implemented across all zones in the province. Where appropriate, NCT is being utilized based on guidelines for alternate modes of transportation from acute to designated living options. Partnerships have been established with community service providers to facilitate transport through the provision of taxi vouchers and invoicing with community-based providers.

Supporting Our Workforce

- The *AHS EMS Workforce Strategy* was developed under the umbrella of the *AHS Health Workforce Strategy*. The strategy outlines growing the EMS workforce through recruitment, education, and improving retention. The strategy was approved in December 2023 and is effective until March 31, 2027.
- AHS hired 119 external frontline EMS staff and expanded a national recruitment advertising campaign with an on-line candidate intake survey. Surveys were received from 861 respondents interested in a career with AHS EMS.
- Additional recruitment and retention activities included attending 162 career events across the province, event booth displays, handouts and promotional items to 11 EMS locations provincially, as well as upgrading uniforms for formal settings, such as award ceremonies and Line of Duty ceremonies.
- AHS implemented strategies to improve the work environment for paramedics. These included:
    - Reducing workplace fatigue through alternate shift schedules, access to scheduled breaks, and time off including on short notice. Staff surveys have been instrumental in informing future shift schedules.
    - Hiring 32 Ambulance Readiness Attendants in Calgary and Edmonton to help improve ambulance availability through completion of some duties previously performed by paramedics. Ambulance Readiness Attendants help reduce the amount of time paramedics are unavailable for services allowing them to reach communities faster.
    - Hiring more regular full-time Emergency Communications officers to support implementation of scheduled break planning for paramedics.
    - Implementing the End of Shift policy to reduce overtime hours.
    - Reducing fatigue-related service outages through the EMS Fatigue Management initiative.

- In 2023-24, the following mental health supports for the EMS workforce were implemented:
    - Hired 1 FTE Program Manager, 1 FTE Supervisor, 5 FTE Wellness Facilitators and 2 FTE Reintegration Facilitators to the EMS Employee Wellness team.
    - Created a new classification for an FTE Emergency Communication Officer Team Lead to support the recruitment of a Dispatch Wellness Facilitator role.
    - Developed and implemented a new provincial Peer Support Program that provides training for peer team members, and includes a peer support framework, guidelines, and a mentorship manual. The program includes additional initiatives to improve the visibility of the Peer Support Program such as new identifiers for peer support members as well as pocket cards with QR code to access 24/7 peer support.
- Implemented the Behavioural Safety Program, which supports violence prevention among front-line staff. In 2023-24, more than 3,000 front-line EMS staff completed the training and now use the program.
- Additional scheduling clerks have been hired to ensure responsive scheduling and workforce planning is also being restructured to ensure provincial consistency and local responsiveness.

Strategic Enablers

- All recommendations from the *Health Quality Council of Alberta (HQCA) Alberta Health Services Emergency Medical Services Incident Review* were implemented in 2023-24. Use of technology solutions to automate areas of quality improvement is ongoing, and additional EMS dispatch training days have been planned for 2024-25. Due to cost management pressures, hiring of Emergency Communications Officer Educator positions has been paused.
- All 12 of the AHS-owned HQCA recommendations were implemented in 2023-24. Alberta Emergency Medical Services Provincial Advisory Committee (AEPAC) recommendations are also on track with 20 of 39 AHS-owned recommendations and 13 of the 29 AHS-owned Dispatch Review recommendations implemented.
- In response to the recommendations from AEPAC, Medical First Responder strategists were recruited, and engagement with providers and communities to review and improve the governance, operations and supports to these agencies is underway.

PERFORMANCE MEASURE RESULTS: REDUCING EMS RESPONSE TIMES

EMS response time (minutes) for the most urgent calls in metro/urban communities 90% of the time

2023-24 Target: 14.0 minutes

Desired Direction: ↓

2019-20	2020-21	2021-22	2022-23	2023-24
11.1	11.7	14.6	17.5	13.8

EMS response time (minutes) for the most urgent calls in communities with >3000 residents 90% of the time

2023-24 Target: 16.5 minutes

Desired Direction: ↓

2019-20	2020-21	2021-22	2022-23	2023-24
15.0	15.7	18.6	18.9	16.3

EMS response time (minutes) for the most urgent calls in rural communities (under 3000 residents) 90% of the time

2023-24 Target: 32.0 minutes

Desired Direction: ↓

2019-20	2020-21	2021-22	2022-23	2023-24
30.4	31.6	33.8	33.9	33.3

EMS response time (minutes) for the most urgent calls in remote communities 90% of the time

2023-24 Target: 65.0 minutes

Desired Direction: ↓

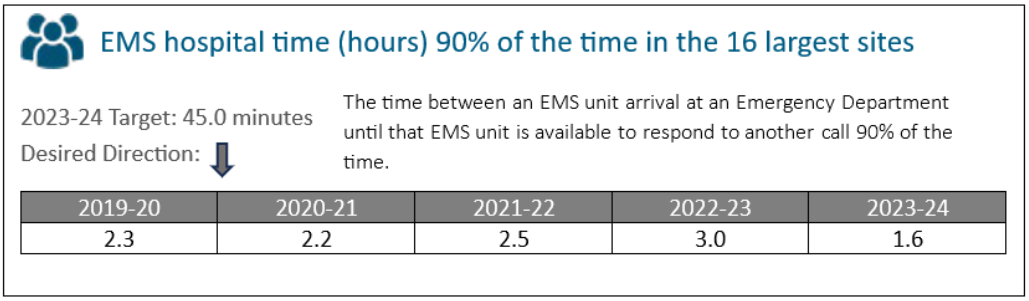
2019-20	2020-21	2021-22	2022-23	2023-24
60.5	55.1	55.4	61.8	64.9

Note:
Historical values for EMS Response Times in urban communities were restated for 2019-20 and 2020-21, due to reporting updates.
Historical values for EMS Response Times in communities with >3000 residents were restated for 2019-20, due to reporting updates.
Historical values for EMS Response Times in rural communities were restated for 2020-21, due to reporting updates.
Historical values for EMS Response Times in remote communities were restated for 2019-20 and 2020-21 due to reporting updates.

Results summary on following page

Results:

- EMS response time is the time (in minutes) from when a 911 call is received at an EMS dispatch centre until the first ambulance arrives on scene. 90th percentile response times are reported. This means that 90 per cent of the time, the response time is equal to or less than the time reported. Events that are deemed "life threatening" (i.e., high acuity) at the time of EMS dispatch represents the capability of the system to respond urgently when patients need it most. The shorter the time the better, as it demonstrates system responsiveness and ability to provide timely medical care to patients in the community.
- The EMS response time for the most urgent calls in metro/urban communities improved to 13.8 minutes compared to 2022-23 (17.5 minutes) and met 2023-24 target performance.
- The EMS response time for communities with >3000 residents improved to 16.3 minutes compared to 2022-23 (18.9 minutes) and met 2023-24 target performance.
- In rural communities, the response time for urgent calls remained stable at 33.3 minutes compared to 2022-23 (33.9 minutes). The 2023-24 fiscal year target of 32.0 minutes was not achieved.
- In remote communities, the EMS response time met the fiscal target of 65.0 minutes but deteriorated by 5 per cent from 61.8 minutes in 2022-23 to 64.9 minutes in 2023-24.
- 90th percentile response times in remote communities have high variability due to having lower volumes than other areas. In addition, response times have been negatively impacted by reduced staffing. It is more challenging to recruit and retain staff in remote areas.



EMS hospital time (hours) 90% of the time in the 16 largest sites

2023-24 Target: 45.0 minutes

Desired Direction: ⇩

The 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	2023-24
2.3	2.2	2.5	3.0	1.6

*Note: The 2022-23 value has been restated with updated data.

Results:

- EMS hospital time is the time (in hours) elapsed from when an EMS ambulance arrives at the emergency department (ED) until that ambulance is available to respond to another call. The amount of time EMS spends in hospital can significantly affect EMS resource availability and therefore system capacity. The lower the number the better, as it indicates that EMS teams are spending less time waiting in hospitals and are freed up to respond to other calls.
- In the 16 largest sites, EMS units spent 1.6 hours or less in hospital before being able to respond to another call 90 per cent of the time in 2023-24. This is a decrease of 47 per cent compared to 2022-23 (3.0 hours) however this measure did not meet the 2023-24 fiscal year target of 45 minutes. This may be due to recruitment challenges to support EMS offload, higher volumes of mental health and addiction and medicine emergency patients, as well as overcapacity and surge capacity (seen during respiratory virus and wildfire season) which impacts bed availability and flow. EMS continues to engage with clinical operations and explore areas for improvement to address recruitment, over capacity, high patient volumes and surge capacity issues.

EMS/811 shared response calls (average number of 911 EMS calls diverted per day)

2023-24 Target: 35 calls per day

Desired Direction: ↑

2022-23	2023-24
28	19

Note: The EMS/811 shared response call program launched in January 2023. The 2022-23 value represents January to March 2023

Results:

- This measure represents the daily average number of 911 calls received by EMS dispatch that were transferred to the EMS/811 Shared Response Line, then assessed by a Registered Nurse and not returned to EMS nor transferred to Mobile Integrated Health. A higher number indicates that more patients can get the care they need after being assessed by 811 Registered Nurses, hence reducing the number of non-urgent ambulance responses.
- In 2023-24, on average, 19 callers per day were transferred from EMS to Health Link who were assessed and not returned to EMS. This measure deteriorated by 33 per cent from 2022-23 and did not meet the 2023-24 fiscal year target of 35 callers per day. The baseline of 28 calls per day and the subsequent target of 35 calls per day was based on early implementation of the initiative. As the initiative evolved, protocols were adjusted to accommodate for Albertans that did not have any emergency transport alternatives. The effect of the initiative has now stabilized resulting in the lower number of calls that are transferred per day. Work is underway to provide additional support through the Mobile Integrated Health teams which will allow some Shared Response Line patients to move to the MIH team for assistance thereby freeing up EMS resources.

STRATEGIC PRIORITY

Decreasing Emergency Department Wait Times

AHS is committed to reducing wait times for patients accessing emergency care. By reducing the time spent waiting in emergency departments (EDs), AHS will improve the quality of care for patients and families at a time when they need it most. Improvements in ED wait times will be driven by better access to services in the community, efficient system capacity management, the addition of innovative approaches to expanding capacity, and improvements made in protocols for patient triage and hospital stays. The goal is to provide quality emergency care until the patient is discharged or admitted to an appropriate care setting.

Desired Outcomes:

- Decreased wait times for patients accessing emergency care.

Actions & Achievements

Initiatives that aim to reduce unnecessary ED presentation and redirect patients to more appropriate care

- The Health Link Virtual MD Program allows patients to speak with a physician or nurse practitioner about an acute health problem and potentially avoid unnecessary ED visits. The program continued to grow its inclusion criteria, allowing more 811 callers to be eligible for the program, further minimizing ED and urgent care visits. Q3 and Q4 saw an additional 25,086 patients referred to the program, resulting in a total of 40,935 patients referred in 2023-24. This is a 77 per cent increase in patients referred compared to 2022-23 (23,171). Data shows Albertans continue to be diverted from EDs and urgent care with only 10.7 per cent of patients advised to proceed to an ED in 2023-24.
- The EMS/811 Shared Response Line was expanded to include direct referral to the Health Link Registered Nurse team and the Addiction and Mental Health Helpline. Since launching in 2023, approximately 8,900 EMS responses have been avoided with a subsequent decrease in transports to the ED.
- To support clients waiting in hospital for alternate levels of care, a temporary capacity call out for community spaces was opened in December 2023 to increase system flow. As of 2023-24, 235 temporary beds are currently in use (158 net new, 77 repurposed). An additional 66 (net new) are scheduled to open in 2024-25. The temporary capacity call out will remain open with no fixed end date.
- In the South Zone, processes are in place at both the Chinook Regional Hospital and the Medicine Hat Regional Hospital for direct admit patients to be admitted to inpatient units resulting in no transfers to EDs.
- In the Calgary Zone, a standardized process for conducting outpatient Electroconvulsive Therapy (ECT) starts is being established to minimize the need for admission through the ED as an inpatient prior to initiating ECT.
- In the Central Zone, the MIH program is now available to Red Deer, Camrose, and communities within a 50 km radius. This allows EMS to respond to clients in designated supportive living sites and home care who have urgent health needs that require attention.
- In the Edmonton Zone, the model of care in the AMH Day Hospital has been updated to provide a valid alternative to acute care hospitalization and will be re-opened to new referrals under a modernized model of care in April 2024. Direct admissions for postpartum readmissions to Women's Health have also been facilitated to avoid ED visits; expansion of direct referrals to orthopedics commenced in fall 2023.
- In the North Zone, education is offered to staff to reduce unnecessary ED and hospital admissions and improve services available through home care. This includes increasing clinical knowledge related to caring for complex wounds, wound prevention, ostomy care, negative pressure wound therapy and lower leg edema management.
- Calgary and Edmonton operations are expanding Police and Crisis Teams which respond to mental health or addiction-related calls from clients in the community. Calgary has hired an additional 12.0 FTE clinicians, all of which are operational. Edmonton is in the process of hiring 22.4 FTE clinicians and is anticipated to be operational in 2024-25. Recruitment for expansion of the Regional Police and Crisis Teams is ongoing.
- To ensure all avenues to primary care are optimized, the LACE tool was made available in Connect Care to identify higher risk hospital-admitted patients who require early follow-up appointments in primary care.
- Processes established through Home to Hospital to Home (H2H2H) are helping to minimize the risk of readmission. A H2H2H report was developed and shared with acute and primary care teams in October 2023, and showed that

high LACE patients are followed-up in primary care within the recommended guideline of two weeks approximately 55 per cent of the time. Full implementation of the H2H2H guideline as well as provider education and quality improvement initiatives are underway.

Initiatives that aim to improve flow through the ED and reduce ED length of stay

- Dedicated allied health resources including physiotherapy, occupational therapy, pharmacy, and social work positions were put in place across the zones with over 80 per cent allied health and pharmacy positions recruited.
- In the Calgary Zone, recruitment of additional permanent staff to support the expansion of the psychiatric emergency teams was completed.
- In the Central Zone, the Psychiatric Emergency Services (PES) team began operation at the Red Deer Regional Hospital Centre (RDRHC) ED in November 2023 to provide care for individuals presenting with addiction and/or mental health concerns. In 2023-24, 339 patients presenting at the RDRHC ED were transferred to the PES team which helped to reduce workload for ED staff, improve patient flow, and reduce the number of patients leaving without being seen. In addition, the average length of stay for mental health clients was reduced by more than 25 per cent from over 12 hours to less than 9 hours.
- In the South Zone, development of a Psychiatric Nursing Assessment team for the Medicine Hat Regional Hospital is ongoing. Implementation of the Short Stay Service has been staggered with two beds opened in March 2024 and the other two planned for April 2024.
- The expansion of the Emergency Physician Liaison role to help support triage decision-making and expedite care will not be proceeding due to ongoing physician workforce challenges. Zones continue to regularly review demand as well as available resources and augment where required. For example, Central Zone has created a surge escalation process that triggers calling in an additional emergency department physician when department wait times require extra resourcing. Adding support is dependent on physician availability.
- The Integrated Operations Centres in Edmonton and Calgary that were set up to support coordinated patient flow and bed capacity, continue to be staffed for real-time coordination.
- To support Indigenous patients in the ED, an Indigenous cultural support role at the University of Alberta Hospital was relocated to have a greater presence in the ED, and on-call cultural support services were made available in some EDs in the Calgary and South Zones.
- To support expedited care and discharges for low acuity pediatric patients from the ED, the Alberta Children's Hospital in Calgary has recruited additional positions to enable expanded hours and beds in the ED Fast Track. Data from November 2023 to March 2024 indicates that targets are being met for the ED Fast Track area with an average of 1,795 patients seen per month (target is 1,700 per month). The Stollery Children's Hospital in Edmonton also established a low acuity fast track clinic as a temporary measure in 2021. Since that time, funding was approved for expansion including the recruitment of additional positions.

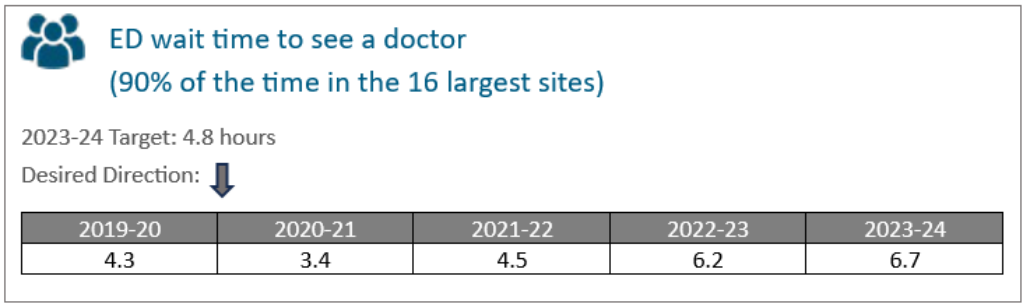
Initiatives that aim to improve patient movement from the ED to a more appropriate care setting

- AHS opened 221 new permanent acute care beds in 2023-24. This is included approximately 50 beds added in the fall of 2023 during peak respiratory virus season.
- Sites continue to implement and monitor the Provincial Capacity Escalation Protocol where emergency inpatients are sent from the EDs to inpatient units once ED thresholds are met. Consistent use of the protocol requires ongoing change management support and will remain a priority area of focus.
- In the South Zone, alternate care spaces have been identified and are readily available or in use as needed.
- Community-based capacity was increased through home care innovation partnerships with contracted health service providers to support hospital discharges for alternate level care clients to their homes. This enables discharge from hospital, functional assessments being conducted in the home setting, and potential transition to traditional home care or support until a designated living option is available. The following programs were initiated in 2023-24:
    - The Calgary In-Home Restorative Care program provided rehabilitative services in the client's home to enable early discharge with continued rehab services.
    - The Red Deer Destination Home intensive home care program enrolled 15 clients for short-term intensive wrap-around 24/7 services that enable early discharge with in-home supports from a contracted provider.
    - The Rimbey Destination Home program design was completed to support early discharge with 24/7 wrap-around services.

- Temporary funded and staffed non-ICU surge capacity were added to support the respiratory virus season. A proportion of these beds 89 of 148 have been closed as of March 31, 2024.
- Zones continue to maintain readiness to add inpatient surge capacity in response to changes in demand, such as emerging viruses and wildfire season. This includes the Short-Term Capacity Escalation Plans to optimize patient movement through the ED in the Edmonton Zone, and the use of the Provincial Capacity Escalation Protocol and the Calgary Zone Acute Care Emergency Department to Inpatient Surge Unit Guideline in the Calgary Zone.
- In rural zones, transition teams are leading daily and/or weekly rounds in acute care facilities with high Alternate Level of Care numbers. Daily bed meetings are also in place to manage capacity and demand.

Flow within the emergency department is highly contingent on the efficient movement of patients across all areas of service delivery. Additional actions are described within the Improving Patient Flow and Continuity of Care section.

Performance Measure Results: Decreasing Emergency Department Wait Times



2019-20	2020-21	2021-22	2022-23	2023-24
4.3	3.4	4.5	6.2	6.7

Source: Scarlett, J. J. (2024). Performance Measures on Priority Actions [Tableau dashboard]. Data & Analytics/Alberta Health Services.
Note: The historical values for 2019-20, 2021-22, and 2022-23 have been restated with updated data.

Results:

- This measure represents the maximum length of time (in hours) 90 per cent of patients wait to see an ED physician after being triaged on arrival and helps evaluate the timeliness and efficiency of care delivery in the ED. Longer waits may result in poorer patient outcomes. The lower the number the better, as it demonstrates patients are receiving timely assessment and treatment in the ED.
- In 2023-24, the 90th percentile ED wait time to see a doctor (6.7 hours) deteriorated by 8.3 per cent compared to the same period last year (6.2 hours) and did not achieve the 2023-24 fiscal year target of 4.8 hours. Factors that influence ED wait times remain largely unchanged from previous reporting and include high ED volumes (1,983,852 visits in 2022-23; 2,028,196 visits in 2023-24), high average number of daily ED visits via ground ambulance (286,951 visits in 2022-23; 315,354 visits in 2023-24 via ground ambulance), short notice sick time and high vacancy rates amongst staff, and challenges with access to healthcare providers and patient flow.
- Using a similar definition, in 2022-23, Alberta ranked tied for 4th of seven provinces for the shortest time to see a physician in teaching hospitals (AB=6 hours; Canada=5 hours; Best Performing Province=4 hours) and 4th of seven provinces for community-large hospitals (AB=5 hours; Canada=5 hours; Best Performing Province=4 hours) (CIHI, 2022-23)[1].

[1] *Parts of this material are based on data and information provided by the Canadian Institute for Health Information (CIHI). However, the analyses, conclusions, opinions, and statements expressed herein are those of the author and not necessarily those of CIHI.*

Total time in ED for discharged patients (90% of the time in the 16 largest sites)

2023-24 Target: 8.8 hours

Desired Direction: ⇩

2019-20	2020-21	2021-22	2022-23	2023-24
8.4	8.5	9.5	11.2	11.7

Source: Scarlett, J. J. (2024). Performance Measures on Priority Actions [Tableau dashboard]. Data & Analytics/Alberta Health Services.

Results:

- This measure represents the maximum time (in hours) between triage in an ED and the time the patient is discharged or transferred from the ED for 90 per cent of patients. Patients that present to an ED should be assessed, treated, and discharged in a timely fashion if they do not require a hospital admission. The lower the number the better, as it demonstrates patients are receiving timely assessment and treatment in the ED.
- In 2023-24, patients treated in an ED and discharged stayed 11.7 hours or less 90 per cent of the time. This measure did not meet the 2023-24 fiscal year target of 8.8 hours and deteriorated by 4.9 per cent compared to 2022-23 (11.2 hours). Factors impacting length of stay for discharged patients include the higher acuity and complexity of elderly patients. Elderly patients tend to present with increased complexity and spend more time in EDs due to increased requirements for diagnostic testing and ability to safely return to their home environment.
- Using a similar definition, in 2022-23, Alberta ranked 5th of seven provinces for the shortest total time in ED for patients who were discharged home from teaching hospitals (AB=12 hours; Canada=10 hours; Best Performing Province=8 hours) and 4th of seven provinces for community-large hospitals (AB=9 hours; Canada=10 hours; Best Performing Province=7 hours) (CIHI, 2022-23)[1].

Total time in ED for patients admitted to hospital (90% of the time in the 16 largest sites)

2023-24 Target: 31.0 hours

Desired Direction: ⇩

2019-20	2020-21	2021-22	2022-23	2023-24
27.6	26.2	26.7	35.3	34.4

Source: Scarlett, J. J. (2024). Performance Measures on Priority Actions [Tableau dashboard]. Data & Analytics/Alberta Health Services.

Results:

- This measure represents the maximum total time (in hours) from time a patient is triaged in the ED to the time the patient leaves the ED for an inpatient hospital bed for 90 per cent of patients. The lower the number the better, as it demonstrates patients are receiving timely assessment and treatment in the ED, as well as being moved into a hospital bed to receive the right care in the right place.
- In 2023-24, the total time in the ED for patients admitted to hospital (34.4 hours) remained stable compared to compared 2022-23 (35.3 hours) but did not meet the 2023-24 fiscal year target of 31.0 hours. The target was not met due to the considerable impact the respiratory virus season had on this measure which saw the highest number of the most acute patients, a rise in patients 70 years or older, and record high EMS volumes to the ED during that period.
- Using a similar definition, in 2022-23, Alberta ranked 1st of seven provinces for the shortest total time in ED for admitted patients for teaching hospitals (AB=36 hours; Canada=47 hours; Best Performing Province=36 hours) and 2nd of seven provinces for community-large hospitals (AB=46 hours; Canada=53 hours; Best Performing Province=11 hours) (CIHI, 2022-23)[1].

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STRATEGIC PRIORITY

Reducing Surgery Wait Times

Through the Alberta Surgical Initiative (ASI), AHS is improving access to surgical care in Alberta. The goal is to reduce surgical wait times for all patients who are waiting outside of clinically recommended wait times. This target will be achieved by implementing a series of projects and initiatives targeted at increasing capacity and reducing wait times across the patient journey. Projects such as the Rapid Access Clinics (RACs) and the expansion of Chartered Surgical Facilities contracts and volumes will help to address the growing surgical demand across the province. Improved health system capacity and reduced wait times for surgical procedures will improve the health and quality of life experienced by Albertans.

Desired Outcomes:

- More Albertans will receive their surgeries within clinically recommended wait times.
- Surgeries will be offered at hospitals and chartered surgical facilities, depending on what best meets the clinical needs of any given patient while maximizing surgical capacity.
- Improved health system capacity and reduced wait times for surgical procedures will improve health and quality of life.
- Improved surgical and specialty access through central access and intake.

Actions & Achievements

Maximizing Surgical Capacity and Managing Waitlists

- Approximately 304,595 surgeries were completed across all acute care sites and chartered surgical facilities (CSFs) in 2023-24. This equates to 98.3 per cent of the volume targeted and reflects a 3.5 per cent increase over 2022-23. This is the highest total volume of surgeries completed by AHS in any prior year. Surgery workforce constraints (anesthesia, nursing, surgeons) remain the primary factor contributing to the variance against the annual target.
- Approximately 62,410 surgeries were completed at CSFs in 2023-24. This was 5 per cent higher than the targeted volume for 2023-24 (60,000 cases) and represents an increase of approximately 23 per cent above the 2022-23 volume (51,300 cases).
- Several existing CSF contracts were renewed or updated to optimize volumes and terms. AHS also implemented the CSF Information System, enhancing the analytics infrastructure for CSF case management, invoicing, and reporting.
- Approximately 50,090 surgeries were completed in rural operating rooms in 2023-24 which is a small improvement compared to the 49,650 completed in 2022-33.
- As of March 31, 2024, there were 27,159 surgery cases waiting longer than clinically recommended on the waitlist for adults; this is approximately 5,040 fewer cases than the start of 2023-24 (32,200).
- The 2023-26 AHS Health Plan that was approved by the Minister in April 2023 had indicated a target of 0 cases waiting outside clinically recommended wait times. While this target was not achieved, significant waitlist improvements were made including:
    - Approximately 3,720 fewer cases waiting beyond three times clinically recommended wait times compared to the start of the fiscal year (meeting the reduction target set for this group).
    - More than 62 per cent of surgery cases are waiting within clinically recommended wait times, which represents an improvement over the start of the fiscal year (52 per cent) and pre-pandemic measures (approximately 60 per cent).
- The Rural Surgical and Obstetrical Networks of Alberta (RSONA) was implemented in fall 2023 to support the optimization of rural surgical capacity. RSONA supports increased availability and use of rural operating rooms through consistent workforce availability as an enabler for increased surgical volume at RSONA networked sites. RSONA also increases the availability of 24/7 emergent surgical service access points to optimize patient care. This

[1] Total number of procedures completed at facilities contracted under the *Health Facilities Act (HFA)* and those completed at facilities not contracted under the *Health Facilities Act (non-HFA).*

initiative offers a framework through which inter-professional teams for both surgery and obstetrics can be linked through sharing of human and infrastructure resources.
    - As part of RSONA, development of Enhanced Surgical Skills (ESS) Core competency modules were completed developed in January 2024. An ESS coach and mentor was identified with resident training to begin in July 2024 and placement to occur in fall 2024.
- Work continues on implementation of the provincial surgery waitlist management operational directive intended to support achieving wait list reduction targets and improving on additional key performance indicators. Detailed analytics include delivery of individualized surgeon waitlist reports. Together these actions are expected to support surgeons and their offices, surgery leadership and AHS operational teams with ongoing waitlist validation, waitlist review and prioritized scheduling of cases waiting longer than clinically recommended wait times.
- Rapid Access Clinics (RACs), targeted at supporting the pre surgical patient journey, are being implemented in all zones. RACs will support waitlist reduction by providing faster access to specialist care using Expert Musculoskeletal Assessor (EMA) services (an EMA is a non-physician support who can perform a musculoskeletal assessment) for those patients waiting for orthopedic surgery.
- Ongoing development and implementation of clinical pathways for surgical specialities are underway. Pathways support primary care providers to manage patients within the community while providing specialist informed care within a primary care setting. The aim is to reduced referrals to specialist when appropriate.
- In September 2023, the Provincial Pathways Unit launched Alberta's Pathway Hub which provides a centralized website for evidenced informed clinical and referral pathways for primary care providers across Alberta.
- Ongoing implementation of central access and intake of projects like FAST (Facilitated Access to Specialty Treatment) will continue to improve the referral processes for surgery. Surgical subspecialties including vascular and general surgery were launched in 2023-24 with the remaining surgical subspecialties (planned for launch in the 2024-25 FY).

Increasing Surgical Workforce

- The overall RN surgical vacancy rate dropped from 12.0 per cent in Q2 to 8.5 per cent in Q4.
- Additional strategies are being developed to improve the recruitment and transition of nursing graduates, international educated nurses, and students.
- The draft AHS surgery workforce plan for 2024-25 is being updated with strategies to improve recruitment and retention of the AHS surgical workforce and align with the current organizational workforce initiatives. Recruitment and retention strategies for accelerated initiatives are being updated based on changes to the 2024-25 budget.
- In 2023-24, approximately 10,558 procedures were completed under the Anesthesia Care Team (ACT) model which supports one anesthesiologist directing surgeries with support from appropriately trained clinical staff such as respiratory therapists, clinical assistants, or anesthesia assistants. In the second half of 2023-24, there were four additional ACT models implemented which resulted in an estimated total of 824 days of anesthesiologist time released to support other surgical procedures.
- In February 2024, the first cohort of 10 participants completed AHS' Anesthesia Assistant Educational Program with an additional seven participants starting in March 2024. Anticipated completion is July 2024.
- AHS received provisional accreditation approval for an in-house Anesthesia Assistant Training Program. The first cohort will begin training in early 2024 and upon completion, will allow for expansion of the Anesthesia Care Team model.
- A full update on the expansion of the ACT model can be found under the priority: A Sustainable Workforce.

Improving Surgical Outcomes

- Activity is underway to implement the recommendations from the Institute for Healthcare Optimization (IHO) to support improved surgical flow and management. In Phase 1, sites are working with the IHO team to implement recommendations to reduce unscheduled and scheduled surgical variation to improve surgical throughput at the six initial sites. Ten additional sites are scheduled for implementation in summer 2024.
- Site surgical teams continue to employ a range of interventions including regular provincial learning sessions to reduce surgical site infections and other complications. National Surgical Quality Improvement Program data is summarized and shared with site, zone, and AHS leadership on a quarterly basis. ERAS pathways and practices are being implemented at participating sites and surgical outcome improvement activities have been included as part of the Acute Care Bundle Improvement initiative.

PERFORMANCE MEASURE RESULTS: REDUCING SURGERY WAIT TIMES

Total annual number of surgeries completed provincially
(cumulative total number of surgeries completed)

2023-24 Target: 310,000

Desired Direction: ↑

2019-20	2020-21	2021-22	2022-23	2023-24
295,000	277,000	278,600	294,300	304,595

Note: Historic surgical values have been adjusted due to the reconciliation of Chartered Surgical Facility data and improvements in methodology. As AHS continues to optimize methods for improved reporting, these numbers may be subject to further changes.
Note: Surgical volume data was extracted June 5, 2024.

Results:

- As of Q4YTD, 304,595 surgeries were completed across the province and equates to 98.3 per cent of the volume targeted for 2023-24. While this measure did not meet the 2023-24 fiscal year target of 310,000 surgeries, it increased by 3.5 per cent compared to 2022-23 (294,300). Surgical workforce constraints remain the primary factor contributing to variance against annual targets. Surgery planning for the 2024-25 fiscal year has been completed with a continued focus on maximizing surgical capacity across the province and increasing surgical volumes where feasible.
- The higher the number the better, as it demonstrates more procedures are being completed.

Number of cases on waitlist outside clinically recommended wait times at all sites (except Stollery & Alberta Children's Hospitals)

2023-24 Target: 0

Desired Direction: ↓

2019-20	2020-21	2021-22	2022-23	2023-24
27,200	35,664	43,597	32,199	27,159

Note: Historical data has been restated for 2020-21, 2021-22 and 2022-23 due to reporting updates.

Results:

- This measure represents the total number of cases booked and waiting for scheduled surgery where the wait time exceeds the clinical target guideline. The lower the number the better, as it indicates that fewer patients are waiting longer than clinically recommended time frames for surgery.
- In 2023-24, there were 27,159 adult surgery cases waiting longer than clinically recommended. This measure improved by 15.7 per cent compared to 2022-23 (32,199) but did not meet the 2023-24 fiscal year target. The target was not achieved due to reduced seasonal activity, ongoing workforce shortages and suboptimal waitlist management practices. Accelerated waitlist reduction is being targeted through enhanced waitlist management practices and prioritization of cases waiting the longest. Provincial townhall sessions, enhanced analytics and individual surgeon reports are also expected to improve surgeon awareness of their out-of-window cases.

STRATEGIC PRIORITY

Improving Local Decision-Making

AHS aims to balance the benefits of an integrated provincial system with flexibility and innovation at the local level. Leaders should feel empowered to make decisions, be free of administrative burdens, and encourage recommendations from front-line staff on long-term reform. By improving and simplifying internal processes, AHS can improve the local decision-making culture and focus efforts on patient care.

Desired Outcomes:

- Leaders feel safe and empowered to make the decisions appropriate to their role.
- Administrative burden is reduced to only that which is essential to the role.
- Input from frontline staff informs and supports recommendations for long-term reform.

Actions & Achievements

Continue to receive, prioritize, and action feedback from frontline leaders, staff, and physicians in areas where local decision-making can be enhanced

- Various avenues were explored to elicit feedback and inform local and program-based decision-making with frontline leaders, staff, and physicians. This included the 2023 Our People Survey which included questions aimed at identifying opportunities to improve local decision-making. Results indicate that further work is required to better respond to local needs and support local decision-making. Leaders have been encouraged to work with teams to identify actions and opportunities for improvement at the local level.
- Other avenues for eliciting feedback included rural acute care town halls, establishment of quality councils, review of patient satisfaction survey results, engagement sessions, newsletters and monthly meetings for staff, physicians, and volunteers to provide suggestions for areas of improvement.
- The *Learn, Improve Together (LIT)* model has continued to develop through consultation and workshops to facilitate efficient and integrated quality management, improvement, and innovation across AHS. A list of potential Program Improvement and Integration Networks (PINs) was approved by AHS leadership and the LIT model will be implemented in 2024-25.

Provide training and development opportunities to empower frontline leaders to make decisions within their accountability

- Efforts are being made to ensure that leaders are aware of their position's formal decision-making authorities, and that they are provided with support and mentorship to act within these parameters.
- To further enhance leadership decision-making authority, education sessions were held across zones on various topics such as understanding legislative responsibilities and performance management. Further training and development opportunities are available through MyLearningLink, scheduled seminars and various workshops.
- Clinical resources have also been developed to support Leadership in implementing practices and processes in their areas (e.g., Nurse On-Call, Medication Assistance Program training, & Foot Care resource).

Continue to make amendments to work related to financial and human resources Delegation of Authority

- Changes to the Delegation of Human Resources Authority (DOHRA) and Delegation of Approval Authority continue to be reviewed and amended opportunities for process and policy enhancements are made.
- The Delegation of Financial Authority remains under review to align with the format and classifications used in the DOHRA.

Increase thresholds or remove the requirement for executive level approval on human resource and financial matters, unless required by the Delegation of Authority Guidelines

- As a result of cost management pressures, thresholds, and requirements for executive level approvals on human resource and financial matters were increased in Q4. To further address AHS' budgetary deficit, vacancy management, vacation management and cost management related to discretionary spending were reinstated.

Review and optimize the organizational approach to benchmarking and Activity Based Budgeting and other related financial processes and tools

- Following the establishment of a multi-disciplinary committee to review current methodology, approval was received to allow operational areas to make skill mix changes or transfer budgets from one department to another providing that the changes are budget neutral.
- Operational areas are also assisting in determining the activity-based budget and benchmarking/operational best practice methodologies and are awaiting review and approval from an appropriate AHS governing council.

Support frontline leaders in identifying and implementing recruitment and hiring processes

- Recommendations from the recruitment process review are being explored by clinical operations teams and decisions regarding implementation are being retained at the zone level to improve the ability to fill vacancies. Incremental improvements to the Recruitment Management System were also completed.
- A full update on recruitment can be found under priority: A Sustainable Workforce.

Streamline processes in other corporate areas such as information technology, procurement, facilities, and property management to support frontline leaders in decision-making within their accountability level

- A limited production rollout of the Information Technology (IT) Entitlement initiative has been implemented to consolidate and automate the provision of common software, devices and access requests for new hires and transfers, thereby simplifying the process for managers. This initiative will help streamline IT requirements for the 17,000 employees who are hired and 64,000 employees who are transferred each year across AHS and its subsidiaries.
- AHS teams are reviewing the availability of contracted office furniture and developing processes to determine office replacement and contract renewals that best suit staff needs.

PERFORMANCE MEASURE RESULTS: IMPROVING LOCAL DECISION-MAKING

Number of policies rescinded to support local decision-making
(net reduction of policy documents from April 5, 2019)

2023-24 Target: Net reduction of 5,139 policy documents or 80%

Desired Direction: ⇩

2019-20	2020-21	2021-22	2022-23	2023-24
2,747	3,680	4,165	4,939	5,180

Results:

- This measure represents the net reduction in the number of AHS policies, procedures, standards, guidelines, protocols, and directives (collectively, 'policy documents') over a fiscal year. It is calculated by counting the number of active policy documents in the AHS Services library at the end of the fiscal year and comparing it to the number at the beginning of that fiscal year.
- In 2023-24, there was net reduction of 5,180 policy documents. This measure met the 2023-24 fiscal year target of 5,139 policy documents rescinded, and improved by 4.9 per cent compared to 2022-23 (4,939).

Workforce experience with local decision-making

(Leader's Satisfaction Survey results)

2023-24 Target: Survey Baseline

Desired Direction: ↑

2023-24
3.21

Note: The Leader's Satisfaction Survey was developed in 2022-23 and first administered in 2023-24. Average score from the survey question "I feel supported to make decisions locally" was used as the baseline on a scale of 1-5 where 1 is strongly disagree and 5 is strongly agree.

Results:

- The Leader's Satisfaction Survey was first administered in 2023-24, and the average score (on a scale of 1 to 5 where 1 is strongly disagree and 5 is strongly agree) for the survey question "I feel supported to make decisions locally" will serve as the baseline for this measure. The higher the score the better, as it indicates that more leaders/managers feel AHS is making progress on local decision-making processes and support.

STRATEGIC PRIORITY

Improving Patient Flow and Continuity of Care

AHS is improving how patients move in a timely and efficient way through the healthcare system. For example, by increasing continuing care capacity, we will reduce pressure on acute care and allow the placement of critical patients waiting in emergency departments for inpatient beds. Investing in the expansion of care in the community affects capacity throughout the system and leads to improved access to care. Appropriate use of acute and community care services is critical to increasing efficiency throughout the continuum of care.

Desired Outcomes:

- Patients will have timely access to necessary acute and community care beds and services.
- Improved patient flow through acute inpatient wards and out to community.
- Acute and community care service utilization is appropriate.
- Continuing care transformation investments will shift more care to the community, enhance workforce capacity, increase choice and innovation, and improve quality of care.

Actions & Achievements

Improving capacity and flow in acute care

- AHS opened 221 new permanent acute care beds in 2023-24. This is included approximately 50 beds added in the fall of 2023 during peak respiratory virus season.
- Following review of existing healthcare capital, 2023 AHS Multi-Year Facility Infrastructure Capital submission was finalized and submitted to the Government of Alberta.
- Zones continue to maintain readiness to add inpatient surge capacity in response to changes in demand. A full update can be found under the priority: Decreasing ED Wait Times.
- The Acute Care Bundle Initiative (ACBI) was implemented in the 14 highest volume acute care sites (excluding Alberta Children's Hospital and Stollery Children's Hospital). This initiative is based upon co-design strategies to improve patient transition practices enabled by Connect Care. As part of the initiative, a provincial reporting dashboard providing real-time access to meaningful data for reducing length of stay was developed.
- To ensure minimal variation between expected and actual date of discharge, implementation of transition tools such as LACE, Discharge Summary Templates, and My Next Steps is ongoing at the 14 highest volume sites (excluding Alberta Children's Hospital and Stollery Children's Hospital). In addition, the development of transition education tools was completed, and education sessions are now being held through the ACBI Community of Practice and with sites that have identified patient transitions as a focused area of improvement.
- In the South Zone, site-based scorecards have been updated for both regional hospitals with medicine and surgery teams having site-specific action plans to implement ACBI initiatives including expected date of discharge, early mobilization, and implementation of clinical pathways. In the North Zone, a position has been recruited to help implement the ACBI.
- In the Edmonton Zone, kidney dialysis services were expanded by six new patients in Lac La Biche and 12 new patients in Wetaskiwin. The Edmonton General Dialysis Unit relocated to the Gene Zwozdesky Centre Norwood Hemodialysis Unit in November 2023 and increased capacity from 23 to 30 hemodialysis stations. Additionally, the West Edmonton Kidney Care Clinic opened three Shared Care hemodialysis stations in October 2023 and will be opening three additional stations in June 2024.
- In the Calgary Zone, quality improvement work related to living donation transplant referral processes and sustaining active transplant waitlist is underway.
- A provincial Alberta Kidney Care Service Model is being developed to map anticipated dialysis and kidney care needs for the next five to 15 years. In the South Zone, four of 16 beds were launched in 2023-24. The program was paused in Q4 due to cost management pressures and will recommence once approved funding is received.
- In the Edmonton Zone, admissions to Virtual Home Hospitals increased by 62 per cent compared to the same period last year (from 509 to 827 admissions), and expansion of Digital Remote Patient Monitoring (dRPM) was facilitated through the addition of 30 kits to the inventory, for a total of 180 kits.
- Expansion of the Virtual Home Hospital program in other zones is underway.

- AHS has begun optimizing Referral, Access, Advice, Placement, Information and Destination (RAAPID) call flow and referral pathways to enable seamless access to specialty consultation. As of 2023-24, 17 flow maps have been reviewed with an additional five maps under consultation with clinical services.

Enhancing continuing care and community services

- In 2023-24, 866 net new beds/spaces were staffed and placed into operation as part of the Community Care Capacity Plan (including 623 long-term care and designated supportive living beds, 7 community palliative and end of life care, 103 Integrated Home Living/other and mental health and addiction wrap-around, 148 community mental health and addiction spaces, and a decrease of 15 sub-acute spaces), meeting the target of 750 beds/spaces.
- In 2023-24, 36 community-based recovery-oriented support beds were opened in Edmonton as part of the Bridge Healing Program. A comprehensive evaluation of the program pre and post intervention is ongoing with results expected in June 2024.
- AHS opened 235 temporary Continuing Care beds (158 net new and 77 repurposed) during 2023-24.
- As of 2023-24, the South Zone added 24 continuing care transition beds and 12 restorative care beds along with 4.5 FTE social workers recruited to assist with expediting discharges and transitions to community care to reduce Alternate Level of Care (ALC) days in acute care.
- In the Calgary Zone, 27 temporary ALC/Transition beds were added by converting underutilized long-term care beds. A feasibility study is also in progress regarding the commissioning of units at the Holy Cross Centre to ALC/Transition units.
- In the Central Zone, an eight-bed ALC unit was opened at the Ponoka Hospital and Care Centre in November 2023, and 10 temporary ALC spaces were opened in the Edmonton Zone.
- A number of ALC spaces have been opened across the North Zone including a 10-bed transition unit in Fort McMurray, six transitional beds in Peace River and the temporary conversion of 11 existing vacant Continuing Care Home Spaces in Valleyview and Westlock.
- To reduce ALC days in acute care, AHS is participating in a weekly cross-ministry meeting with the Government of Alberta focused on ALC reduction. An ALC Reduction Steering Committee has also been formed for the purpose of identifying strategies with the greatest potential to improve ALC patient outcomes, optimize resource utilization and reduce the length of stay in acute care, while ensuring patients receive the appropriate level of care in the most suitable setting.
- To support consistent daily admissions into continuing care (seven-days a week) in 2023-24, AHS facilitated 405 weekend admissions. This met the target of 400 weekend admissions.
- The implementation of the Client Directed Home Care Invoicing (CDHCI) program was completed for Central, North, and South Zones with all zones actively enrolling clients. The program has expanded throughout the North Zone and is offering CDHCI wherever vendor support is available. The total number of clients served through the CDHCI program has grown from 856 clients served in August 2023 in the Calgary and Edmonton Zones to 2,026 clients served to the end of March 2024 in all zones.
- The Rural Palliative Care In-Home Funding Program supports the provision of end-of-life care in rural and remote areas so clients can remain at home instead of being admitted to hospital. In 2023-24, 442 clients have been served by the program. For clients that that were part of the program and passed away, 74 per cent died at home and were supported by the program for an average of 43 days.
- The Alberta Health Continuing Care Transformation Initiative, with a target to increase care to 500 net new Palliative and End-of-Life Care (PEOLC) clients by 2025-26, commenced in Q4 2023-24. The first-year target of providing PEOLC care at home to 21 net new clients was met.
- Re-contracting of community home care services with contracted heath service providers across the province was completed during 2023-24.
- Existing Congregate Living Environment home care contracts have been updated and signed with an expression of interest (EOI) posted for new operators interested in contracting with AHS for care within their congregate building. The EOI proposals are currently under review.
- AHS evaluated home care innovation proposals submitted by qualified operators in Q1 2023-24. Innovation proposals moving forward as part of the Continuing Care Transformation include:
    - Partnership with a contracted pharmacy vendor in Edmonton Zone for enhanced medication compliance among marginalized individuals with complex health conditions and social barriers such as homelessness and financial stressors. Contracts are signed and the program is ready to being enrollments.

- Rimbey Evening Adult Day Program with Family and Community Support Services (FCSS) program enhances services in a rural area enabling enhanced caregiver supports. Contracting was completed and FCSS is ready to begin enrollments.
- The Adult Overnight Program in Calgary is designed to provide caregiver relief and enable caregivers to have an undisturbed nights rest. The program design and contract work were completed in 2023-24.

PERFORMANCE MEASURE RESULTS: IMPROVING PATIENT FLOW & CONTINUITY OF CARE

Number of patients waiting in hospital for Continuing Care placement

2023-24 Target: 194

Desired Direction: ⇩

Note: Number of patients waiting in hospital approved and ready for placement in Designated Supportive Living or Long-Term Care in the 14 highest volume acute care sites (excluding Alberta Children's Hospital & Stollery Children's Hospital).

2019-20	2020-21	2021-22	2022-23	2023-24
215	190	216	240	205

Results:

- This measure represents the number of persons who have been assessed and approved for placement in publicly funded continuing care living options, who are waiting in a hospital acute care or sub-acute bed in one of the 14 highest volume acute care hospitals (excluding Alberta Children's Hospital and Stollery Children's Hospital) at a specific point in time. The lower the number the better, as it demonstrates availability of long-term care or designated supportive living beds, as well as overall system efficiency through timely and appropriate access to continuing care.
- At the end of March 2024, there were 205 patients waiting in hospital for continuing care placement. This measure did not meet the 2023-24 fiscal year target of 194 patients but improved by 14.6 per cent compared to end of March 2023 (240). Although AHS opened 771 continuing care (623) and community mental health and addiction beds (148) over the fiscal year, this was not sufficient new capacity to meet demand. In addition, AHS responded to a request for assistance from the Northwest Territories to support long-term care evacuees due to wildfire in Q2 which resulted in a decrease in the number of beds available in the community that were able to accept a transfer from acute care.

Ratio of acute length of stay to expected length of stay in 14 highest volume sites

2023-24 Target: 1.00

Desired Direction: ⇩

Note: 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	2023-24
1.03	0.98	0.98	1.01	1.02

Results:

- This measure represents the ratio of the total number of patient days, excluding alternate level of care (ALC) days, in inpatient acute care hospitals compared to the total acute length of stay that is expected based on factors such as patient age, diagnoses and interventions. A ratio greater than one indicates the acute length of stay was longer than expected, and a ratio less than one indicates the acute stay was shorter than expected, potentially representing greater efficiency and that more patients can be treated for a given inpatient bed.
- In 2023-24, the ratio of acute length of stay to the expected length of stay in the 14 highest volume adult acute care hospitals (excluding Alberta Children's Hospital and Stollery Children's Hospital) (1.02) remained stable compared to the same period last year (1.01) and did not meet the 2023-24 fiscal year target of 1.00. The target was not met due to high demand on the acute care system over the past six months (including during respiratory virus season) as well as increased complexity and acuity of patients.

- Using a similar definition, in 2022-23, Alberta ranked tied for 2nd among nine provinces for the lowest ALOS:ELOS ratio (AB=1.01; Canada=0.98; Best Performing Province=0.93) (CIHI, 2022-23)[1].

Home care clients served

2023-24 Target: 131,500

Desired Direction: ⇧

Note: Total number of individual clients within a Home Care program. (Note: The Alberta Health Business Plan refers to this measure as unique home care clients served.)

2019-20	2020-21	2021-22	2022-23	2023-24
124,779	117,502	122,084	126,539	130,111

Note: Numbers are understated for 2023-24 as a site in one zone was involved in Connect Care Implementation and data was not available at time of reporting. Historical data have been restated for 2019-20, 2020-21, 2021-22 and 2022-23 due to reporting updates.

Results:

- This measure represents the total number of unique individuals with an active registration in the Home Care Program. 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. Monitoring this measure can help evaluate system capacity and barriers to access. The higher the number the better, as it demonstrates improvement in home care services capacity.
- In 2023-24, there were 130,111 home care clients served. This measure improved by 2.8 per cent compared to the 2022-23 fiscal year (126,539) but did not meet the target of 131,500 clients served. It should be noted that 2023-24 value of 130,111 is missing data from one site in Central Zone. It is estimated that the number is under-reported by approximately 1,200 home care clients served.

[1] *Parts of this material are based on data and information provided by the Canadian Institute for Health Information (CIHI). However, the analyses, conclusion, opinions and statements expressed herein are those of the author and not necessarily those of CIHI.*

STRATEGIC PRIORITY

Strengthening Mental Health and Addiction Recovery-Oriented Services and Supports

Working with the Ministry of Mental Health and Addiction, AHS aims to enhance access and expand capacity to addiction and mental health (AMH) services. AHS has focused on implementing new models of care, improving integration and coordination with community partners, and increasing capacity and access for those living with addiction and/or mental health issues. AHS has also implemented initiatives to address child and youth wait times across the province and has offered a range of community-based services, supports, and treatments in response to the addiction crisis. As of July 1, 2024, AHS will no longer provide mental health and addiction service delivery. These services will be coordinated through Recovery Alberta.

Desired Outcomes:

- Improved access to a continuum of recovery-oriented services and supports in the community (including virtual options) for Albertans living with, or at risk of mental health or addiction issues.
- Albertans seeking AMH services experience continuity of care between AHS and community service providers.

Actions & Achievements

Continue to support the Ministry of Mental Health and Addiction to address recommendations from the *Alberta Mental Health & Addiction Advisory Council Report: Toward an Alberta Model of Wellness*

- AHS continues to work with the Ministry of Mental Health and Addiction to address recommendations from the *Toward an Alberta Model of Wellness* report.

Continue to work with the Ministry of Mental Health and Addiction to prioritize the design and implementation of standardized AMH models of care

- Implementation of My Recovery Plan (MRP) continues with AMH contracted agencies and AHS bed-based services. Twenty-three contracted service providers that were identified for implementation of Phases 1 and 2 are actively using MRP with clients. Phase 3 implementation of MRP within 10 AHS-operated bed-based addiction treatment sites was initiated March 31, 2024.
- Provincial standardization and expansion of medical detoxification and bed-based addiction treatment continues with clients being accepted by all contracted service providers identified for funding. In 2023-24, capacity has increased by 6 young adult treatment beds and 51 bed-based addiction treatment service beds.

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

- A Virtual Consultation Service model has been developed to support local AMH programs and services due to service pressures in primary care and child and adolescent psychiatry. AMH will continue to work with the Ministry of Mental Health and Addiction to advance virtual models of care under the Toward Alberta Wellness model.
- In 2023-24, the Virtual Opioid Dependency Program (VODP) has provided services to 6,595 unique clients from 239 different communities across Alberta.

Continue to work with the Ministry of Mental Health and Addiction, other ministries, and community partners on strengthening the integration and coordination of AMH services

- AHS and other provincial ministries are collaborating to provide housing and treatment for youth and emerging adults with complex needs (e.g., trauma, cognitive impairment, educational and vocational supports). This includes implementation of a community-based intensive in-home treatment model with youth and emerging adults with complex needs.
- Provincial standardization of Supervised Consumption Services continues to advance. Initiation of new Overdose Prevention Services in Edmonton (Strathcona) is pending.

- The Youth VODP continues to expand and as of 2023-24, has increased from 42 to 88 clients from 20 different communities across Alberta.

Work in partnership with the Ministry of Mental Health and Addiction to conduct a review of AHS expenditures related to AMH services and make recommendations for alignment with recovery-oriented systems of care

- AHS worked with the Ministry of Mental Health and Addiction to provide the necessary data and information to support the expenditure review and future planning.

Work with the Ministry of Mental Health and Addiction on reporting addiction and recovery performance for consideration in future years

- AHS is collaborating with reporting teams in the Ministry of Mental Health and Addiction to support analysis of AHS data sources for development of potential performance measures.

Further consider models to expand capacity and improve accessibility

- Access AMH continues to support residents living in southern, central, and northern Alberta by providing a primary point of entry to non-urgent AMH services. In 2023-24, Access AMH received 24,018 calls, compared with 27,929 calls in 2022-23. During this period, the clinics in southern Alberta and remaining half of northern Alberta launched Connect Care, enabling care coordination between Access AMH and community clinics. This enhanced efficiency allowed for fewer repeat calls into the Access AMH system and resulted in a lower number of calls.
- An addiction recovery program framework is under development to provide addiction medicine consultation services. This program is being established to better support Alberta's busiest acute care sites to serve individuals with behavioural addiction and non-opioid substance use disorders. Implementation is anticipated for 2024-25.

Address child and youth wait times for community AMH services by increasing the number of group sessions, increasing the number of initial appointments completed by therapists per month, and strengthening relationships between AHS and community operators

- In the Edmonton Zone, median wait times for children's community mental health services was reduced from 46 days in Q1 to 26 days in Q4. Process improvements to centralized intake, regular case load reviews promoting goal-oriented care and outflow to primary care, and adapting the workforce to enhance recruitment all contributed to decreased wait times.
- In the Calgary Zone, group sessions are being offered through community programs such as the Child and Adolescent Addictions Mental Health & Psychiatry Program and The Summit Centre. In addition, first group sessions are being offered within a week of referral and community clinics have operated without a waitlist throughout 2023-24.
- In the South Zone, teams have been successfully filling long-standing position vacancies and have been working with new Connect Care dashboards to monitor wait times for service to ensure timely connection to services for clients in rural communities. Relationships have continued to develop between community operators and schools with the clinic-based programs across the zone.

Improve access and integration of AMH services with first responder models of care to support response to local pressures

- The Provincial Law Enforcement Mental Health Line is providing services to RCMP and other police services in all rural areas. Optimizing this virtual service with along with Health Link/811 will continue in 2024-25.
- A number of mental health and addictions resources have been established for the Indigenous community including the Honouring Life Grant Program and the Indigenous Continuum of Addictions and Mental Wellness Grant Program, which have been detailed under the "Improving Engagement and Access to Care for Rural and Indigenous People" priority in this report.

PERFORMANCE MEASURE RESULTS: STRENGTHENING MENTAL HEALTH & ADDICTION RECOVERY-ORIENTED SERVICES & SUPPORTS

Child and youth wait times for core community outpatient AMH services (50th percentile) – median days

2023-24 Target: 20

Desired Direction: ↓

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	2022-23	2023-24
15	14	20	21	21

Results:

- This measure represents the maximum number of days at which 50 per cent of individuals aged 17 or younger received their first scheduled therapeutic appointment for basic, core mental health outpatient/community treatment services from the date the referral was received. This measure helps evaluate system capacity to meet patient demand as long wait times for AMH outpatient services contribute to overreliance on urgent and emergency care services. The lower the number the better, as it demonstrates children and youth are waiting for a shorter time to receive community outpatient AMH services.
- In 2023-24, children and youth waited 21 days or less for core community outpatient AMH services 50 per cent of the time. This measure has remained stable compared to the same period last year (21 days) and has not met the target of 20 days due to challenges with recruitment of child and youth therapists.

STRATEGIC PRIORITY

Improving Engagement & Access to Care for Rural and Indigenous People

Opportunities exist for AHS to improve relationships and connections with rural and Indigenous Peoples, regardless of where they live in Alberta, to ensure their unique healthcare needs are addressed and to enhance access to services. This work aligns in part with *AHS' Indigenous Health Commitments: Roadmap to Wellness*. Through enhanced engagement, AHS will continue to build trust and better reflect the needs of diverse communities and populations when delivering healthcare. Both zonal and functional operational plans will outline plans for AHS to strengthen partnerships and develop innovative care and service models that better meet the health needs of rural, remote, and Indigenous communities, span the continuum of care, and focus on community-based care.

Desired Outcomes:

- Better reflect the needs of Indigenous Peoples, diverse communities, and populations by increasing their opportunities for Albertans to inform the future of healthcare delivery.
- Improved recruitment and retention of clinical staff in rural and remote areas of the province.
- Improved quality and access to care in rural and remote communities through virtual care options.
- Improved access to primary care, mental health and addictions services, and cultural safety supports to better meet the needs of First Nations, Metis, and Inuit Peoples.

Actions & Achievements

Strengthen engagement with advisory councils such as the Health Advisory Councils and the Wisdom Council and Elder Circle to improve access to quality care for rural and Indigenous Peoples

- AHS supported 26 Health Advisory Council meetings and events, which welcomed more than 450 members of the public to contribute to clinical service planning, discuss mental health and addiction services, and learn about Health Link, Connect Care, and other topics identified by council members as priorities for the communities they represent. Five Provincial Advisory Council meetings were also held, with 35 members of the public attending.
- Advisory Councils provided input to Accreditation Canada Surveyors, the Edmonton Zone Primary Care Network, and the Addiction and the Mental Health subcommittee regarding access to psychiatry services. The councils also provided information through primary care physicians, a hand hygiene workshops, and the Alberta Organ and Tissue Donation Program Naming Survey.
- AHS supported three Wisdom Council meetings which focused on addressing racism to increase Indigenous patients' sense of safety when accessing services, providing guidance and advice on operational planning, and contributing to development of an AHS engagement strategy inclusive of First Nations, Metis and Inuit in Alberta.
- Topics with increased public interest included a session on palliative care and end-of-life care, Medical Assistance in Dying (MAID), a session on the retention of healthcare professionals, and a session on advancing access to healthcare for racialized populations.
- Nearly 19,600 Albertans engaged with AHS through the Together4Health online platform by completing surveys on Zone Healthcare planning, contributing to branding activities, and sharing their healthcare experiences. This included a survey of Calgary Zone staff, physicians and volunteers that received 1,645 responses. In addition, more than 650 staff joined 15 employee-specific engagement sessions on similar topics: zone healthcare planning, clinical services planning and wildfire preparations.
- More than 430 Albertans joined virtual engagement sessions to discuss topics such as preparation for the 2024 wildfire season, the Virtual Opioid Dependency Program, and clinical services planning. As of March 31, 2024, 7,000 Albertans have subscribed to AHS' bi-weekly e-newsletter; the average open rate (percentage of emails opened) in 2023 was 41.6 per cent (the average across industries in 2023 was 21 per cent).

Co-develop zone-based Indigenous Health Action Plans (IHAP) in South, Central, Edmonton and North Zones and implement the Calgary Zone IHAP in collaboration with First Nations, Metis, and Inuit peoples, in alignment with protocol agreements, where they exist

- In the North Zone, a draft of the Indigenous Health Action Plan (IHAP) was completed in collaboration with Indigenous Elders and leaders. Several initiatives have also been implemented including:
    - Development of partnerships with First Nation and Metis groups to improve primary healthcare.
    - Consultations with Frog Lake Cree Nation, Cold Lake First Nations, and Metis settlements to listen to concerns, build positive relationships and ensure safe spaces for Indigenous patients and families within these communities.
    - Recruitment of an Indigenous liaison for Beaverlodge and Horse Lake.
- In the South Zone, engagement sessions were held with First Nation and urban Indigenous populations and a first draft of the IHAP was completed in March 2024.
- Implementation of the IHAP in the Calgary Zone in 2023-24 has included committee operational meetings and meetings with National Health Directors that occur on a quarterly basis, activation of a Zone Eliminating Racism Working Group, and regular partnership discussions with First Nation, Metis, and Inuit communities.
- In the Central Zone, relationships continue to be built with First Nations communities, Indigenous organizations, and partners with a focus on addressing racism in the emergency department and discharge planning process. This includes the Montana, Ermineskin, Louis Bull Tribe, Samson Cree, Sunchild, O'Chiese, and Big Horn First Nations, as well as the Rocky Friendship centre, Red Deer Friendship Centre, Samson Community Wellness and Urban Aboriginal Voices organizations.
- In the Edmonton Zone, the IHAP has been completed in partnership with Indigenous communities and partners. Regular IHAP Steering Committee meetings are scheduled and relationships continue to be fostered through active engagement, ceremonies and the establishment of four task forces to implement the IHAP actions.

Explore accessible service provider models with physicians, pharmacists, nurse practitioners and midwives for rural and remote communities and expand access to virtual supports through the Alberta Indigenous Virtual Care Clinic (AIVCC)

- The Nurse Practitioner Locum Pool continues to provide coverage for rural communities to provide support to avoid service disruption. Areas supported include High River, Didsbury, Daysland, Fort McMurray, and Ponoka. Most locum requests have been to support the integration of the Nurse Practitioner (NP) as the Most Responsible Practitioner in rural emergencies and inpatient settings. The NP Locum Pool has also been used to support Continuing Care and Sexual Transmission Infection/Reproduction clinics.
- In 2023-24, 120 family physician recruits and 82 specialist recruits accepted offers of employment in the South, Central and North Zones. Progress continues with introducing mid-level and advanced alternative providers, such as nurse practitioners, clinical assistants and physician assistants into rural and/or regional centres.
- NP Staff Rules is nearing approval with an implementation plan designed to support practice and culture change management. This is a foundational piece to the integration of NP provider models in rural settings.
- The Indigenous Wellness Alternative Relationship Plan provides holistic primary care services to Indigenous peoples in their home communities including in urban centers at the Indigenous Wellness Clinic (Edmonton), Bigstone Medical clinic (Inglewood Professional Centre, Edmonton) and Elbow River Healing Lodge (Calgary). These services foster a culturally safe approach that integrates the mind, body, spirit, and emotions.
- Primary care services are provided through the AIVCC in First Nations communities and in Metis Settlements to overcome geographic, economic, political, cultural, and socio-historical barriers faced by Indigenous Peoples. Since its inception in November 2020, the AIVCC has successfully completed 19,474 appointments and has increased the number of appointments completed each year by 58 per cent in 2022-23 and an additional 77 per cent in in 2023-24.
- The Indigenous Wellness Clinic at the Royal Alexandra Hospital in Edmonton provides a culturally informed and safe environment for Indigenous patients and their families to receive care and the best health outcomes within a multidisciplinary team. The clinic provides primary care services and holistic individual and group support to Indigenous patients of all ages. In 2023-24, the clinic completed 5,985 visits.

Expand Indigenous cultural supports (e.g., Indigenous Spiritual Ceremony, Elder supports) in AHS facilities to promote cultural safety across AHS

- There are currently over 50 Indigenous cultural support positions in AHS facilities across the province including Elders, Indigenous Hospital Liaisons, Traditional Wellness Counsellors, Cultural Helpers, Indigenous Patient Navigators, and Indigenous Health Coordinators. These positions help increase satisfaction with the care Indigenous patients receive, increase trust, and create a safe space for Indigenous people to interact with the healthcare system. In 2023-24, 91 per cent of the 15.4 FTE positions that were added in 2022-23 have been filled.
- Access to the Indigenous Cultural Support workers at AHS sites has increased through updated web content, enhanced connections with the Indigenous Support Line, and the Indigenous Health Consult Order Tip Sheet which guides providers on how to access Indigenous cultural support.
- To enhance care provided to Indigenous patients and communication with AHS, 38 Indigenous Cultural support staff across the Calgary, Edmonton, Central and South Zones were provided with augmented training in Connect Care, creation of clinical documents, and the process to enable informed consent as a core ethical principal. A Connect Care Community of Practice was also established to help Indigenous cultural support staff navigate emerging challenges and issues.
- The Patient Access to Indigenous Spiritual Ceremony Policy was developed and implemented in June 2023. The policy, which is Canada's most comprehensive policy on access to Indigenous ceremonial practices, provides Indigenous patients and their families with consistent access to ceremonies and practices that help healing in mind, body, spirit and emotion. AHS facilities were provided with guidance on implementation of the policy as well as web-based resources and support.
- AHS supported the Northwest Territory evacuation of over 21,000 residents to Alberta and worked with municipalities to support reception centers with cultural safety and Indigenous informed health practices. An Indigenous Emergency Disaster Management Provincial Framework was also co-designed to detail roles and responsibilities for integration into Zone Emergency Operations Centres and Emergency Coordination Centre.
- The following quality improvement initiatives were implemented to address racism and improve culturally sensitive care for Indigenous Peoples:
    - 76 virtual workshops hosted by the AHS Indigenous Education team to build cultural awareness and improve provision of care to Indigenous patients. Workshops were attended by 2,377 AHS staff members.
    - Completion of the Indigenous-themed eSIM (Educate, Simulate, Innovate, Motivate) project to facilitate discussions on personal bias, speaking out against racism and building trusting relationships with Indigenous patients and families.
    - Provision of high-impact education to frontline staff including 155 new EMS recruits and 165 new protective services recruits. This included in-person workshops for new recruits on the accredited Indigenous Cultural Awareness and Sensitivity training program, which were facilitated through partnership between the Indigenous Education Team, EMS and protective services.
    - Redesign of AHS' Indigenous Cultural Awareness and Sensitivity Training to create staff education that is more impactful and aligns with best practice and community needs. Data from focus groups held with 35 First Nations, Metis, and Inuit health technicians is being used to inform the redesign which is 60 per cent complete. Anticipated completion is winter 2024 in both virtual and e-learning formats.
    - All AHS employees are required to complete the Indigenous Cultural Awareness and Sensitivity certificate as part of ongoing organizational learning. The AHS program completion rate is 66 per cent.

Increase uptake of AHS' opioid addictions and recovery services such as naloxone services and the Virtual Opioid Dependency Program within Indigenous communities

- The AHS Community Based Naloxone Program (CBN) provides naloxone kits to organizations who interact with the public at risk of or likely to witness an opioid poisoning. AHS also worked with the Alberta Native Friendship Centres Association (ANFCA) to improve naloxone access to Indigenous serving organizations through the following:
    - Meetings with 60 Elders, community members and the ANFCA and 21 Friendship Centre Executive Directors to better understand how to make life saving kits available.
    - Registration of seven new Indigenous organizations for the CBN bringing the total number of Indigenous registered active sites to 59.
    - Distribution of 15,564 naloxone kits to Indigenous serving organizations.
- AHS continued work to connect Indigenous populations to Opioid Agonist Therapy (OAT) – a life saving treatment that enables opioid users to improve day to day functioning and stability. This included:

- Partnering with communities to coordinate integrated access to the Virtual Opioid Dependency Program (VODP) and wrap-around care.
- Establishing partnerships between eight Indigenous communities/organizations and the VODP including Stoney Nakota, O'Chiese First Nation, Fort Chipewan, Goodfish Lake First Nation, Paddle Prairie, Blood Tribe, Kapawe'no First Nation, and Piikani Nation.
- Hosting three province-wide virtual presentations that highlighted successful community partnership such as the Stoney Nakoda First Nation and the VODP. Sessions were attended by over 250 people from 182 different organizations, including 92 Indigenous communities and/or community services.
- Developing two Indigenous-targeted OAT brochures for Indigenous community partners (Youth and Adult).

Evaluate the hospital-at-home program in Central Zone (Wetaskiwin) and assess implementation in other rural settings

- The Hospital at Home program in Wetaskiwin was completed in December 2023 and admitted 37 patients using in-kind re-allocated resources only. Ongoing Virtual Home Hospital (VHH) beds in Wetaskiwin will be dependent on the outcomes of provincial VHH funding. An internal AHS qualitative evaluation was completed on the program and will be used to inform feasibility of implementation in additional rural communities.

Build a culture of engagement across AHS and sustain engagement of local community and Indigenous leaders on health service delivery planning, issues and opportunities, and relationship building

- Research shows that Indigenous peoples in Alberta experience a disproportionate burden of cancer and chronic disease. The Health Innovation and Cancer Project empowered Indigenous organizations/communities to develop and implement Indigenous-specific cancer prevention projects including:
  - Financially supporting 12 Indigenous organizations in providing cancer prevention and chronic disease management interventions across Alberta in urban, rural, and remote Indigenous communities.
  - Identifying 158 referrals for care
  - Sharing of information on cancer and cancer journey supports and services to over 5000 Indigenous peoples.
  - Establishing 89 relationship networks in their communities with cultural supports and addressing cancer journey services for referral pathways and collaboration.
- The Keep Tobacco Sacred Collaboration (KTSC) was developed to support culturally appropriate cessation services, community-driven prevention approaches, and connection with the revitalization of Sacred Tobacco. Work is guided by Elder and Knowledge Teacher voices, and by community needs using a two-eyed seeing lens. In 2023-24, the KTSC:
  - Held 10 engagement sessions across all three Treaty areas and presented at several groups and conferences including the Alberta First Nations Health Co-Management, the National Institute on Drug Abuse, the Ontario Public Health Conference, and the National Tobacco Conference.
  - Participated in Beaver Bundle Ceremonies with Elders from the three Nations of the Blackfoot Confederacy and engaged with over 50 Elders and 200 youth across all three Treaty areas.
  - Harvested 500 traditional tobacco plants guided by protocol to support Sacred Tobacco community revitalization efforts in Nations and developed a community toolkit to support this.
- The Honouring Life Program funds community programming that provide strengths-based approaches to life promotion and suicide prevention for Indigenous youth in Alberta. In 2023-24, the Honouring Life Program funded the expansion of access to life promotion services across 65 communities including 13 new communities, provided seven crisis grants to support communities with community-led mental health crises, and promoted program participation and relationship building through presentations, community visits, and events.
- The Indigenous Continuum of Mental Health & Addictions grant aims to improve addiction and mental wellness supports and services to Indigenous peoples in Alberta to increase the likelihood of recovery, strengthen client experiences, and improve the quality of life of those on their recovery journey. The program supported the implementation of 22 multi-year projects and the completion of two single-year projects. The program also funded projects such as treatment-based programming, aftercare programs, traditional and land-based activities, harm reduction programs, and workshops.

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

- AHS collaborated with post-secondary institutions to establish rural-based nursing and other healthcare professional programs and pathways for rural placements. The following actions were undertaken in 2023-24:

  - The Hybrid-Undergraduate Nursing Employee pathway was expanded to enable nursing students to be hired in rural areas and added 122 positions.
  - The Healthcare Aide (HCA) training program, which supports recruitment in rural areas of the province for HCA positions, had an enrollment of 121 HCAs with a total of 23 graduates from the program.
  - The Transitional Graduate Nurse Recruitment Program has provided the opportunity for New Graduate Nurses (NGNs) to find full-time employment in supernumerary positions that support the transition from NGN to independent practitioner. This program was used in rural sites with all 20 nursing positions filled.
  - Two new education programs were launched for rural nurses including Leadership Essentials for Rural Nursing which was launched in January 2024 and saw a total of 40 learners, and the Foundations in Emergency Rural Nursing program which was piloted in the fall of 2022 and fully implemented in 2023-24 with a total of 287 learners.
- Allied Health continues to collaborate with post-secondary institutions to address placement capacity and has made progress with the following initiatives:
  - Developing a process for proactive student placement demand forecasting and preceptor supply with the University of Alberta (UofA) Faculty of Rehabilitation Medicine, MacEwan University, and the University of Calgary social work programs.
  - Initial visits to Camrose and area by UofA Faculty of Rehabilitation Medicine Occupational Therapy (OT) and Speech Language Pathology (SLP) programs regarding the expansion of OT, SLP and Physiotherapy seats at the Augustana campus.
  - Following consultation with graduating students, an Allied Health Transitional Graduate program was developed to facilitate the transition from students to practice. A pilot is planned for fall 2024.

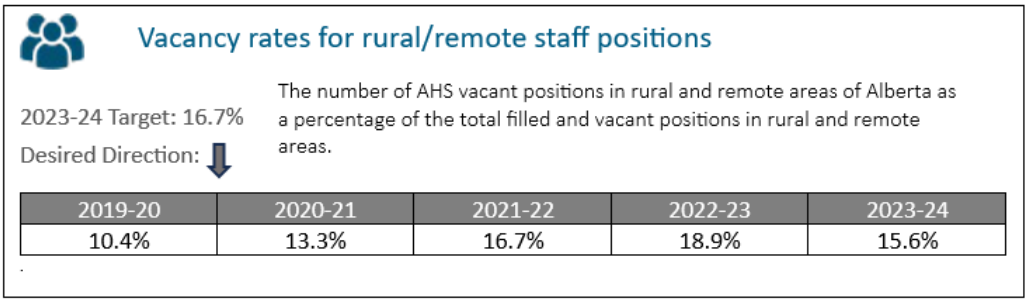
Refine internal review processes to rural foundations to ensure they are receiving requests that demonstrate a larger strategy and impact on local and rural health

- Work continues to optimize alignment between AHS and rural foundations through acceleration and streamlining of opportunities for local philanthropy and local impact, and participation of AHS leadership on the boards of all foundations. AHS has also hosted priority setting discussions with foundations during the Philanthropic Leadership Forum, zone meetings and professional development sessions for AHS leaders.

Complete the *South Zone Healthcare Plan* in partnership with Alberta Health, co-designed through community and clinical engagement

- With the Refocus of Alberta's healthcare system, AHS responsibility for completing zone healthcare plans was discontinued. Alberta Health has assumed responsibility for system planning.

PERFORMANCE MEASURE RESULTS: IMPROVING ENGAGEMENT & ACCESS TO CARE FOR RURAL AND INDIGENOUS PEOPLE



2019-20	2020-21	2021-22	2022-23	2023-24
10.4%	13.3%	16.7%	18.9%	15.6%

Note: Historical data were updated using an improved postal code mapping tool resulting in minor fiscal year changes for 2020-21, and 2022-23.

Results:

- This measure represents the number of vacant positions in rural and remote areas of Alberta as a percentage of the total filled and vacant positions in rural and remote areas. It helps identify areas or positions with the highest staffing

needs and supports evidence-based planning to ensure availability of the health workforce to deliver services. The lower the rate the better, as it demonstrates AHS ability to fill positions needed to provide and support care to patients and families.

- In 2023-24, the vacancy rate for rural/remote staff positions was 15.6 per cent. This measure met the 2023-24 fiscal year target of 16.7 per cent and showed an improvement of 17.1 per cent compared to 2022-23 (18.9%).

Advisory Council Satisfaction Rate

2023-24 Target: 74%

Desired Direction: ⇧

The percentage of Advisory Council members satisfied with the role as a Council member (agree and strongly agree)

2019	2020	2021	2022	2023
72%	68%	71%	72%	78%

Note: The Advisory Council Satisfaction Rate is measured over the calendar year.

Results:

- This measure represents the number of advisory council members who agreed or strongly agreed with the statement "Overall, I am satisfied with my role as a member of an AHS Advisory Council" divided by the number of eligible survey responses received, expressed as a percentage. The higher the percentage the better, as it facilitates the Advisory Council members' willingness and ability to help improve healthcare delivery and supports recruitment and retention on the Councils.
- In 2023-24, the Advisory Council satisfaction rate saw a relative improvement of 8.3 per cent (from 72% in 2022, to 78% in 2023), and exceeded the target of 74 per cent satisfaction with the role as a Council member.

Total number of Indigenous direct care visits including in-person and virtual

Desired Direction: ⇧

Note: This measure reflects a collaboration between Alberta Health Services, Alberta Health and contracted physicians. As a result, this measure is tracked as an indicator rather than a performance measure with targets.

2019-20	2020-21	2021-22	2022-23	2023-24
35,679	42,706	51,128	50,276	51,636

Note: The 2022-23 annual value was updated to include late invoice submissions.

Results:

- This measure reflects the total number of Indigenous direct care visits including in-person and virtual provided though the Indigenous Wellness Program Alternate Relationship Plan. For this measure, the higher the number the better, as it demonstrates better access to health care services for Indigenous populations.
- In 2023-24, there were 51,636 Indigenous direct care visits (in-person and virtual). This is an improvement of 2.8 per cent compared to 2022-23 (50,276). This measure reflects a collaboration between Alberta Health Services, Alberta Health, and contracted physicians. As a result, this measure is tracked as an indicator rather than a performance measure with targets.

FOUNDATIONAL PRIORITY

A Sustainable Workforce

The *AHS Workforce Strategy*, in alignment with the *Alberta Health Workforce Strategy*, is a focused effort to address current and future labour market demands for healthcare workers. AHS will continue to attract, retain, and optimize a skilled workforce while providing a safe and engaging workplace that supports staff health, safety, and wellness. Optimizing the clinical workforce by building models of care with an appropriate provider mix and ensuring all clinical professions are working to their full scope of practice is essential. AHS supports a workplace where individuals thrive and feel empowered and where equity, diversity, inclusion, and accessibility are fostered.

Desired Outcomes:

- Respond to immediate clinical workforce shortages by recruiting needed staff and physicians (including anesthesiologists), retaining, and optimizing the current workforce, and using a contingent workforce as needed.
- Effectively anticipate and respond to future clinical workforce demand and supply through advanced forecasting models and integrated workforce planning.
- Grow the AHS talent supply to align with effective workforce planning and focused recruitment efforts for prioritized clinical professions.
- Build and sustain optimized models of care that effectively leverage the clinical workforce.
- Maintain a supportive environment where employees thrive in the context of busy work environments where services are in high demand.

Actions & Achievements

Continue to work with Alberta Health, licensing bodies and other partners on initiatives to increase the supply of qualified clinical professionals. This includes expanding the number of educational seats for clinical professions in Alberta, expediting processes for recruitment and placement of internationally educated health professionals, and working with community partners to support settlement of new employees

- In 2023-24, 426[1] Internationally Educated Nurses (IENs) were hired through the International Nurse Recruitment Initiative and 42[2] nurses have arrived in the province.
- A new IEN pipeline to target specialty practice nurses including ICU, emergency, and labour and delivery opened in Q4. Collaboration with community stakeholders to optimize the settlement and integration of arriving nurses is ongoing. AHS is on track to meet the target of 1,000 IENs recruited from overseas by the end of 2024-25.
- Collaboration with all nursing regulatory colleges continued to streamline credentialling processes including domestic IEN transitional support with 317 domestic IENs hired through bridging and work re-entry transitional support programs throughout 2023-24.
- A Workforce Resource Group for internationally educated clinical professionals was established in September 2023.
- Work continued to identify dedicated resources to support the recruitment of internationally educated Occupational Therapists and Physiotherapists.
- The Alberta Allied Health and Rehabilitation Strategic Coalition, post-secondary institutions and regulatory colleges have partnered to commit to early action to address rural supports for new employees through the Rural Health Professions Action Plan (RhPAP).
- To enhance exposure and orientation support for new graduates in critical care units and EDs, the Student Transition Extended Exposure Program was launched at two pilot sites in Edmonton Zone in the first half of 2023-

[1] This total includes 360 IENs that were hired and had accepted the positions at time of reporting, and 66 IENs who had job offers in progress but had not yet accepted the position.

[2] The number of nurses arrived changed from 44 to 42 nurses at the time of reporting due to 2 nurses having resigned from their positions.

24 and saw 16 participants complete the Q3/Q4 pilot of the program. An evaluation of the program is underway with the next intake set for fall 2024.

- AHS continues to collaborate with post-secondary partners to offer a range of innovative allied health placements and preceptor supports to increase the number of student placements. University of Alberta and allied health leaders in the North and Central Zones are also developing rural practicum experiences. In addition, a virtual gaming simulation for allied health students is being trialed as an adjunct to in-person learning and as a resource to support the transition of new employees.
- AHS supported Alberta Health billing registration processes to enable effective recruitment of physicians and surgeons by ensuring that compensation of specialists with international credentials is commensurate with that of Canadian specialists.
- In collaboration with the College of Physicians and Surgeons of Alberta, AHS is updating the sponsorship policy and guidelines for positions eligible for a Practice Readiness Assessment.

Expand the Anesthesia Care Team model using alternate providers to support known anesthesia workforce gaps

- As of 2023-24, approximately 10,558 procedures were completed under the Anesthesia Care Team (ACT) model which supports one anesthesiologist directing surgeries with support from appropriately trained clinical staff such as respiratory therapists, clinical assistants, or anesthesia assistants. In the second half of 2023-24, there were four additional ACT models implemented which resulted in an estimated total of 824 days of anesthesiologist time released to support other surgical procedures.
- AHS' Anesthesia Assistant Educational Program saw its first cohort of 10 participants implemented in February 2024 with an additional seven participants beginning in March 2024. Expected program completion is July 2024.

Engage union partners in information sharing and collaboration to support the development of effective retention strategies which respond to the needs of the workforce

- As part of collective agreements, the Rural Capacity Investment Fund was created to address recruitment and retention challenges in the North, Central and South Zones. As of 2023-24, 100 per cent of funds for the UNA, HSAA and AUPE-ANC have been allocated. Rural recruitment and retentions initiatives are also supported through RhPAP.

Build a workforce forecasting model that anticipates future demand and supply, including consideration of voluntary resignations and retirements, available graduates and growing population needs

- A modelling and forecasting dashboard that considers turnover and changes in vacancy due to demand was made operational in Q3 for RNs, LPNs, HCAs, paramedics, occupational therapists, physiotherapists therapy assistants and therapy aides.

Consider and implement opportunities for alternate providers, ensuring all clinical professions are working to their full scope of practice and underutilized healthcare workers are better engaged

- Communication and coordination of workforce optimization actions have been established through workforce committee structures across all five zones.
- In 2023-24, 26 nursing scope of practice assessments were completed including 6 in the South Zone, 10 in the Central Zone, and 10 in the North Zone.

Work with Alberta Health to implement and scale new physician staffing models, such as the Anesthesia Care Team Model

- Significant recruitments efforts were deployed domestically and internationally, leading to recruitment of 22 anesthesiologists from within Canada (including 11 Alberta medical residents) and 23 anesthesiologists from outside Canada (primarily the United Kingdom).
- AHS adopted an interim compensation structure to remunerate anesthesiologists working within the Anesthesia Care Team Model.. This model supports one anesthesiologist directing surgeries with support from appropriately trained clinical staff such as respiratory therapists, clinical assistants, or anesthesia assistants. AHS signed 227 anesthesiologists on to Anesthesia Care Team clinical compensation contracts in 2023-24.

Develop retention strategies that respond to the voice of the workforce and create a work environment where people can flourish and grow

- The overall participation rate for the 2023 Our People Survey was 39.6 per cent which sits behind the benchmark for healthcare participation rates. AHS' results indicated a low ratio of engaged to actively disengaged staff, which aligns with Canadian and global engagement ratios according to Gallup. Leaders have shared the survey results with staff and are working with their teams to support a stronger workplace environment.
- The AHS Psychological Health and Safety Action Plan continues to implement customized Psychological Health and Safety training, develop tools and education to increase the awareness of psychological hazards, and maintain programs that connect employees with mental health supports.
- A new course on managing unionized workplaces was developed and launched. Provincial resources were developed to support managers and clinical nurse educators with onboarding and training of internationally educated health professionals.
- A Medical Leader Orientation program is underway to enhance new and current medical leaders' knowledge in a variety of areas. Implementation of self-directed, on-demand resources for medical leaders is planned for summer 2024.
- As a retention strategy, AHS has an agreement with the University of Calgary and Red Deer Polytechnic that provides AHS RNs with the opportunity to work in a temporary position as clinical nurse instructor at the post-secondary institutions while maintaining their seniority and benefits.

Expand the availability of and access to initiatives which address workforce fatigue and psychological health, safety, and wellness

- A working group has been created to prevent and respond to deaths by suicide, recognizing that there are occupational risk factors associated with increased risk of suicide. Suicide Prevention Protocol training sessions were attended by over 1,000 staff members over the course of the fiscal year.
- AHS continued to connect physicians and medical leaders with supports that promote wellness and that can be accessed proactively or in response to signs of stress and burnout including:
    - The Employee Family Assistance Program which offers coaching, counselling and support services for mental health and wellness.
    - The Physician and Family Support Program which offers a 24/7 assistance line with peer-to-peer support and counselling services, educational activities to promote prevention and awareness, and case coordination for physicians, residents and medical students with complex health concerns.
    - Well Doc Alberta – an initiative aimed at advancing a collaborative, co-operative, pan-provincial approach to physician wellness that includes departmental, site-based or section-based peer support teams.
- There was a soft launch of the AHS Peer Support Framework and training in Q4 for teams/sites to start a peer support team in their area. Similarly, the Peer Support Community of Practice launched in March 2024 to provide a space for peer supporters across the organization to learn from each other and be supported in their role.
- There was increased use of the Violence/Aggression Screening Tool (VAST) in Connect Care which has resulted in a decrease in the percentage of unique patients screened as presenting a risk of aggression/violence from 9 per cent to 8 per cent over the Q2 to Q4 period.
- Three Behavioral Safety Programs (BSP) were made available in MyLearningLink for different audiences. As of 2023-24, 2,635 AHS and APL staff have completed the BSP-VAST, 108 AHS staff have completed the BSP-VAST: Continuing Care, and 766 AMH staff have completed the Dynamic Appraisal of Situational Aggression course.
- The Violence Prevention in Emergency Departments/Urgent Care Centres project was implemented with plans to complete for 23 EDs and Urgent Care Centres and an additional 86 sites anticipated for completion for early 2025.
- Addictions and Mental Health Safe Care Strategies were implemented in all five zones.

Review AHS' Hybrid Work Policy, including a risk assessment, achievement of benefits, and further review of best practices of other organizations. The review will be focused on assessing the policy and processes to ensure workforce productivity, accountability, fairness, and value for money. This review will consider the further consolidation of leased sites impacted by the policy to enable workforce flexibility as well as offer cost savings and avoidance

- A review of the Hybrid Work Policy was paused as a result of the organizational refocus. It is anticipated that the newly formed organizations will examine the policy going forward. Information on lease consolidation can be found under *Sustainability & Value for Money*.

PERFORMANCE MEASURE RESULTS: A SUSTAINABLE WORKFORCE

Vacancy rate for all AHS positions

2023-24 Target: 14.3%

Desired Direction: ⇩

The number of AHS vacant positions as a percentage of the total filled and vacant positions.

2019-20	2020-21	2021-22	2022-23	2023-24
9.9%	13.4%	14.3%	15.0%	11.9%

Results:

- This measure represents the number of vacant positions as a percentage of total filled and vacant positions throughout AHS. It helps identify areas or positions with the highest staffing needs and supports evidence-based planning to ensure availability of the health workforce to deliver services. The lower the rate the better, as it demonstrates AHS ability to fill positions needed to provide and support care to patients and families.
- In 2023-24, the vacancy rate for all AHS positions was 11.9 per cent. This measure met the 2023-24 fiscal year target of 14.3 per cent and showed a relative improvement of 20.5 per cent compared to 2022-23 (15.0%).
- Using a similar definition, between 2019 and 2022, AHS' vacancy rate increased by 4 percentage points and Canadian healthcare saw a similar vacancy rate increase of 4 percentage points (HealthCareCAN, 2019 to 2022).

FOUNDATIONAL PRIORITY

Strong Population and Public Health

AHS is dedicated to improving health outcomes, minimizing health disparities between populations, and contributing to a more sustainable healthcare system. AHS is working to reduce avoidable illness and injury, prevent and respond to public health threats, and advance programs that allow people to be as healthy as possible. By offering comprehensive supports to communities, AHS will ensure prevention and screening services are integrated across the continuum of care. Support includes enabling informed decision-making and supporting cancer screening and immunization access province wide. Focusing on health prevention and creating conditions for people to stay healthier, AHS will improve quality of life and alleviate pressures on the health system.

Desired Outcomes:

- Enhanced capacity for public health management of routine communicable diseases and outbreak management.
- Improved participation in disease and injury prevention and health promotion programs and services including increased cancer screening participation rates and childhood immunization rates.

Actions & Achievements

Maintain sufficient capacity to respond to threats from all communicable diseases

- The Communicable Disease Emergency Response Plan along with all associated communication was launched in April 2023 and completed in September 2023 to support the planning and response to communicable disease emergencies.
- A draft of The Communicable Disease Control (CDC) Staff Utilization Plan was developed including a current state review. The plan is intended to ensure that the CDC teams are prepared to scale up services and staffing in times of increased demand and optimize capacity and efficiency within CDC and other program areas when clinical program demand is lower.

Develop, implement, and evaluate a health marketing campaign to encourage parents/caregivers to keep their children's immunizations up-to-date

- The Childhood Immunization search engine marketing campaign was developed in 2023-24 to share resources with parents looking for information related to childhood immunization, and direct individuals to the AHS Immunize Alberta webpage. As of Q4YTD, the site has achieved a Click Through Rate (CTR) of 33-36 per cent; well above typical industry standards and search benchmarks of around four to five per cent. Advertisements and clicks are spread across the province with about 62 per cent occurring in Calgary and Edmonton and the remaining 38 per cent in the smaller cities and rural areas. The campaign garnered a total of 357,282 impressions related to infant and preschool-aged children immunizations and 11,229 impressions related to school-aged children immunizations. It was also noted that interest in immunization information peaked in October 2023, aligning with the start of school and seasonal immunizations.

Develop, implement, and evaluate a health marketing campaign to encourage eligible people living in Alberta to participate in population-based cancer screening

- The Cancer Screening Program search engine marketing campaign was completed in March 2024 and showed strong performance with all four cancer types achieving a CTR between 12-17 per cent. This is above industry standards.
- A marketing campaign was implemented to promote the Fecal Immunochemical Test ordering system for eligible Albertans aged 50 to 74. The campaign aimed to increase awareness about the importance of getting screened regularly for colorectal cancer. The campaign which ran during three separate months, garnered 159,665 impressions with a CTR of 17 per cent. Colorectal cancer screening along with breast cancer screening, received the highest number of clicks (colorectal cancer had 26,494 clicks and breast cancer 25,494 clicks).
- To increase referrals to the lung cancer screening pilot program, a marketing campaign was implemented to reach Albertans aged 50 to 74 who currently smoke cigarettes or quit after smoking for many years and reside in the

Edmonton, Wainwright, or Grand Prairie areas. Although this campaign received lower impressions (91,109), it had the highest CTR of the cancer types, at 16.96 per cent.

Continue regular public health activities such as oral health; tobacco, cannabis, and vaping reduction; newborn blood spot screening and early hearing detection and intervention; and, childhood, routine in-school and targeted adult immunization programs

- In 2023-24, 2,941 patients received services and 21,016 procedures were completed at the at the Calgary Public Health Dental Clinics.
- Services at the newly opened Red Deer Public Health Dental Clinics saw 206 patients with 2,086 dental procedures completed and 34 patient visits referred from emergency department and primary care (June 2023-March 2024).
- There were 387 participants in the Quit Core Group Cessation services which were offered in-person, virtually and by phone. This is almost double the number of participants from 2022-23 (192).
- There were 4,886 compliance checks (inspecting tobacco and vaping retailers) completed including 3,394 youth test shop visits. Compliance checks have enabled tobacco and vaping retailers to be better informed regarding Alberta's Tobacco Smoking Vaping legislation and has led to better compliance across the province between 2021-22 and 2023-24. The findings have been used by AHS to target areas within Alberta where more work is needed to protect youth, and will be reviewed with Alberta Health to improve or adjust the Tobacco, Smoking and Vaping Reduction Act Enforcement Program.
- There were 412 texting service subscriptions for smoking and/or vaping cessation support.
- Nearly 1,500 individuals were referred for tobacco cessation case management support as part of the Lung Cancer Screening Program. Support was accepted by 30 per cent of referred individuals with 420 quit attempts.
- From April 2023 to March 2024, 720 individuals were supported with Nicotine Replacement Therapy Alberta Blue Cross Coverage Cards with 1,711 total claims made between April 2023 and March 2024.
- Training sessions to deliver intensive cessation treatment services were completed including Foundational Health Education Training (7 facilitators), Applied Tobacco Intervention Training (20 facilitators), Community Practice Sessions (attended by 19 QuitCore facilitators), and new QuitCore facilitator training (3 participants).
- 1,117 health professionals completed training in tobacco screening, brief intervention and referral to treatment.
- In 2023-24, 48,923 infants (99 per cent of births) were provided with newborn blood spot screening and 45,380[1] infants (88 per cent of births) were screened for permanent congenital hearing loss through the Early Hearing Detection & Intervention Program.
- 3,483 Fecal Immunochemical Test kits were sent out to eligible Albertans aged 50-74, increasing access to colorectal cancer screening for Albertans, including rural and remote participants. Of note, 605 of these individuals were unattached or had no family doctor.

Continue public health inspection levels

- There were 20,714 public health inspections completed (141 per cent of total target). The target was exceeded due to an increase in FTE of public health inspectors that had temporarily been paused during the pandemic.

Engage with at least 70-80% of the school authorities across the province to implement the Comprehensive School Health approach

- In 2023-24, partnerships have been established with 78 per cent of school authorities to support the implementation of Comprehensive School Health and the Healthy Schools 5-Step approach, and 43 professional learning sessions were delivered to 2,501 school partners.
- Multiple health promotion materials have been produced for the Healthier Together – Schools website including: a school health nursing webpage with guidance for managing health conditions at school, eight monthly articles for families on various health topics shared through the website and with school authorities, lesson plans and classroom activities for kindergarten to Grade 12, and two new inspirational stories of school health promotion in action across Alberta schools.

[1] This is an approximate number. Final data for permanent congenital hearing loss screening will be available in October 2024.

Maintain population and public health online content and tools that enhance opportunities for self-care and provide health information and guidance on when to seek health care services

- Quality improvements to enhance user experience were made to health promotion websites including HealthierTogether.ca, HealthyParentsHealthyChildren.ca, TeachingSexualHealth.ca, ReadyorNot.ca and ScreeningforLife.ca, as well as the AHS.ca and MyHealthAlberta online content. The BehindTheHaze.ca website which provides Alberta's youth with access to information about the harms of vaping and vaping, launched in October 2023 and has since seen 158,530 unique users with an engagement[1] rate of 77 per cent.

Update the Immunizealberta.ca website and integrate within the AHS.ca redesign

- AHS.ca/Immunize was launched in July 2023. The revitalized web platform provides a one-stop-shop for Albertans to access streamlined, provincewide immunization resources.

Begin implementation of *Healthier Together* demonstration projects in at least one city/municipality in each zone

- The Healthier Together project is underway in all five zones with staff recruitment complete for 2023-24. Seven partnership agreements were signed, representing over 200,000 citizens residing within communities across the zones. Two communities have completed asset mapping and data profiles with work underway for the remaining communities. Action plans are also under development for each of the communities.

PERFORMANCE MEASURE RESULTS: STRONG POPULATION AND PUBLIC HEALTH

Childhood immunization rate: DTaP-IPV-Hib dose 4 by age 2

2023-24 Target: 76.0%
Desired Direction: ⇧

The number of children who turned 2 years of age and had received four doses of diphtheria, tetanus, pertussis, polio, and Haemophilus influenzae type b containing vaccine as a percentage of all children who turned 2 years of age.

2019	2020	2021	2022	2023
76.4%	75.6%	72.5%	70.7%	70.6%

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, are significantly lower than those stated in the 2023-26 Health Plan. AHS' target was set before the methodological change.

Note: Historical values were restated as of May 2024. The target represents the 2023 AHS organizational target. Alberta Health uses the national target (set by CIHI) for childhood immunization by two years of age.

Results:

- In 2023-24, the childhood DTaP-IPV-Hib immunization rate (70.6%) remained stable compared to the same period last year (70.7%) and did not achieve the target of 76 per cent. The higher the percentage the better, as it demonstrates more children are vaccinated and protected from preventable childhood diseases.
- Using a similar definition, in 2021, Alberta ranked 9th among the 10 provinces for DTaP immunization at two years (AB = 75%; Canada = 77%; Best Performing Province = 96%), 9th among 9 provinces for Polio immunization at two years (AB = 86%; Canada = 92%; Best Performing Province = 95%), and 9th among the 10 provinces for Hib immunization at two years (AB = 71%; Canada = 75%; Best Performing Province = 96%) (Statistics Canada, 2021).

[1] Engagement rate measures audience interaction with content or advertisements. Examples of engagement metrics include comments, shares, likes, page views, amount of time on a webpage, clicking or commenting on the advertisement, as well as browsing the information.

Childhood immunization rate: MMR dose 1 by age 2

2023-24 Target: 86.0%
Desired Direction: ↑

The number of children who turned 2 years of age and had one dose of mumps, measles, and rubella containing vaccine as a percentage of all children who turned 2 years of age.

2019	2020	2021	2022	2023
87.0%	86.7%	83.2%	82.1%	81.7%

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, are significantly lower than those stated in the 2023-26 Health Plan. AHS' target was set before the methodological change.
Note: Historical values were restated as of May 2024. The target represents the 2023 AHS organizational target. Alberta Health uses the national target (set by CIHI) for childhood immunization by two years of age.

Results:

- In 2023-24, the childhood MMR immunization rate (81.7%) remained stable compared to the same period last year (82.1%) and did not achieve the target of 86 per cent. The higher the percentage the better, as it demonstrates more children are vaccinated and protected from preventable childhood diseases.
- Using a similar definition, in 2021, Alberta ranked 9th among the 10 provinces for MMR immunization at two years (AB = 88%; Canada = 92%; Best Performing Province = 98%) (Statistics Canada, 2021).

Colorectal cancer screening participation rate

2023-24 Target: 54.5%
Desired Direction: ↑

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	2023-24
55.4%	50.0%	50.3%	53.5%	55.6%

Results:

- For this measure, 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 there is an option for surgical cure of early disease, rather than less effective, and often palliative options.
- In 2023-24, the participation rate for screen-eligible individuals for colorectal cancer was 55.6 per cent (for the calendar year). This measure met the target of 54.5 per cent and improved by 3.9 per cent compared to 2022-23 (53.5%).
- Using a similar definition, in 2017, Alberta ranked tied for 2nd among the 10 provinces for the highest self-reported up-to-date testing (fecal test last two years, sigmoidoscopy/colonoscopy last 10 years) for people 50-74 (Alberta=69%; Canada=N/A; Best Performing Province=71%) (Canadian Partnership Against Cancer, 2017).

FOUNDATIONAL PRIORITY

Digital Health Evolution and Innovation

AHS will engage providers, researchers, and industry partners to bring innovative solutions that advance virtual technologies to support healthcare delivery. Through the launch of Connect Care, an electronic clinical information system, AHS will directly impact patient care providers. Both patients and clinicians benefit from Connect Care by sharing a consistent record provincially and utilizing consistent clinical decision support. Through Connect Care's patient portal, MyAHS Connect, AHS is working to give patients direct access to their health information. These functions all support the critical health decisions made by patients and care providers. AHS will continue to invest in virtual care options to increase access to services.

Desired Outcomes:

- Improved patient safety and quality through enhanced decision-making information provided at point of care.
- Improved patient-centred care through access to the Connect Care patient portal.
- Realize benefits through Connect Care implementation with appropriate change management tools and supportive onboarding.
- Improved patient access to services through virtual care options.

Actions & Achievements

Deploy Connect Care Launches 6 and 7 (approximately 33,000 clinicians)

- Connect Care successfully completed its seventh launch in November 2023 which included 79 urban and rural sites primarily in the North and South Zones. With this launch, approximately 112,000 staff, physicians and other healthcare providers at AHS and partner acute and sub-acute care sites, ambulatory care locations, clinical lab services and diagnostic imaging teams in Alberta are now using Connect Care.

With Alberta Innovates, continue to invest in digital health solutions through the Alberta Partnership for Research and Innovation in the Health System Program

- The Partnership for Research and Innovation in the Health System (PRIHS) program advances health system sustainability by testing the implementation of promising solutions to priority health system challenges. Launched in April 2023, PRIHS 8 received 17 projects focused on digital health solutions. Four projects were awarded funding in February 2024 and focused on
    - Reducing rehospitalization for cardiovascular-related chronic diseases
    - Strengthening the ability of patients to withstand post-surgical inactivity and decline before coming to hospital
    - Expanding Indigenous access to the Virtual Opioid Dependency Program, and
    - Implementing remote symptom management for patients with cancer.

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

- The following are examples of technologies currently under development and review at AHS:
    - The Alberta EnvisAGE Beachhead project allows staff and clinicians in AHS and partner organizations to assess Canadian-developed solutions that enable Albertans to age in their preferred location. Assessments of needs are being conducted with clinicians, patients and leaders to identify areas to conduct real world trials in the fall of 2024.
    - Through a hands-on trial in July 2023, the innovative NanoSalv wound gel created by NanoTess, was found to promote faster healing of complex wounds at a comparable cost to current dressings. Based on the evidence generated, AHS procured the innovative NanoTess gel for use at selected sites.
    - A trial of a novel abdominal closure device was completed at three major surgical hospitals in Edmonton and Calgary. Based on the results showing faster closures of surgical incisions after surgery, AHS procured the technology for ongoing assessment.

- A trial of the Robotic Walking Device for children's rehabilitation was completed at the Alberta Children's Hospital in Calgary. It concluded that intensive robotic gait training is safe for patients and therapists, and improved achievement of rehabilitation goals set by both patients and their caregivers.

Expand virtual physician/nurse practitioner assessments provided through Health Link triage

- The Health Link Virtual MD Program has expanded its operational hours. A full update can be found under priority: *Decreasing ED Wait Times*.

Continue to expand virtual care access to acute specialist consultations

- AHS has enhanced access to acute specialist consultations by transitioning from traditional telehealth to AHS Zoom for Neonatal ICU/Pediatric ICU and is currently working to implement AHS Zoom with Acute Stroke (North and South zones).
- The Privacy Impact Assessment for Provincial Tuberculosis Services regarding Asynchronous Video Observed Therapy (AVOT) was escalated to the Office of the Information and Privacy Commissioner of Alberta in March 2024. The AVOT evaluation plan is currently under development.
- The Virtual Opioid Dependency Program and Corrections Services are supported through the implementation of asynchronous video visits to address wait times for services. The video visits were launched at the Edmonton Remand Centre in Q2 and Phase 1 expansion including five correctional facilities were launched in Q4. The remaining four sites will launch in the first half of 2024-25. Implementation of virtual psychiatric consults for patients in Fort Chipewyan and Wabasca with providers in Fort McMurray is currently in the planning phase.

Expand peer and text message support for patients discharged from acute psychiatric care

- Expansion of peer and text message support in the Calgary Zone was completed in Q4 with a total of 31 referrals and 28 clients participating in the project. Remaining active clients from the project have been transitioned to other peer support workers, community resources or other professionals for ongoing support. This work is also currently in progress in the Edmonton Zone.

Continue to implement targeted Digital Remote Patient Monitoring

- To date, over 1,228 Albertans have engaged as full partners in their care through Digital Remote Patient Monitoring (dRPM), and Virtual Home Hospitals continue to plan for program expansion using this technology. A privacy impact assessment to reflect the use of dRPM as a data capture system is under development.
- The integration of the dRPM platform (Cloud DX) with Connect Care is in progress to ensure dRPM data is fully available within the Connect Care system and is expected to launch in the first half of the 2024-25 fiscal year.

Complete assessment of App Orchard (where developers can learn about Epic Systems' application programming interfaces) to enable the co-development of Connect Care-compatible software solutions with AHS.

- Assessment of the App Orchard program was completed in the first half of 2023-24.

Implement a virtual care evaluation framework and data model and use results to determine impact on care delivery

- In partnership with the Strategic Clinical Networks, a Virtual Care Evaluation Framework was developed to inform a comprehensive approach to planning and implementing virtual care. A webinar was held in January 2024, to introduce and launch the framework and Virtual Health Shared Data Model (SDM) and was attended by over 150 staff across AHS. The SDM is accessible to analysts across the organization upon successful completion of two MyLearningLink Courses and completion of an Enterprise Data Warehouse access request form.

Expand group therapy options in rural Alberta for virtual mental health treatment

- Virtual services in the North Zone were supported by children and youth AMH programs and child psychiatrists in the Edmonton Zone.

PERFORMANCE MEASURE RESULTS: DIGITAL HEALTH EVOLUTION & INNOVATION

Number of virtual physician/nurse practitioner assessments provided through Health Link triage

2023-24 Target: 22,800

Desired Direction: ↑

2019-20	2020-21	2021-22	2022-23	2023-24
Program launched in January 2022		2,315 (Jan-Mar)	20,842	36,487

Note: Historical data updated resulting in restatement of 2021-22 and 2022-23 values.

Results:

- In 2023-24, 36,487 virtual assessments were provided by physicians and nurse practitioners through Health Link triage. This measure met the target of 22,800 virtual assessments and increased by 75.1 per cent compared to the number of virtual assessments completed in 2022-23 (20,842). The higher the number the better, as it demonstrates higher uptake of video and telephone visits to deliver virtual care.

FOUNDATIONAL PRIORITY

Excellence in Patient Outcomes and Experience

AHS aims to deliver high-quality, accessible healthcare that allows Albertans to live with the best possible health outcomes. Through quality improvement processes, AHS will reduce unwarranted variation, enhance the culture of patient safety, improve patient experience, and increase the quality of services. AHS encourages Albertans to be partners in their health to achieve better health outcomes for themselves, their families, and their communities.

Desired Outcomes:

- Reduced unwarranted variation in testing and treatment through initiative prioritization and implementation.
- Increased patient safety, experience, and quality of service through implementation of quality improvement initiatives.
- Enhanced staff/physician culture of patient safety and quality through training and other experiential opportunities.
- Reduced wait times while managing rising costs for CT and MRI exams.

Actions & Achievements

Designate and offer *Culture of Patient Safety* course as Required Organizational Learning

- The Culture of Patient Safety course has been designated as required learning for all employees and physicians working in clinical service areas. A total of 1,634 learners completed the Culture of Patient Safety Course in 2023-24. A staggered facilitated option for this course is under development and will provide more flexibility for learners in 2024-25.

Communicate patient safety and quality foundational stream courses throughout the organization

- The Academy of Quality Improvement Sciences (AQuIS) offers additional learning opportunities to AHS staff through certificate programs related to patient safety and quality improvement. The AQuIS webpage was launched on both internal and external AHS websites in August 2023, with further promotion of the website occurring in Q3 through internal staff distribution.
- The Culture of Patient Safety course was communicated to be a required learning through the AHS, Interchange and Leadership Matters updates to staff in December 2023.

Work with Alberta Health and the Alberta Health Advocate to implement targeted improvements to improve the patient concerns management process and provide a culturally safe pathway for complaints from Indigenous patients

- The award-winning Indigenous Support Line (ISL) provides supportive listening, connections to health resources, Indigenous cultural supports, help with mental health and addictions concerns, and a safe place to bring forward patient concerns for Indigenous patients, their families and the providers who support them. In 2023-24, the ISL managed 5,248 calls maintaining a 100 per cent caller satisfaction rate and expanded service from the North Zone to the Central and South Zones. Data from completed phone calls is being leveraged to inform and improve patient concern processes and cultural safety.
- An enhanced cultural education curriculum for patient concern consultants has been initiated and development is in progress.
- AHS teams worked on increasing cultural competency and supporting the creation of ethical spaces by integrating culturally safe and relevant Indigenous approaches into the Quality Assurance Review process, education, and training. Learnings from a focus group will be used to inform a new Disclosure Done Well video using an Indigenous patient and family as well as other training tools on disclosure.

Evaluate implementation of *Shared Commitments* between patients and providers

- AHS' *Shared Commitments* were developed through extensive engagement with more than 70 stakeholder groups, including AHS physicians and other healthcare providers, staff and patient and family advisors. A pilot evaluation was completed in the fall of 2023 along with a finalized communication plan and supporting resources in preparation for a launch in April 2024.

Work with Alberta Health and Primary Care Networks to implement health innovation funded projects aimed at improving patient outcomes and quality of care

The following funded projects that are related to supporting primary care were submitted to the Ministry:

- The assessment tool for the Enhance Lipid Reporting project is available in all zones with Launch 6 of Connect Care. This project aims to reduce severe cardiovascular events in Alberta through the screening, identification, and treatment of cardiovascular disease at-risk patients. Results of the lab test are available to family physicians.
- Implementation of Central Access and Triage system for surgery continues, with this integrated into the Alberta Facilitated Access to Specialized Treatment (FAST). Primary care physicians and surgeons are engaged in the working groups, including significant progress on the co-design with urology and orthopedics.

Implement *Right Care Alberta* clinical appropriateness initiatives provincially

- Clinical appropriateness initiatives continue to be implemented across the province with eight projects currently in progress including:
    - Collaborations with Pharmacy, Maternal Newborn Child & Youth Strategic Clinical Network, Diagnostic Imaging and Lab Services. Two clinical appropriateness projects were successfully completed and closed in 2023-24. Since 2021, there has been $3.2 million in total savings and $6.1 million in cost avoidance due to clinical appropriateness initiatives approved by *Right Care Alberta*.
    - Bronchiolitis appropriate care and optimizing chronic shoulder magnetic resonance imaging utilization for surgical decision-making.
    - The MRI Knee Decline Project was launched in the Calgary Zone in November 2023, as an avenue for optimizing knee magnetic resonance imaging in patients aged 55 and older with known osteoarthritis. Data showed an initial decrease in MRI exams ordered for chronic knee pain followed by a return to pre-project levels.

Execute the CT and MRI Implementation Plan to reduce wait times for CT and MRI exams

- As of 2023-24, service volumes have increased by 14.3% for CT scans and 10.5% for MRI exams compared to the same period in 2022-23. The median wait time for CT scans rose to 28 days, up from 26 days in 2022-23, while the median wait time for MRI scans decreased by four days, from 57 days to 53 days. Additionally, the rollout of Connect Care in Diagnostic Imaging (DI) was successfully completed across 100% of DI sites.
- Efforts continue to focus on reducing wait times through increased understanding of the drivers of demand in inpatient and emergency care settings, as well as increased outsourcing of lower-acuity MRI exams to community providers. Progress continues to be impacted by increasing demand (up 18.5 per cent per year) compared to that expected in the CT and MRI Implementation Plan (3 per cent per year). Aging equipment and staffing shortages are also contributing to increased downtimes.

PERFORMANCE MEASURE RESULTS: EXCELLENCE IN PATIENT OUTCOMES & EXPERIENCE

Surgical site infection rate (14 large volume adult acute care sites)

2023-24 Target: 4.19%
Desired Direction: ⇩

The percentage of cases that developed infections in a surgical site within 30 days of surgery.

2019-20	2020-21	2021-22	2022-23	2023-24 Q3YTD
4.15%	4.49%	3.91%	3.99%	3.86%

Note: This measure is lagged by one quarter.

Results:

- This measure represents the percentage of surgical cases with infections within 30 days after surgery date in a site. It is an indicator of care quality and supports evidence-based process improvements as lower rates of surgical site infections contribute to improved health outcomes and lower readmission rates. The lower the rate the better, as it demonstrates fewer infections are occurring following surgical procedures.
- The surgical site infection rate at the 14 large volume adult acute care sites decreased from 3.99 per cent in 2022-23, to 3.86 per cent as of Q3YTD. This is a 3.3 per cent improvement and indicates the measure is on track to meet the 2023-24 fiscal year target of 4.19 per cent.
- From the period of July 2022 to June 2023, the surgical site infection rate for the 66 Canadian hospitals participating in the National Surgical Quality Improvement Program (NSQIP) was 3.95 per cent (NSQIP, Semi-annual Report, July 2022 to June 2023).

Adult patient satisfaction with hospital experience

2023-24 Target: 63.4%
Desired Direction: ⇧

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	2022-23	2023-24
66.3%	66.8%	65.6%	63.4%	63.4%

Note: Historical values for adult patient satisfaction with hospital experience for 2019-20 has been restated to ensure methodological consistency across years.

Results:

- This measure is an indicator of system performance from the patient's perspective and monitors patients' overall perceptions associated with the hospital where they received care, based on survey ratings. It identifies the percentage of patients rating hospital care as 9 or 10 on a scale from 0-10, where 10 is the best possible rating. The higher the number the better, as it demonstrates more patients are satisfied with their care in hospital.
- In 2023-24, the percentage of patients rating hospital care as 9 or 10 (63.4%) remained stable compared to the 2022-23 fiscal year (63.4%). This measure met the 2023-24 fiscal year target of 63.4 per cent.
- In 2021-22, Alberta ranked 1st among three provinces for the highest overall hospital experience (AB=66%; Canada= 63%; Best Performing Province=66%) (CIHI, 2021-22).

FOUNDATIONAL PRIORITY

Sustainability and Value for Money

AHS continues to implement sustainability-related initiatives which slow the rate of expense growth and allow cost savings to be re-invested into the health system. By making key investments, AHS can avoid costs through less complications, fewer re-admissions, shorter hospital stays and reduced emergency care. AHS is holding leaders accountable to deliver innovative initiatives that enable systemic transformation, including reductions in greenhouse gas emissions to ensure the health delivery system and the environment are sustainable for current and future generations.

Desired Outcomes:

- Increased 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.
- New models and innovations with supporting infrastructure to help AHS meet sustainability goals and improved patient outcomes.
- Reduction in AHS' electricity, natural gas, water, and emissions environmental footprint.

Actions & Achievements

Continue to work with Alberta Health on the AHS Sustainability Program which includes savings and investment initiatives

- The AHS Sustainability Program continues to support various savings and efficiency initiatives, such as robotic process automation, energy efficiency upgrades and lease consolidations. Between April 1, 2020 and March 31, 2024, actual cumulative savings are $236 million.

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

- A joint committee for Sustainability and Energy projects was established by Alberta Health with AHS as an active participant. This work was paused in January 2024 due to the organizational refocus.

Improve organizational awareness and culture of value-based decision-making supported by tools such as an enterprise-wide *Value Based Report Card* for AHS

- In collaboration with the Strategic Clinical Networks and clinicians, a *Value-Based Report Card* framework has been developed. The framework includes a scoring function for clinical-based targets and examines health expenditures and quality of care that allows for an analysis of the overall value for money.

Continue Implementing energy and water reduction projects to reduce energy and utility costs and reduce greenhouse gases, as well as develop waste and recycling programs

- The following projects were undertaken to reduce utility usage: installation of LED lighting systems and low flow plumbing fixtures, recommissioning of mechanical systems, ventilation and building management system upgrades, and encouraging lower anesthetic gas emissions.

Review Remote Work Policy for efficiencies and accountability and consider consolidating leased sites impacted by the policy to enable workforce flexibility as well as offer cost savings and avoidance

- Lease consolidation continued throughout 2023-24 as planned. Six of the 10 planned lease consolidations for the Edmonton Zone were completed, with a projected annual lease saving cost of $5.4 million. Five of the 10 planned lease consolidations have been completed in the Calgary Zone, representing $2.68 million in annualized lease savings. To date, total annualized lease savings is $8.57 million of total projected $15.7 million.

PERFORMANCE MEASURE RESULTS: SUSTAINABILITY AND VALUE FOR MONEY

Total corporate/administrative leased space (in square meters)

2023-24 Target: 71,000

Desired Direction: ⇩

2019-20	2020-21	2021-22	2022-23	2023-24
109,300	109,300	109,300	92,800	80,678

Results:

- This measure represents the quantity of AHS corporate/administrative leased space in square meters. With the implementation of hybrid or remote work options for eligible staff, considerable administrative space reduction is possible creating new opportunities for sustainability and value for money. The lower the amount of leased space for AHS corporate or administrative functions the better as this leads to an overall reduction of annual lease costs.
- In 2023-24, AHS leased 80,678 square meters of corporate/administrative space. This measure did not meet the 2023-24 fiscal year target of 71,000 square meters but improved by 13.1 per cent compared to 2022-23 (92,800 square meters). The target was not met, as projects intended to reduce leased space were paused as a result of the organizational refocus. It is anticipated that these projects will resume in 2024-25 and AHS will continue to decrease its leased space.

Financial Summary

Financial Statement Discussion & Analysis
For the year ended March 31, 2024

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, 2024. 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' 2023-24 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, 2024 audited consolidated financial statements, notes, and schedules.

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

Highlights

AHS finished the year in a nearly balanced operating position with a $184 million annual operating surplus, representing 0.98 per cent of total expenses.

The operating surplus was largely a result of one-time funding from Alberta Health to support the community lab services acquisition. Higher than expected investment and other income, fees and charges revenue, and a significant endowment contribution for the Arthur J.E. Child Comprehensive Cancer Centre further contributed to the surplus. AHS continued to implement efficiency and cost containment strategies throughout the year and was able to achieve expense reductions in targeted areas in efforts to meet expense budgets, which partially offset workforce pressures and increases in overtime and agency nursing costs.

Strategic Priorities

In 2023-24, AHS implemented multiple transformational initiatives to increase capacity and flow, and support the future sustainability of the healthcare system.

Under the guidance of the Health Care Action Plan, AHS continued to focus on improvements in four strategic 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 $66 million on **emergency medical services** in 2023-24, including increased funding to ground ambulance integrated contract providers, increased capacity by adding new ambulances in Edmonton and Calgary, implementing fatigue management initiatives, and investing in additional inter-facility and ambulance resources in Red Deer and medical first responder initiatives.

AHS also continued to invest in decreasing **emergency department wait times** by adding additional dedicated allied health resources in emergency departments and expanding the Health Link Virtual MD Program and EMS/811 Shared Response Line to improve emergency department flow, and where appropriate, redirect care outside the emergency department.

To improve **patient flow**, AHS continued to invest in hospital capacity, including the opening of 221 new acute care beds of which 50 beds were added during the peak of respiratory virus season. AHS also continued to expand continuing care, community care, and home care options to ease pressures on hospitals and ensure sufficient capacity for the flow of patients, increasing expenses $193 million from the prior year in these areas. To support clients waiting in hospital for alternate levels of care, a temporary capacity call-out for community spaces occurred to increase system flow, and by year-end, 235 temporary continuing care beds were in use. AHS also added additional hours of home care to support patients at home, including new palliative and end-of-life care clients under the Continuing Care Transformation Initiative.

AHS focused on **reducing surgical wait times** by continuing to implement strategies and resources 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 2023-24, 304,595 surgeries were performed; a 3.5 per cent increase from the prior year.

AHS also continued to expand its transformative provincial clinical information system, Connect Care, investing $159 million in operating and capital expenditures in 2023-24 with an expected project completion date of 2024-25. Connect Care will provide better care for Albertans, ensuring the whole healthcare team, including patients, have the best possible information throughout their care journey.

The public opening of the Arthur J.E. Child Comprehensive Cancer Centre is scheduled for 2024-25 and will support local patient needs as well as improve the overall access and referral pathways and options for cancer patients throughout the province. Construction on the building is now complete and work this year focused on building commissioning and operational readiness, including recruitment, training, and orientation of staff.

Community Lab Services Acquisition

Effective August 31, 2023, AHS acquired the operations of DynaLIFEDX, including specific assets, liabilities, and workforce. Through this mutually agreed transition, AHS, through Alberta Precision Laboratories, became the sole provider of community laboratory services in Alberta. With the goal of improving laboratory service delivery to all Albertans, AHS completed 6.8 per cent more laboratory tests than in the prior year.

Refocusing Healthcare

On November 8, 2023, the Premier of Alberta announced the refocusing of Alberta's healthcare system with a goal to improve the outcomes for Albertans and empower

healthcare workers to deliver quality care across the province.

Four new provincial agencies focusing on mental health and addiction, continuing care, primary care, and acute care will provide oversight and coordination of service delivery to improve health outcomes and access, provide seamless care between different healthcare providers, improve local decision-making, and prioritize the wellbeing and expertise of health care workers.

During this period of transition, AHS is committed to continuing to provide seamless care by supporting the Government of Alberta as part of the refocus work.

Key Financial Trending

Annual Operating Surplus (Deficit)

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

(in $ millions)	2024	2023	2022*	2021*	2020*
Revenues	19,028	17,749	17,499	16,789	15,468
Expenses	18,844	17,665	17,368	16,697	15,626
Annual operating surplus (deficit)	**184**	**84**	**131**	**92**	**(158)**
Accumulated surplus	1,305	1,121	1,037	906	814

** Select prior year information has been restated for the adoption of PS 3280 Asset Retirement Obligations in 2022-23.*

Workforce

The largest cost for AHS is workforce compensation (52 per cent of total expenses). Alberta's health workforce is facing considerable challenges with higher demand for healthcare workers and services, increased fatigue and burnout, and a lower number of external applicants. These challenges are not unique to Alberta and are being seen nationally and globally.

AHS continues to implement the *AHS Health Workforce Strategy* in response to short and medium-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.

Calculated Full Time Equivalents (FTEs) is the total number of paid hours (including regular hours, overtime, relief, and paid time off), divided by the annuals hours of a full-time employee , which is 2023.50 for the current year due to the impact of the leap year (2022-23 – 2022.75).

Calculated FTE	2023-24	2022-23	Increase (Decrease)	
			FTE	%
Clinical staff[1]	56,685	54,243	2,442	4.5
Other staff[2]	29,312	29,191	121	0.4
Management – includes both clinical and other management	3,327	3,234	93	2.9
Total Calculated FTEs	**89,324**	**86,668**	**2,656**	**3.1**

The increase in Calculated FTEs was mainly due to increased overtime and the transfer of lab employees from DynaLIFEDX to AHS in the year. Vacancy rates declined in the latter half of the year, however, remained high and continued to be a significant cause of overtime for many areas. The overtime rate remained consistent with prior year at 2.9 per cent, however, continues to be above the AHS five-year average of 2.3 per cent.

Clinical staff FTEs including registered nurses and emergency medical services increased compared to the prior year. AHS increased recruitment and retention efforts in the year, targeting vacancies, talent supply, and alternative delivery models. This included launching an emergency medical services recruitment campaign and hiring 463 internationally educated nurses.

The sick-leave rate decreased by 0.3 percentage points, and sick hours increased by 0.5 per cent from the prior year; however, both remain higher than the five-year average. Sick leave continued to be influenced by the impact of influenza, COVID-19, and other respiratory viruses, as well as employee fatigue.

AHS continues to be one of the most efficiently managed public sector organizations in Canada, with clinical and other managers overseeing an average of 34 employees each. The average ratio for Canadian public administration agencies, according to the most recent Conference Board of Canada report was eight employees per manager[3].

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

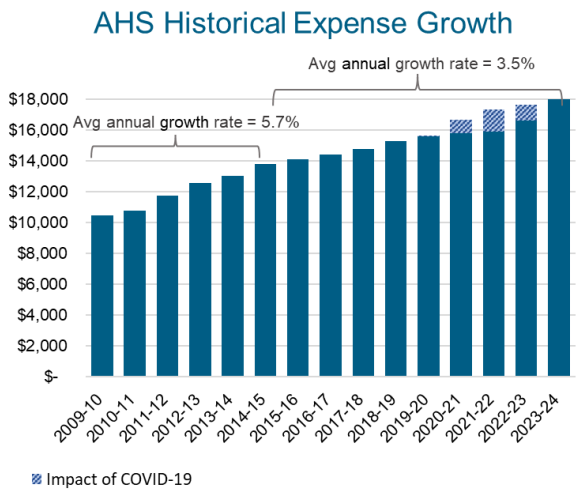
[2] Other staff include support services employees such as food services, facilities and maintenance, clerical and administrative support staff.

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

Expense Growth

In 2023, Alberta's population grew by 4.4 per cent[4]. This growth, along with an aging population, continues to increase demand for healthcare services.

Alberta's general inflation rate remained high during fiscal 2023-24, ending at 3.5 per cent[5] in March 2024, and has resulted in AHS experiencing higher costs related to utilities, food and dietary supplies, leases, liability insurance, drugs and gases, and medical supplies. While continuing to focus on value for money and containing costs, AHS' expense growth has averaged 3.5 per cent per year over the past eight years.



To support Alberta's population growth, AHS invested in key priority areas such as the Alberta Surgical Initiative, acute care and continuing care capacity, emergency medical services, home care initiatives, and Continuing Care Transformation. Due to the investment in these initiatives, as well as wage and inflationary increases, annual expenses increased by 6.7 per cent compared to the prior year.

In 2023-24, wages increased for all unionized employees as per collective bargaining agreements ratified in 2022-23. Contracted providers including Covenant Health, continuing care, home care, mental health and addiction, emergency medical services, housekeeping services, and protective services also experienced similar cost increases.

Cost Management and Efficiencies

The AHS Sustainability Program continues to support initiatives focused on improving value, resulting in significant savings achieved since inception of the program in 2020. Examples of savings initiatives include reducing discretionary spending, review and realignment of management positions, vacancy management, consolidation of lease spaces, and efficiencies through environmental sustainability and energy management projects.

Additional cost management strategies were further implemented in January 2024 to help AHS achieve a balanced budget through both expense reductions and revenue increases.

AHS' efforts to manage costs and realize efficiencies will continue into the next fiscal year to help prioritize AHS' resources and to help support work to refocus the health system.

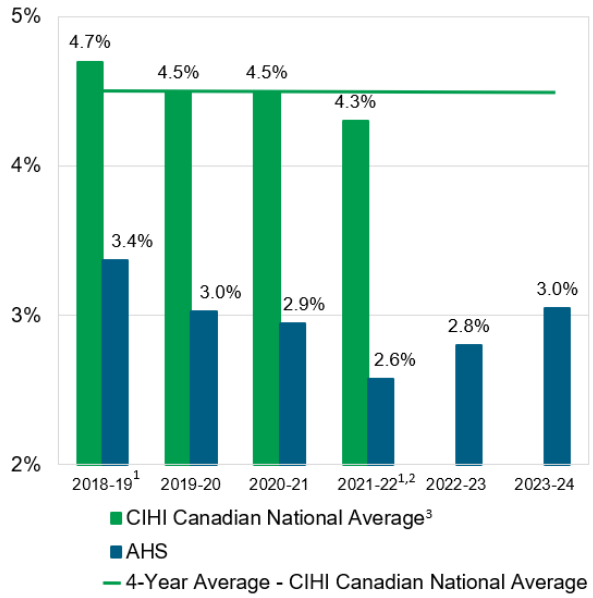
[4] Statistics Canada. Population Estimates, Quarterly. January 2023 and January 2024 data points: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000901

[5] Statistics Canada. (2024). Table 18-10-0004-01 Consumer Price Index, monthly, not seasonally adjusted: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1810000401

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[6]. For 2023-24, AHS' indicator was 3.0 per cent.

Administration Performance Indicator



[1] Certain amounts have been reclassified to conform to subsequent years presentation.

[2] 2021-22 AHS administration indicator was impacted by significant additional spending due to COVID-19 across other expense lines, including population and public health, acute care, support services, and diagnostic and therapeutic.

[3] CIHI Canadian national average for the administration indicator for 2023-24 was not available at the time of publication of this report.

AHS' indicator has increased over the last two years, primarily due to higher liability insurance costs as a result of increased reserves for existing and new claims, and investment in recruitment and retention initiatives. Further contributing in 2023-24 were additional administration costs related to the acquisition of DynaLIFEDX.

AHS 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.

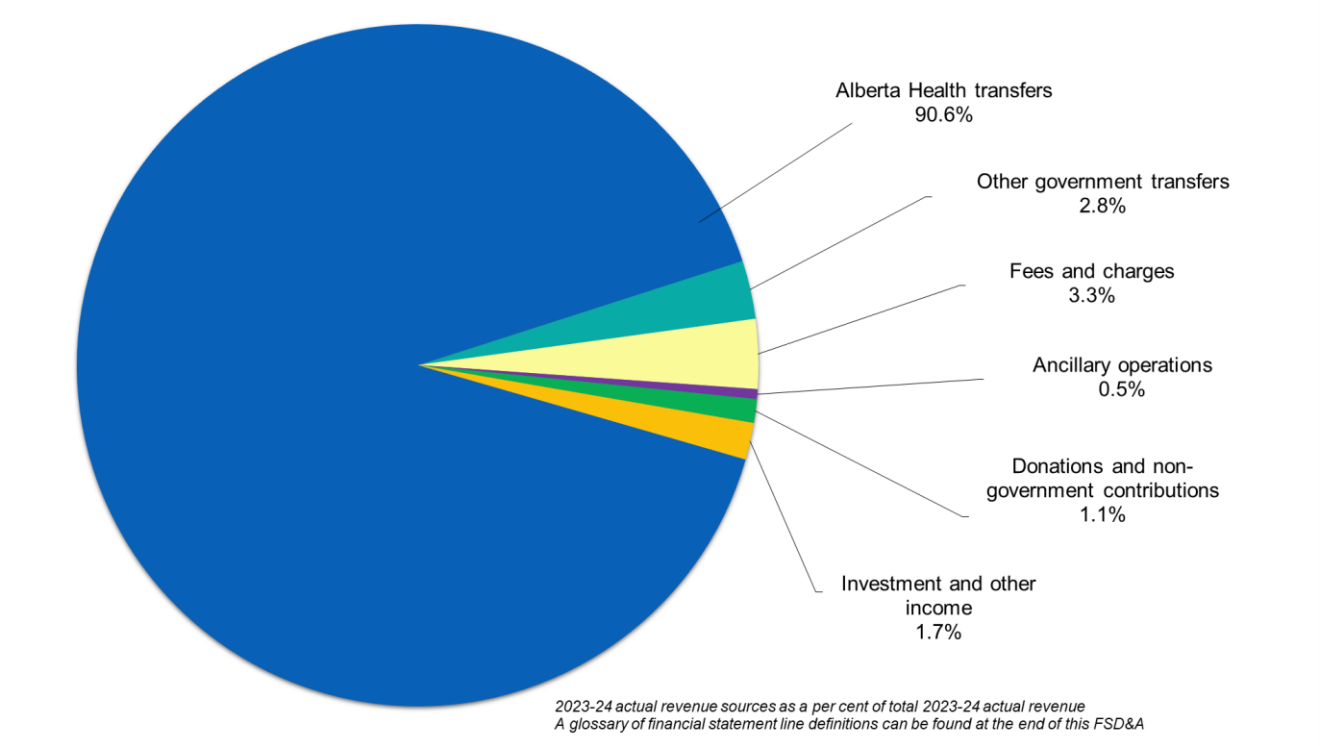
[6]Canadian Institute for Health Information. (n.d.). Your Health Systems. Retrieved from Interactive Map: Corporate Services Expense Ratio (Percentage), 2021-22: https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en&_ga=2.59018553.2003620571.1682440829#/indicator/041/2/C20018/

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 2023-24 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



2023-24 actual revenue sources as a per cent of total 2023-24 actual revenue
A glossary of financial statement line definitions can be found at the end of this FSD&A

Alberta Health transfers accounted for 90.6 per cent of AHS' total revenues in 2023-24 (2022-23 – 91.3 percent). The decrease in the proportion of Alberta Health revenues to total revenues is a result of additional transfers received in the prior year related to the response to and recovery from COVID-19. AHS' total revenues amounted to $19,028 million, which was $558 million or 3.0 per cent higher than the budget of $18,470 million.

(in $ millions)	Budget 2023-24	Actual 2023-24	Actual to Budget Variance	Actual 2022-23	Year over Year Increase (Decrease)
Alberta Health transfers	16,906	17,243	337	16,204	1,039
Other government transfers	471	528	57	476	52
Fees and charges	586	626	40	537	89
Ancillary operations	110	87	(23)	103	(16)
Donations and non-government contributions	182	214	32	189	25
Investment and other income	215	330	115	240	90
Total revenues	**18,470**	**19,028**	**558**	**17,749**	**1,279**

Actual to Budget

Alberta Health transfers were higher than budget mainly due to one-time transfers related to funding the acquisition of DynaLIFEDX and other cost pressures, including agency nursing and overtime. Further contributing to the variance was revenue recognized for the utilization of COVID-19 personal protective equipment and other supplies inventory purchased in prior years. New grant funded initiatives, including additional funding to support seniors aging with dignity in their community, and additional resources for CT and MRI testing further contributed to the variance. The overall variance was partially offset by lower utilization of grant funded drugs.

Other government transfers were higher than budget due to the receipt of COVID-19 drugs and supplies from the federal government, and increased activity in various addiction and mental health initiatives funded by the Ministry of Mental Health and Addiction, and other Government of Alberta funded initiatives.

Fees and charges were higher than budget due to increased clinical activity resulting in a higher than anticipated number of patients who were provided healthcare services that are billable to non-residents of Canada and other provinces.

Ancillary operations were lower than budget due to the outsourcing of retail food services in Calgary and Edmonton during the year, and lower than budgeted revenues from parking operations.

Donations and non-government contributions were higher than budget mainly due to an endowment contribution received for the Arthur J.E. Child Comprehensive Cancer Centre.

Investment and other income were higher than budget mainly due to higher than anticipated recoveries from the Workers Compensation Board and other external entities, and increases in interest and dividend income due to favorable market conditions. Additionally, higher than anticipated net realized gains from active portfolio management, increased income related to physician services, and commissions from retail food services further contributed to the variance. The overall variance was partially offset by lower than anticipated revenue related to the usage of children's pain medication.

Year over Year

Alberta Health transfers were higher than the prior year mainly due to an increase in funding to support investments in improving capacity and patient flow across the healthcare system, as well as collective agreement increases, overtime, inflation, and agency nursing. Additional funding was also received for the acquisition of DynaLIFEDX. Further contributing to the increase were revenues for new grant funded initiatives mainly related to emergency medical services, continuing care, CT and MRI testing, and surgical services, a higher volume of outpatient cancer drugs provided at no cost to patients, and increased activity in various grant funded programs. The overall increase was partially offset by a decrease in transfers related to the COVID-19 response and recovery.

Other government transfers were higher than the prior year mainly due to increased activity in addiction and mental health programs, tangible capital asset additions resulting in a higher recognition of externally funded capital revenue, and revenue recognized for new initiatives and wildfires. Decreased federal contributions of COVID-19 drugs and other supplies partially offset the overall increase.

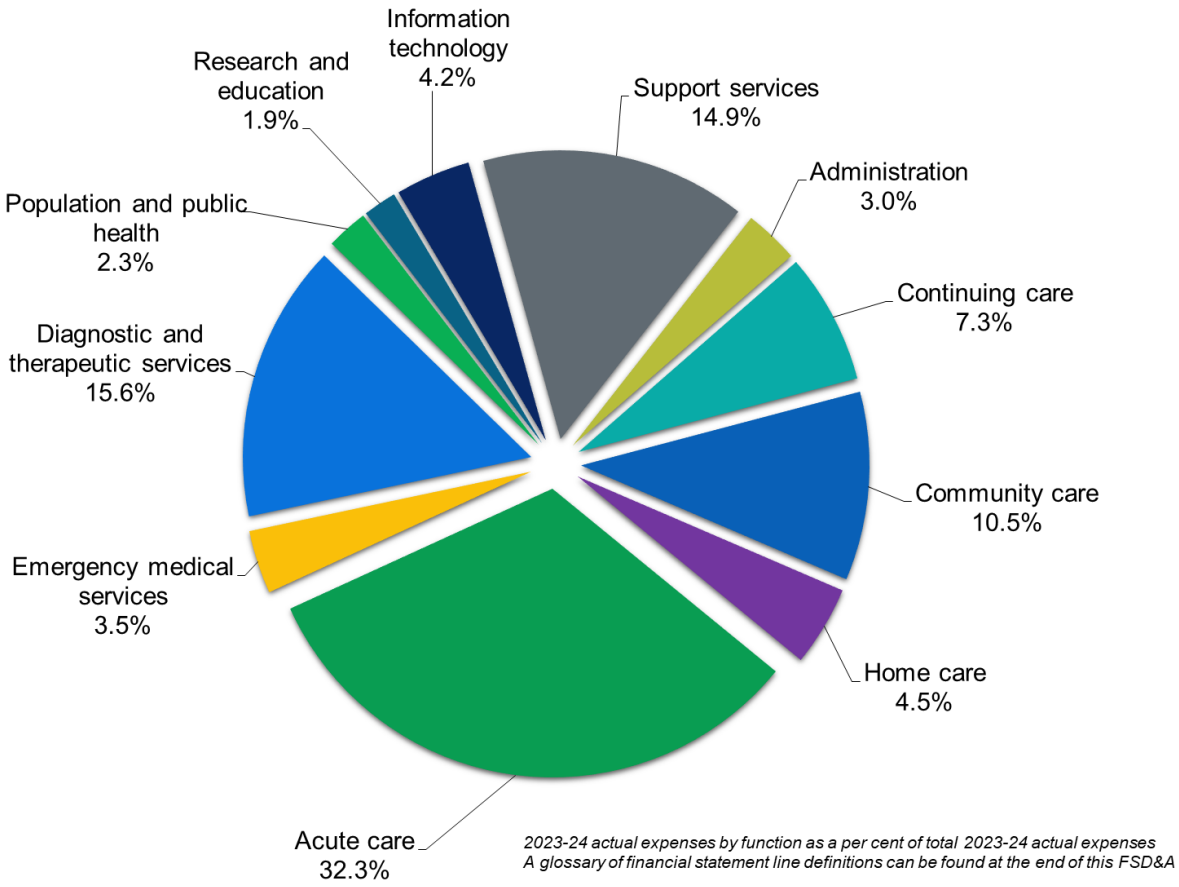
Fees and charges were higher than the prior year mainly due to an increase in interprovincial reciprocal billing rates, as well as an increased number of patients who were provided healthcare services that are billable to other provinces, non-residents of Canada, and other responsible parties.

Ancillary operations were lower than the prior year mainly due to the outsourcing of retail food services in Calgary and Edmonton during the year.

Donations and non-government contributions were higher than the prior year mainly due to an endowment contribution received for the Arthur J.E. Child Comprehensive Cancer Centre.

Investment and other income were higher than the prior year mainly due to increased interest and dividend income as a result of favourable market conditions, active portfolio management resulting in greater realized gains on investments, and increased recoveries from the Workers Compensation Board and other external entities.

Expenses by Function



2023-24 actual expenses by function as a per cent of total 2023-24 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 remained consistent with prior year, with only population and public health changing slightly due to decreased costs associated with dedicated COVID-19 response and recovery efforts compared to the prior year. Acute care, which comprises mainly inpatient, outpatient and emergency services, continued to be the largest function, making up 32.3 per cent of total expenses (2022-23 – 31.7 per cent).

(in $ millions)	Budget 2023-24	Actual 2023-24	Actual to budget variance	Actual 2022-23	Year over Year Increase (Decrease)
Continuing care	1,373	1,375	(2)	1,382	(7)
Community care	2,074	1,984	90	1,888	96
Home care	903	844	59	740	104
Acute care	5,788	6,085	(297)	5,595	490
Emergency medical services	741	666	75	600	66
Diagnostic and therapeutic services	2,872	2,932	(60)	2,646	286
Population and public health	500	439	61	589	(150)
Research and education	364	353	11	342	11
Information technology	775	794	(19)	749	45
Support services	2,539	2,798	(259)	2,639	159
Administration	541	574	(33)	495	79
Total expenses by function	**18,470**	**18,844**	**(374)**	**17,665**	**1,179**

Actual to Budget

Community care was lower than budget due to the staggered timing of contract rate increases, less than planned designated supportive living bed openings due to delays with contracted providers securing space, and recoveries of prior year surplus COVID-19 funds from community care providers. Further contributing to the variance was lower than anticipated use of the federally funded outpatient COVID-19 drug therapy program due to reduced cases. This was partially offset by additional funding provided to community care operators to support seniors aging with dignity in their community funded by a new restricted grant from Alberta Health.

Unique Home Care Clients

130,111

(2022-23 – 126,539)

Home care was lower than budget due to delays in implementing home care innovations and palliative home care initiatives as a result of the additional time required to review, negotiate, and implement new contracts, mainly related to rural home care travel and congregate living, and home care services still not operating at pre-pandemic levels.

Acute care was higher than budget due to the increased use of agency nursing, overtime, and relief throughout the organization resulting from a higher number of inpatients, emergency room visits, ongoing vacancies, recruitment challenges, and increased sick leave. Further contributing to the variance were changes in the mix and volume of activities performed resulting in higher staffing and use of medical supplies. Partially offsetting the variance were vacancies and delayed recruitment related to the Alberta Surgical Initiative and the timing of building commissioning for the Arthur J.E. Child Comprehensive Cancer Centre.

Emergency Department Visits

2,028,196

(2022-23 – 1,983,852)

Emergency medical services were lower than budget due to delays in implementing certain initiatives, including fatigue management and workforce initiatives, as a result of ongoing vacancies and delays related to contract negotiations.

Diagnostic and therapeutic services were higher than budget due to additional costs related to the transition of lab services from DynaLIFEDX to AHS. Increased spending related to CT and MRI testing funded by a new restricted grant from Alberta Health, higher patient volumes and drug utilization, wage increases, and increased supply costs further contributed to the variance.

Population and public health were lower than budget due to lower than expected utilization of children's pain medication.

Research and education were lower than budget due to vacancies related to resident physician grants, 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 costs to support activities and associated training for

launches six and seven of Connect Care, and application licences related to the system.

Support services were higher than budget due to higher utility costs resulting from inflation and carbon tax. Further contributing was a valuation adjustment of personal protective equipment and other supplies inventory due to reduced demand. Increased requirements for overtime and relief, Connect Care education and training costs, and additional procurement and capital management costs as a result of transitioning lab services from DynaLIFEDX to AHS further contributed to the variance

Administration was higher than budget due to higher liability insurance costs as a result of increased reserves for existing and new claims, and additional finance and human resource costs related to the transition of lab services from DynaLIFEDX to AHS. Higher operational support and maintenance costs related to Connect Care, wages, overtime and relief also contributed to the variance.

Year over Year

Community care was higher than the prior year due to increased funding provided to supportive living providers and other community health providers under the Continuing Care Transformation initiatives and the opening of 506 net new designated supportive-living and community mental health beds. A new restricted grant from Alberta Health provided additional funding to community care operators to support seniors aging with dignity in their community. Increased compensation costs due to vacancies being filled in the year and contract inflation related to community care providers further contributed to the increase. Reduced COVID-19 response and recovery funding to supportive living facilities and other community health providers partially offset the increase.

Net New Continuing Care Beds Opened Since 2010 Stat

10,054 (2022-23 – 9,424)

Home care was higher than the prior year due to contracted rate increases to agency home care providers, increased home care activity as AHS and contracted home care providers continued to work towards providing additional hours of care and choices to home care patients, and new client directed home care services.

Acute care was higher than prior year due to increased activity, including utilization of oncology drugs, a higher number of inpatients, emergency room visits and surgeries performed related to the Alberta Surgical Initiative. Additionally, increased compensation costs including wages, and increased utilization of agency nursing staff, overtime, and relief throughout the organization further contributed to the increase.

Emergency medical services events

724,783

(2022-23 – 661,777)

Emergency medical services were higher than the prior year due to the implementation of initiatives, including fatigue management, inter-facility and ambulance resources, and wage increases.

Diagnostic and therapeutic services were higher than the prior year due to costs associated with the acquisition of DynaLIFEDX, and increased activity, including lab testing, CT and MRI testing as a result of a new restricted grant from Alberta Health, and testing associated with surgery recovery under the Alberta Surgical Initiative. Wage increases and higher amortization expense due to Arthur J.E. Child Comprehensive Cancer Centre equipment additions and acquired DynaLIFEDX lab equipment further contributed to the increase.

CT & MRI Exams

851,017

(2022-23 – 751,540)

Population and public health were lower than the prior year due to decreased costs associated with COVID-19 response and recovery efforts such as contract tracing, vaccinations and assessment centres, entry screening, and rapid test kit distribution.

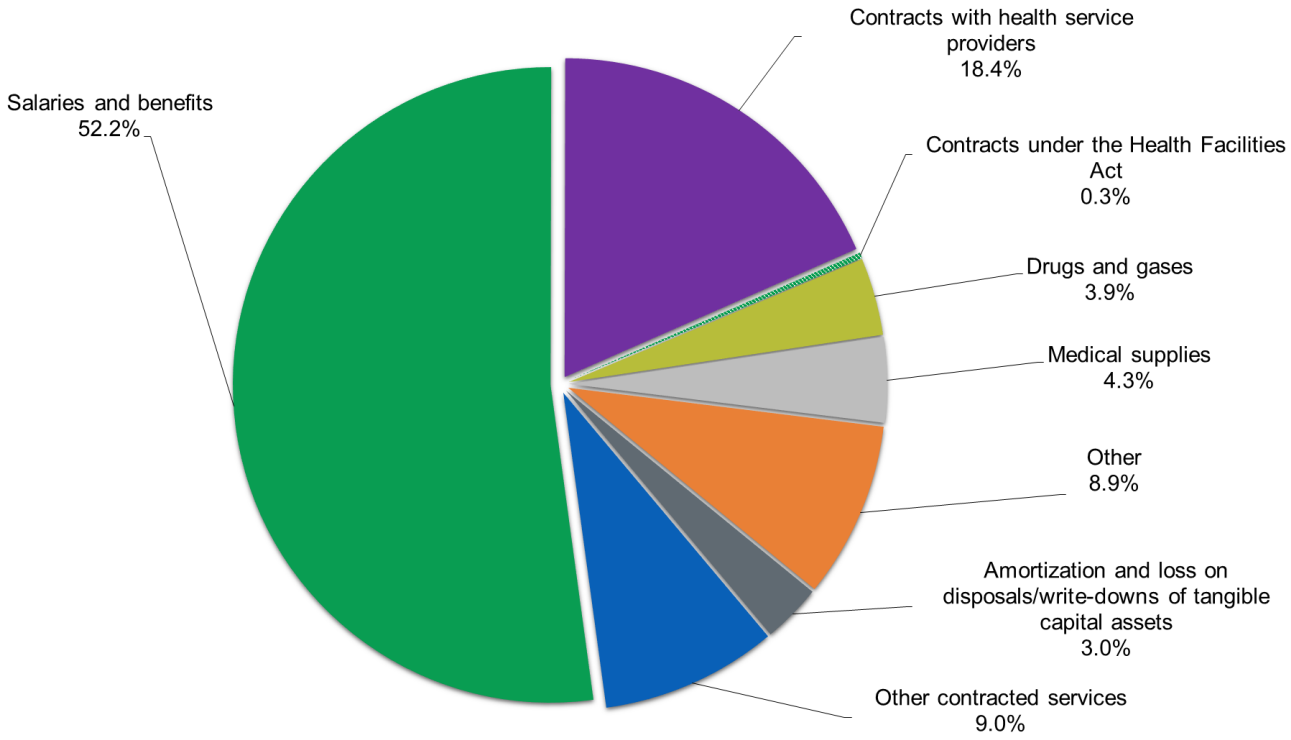
Information technology was higher than the prior year due to additional minor equipment purchased to support the growing organization and refresh of existing equipment, higher Connect Care licencing costs, and additional warranty costs. Higher amortization expense due to Connect Care equipment additions further contributed to the increase.

Support services were higher than the prior year due to increased utility costs resulting from inflation and carbon tax, higher food supplies costs, and higher amortization expense due to Arthur J.E. Child Comprehensive Cancer Centre equipment additions. Further contributing to the increase were costs related to children's pain medication and increased Connect Care education and training costs. Additionally, increased costs were incurred related to building commissioning and operational readiness of the

Arthur J.E. Child Comprehensive Cancer Centre, additional procurement and capital management costs resulting from the transition of lab services from DynaLIFEDX to AHS, and wage increases. Offsetting the increase were reduced costs achieved through the outsourcing of retail food services, cost management strategies implemented, and decreased costs associated with direct COVID-19 response and recovery efforts.

Administration was higher than the prior year due to higher liability insurance costs as a result of increased reserves for existing and new claims, the investment in recruitment and retention initiatives, and increased compensation costs.

Expenses by Object



2023-24 actual expenses by object as a per cent of total 2023-24 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 52.2 per cent of total expenses (2022-23 – 51.8 per cent). This does not include employees who work for contract providers.

(in $ millions)	Budget 2023-24	Actual 2023-24	Actual to Budget Variance	Actual 2022-23	Year over Year Increase (Decrease)
Salaries and benefits	9,409	9,840	(431)	9,155	685
Contracts with health service providers	3,790	3,466	324	3,328	138
Contracts under the Health Facilities Act	59	56	3	30	26
Drugs and gases	827	739	88	679	60
Medical supplies	707	815	(108)	828	(13)
Other contracted services	1,559	1,688	(129)	1,534	154
Other	1,591	1,685	(94)	1,596	89
Amortization and loss on disposals/write-downs of tangible capital assets	528	555	(27)	515	40
Total expenses by object	**18,470**	**18,844**	**(374)**	**17,665**	**1,179**

Actual to Budget

Salaries and benefits were higher than budget due to the increased use of overtime and relief throughout the organization as a result of ongoing vacancy rates, recruitment challenges, and increased sick leave. Further contributing to the increase were costs from transitioning lab staff to AHS as part of the DynaLIFEDX acquisition, increased costs related to the training and operational support of Connect Care, and clinical activity requiring higher staffing levels to support the change in the mix and volume of activities performed. Partially offsetting the variance were vacancies and slower than expected recruitment in certain areas.

Contracts with health service providers were lower than budget due to a decrease in contract payments related to the transitioning of lab services, previously performed by DynaLIFEDX, into AHS. Further contributing to the variance were delays in certain continuing care, community care, home care, and emergency medical services initiatives, as well as recoveries of surplus COVID-19 funds from contracted providers. The variance was partially offset by additional funding to contracted providers to support seniors aging with dignity in their community under a new restricted grant from Alberta Health, and increased activity.

Lab Tests

87,980,881

(2022-23 – 82,410,198)

Drugs and gases were lower than budget due to lower than anticipated utilization of children's pain medication, and lower utilization of grant funded drugs including newly approved drugs, chemotherapy drugs, rare disease drugs, and specialized high-cost drugs. Further contributing to the variance was lower than anticipated use of the federally funded outpatient COVID-19 drug therapy program due to reduced cases.

Total Surgical Volumes

304,595

(2022-23 – 294,300)

Medical supplies were higher than budget due to increased clinical activity, resulting in a higher volume of surgical procedures performed and supplies used such as catheters, implantable parts and accessories, high-cost orthopedic cases, and complex fractures. Additional medical supplies costs as a result of transitioning lab services from DynaLIFEDX to AHS also contributed to the variance.

Other contracted services were higher than budget due to the increased utilization of agency nursing to cover staffing needs. Physician costs from the transitioning of lab services from DynaLIFEDX to AHS further contributed to the variance.

Other was higher than budget due to increased utility costs resulting from inflation and carbon tax, increased liability insurance costs as a result of increased reserves for existing and new claims, and costs from transitioning lab services from DynaLIFEDX to AHS. Further contributing to the increase was a valuation adjustment for personal protective equipment and other supplies inventory due to reduced demand. Savings resulting from cost containment strategies in areas such as office supplies, rent, and minor equipment expenses partially offset the variance.

Amortization and loss on disposals/write-downs of tangible capital assets were higher than budget due to

additional amortization of equipment and capital leases acquired as part of the DynaLIFEDX acquisition, and additional amortization recognized from asset retirement obligations.

Year over Year

Salaries and benefits were higher than the prior year due to the increased use of overtime and relief throughout the organization as a result of ongoing vacancy rates, recruitment challenges, and increased sick leave. Further contributing was increased activity, including increased inpatient days, emergency room visits, and surgeries performed related to the Alberta Surgical Initiative, the transition of lab services staff from DynaLIFEDX to AHS, as well as additional staff hired to fill vacancies. Increased spending associated with implementing emergency medical services initiatives, the additional leap year day in February, and wage increases further contributed to the increase.

Contracts with health service providers were higher than the prior year due to the implementation of priority initiatives, including Continuing Care Transformation, emergency medical services initiatives, and the opening of 623 net new long-term care and designated supportive living beds. Further contributing to the increase were contract inflation, wage increases, and additional funding to contracted providers to support seniors aging with dignity under a new restricted grant from Alberta Health. Decreased costs associated with dedicated COVID-19 response and recovery efforts, and the transition of lab services from contracted DynaLIFEDX to AHS partially offset the increase.

Contracts under the Health Facilities Act were higher than the prior year due to an increase in surgeries performed at chartered surgical facilities under the Alberta Surgical Initiative.

Drugs and gases were higher than the prior year due to the increased utilization of high-cost oncology and rare disease drugs, and a valuation adjustment related to children's pain medication inventory.

Medical supplies were higher than the prior year due to increased operating room volumes, including surgical procedures performed under the Alberta Surgical Initiative, emergency room visits, and the transition of lab services from DynaLIFEDX to AHS in the year.

Other contracted services were higher than the prior year due to the increased utilization of agency nursing to cover staffing needs, increased physician costs, including additional physician costs as a result of the transitioning of lab services from DynaLIFEDX to AHS. Decreased costs associated with dedicated COVID-19 response and recovery efforts, including physician services, on-site protective services, and housekeeping services, partially offset the increase.

Other was higher than the prior year due to increased costs related to the transition of lab services from DynaLIFEDX to AHS, increased liability insurance costs as a result of increased reserves for existing and new claims, higher utility costs resulting from inflation and carbon tax, wage increases, and additional information technology minor equipment purchases. Increased costs associated with the implementation of priority initiatives, including emergency medical services, Connect Care, and building commissioning of the Arthur J.E. Child Comprehensive Cancer Centre further contributed to the increase.

Amortization and loss on disposals/write-downs of tangible capital assets were higher than the prior year due to the first full year of amortizing the Arthur J.E. Child Comprehensive Cancer Centre as well as equipment purchased to ready the centre for patients in the coming year, the capitalization of Connect Care launches six and seven, and additional equipment and capital leases acquired as part of the DynaLIFEDX acquisition.

Financial Position

(in $ millions)	2023-24	2022-23	Change
Financial assets	3,587	3,269	318
Liabilities	4,542	4,328	214
Net debt	**(955)**	**(1,059)**	**104**
Non-financial assets	11,020	10,842	178
Expended deferred revenue	8,696	8,642	54
Net assets	**1,369**	**1,141**	**228**

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 $243 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 investment portfolio had an aggregate return of 6.6 per cent for the year (2022-23 – 0.8 per cent), exceeding benchmarks in each of the past two years. The portfolio is sufficiently liquid in nature to enable AHS to respond to cash-flow requirements quickly and efficiently. AHS' investment portfolio increased $403 million primarily due to higher net investment contributions, positive returns due to interest earned, realized gains, and dividends received, as well as unrealized gains related to market conditions. Interest rate increases early in the year caused erosion of bond values and concerns of recessionary impact on the economy. Investor confidence started to improve as inflation rates trended toward the target, reducing the requirement for further interest rates increases. This, along with active management of the investment portfolio, contributed to an increase in both fixed income and equity values.

Accounts receivable increased $6 million primarily due to receivables related to the recoveries of surplus COVID-19 funds from operators and an endowment contribution for the Arthur J.E. Child Comprehensive Cancer Centre. Additional contributing factors included increased patient receivables, Alberta Health capital grants, and drug rebates. The overall increase was partially offset by decreased Alberta Health operating grants receivable.

Liabilities

Liabilities represent AHS' existing financial obligations at year end.

Accounts payable and accrued liabilities increased $83 million mainly due to higher payroll accruals resulting from timing of payroll remittances, increased obligations under capital leases including the addition of lab, diagnostic and surgical equipment, vehicles, and changes in the provision for liability claims. Partially offsetting the increase was the timing of payments related to various trades accounts payable.

Employee future benefits increased $31 million mainly due to the revaluation of vacation banks and the transition of DynaLIFEDX employees to AHS.

Unexpended deferred operating revenue increased $126 million mainly due to increased foundation donations and Alberta Health funding received for the outpatient cancer drug program, outpatient specialized high-cost drug programs, and emergency medical services initiatives. Various research grants under mental health and addictions and unrealized net gains on investments during the year further contributed to the increase.

AHS' **debt** is primarily comprised of debentures issued to finance the construction of parking facilities. AHS pledges the revenue derived from all parking facilities as security for the debentures. As of March 31, 2024, AHS' debt balance was $416 million (2022-23 – $434 million). Repayments of $38 million during the year were offset by loan proceeds of $20 million received to support the expansion of the Red Deer Regional Hospital Centre Parkade.

Asset retirement obligations represent AHS' legal obligation associated with the retirement of tangible capital assets. The liability decreased by $44 million primarily due to a revision in estimated remediation cost assumptions used in calculating the liability.

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)	**2023-24**	**2022-23**	**Increase (Decrease)**
Cost	20,869	20,199	670
Accumulated amortization	10,401	9,895	506
Net book value	**10,468**	**10,304**	**164**

AHS receives significant external funding for **tangible capital asset** expenditures, primarily from Government of Alberta ministries. Capital asset additions amounted to $761 million, of which 69 per cent were externally funded (2022-23 – 74 per cent). These additions were offset by the $49 million in asset disposals made throughout the year as well as transfers and adjustments of $42 million. Several capital projects totaling $509 million were completed during the year, including the Norwood Care Centre (Phase 2), Misericordia Community Hospital Modernization, Connect Care launches six and seven, 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 $661 million includes facilities construction and improvements, and information technology initiatives that include:

- Connect Care
- Bridgeland Riverside Continuing Care Centre
- Foothills Medical Centre Power Plant Upgrade

AHS maintains **inventories of supplies** to ensure goods, such as pharmaceuticals, medical and surgical supplies, are available for operational needs. Over the past year, AHS' inventory balance decreased by $111 million primarily due to the drawdown, including usage and valuation adjustments, of personal protective equipment (PPE), non-PPE pandemic supplies, and children's pain medication, as demand has reduced for inventories purchased in prior years to support public health emergencies.

Prepaid expenses increased by $125 million primarily due to an increase in the Health Benefit Trust of Alberta (HBTA) prepaid balance. This represents, in substance, AHS' prepayment of future premiums to the HBTA due to reduced employee sick time resulting in fewer short-term and long-term disability claims, as well as the pre-payment of a pharmaceutical contract.

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 was 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 $8,455 million, or 97 per cent of the $8,697 million total balance (2022-23 – $8,297 million or 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. Over the past year, the balance decreased by $117 million due to a valuation adjustment recorded related to children's pain medication inventory, as well as utilization of the COVID-19 personal protective equipment and other supplies inventory.

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)	2023-24	2022-23	Increase (Decrease)
Unrestricted surplus	379	262	117
Invested in tangible capital assets	1,057	1,000	57
Endowments	105	77	28
Internally restricted surplus for insurance equity requirements and foundations	124	132	(8)
Asset retirement obligations	(360)	(350)	(10)
Accumulated Surplus	**1,305**	**1,121**	**184**
Accumulated remeasurement gains	64	20	44
Total Net Assets	**1,369**	**1,141**	**228**

The **unrestricted surplus** grew $117 million as a result of the $184 million operating surplus, offset by the net internal investment in tangible capital assets, and the transfer of endowment contributions received in the year.

Outlook

AHS operates a broad and complex organization. AHS knows the importance of being adaptable, innovative, and proactive. While AHS has managed its expense growth, it has become evident that continued work is needed to enhance and transform the delivery of healthcare to meet the changing needs of Albertans.

The Minister of Health is refocusing Alberta's healthcare system with the goal to improve health outcomes for Albertans and empower healthcare workers to deliver quality care across the province.

AHS will support the ongoing work to refocus the healthcare system, led by Alberta Health, and will continue to address current priorities. AHS continues to focus on financial sustainability while also making efforts to improve capacity and flow. 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.

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*.

The Finance, Audit & Risk Committee is a governance-advisory committee established by the Board of AHS. The purpose of the Committee is to assist the **Board** in fulfilling their oversight and governance responsibilities with respect to finance, audit, and risk.

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 Board 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 Board 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 an **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

Revenues

Alberta Health transfers comprises 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 (excluding embedded retail 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 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 comprise 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, palliative 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 comprise 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, rehabilitation services such as physiotherapy, occupational therapy, respiratory therapy and speech-language pathology.

Population and public health comprise 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 comprise 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, implementation, security and support of information-technology services and systems.

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

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, legal and coordination of virtual health services.

Expenses by Object

Salaries and benefits comprise 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 – Bill 11* 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 relate 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, 2024

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the year ended March 31, 2024 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 Finance, Audit and Risk Committee (the Committee). The Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to the Alberta Health Services Board for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Committee.

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

[Original signed by]

Athana Mentzelopoulos
President and Chief Executive Officer
Alberta Health Services

[Original signed by]

Michael Lam, CPA, CA, CHE
Interim Vice President, Corporate Services and Chief Financial Officer
Alberta Health Services

June 3, 2024

Auditor General OF ALBERTA

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

Report on the Consolidated Financial Statements

Opinion

I have audited the consolidated financial statements of Alberta Health Services (the Group), which comprise the consolidated statement of financial position as at March 31, 2024, 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, 2024, 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.

Emphasis of matter

I draw attention to Note 29 of the consolidated financial statements, which describes the subsequent events and restructuring/refocusing of the Group. My opinion is not modified in respect of this matter.

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 3, 2024
Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS YEAR ENDED MARCH 31	2024		2023
	Budget (Note 3)	Actual	Actual
Revenues:			
Alberta Health transfers			
Base operating	$ 15,137,611	$ 15,138,434	$ 13,446,558
One-time base operating	-	286,083	185,146
Other operating	1,655,938	1,712,435	2,467,695
Recognition of expended deferred capital revenue	113,400	106,297	104,165
Other government transfers (Note 4)	470,718	527,925	475,512
Fees and charges	586,000	625,668	536,774
Ancillary operations	110,000	87,178	103,324
Donations and non-government contributions (Note 5)	182,000	213,382	189,244
Investment and other income (Note 6)	214,800	330,376	240,285
TOTAL REVENUES	**18,470,467**	**19,027,778**	**17,748,703**
Expenses:			
Continuing care	1,373,300	1,375,360	1,381,494
Community care	2,073,700	1,983,628	1,888,404
Home care	902,800	843,709	740,152
Acute care	5,788,067	6,084,875	5,594,950
Emergency medical services	741,400	665,954	599,476
Diagnostic and therapeutic services	2,872,000	2,932,784	2,645,702
Population and public health	500,200	439,173	589,216
Research and education	363,500	352,707	341,797
Information technology	775,000	793,775	749,085
Support services (Note 7)	2,539,200	2,798,372	2,639,431
Administration (Note 8)	541,300	573,810	495,326
TOTAL EXPENSES (Schedules 1 and 3)	**18,470,467**	**18,844,147**	**17,665,033**
ANNUAL OPERATING SURPLUS	**-**	**183,631**	**83,670**
Accumulated surplus, beginning of year	1,120,827	1,120,827	1,037,157
Accumulated surplus, end of year (Note 21)	**$ 1,120,827**	**$ 1,304,458**	**$ 1,120,827**

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

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31	2024 Actual	2023 Actual
Financial Assets:		
Cash and cash equivalents	$ 243,462	$ 334,649
Portfolio investments (Note 10)	2,587,692	2,184,694
Accounts receivable (Note 11)	755,525	750,083
	3,586,679	3,269,426
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,855,955	1,773,424
Employee future benefits (Note 13)	818,539	787,643
Unexpended deferred operating revenue (Note 14)	697,922	572,628
Unexpended deferred capital revenue (Note 15)	214,072	177,901
Debt (Note 17)	415,813	434,088
Asset retirement obligations (Note 18)	539,421	583,172
	4,541,722	4,328,856
NET DEBT	**(955,043)**	**(1,059,430)**
Non-Financial Assets:		
Tangible capital assets (Note 19)	10,467,655	10,303,649
Inventories of supplies (Note 20)	197,169	307,725
Prepaid expenses, deposits, and other non-financial assets	355,181	231,254
	11,020,005	10,842,628
NET ASSETS BEFORE EXPENDED DEFERRED REVENUE	10,064,962	9,783,198
Expended deferred revenue (Note 16)	8,696,431	8,642,101
NET ASSETS	**1,368,531**	**1,141,097**
Net Assets is comprised of:		
Accumulated surplus (Note 21)	1,304,458	1,120,827
Accumulated remeasurement gains	64,073	20,270
	$ 1,368,531	**$ 1,141,097**

Contractual Obligations and Contingent Liabilities (Note 22)

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

Approved by:

[Original signed by]

Dr. Lyle Oberg
Executive Board Chair
Alberta Health Services

[Original signed by]

Paul George Haggis
Finance, Audit & Risk Committee Chair
Alberta Health Services

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT YEAR ENDED MARCH 31			
	2024		2023
	Budget (Note 3)	Actual	Actual
Annual operating surplus	$ -	$ 183,631	$ 83,670
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets:			
Purchased	(530,000)	(452,501)	(497,852)
Purchased as part of DynaLIFEDX asset purchase	-	(71,760)	-
Leased	(10,000)	(37,753)	(19,031)
Constructed by Alberta Infrastructure on behalf of AHS	(457,000)	(198,774)	(262,429)
Contributed by others	-	(24)	(35)
Revision to asset retirement cost estimates	-	41,773	(41,164)
Amortization and loss on disposals/write-downs of tangible capital assets	527,500	555,033	514,897
Effect of other changes:			
Net increase in expended deferred capital revenue	485,600	170,966	246,496
Net decrease in expended deferred operating revenue	(161,000)	(116,636)	(220,336)
Net decrease (increase) in inventories of supplies	(123,000)	118,442	205,294
Net increase in prepaid expenses, deposits and other non-financial assets	(19,000)	(118,968)	(54,684)
Net increase in non-financial assets due to DynaLIFEDX acquisition	-	(12,845)	-
Net remeasurement gains (losses) for the year	(7,000)	43,803	(4,616)
Decrease (increase) in net debt for the year	**(293,900)**	**104,387**	**(49,790)**
Net debt, beginning of year	(1,059,430)	(1,059,430)	(1,009,640)
Net debt, end of year	**$ (1,353,330)**	**$ (955,043)**	**$ (1,059,430)**

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

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31	2024 Actual	2023 Actual
Unrestricted unrealized gains (losses) attributable to:		
Derivatives	$ 586	$ 2,572
Portfolio investments		
Quoted in an active market	6,600	(3,208)
Designated at fair value	35,815	(36,392)
Amounts reclassified to the Consolidated Statement of Operations:		
Derivatives	(998)	(1,710)
Portfolio investments		
Quoted in an active market	-	-
Designated at fair value	1,800	34,122
Net remeasurement gains (losses) for the year	**43,803**	**(4,616)**
Accumulated remeasurement gains, beginning of year	20,270	24,886
Accumulated remeasurement gains, end of year (Note 10)	**$ 64,073**	**$ 20,270**

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

CONSOLIDATED STATEMENT OF CASH FLOWS YEAR ENDED MARCH 31	2024 Actual	2023 Actual
Operating transactions:		
Annual operating surplus	$ 183,631	$ 83,670
Non-cash items:		
Amortization and loss on disposals/write-downs of tangible capital assets	555,033	514,897
Revenue recognized for acquisition of land	-	(3,934)
Recognition of expended deferred capital revenue	(355,407)	(328,651)
Recognition of expended deferred operating revenue	(116,636)	(289,853)
(Gain) loss on disposal of portfolio investments	(13,736)	32,218
Change in employee future benefits	24,268	9,765
(Increase) decrease in:		
Accounts receivable related to operating transactions	(14,564)	(155,654)
Inventories of supplies	118,442	205,294
Prepaid expenses, deposits, and other non-financial assets	(118,968)	(54,684)
Increase (decrease) in:		
Accounts payable and accrued liabilities	23,669	(171,577)
Unexpended deferred operating revenue	115,570	59,541
Asset retirement obligations	(1,978)	(2,409)
Cash provided by (applied to) operating transactions	399,324	(101,377)
Capital transactions:		
Purchased tangible capital assets	(452,501)	(497,852)
DynaLIFEDX purchase consideration net of cash acquired	(29,388)	-
Cash applied to capital transactions	(481,889)	(497,852)
Investing transactions:		
Purchase of portfolio investments	(5,284,617)	(4,110,544)
Proceeds on disposals of portfolio investments	4,948,882	4,476,003
Cash (applied to) provided by investing transactions	(335,735)	365,459
Financing transactions:		
Restricted operating contributions received	-	69,517
Restricted capital contributions received	367,372	345,074
Unexpended deferred capital revenue returned	(3,626)	(73)
Proceeds from debt	20,000	11,500
Principal payments on debt	(38,275)	(32,405)
Payments on obligations under capital leases	(17,745)	(25,639)
Net repayment of life lease deposits	(613)	(246)
Cash provided by financing transactions	327,113	367,728
(Decrease) increase in cash and cash equivalents	**(91,187)**	**133,958**
Cash and cash equivalents, beginning of year	334,649	200,691
Cash and cash equivalents, end of year	**$ 243,462**	**$ 334,649**

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS FOR THE YEAR ENDED MARCH 31, 2024

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:

  The largest foundations controlled by AHS are the Alberta Cancer Foundation and the Calgary Health Foundation. AHS also controls 33 other foundations that 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 healthcare 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, 2023. Significant transactions occurring between this date and March 31, 2024 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 39 (2023 – 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

All revenues are recorded on an accrual basis, except when the accrual cannot be determined within a reasonable degree of certainty or when estimation is impracticable. Revenues from transactions with performance obligations are recognized when AHS provides the promised goods and/or services to a payor. Revenue from transactions with no performance obligations are recognized at their realizable value when AHS has the authority to claim or retain an inflow of economic resources and identifies a past transaction or event that gives rise to an asset. 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.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Deferred revenue consists of unexpended deferred operating revenue (Note 14), unexpended deferred capital revenue (Note 15), expended deferred capital revenue (Note 16(a)) and expended deferred operating revenue (Note 16(b)). The term deferred revenue in these consolidated financial statements refers to the components of deferred revenue as described.

(ii) Donations and Non-Government Contributions

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

Unrestricted donations, 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, 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.

Endowment contributions are recognized in the Consolidated Statement of Operations in the period in which they are received or receivable.

(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 considered revenue arising from exchange transactions with performance obligations. These 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 (excluding gains or losses from restricted transfers, endowments, 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 including endowments 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.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(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.

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.

Amortized cost is the amount at which a financial instrument asset or a financial instrument liability is measured at initial recognition minus principal repayments, plus or minus the cumulative amortization using the effective interest method of any difference between that initial amount and the maturity amount, and minus any reduction (directly or through the use of an allowance account) for impairment or uncollectibility.

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 are used to measure fair value are disclosed in Note 10.

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 respectively. Unrealized gains and losses from changes in the fair value of derivatives are recognized in the Consolidated Statement of Remeasurement Gains and Losses until realized, at which time the gains or losses are recognized in the Consolidated Statement of Operations.

Contractual obligations are evaluated for the existence of embedded derivatives. 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. 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.

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.

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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.

(f) Accounts receivable

Accounts receivable are recognized at the lower of cost or net recoverable value. A valuation allowance is recognized when recovery is uncertain.

(g) 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.

(h) Tangible Capital Assets

Tangible capital assets are recorded at cost less accumulated amortization, 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.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(i) 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.

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, sick leave accumulation and utilization, and mortality. Actuarial gains and losses are amortized on a straight-line basis over the expected average remaining service life of the related employee groups.

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Other Benefits

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

(j) 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 on a straight- line basis over the estimated useful life of the underlying tangible capital asset (Note 2(h)). 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.

(k) 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.

(l) 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.

(m) 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.

Measurement uncertainty exists in the fair values reported for portfolio investments designated to the fair value category (see Note 10). The fair values of these investments are based on estimates. Estimated fair values may not reflect amounts that could be recognized upon immediate sale or amounts that ultimately may be recognized.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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.

(n) Changes in Accounting Policy

AHS has adopted on a prospective basis the following accounting standards and guideline as of April 1, 2023:

- **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. The adoption of this standard did not have any significant impact on AHS' consolidated financial statements.

- **PSG-8 – Purchased Intangibles**
  PSG-8 provides guidance on the recognition, accounting, and classification of purchased intangible assets. The adoption of this standard did not have any impact on AHS' consolidated financial statements.

- **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. The adoption of this standard did not have any impact on AHS' consolidated financial statements.

(o) Future Accounting Changes

On April 1, 2026, AHS will adopt the following new conceptual framework and accounting standard approved by the Public Sector Accounting Board:

- **The Conceptual Framework for Financial Reporting in the Public Sector**
  The Conceptual Framework is the foundation for public sector financial reporting standard setting. It replaces the conceptual aspects of Section PS 1000 Financial Statement Concepts and Section PS 1100 Financial Statement Objectives. The conceptual framework highlights considerations fundamental for the consistent application of accounting issues in the absence of specific standards.

- **PS 1202 Financial Statement Presentation**
  Section PS 1202 sets out general and specific requirements for the presentation of information in general purpose financial statements. The financial statement presentation principles are based on the concepts within the Conceptual Framework.

Management is currently assessing the impact of the conceptual framework and the standard on the AHS consolidated financial statements.

Note 3 Budget

The 2023-24 annual budget was approved by the Official Administrator on March 23, 2023 for submission to the Minister who approved it on April 28, 2023.

Note 4 Other Government Transfers

	Budget	2024	2023
Recognition of expended deferred capital revenue (Note 16 (a))	$ 216,200	$ 214,858	$ 192,079
Restricted operating (Note 14(a))	224,318	251,255	218,460
Unrestricted operating	30,200	61,812	64,973
	$ 470,718	**$ 527,925**	**$ 475,512**

Other government transfers include $492,963 (2023 – $433,722) (Note 23) transferred from the Province of Alberta, $34,962 (2023 – $41,790) 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 and Non-Government Contributions

	Budget	2024	2023
Recognition of expended deferred capital revenue (Note 16 (a))	$ 36,800	$ 34,252	$ 32,407
Restricted operating (Note 14(a))	144,000	139,182	150,190
Unrestricted operating	1,200	12,167	6,537
Endowment contributions (Note 21)	-	27,781	110
	$ 182,000	**$ 213,382**	**$ 189,244**

Note 6 Investment and Other Income

	Budget	2024	2023
Investment income	$ 54,000	$ 118,227	$ 39,658
Other income:			
AH	10,525	11,507	12,883
Other Province of Alberta Ministries (Note 23)	23,800	29,791	31,307
Other [(i)]	126,475	170,851	156,437
	$ 214,800	**$ 330,376**	**$ 240,285**

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

Note 7 Support Services

	Budget	2024	2023
Facilities operations	$ 1,006,700	$ 1,070,364	$ 994,103
Patient health records, food services, and transportation	416,600	513,793	492,530
Housekeeping, laundry, and linen	273,700	264,093	260,404
Materials management [(i)]	189,600	233,350	243,399
Support services expense of full-spectrum contracted health service providers	162,700	182,462	166,462
Ancillary operations	86,600	61,412	73,236
Fundraising expenses and grants awarded	47,200	53,310	51,705
Other [(i)]	356,100	419,588	357,592
	$ 2,539,200	**$ 2,798,372**	**$ 2,639,431**

[(i)] Materials management and other include inventory valuation adjustments of $78,997 (2023 – $71,419) (Note 20).

Note 8 Administration

	Budget	2024	2023
General administration	$ 233,500	$ 276,775	$ 219,583
Human resources	146,700	143,236	127,969
Finance	87,100	80,422	80,565
Communications	26,500	28,038	26,496
Administration expense of full-spectrum contracted health service providers	47,500	45,339	40,713
	$ 541,300	**$ 573,810**	**$ 495,326**

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 AHS Board 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 3.70% (2023 – 3.79%) increase or decrease, with all other variables held constant, the portfolio could expect an increase or decrease in unrealized net gains and losses of $95,745 (2023 – $82,800).

(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 $53,723 or 2.06% of total portfolio investments (2023 – $49,936 or 2.27%).

(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 $62,499 (2023 – $62,550).

Interest bearing securities have the following average maturity structure:

	2024	2023
Less than one year	33%	27%
1 – 5 years	49%	52%
6 – 10 years	10%	8%
Over 10 years	8%	13%

	Average Effective Market Yield	
Asset Class	**2024**	**2023**
Money market instruments	5.06%	4.45%
Fixed income securities	4.41%	4.21%

(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, 2024, investments in non-Canadian equities represented 11.6% (March 31, 2023 – 12.5%) 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, 2024, AHS held derivatives in the form of forward contracts for future settlement of $18,000 (2023 – $18,000). The fair value of these forward contracts as at March 31, 2024 was $434 (2023 – $846) 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 bylaws 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	2024	2023
AAA	58%	51%
AA	10%	19%
A	17%	14%
BBB	11%	12%
Unrated	4%	4%
	100%	**100%**

(c) Liquidity Risk

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

AHS issued debentures and the committed repayments with respect to these debentures are described in Note 17(c). The following are contractual maturities of the remaining financial liabilities as at March 31, 2024, 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	$ 816,482	$ -	$ -
Trade accounts payable and accrued liabilities	692,594	-	-
Other liabilities	6,930	13,056	5,961
	$ 1,516,006	**$ 13,056**	**$ 5,961**

Note 10 Portfolio Investments

	2024		2023	
	Fair Value	Cost	Fair Value	Cost
Cash held for investing purposes	**$ 131,690**	**$ 131,690**	**$ 122,940**	**$ 122,940**
Interest bearing securities:				
Money market securities	614,641	614,636	367,815	367,775
Fixed income securities	1,304,133	1,326,783	1,194,576	1,228,624
	1,918,774	**1,941,419**	**1,562,391**	**1,596,399**
Equities:				
Canadian equity investments and funds	199,709	181,927	177,151	171,926
Global equity investments and funds	299,807	224,040	273,522	228,896
	499,516	**405,967**	**450,673**	**400,822**
Real estate pooled funds	**37,712**	**30,926**	**48,690**	**40,371**
	$ 2,587,692	**$ 2,510,002**	**$ 2,184,694**	**$ 2,160,532**

	2024	2023
Items at fair value		
Portfolio investments designated to the fair value category	$ 2,509,350	$ 2,121,012
Portfolio investments in equity instruments that are quoted in an active market	77,908	62,836
Derivative asset, net	434	846
	$ 2,587,692	**$ 2,184,694**

As at March 31, 2024, included in portfolio investments is $188,142 (2023 – $187,959) 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 $105,273 (2023 – $77,492).

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

	2024	2023
Accumulated remeasurement gains	$ 64,073	$ 20,270
Restricted unrealized net gains attributable to unexpended deferred operating revenue (Note 14(b))	13,617	3,892
	$ 77,690	**$ 24,162**

Note 10 Portfolio Investments (continued)

Fair Value Hierarchy

The three levels of information that are 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.

	2024			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ -	$ 131,690	$ -	$ 131,690
Interest bearing securities:				
Money market securities	-	614,641	-	614,641
Fixed income securities	-	1,252,966	51,167	1,304,133
Equities:				
Canadian equity investments and funds	77,908	121,801	-	199,709
Global equity investments and funds	-	299,807	-	299,807
Real estate pooled funds	-	-	37,712	37,712
	$ 77,908	**$ 2,420,905**	**$ 88,879**	**$ 2,587,692**
Percent of total	3%	94%	3%	100%

	2023			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ -	$ 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%

Reconciliation of Investments classified as level 3

	2024		
	Fixed income securities	Real estate pooled funds	Total
Beginning of year	$ 51,325	$ 48,690	$ 100,015
Purchases	2,015	-	2,015
Sales	(333)	(11,129)	(11,462)
Realized (loss) gain	(21)	1,684	1,663
Gain (loss) included in the Consolidated Statement of Remeasurement Gains and Losses	595	(1,533)	(938)
Transfers out[(i)]	(2,414)	-	(2,414)
End of year	**$ 51,167**	**$ 37,712**	**$ 88,879**

Note 10 Portfolio Investments (continued)

	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)
Realized loss	(68)	-	(68)
(Loss) gain included in the Consolidated Statement of Remeasurement Gains and Losses	(1,999)	3,663	1,664
Transfers in[(i)]	930	-	930
End of year	**$ 51,325**	**$ 48,690**	**$ 100,015**

(i) Transfers are attributable to changes in the observability of market data.

Note 11 Accounts Receivable

	2024			2023
	Gross	Allowance for Doubtful Accounts	Net	Net
AH operating transfers receivable	$ 168,549	$ -	$ 168,549	$ 324,146
Other capital transfers receivable	105,534	-	105,534	108,535
Patient accounts receivable	160,934	44,350	116,584	86,584
Drugs rebates receivable	105,960	-	105,960	87,031
AH capital transfers receivable	20,497	-	20,497	10,922
Other operating transfers receivable	50,050	-	50,050	38,117
Other accounts receivable	198,011	9,660	188,351	94,748
	$ 809,535	**$ 54,010**	**$ 755,525**	**$ 750,083**

Accounts receivable are unsecured and non-interest bearing. At March 31, 2023, the total allowance for doubtful accounts was $57,791 of which $48,229 related to patient accounts receivable.

Note 12 Accounts Payable and Accrued Liabilities

	2024	2023
Payroll payable and related accrued liabilities	$ 816,482	$ 697,925
Trade accounts payable and accrued liabilities	692,594	749,089
Provision for unpaid claims[(a)]	167,598	164,312
Obligations under capital leases[(b)]	142,882	122,977
Other liabilities	36,399	39,121
	$ 1,855,955	**$ 1,773,424**

As at March 31, 2024, accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $237,885 (2023 – $237,507). Of these amounts, $9,166 (2023 – $9,779) comprise life lease deposits received from tenants of certain AHS' long term care facilities, and obligations under capital leases of $142,882 (2023 – $122,977).

(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.

The provision has been actuarially estimated using the discounted value of claim liabilities using a discount rate of 4.37% (2023 – 3.80%).

Note 12 Accounts Payable and Accrued Liabilities (continued)

(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 2025 and 2041 and have an implicit interest rate payable ranging from 2.53% to 5.41% (2023 – 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
2025	$ 24,071
2026	22,366
2027	19,928
2028	15,794
2029	11,076
Thereafter	71,055
	164,290
Less: interest	(21,408)
	$ 142,882

Note 13 Employee Future Benefits

	2024	2023
Accrued vacation pay	$ 680,804	$ 646,664
Accumulating non-vesting sick leave[(a)]	137,552	140,592
SERP pension plans	183	387
	$ 818,539	**$ 787,643**

(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.

	2024	2023
Funded status – deficit	$ 99,365	$ 91,650
Unamortized net actuarial gain	38,187	48,942
Accrued benefit liability	**$ 137,552**	**$ 140,592**

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

	2024	2023
Estimated average remaining service life	10 years	10 years
Draw down rate of accumulated non-vesting sick leave bank	18.30%	18.30%
Discount rate – beginning of year	5.60%	2.50%
Discount rate – end of year	5.00%	5.60%
Rate of compensation increase per year	2023-24	2022-23
	2.25%	1.60%
	2024-25	2023-24
	2.00%	2.25%
	2025-26	2024-25
	2.00%	2.00%
	Thereafter	Thereafter
	2.75%	2.75%

Note 13 Employee Future Benefits (continued)

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP. AHS' employees comprise approximately 46% (2023 - 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, 2022 and these results were then extrapolated to December 31, 2023.

	December 31, 2023	December 31, 2022
LAPP net assets available for benefits	$ 63,337,859	**$** 58,747,000
LAPP pension obligation	48,281,339	46,076,000
LAPP surplus	**$ 15,056,520**	**$ 12,671,000**

The 2024 and 2023 LAPP contribution rates are as follows:

Calendar 2024		Calendar 2023	
Employer	**Employees**	**Employer**	**Employees**
8.45% of pensionable earnings up to the YMPE and 11.65% of the excess	7.45% of pensionable earnings up to the YMPE and 10.65% of the excess	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

(c) Pension Expense

	2024	2023
Local Authorities Pension Plan	$ 521,199	$ 462,649
Defined contribution pension plans and group RRSPs	41,331	39,651
Other pension plans	1,727	(253)
	$ 564,257	**$ 502,047**

Note 14 Unexpended Deferred Operating Revenue

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

	2024				2023
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 190,243	$ 98,730	$ 283,655	$ 572,628	$ 529,707
Received or receivable during the year	1,641,288	169,270	205,588	2,016,146	2,596,362
Unexpended deferred operating revenue returned	(7,288)	(2,630)	(404)	(10,322)	(4,585)
Restricted investment income	1,700	1,586	13,574	16,860	2,463
Transferred from unexpended deferred capital revenue [ii]	9,197	95,149	712	105,058	83,435
Transferred to expended deferred operating revenue	-	-	-	-	(69,517)
Recognized as revenue	(1,605,994)	(251,255)	(139,182)	(1,996,431)	(2,546,492)
Miscellaneous other revenue recognized	(1,701)	(923)	(13,118)	(15,742)	(2,125)
	227,445	**109,927**	**350,825**	**688,197**	**589,248**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	(1,677)	1,332	10,070	9,725	(16,620)
Balance, end of year	**$ 225,768**	**$ 111,259**	**$ 360,895**	**$ 697,922**	**$ 572,628**

[i] The balance for other government includes $1,879 (2023 – $2,512) 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] 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:

	2024				2023
	AH	Other Government	Donors and Non-Government	Total	Total
Research and education	$ 4,222	$ 2,741	$ 255,047	$ 262,010	$ 200,129
Cancer prevention, screening and treatment	83,490	197	3,814	87,501	74,806
Addiction and mental health	-	60,278	1,868	62,146	55,053
Acute care	8,369	1,413	41,720	51,502	51,902
Support services	6,756	5,513	32,939	45,208	40,270
Physician revenue and alternate relationship plans	42,527	2,181	-	44,708	49,196
Primary Care Networks	29,240	-	-	29,240	23,150
Diagnostic and therapeutic services	21,639	594	847	23,080	22,694
Emergency medical services	19,936	1,053	255	21,244	200
Long term care partnerships	-	20,171	-	20,171	19,508
Population and public heath	1,941	14,926	1,163	18,030	21,859
Others individually less than $10,000	8,845	40	10,580	19,465	9,969
	226,965	**109,107**	**348,233**	**684,305**	**568,736**
Unrealized net (loss) gain attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 10)	(1,197)	2,152	12,662	13,617	3,892
	$ 225,768	**$ 111,259**	**$ 360,895**	**$ 697,922**	**$ 572,628**

Note 15 Unexpended Deferred Capital Revenue

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

	2024				2023
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 70,973	$ 8,442	$ 98,486	$ 177,901	$ 149,516
Received or receivable during the year	143,304	279,166	51,072	473,542	429,670
Used for the acquisition of land	-	-	-	-	(3,934)
Unexpended deferred capital revenue returned	(1,174)	(2,452)	-	(3,626)	(73)
Transferred to expended deferred capital revenue	(92,938)	(186,853)	(47,784)	(327,575)	(312,683)
Transferred to unexpended deferred operating revenue[(ii)]	(9,197)	(95,149)	(712)	(105,058)	(83,435)
Revenue recognized on settlement of asset retirement obligations (Note 18)	(168)	(630)	(314)	(1,112)	(1,160)
Balance, end of year	**$ 110,800**	**$ 2,524**	**$ 100,748**	**$ 214,072**	**$ 177,901**

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

(ii) 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:

	2024	2023
AH		
Continuing Care Beds	$ 4,150	$ 12,714
Information systems	828	5,505
Medical Equipment Replacement Upgrade Program	9,771	2,367
Diagnostic equipment	2,436	3,612
Alberta Surgical Initiative Capital Program	44,229	15,560
Rural Health Facilities Revitalization Program	31,214	22,119
National Association of Pharmacy Regulatory Authorities	13,687	-
Other equipment	4,485	9,096
Total AH	**110,800**	**70,973**
Other government		
Facilities and improvements	482	2,489
Equipment	2,042	5,953
Total other government	**2,524**	**8,442**
Donors and non-government		
Equipment	89,371	88,792
Facilities and improvements	11,377	9,694
Total donors and non-government	**100,748**	**98,486**
	$ 214,072	**$ 177,901**

Note 16 Expended Deferred Revenue

	2024	2023
Expended deferred capital revenue[a]	$ 8,696,431	$ 8,525,465
Expended deferred operating revenue[b]	-	116,636
	$ 8,696,431	**$ 8,642,101**

(a) Expended deferred capital revenue

Changes in the expended deferred capital revenue are as follows:

	2024				2023
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 591,868	$ 7,705,605	$ 227,992	$ 8,525,465	$ 8,278,969
Transferred from unexpended deferred capital revenue	92,938	186,853	47,784	327,575	312,683
Constructed tangible capital assets on behalf of AHS	-	198,774	-	198,774	262,429
Contributed tangible capital assets	-	-	24	24	35
Recognized as revenue	(106,297)	(214,858)	(34,252)	(355,407)	(328,651)
Balance, end of year	**$ 578,509**	**$ 7,876,374**	**$ 241,548**	**$ 8,696,431**	**$ 8,525,465**

[i] The balance includes $228 (2023 - $nil) of expended deferred capital revenue received from government entities outside of the Province of Alberta. The remaining balance in other government relates to the Province of Alberta (Note 23).

(b) Expended deferred operating revenue

Changes in the deferred operating revenue are as follows:

	2024	2023
	Total	Total
Balance, beginning of year	$ 116,636	$ 336,972
Transferred from unexpended deferred operating revenue	-	69,517
Recognized as unrestricted revenue	(10,195)	-
Recognized as restricted revenue	(106,441)	(289,853)
Balance, end of year	**$ -**	**$ 116,636**

The balance of expended deferred operating revenue in 2023 pertains to unused COVID-19 supplies purchased with AH funding.

Note 17 Debt

	2024	2023
Debentures [(a)]:		
Parkade loan #1	$ 9,811	$ 13,446
Parkade loan #2	11,658	14,677
Parkade loan #3	19,081	22,372
Parkade loan #4	88,956	98,549
Parkade loan #5	22,331	24,473
Parkade loan #6	17,279	18,411
Parkade loan #7	38,774	41,037
Parkade loan #8	149,397	151,400
Parkade loan #9	20,000	-
Energy savings initiative loan	14,887	16,817
EMS support vehicle loan	23,639	32,906
	$ 415,813	**$ 434,088**

(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 issued a debenture to TBF relating to EMS support vehicles. AHS has pledged the vehicles as security for this debenture.

AHS is in compliance with all performance requirements relating to its debentures as at March 31, 2024.

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%
Parkade loan #9	March 2044	5.1200%
Energy savings initiative loan	December 2030	2.4160%
EMS support vehicle loan	September 2026	1.1500%

(b) As at March 31, 2024, AHS has access to a $220,000 (2023 – $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, 2024, AHS has $nil (2023 – $nil) drawn against this facility.

AHS also has access to a $33,000 (2023 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2024, AHS has $3,316 (2023 – $3,353) 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, 2024.

Note 17 Debt (continued)

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

Year Ended March 31	Principal	Interest	Total
2025	$ 40,226	$ 15,535	$ 55,761
2026	41,671	14,090	55,761
2027	36,274	12,584	48,858
2028	28,904	11,236	40,140
2029	28,302	10,023	38,325
Thereafter	240,436	108,280	348,716
	$ 415,813	**$ 171,748**	**$ 587,561**

During the year, the total interest related to debt was $15,788 (2023 – $16,960), comprised of capitalized interest of $nil (2023 – $3,631) (Note 19(a)) and interest expense of $15,788 (2023 – $13,329). Accrued interest at March 31, 2024 amounted to $2,679 (2023 – $2,767).

Note 18 Asset Retirement Obligations

	2024	2023
Asset retirement obligations, beginning of year	$ 583,172	$ 544,416
Liability incurred	-	1,144
Liability settled	(1,978)	(2,780)
Revision in estimates (Note 19)	(41,773)	40,392
Asset retirement obligations, end of year	**$ 539,421**	**$ 583,172**

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. A funding source for this obligation has not been determined.

The timing of settlement of asset retirement obligations is currently unknown. For the year ended March 31, 2024, a recovery of $1,112 (2023 - $1,160) was recognized (Note 15(a)).

Note 19 Tangible Capital Assets

Cost	2023	Additions[a]	Transfers/ Adjustments[i]	Disposals/ Write-downs	2024
Facilities and improvements	$ 12,717,651	$ -	$ 267,024	$ (1,222)	$ 12,983,453
Work in progress	665,094	506,115	(509,307)	(411)	661,491
Equipment	2,974,510	207,650	(2,001)	(40,277)	3,139,882
Information systems	2,268,704	14,038	108,723	(7,067)	2,384,398
Building service equipment	1,025,874	-	64,883	(13)	1,090,744
Land[b]	121,749	32	-	-	121,781
Leased facilities and improvements	317,743	33,000	22,431	-	373,174
Land improvements	107,568	-	6,474	-	114,042
	$ 20,198,893	**$ 760,835**	**$ (41,773)**	**$ (48,990)**	**$ 20,868,965**

Accumulated Amortization	2023	Amortization Expense	Effect of Transfers/ Adjustments	Disposals/ Write-downs	2024
Facilities and improvements	$ 4,994,290	$ 158,195	$ -	$ (1,120)	$ 5,151,365
Work in progress	-	-	-	-	-
Equipment	2,298,163	172,250	-	(38,919)	2,431,494
Information systems	1,682,243	150,060	-	(6,994)	1,825,309
Building service equipment	626,105	49,801	-	(14)	675,892
Land[b]	-	-	-	-	-
Leased facilities and improvements	214,316	19,714	-	-	234,030
Land improvements	80,127	3,093	-	-	83,220
	$ 9,895,244	**$ 553,113**	**$ -**	**$ (47,047)**	**$ 10,401,310**

Cost	2022	Additions	Transfers/ Adjustments	Disposals/ Write-downs	2023
Facilities and improvements	$ 11,129,930	$ 772	$ 1,604,903	$ (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	**$ 781,347**	**$ 40,392**	**$ (92,291)**	**$ 20,198,893**

Accumulated Amortization	2022	Amortization Expense	Effect of Transfers/ Adjustments	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**

[i] Transfers and adjustments relate to reclassifications between capital asset categories and revisions to asset retirement costs of $41,773 (2023 - $40,392) (Note 18).

Note 19 Tangible Capital Assets (continued)

	Net Book Value	
	2024	2023
Facilities and improvements	$ 7,832,088	$ 7,723,361
Work in progress	661,491	665,094
Equipment	708,388	676,347
Information systems	559,089	586,461
Building service equipment	414,852	399,769
Land[(b)]	121,781	121,749
Leased facilities and improvements	139,144	103,427
Land improvements	30,822	27,441
	$ 10,467,655	**$ 10,303,649**

(a) Additions

Additions include tangible capital assets constructed by AI on behalf of AHS of $198,774 (2023 – $262,429) (Note 23) and $24 (2023 – $35) contributed from other sources. During the year, AHS capitalized interest of $nil (2023 – $3,631) (Note 17(c)) within work in progress. Capital lease additions amounted to $37,753 (2023 – $19,031).

(b) Leased Land

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

Site	Leased from	Lease Expiry
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
Laneway adjacent to Queen Elizabeth II Hospital	City of Grande Prairie	Under negotiation

(c) Leased Tangible Capital Assets

Tangible capital assets acquired through capital leases includes vehicle leases, equipment, information systems and facilities with a cost of $579,537 (2023 – $487,324) and accumulated amortization of $286,709 (2023 – $269,475).

(d) Asset Retirement Costs

Facilities and improvements and Building service equipment, include $538,304 (2023 - $581,299) of asset retirement costs and $359,135 (2023 - $348,944) of related accumulated amortization.

Note 20 Inventories of Supplies

	2024	2023
Pharmaceuticals	$ 106,759	$ 114,334
Medical and surgical supplies	47,395	95,817
Other[i]	43,015	97,574
	$ 197,169	**$ 307,725**

[ii] Other is mainly related to staff wearing apparel such as gowns and masks, housekeeping, and other supplies not included under pharmaceuticals and medical and surgical supplies.

Demand has reduced for inventories purchased to support public health emergencies in prior years, resulting in a valuation adjustment of $78,997 (2023 – $71,419) in the current year.

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 $1,459 (2023 – $223,542) on behalf of AH as at March 31, 2024.

Note 21 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2024					2023
	Unrestricted Surplus	Invested in Tangible Capital Assets [a]	Endowments[b]	Internally Restricted Surplus for Insurance Equity Requirements and Foundations[c]	Total	Total
Balance, beginning of year	$ 262,491	$ 649,167	$ 77,492	$ 131,677	$ 1,120,827	$ 1,037,157
Annual operating surplus	183,631	-	-	-	183,631	83,670
Net investment in tangible capital assets	(56,615)	56,615	-	-	-	-
Transfer of insurance equity requirements and foundations deficits	8,182	-	-	(8,182)	-	-
Transfer of net deficits related to asset retirement obligations	9,435	(9,435)	-	-	-	-
Transfer of endowment contributions (Note 5)	(27,781)	-	27,781	-	-	-
Balance, end of year	**$ 379,343**	**$ 696,347**	**$ 105,273**	**$ 123,495**	**$ 1,304,458**	**$ 1,120,827**

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 to date in accumulated surplus net of related liability settlements.

Reconciliation of invested in tangible capital assets:

	2024	2023
Tangible capital assets (Note 19)	$ 10,467,655	$ 10,303,649
Net Book Value of Asset Retirement Costs capitalized (Note 19(d))	(179,169)	(232,355)
Less funded by:		
Expended deferred capital revenue (Note 16(a))	(8,696,431)	(8,525,465)
Debt (Note 17)	(415,813)	(434,088)
Unexpended debt	32,405	20,999
Obligations under capital leases (Note 12)	(142,882)	(122,977)
Life lease deposits (Note 12)	(9,166)	(9,779)
	$ 1,056,599	**$ 999,984**
Asset retirement costs recognized net of related liability settlements	(360,252)	(350,817)
	$ 696,347	**$ 649,167**

(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 $27,781 (2023 – $110) of net contributions received in the year (Note 5).

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

Insurance equity requirements comprise surpluses of $21,042 (2023 – $39,359) related to equity of the LPIP mainly relating to legislative requirements per the Insurance Act. Foundations comprise surpluses amounting to $102,453 (2023 – $92,318) 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
2025	$ 3,533,626	$ 440,411	$ 67,744	$ 315,700	$ 4,357,481
2026	1,890,785	275,754	56,726	63,945	2,287,210
2027	1,360,101	188,217	51,335	16,016	1,615,669
2028	1,138,489	113,045	44,196	17,268	1,312,998
2029	985,707	31,911	33,754	21,905	1,073,277
Thereafter	7,147,609	21,696	119,086	13,644	7,302,035
March 31, 2024	**$ 16,056,317**	**$ 1,071,034**	**$ 372,841**	**$ 448,478**	**$ 17,948,670**
March 31, 2023	$ 20,121,744	$ 1,126,267	$ 312,835	$ 268,567	$ 21,829,413

(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) Transition of Community Laboratory Services

On December 5, 2022, community laboratory services were transferred from AHS to DynaLIFEDX (DLDX). The agreement included an estimated commitment of $4.8 billion over an initial term of 14 years and four months. On August 18, 2023, the government announced that AHS, through Alberta Precision Laboratories, would be the sole provider of community laboratory services in Alberta, to improve service delivery to Albertans (Note 27). The previous agreements with DLDX, including the related commitment, was cancelled effective August 31, 2023.

(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, 2024, accruals have been recorded as part of the provision for unpaid claims and other liabilities (Note 12). Included in this accrual are claims in which AHS has been jointly named with the Minister. The accrual provided for these claims under the provision for unpaid claims represents AHS' portion of the liability.

Note 22 Contractual Obligations and Contingent Liabilities (continued)

AHS has been named in 234 legal claims (2023 – 292 claims) related to conditions in existence at March 31, 2024 where the likelihood of the occurrence of a future event confirming a contingent loss is not determinable. Of these, 201 claims have $706,650 in specified amounts and 33 have no specified amounts (2023 – 256 claims with $777,051 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.

(i) Collective Agreements

AHS currently has 1 (2023 – 7) collective agreement that has expired as at March 31, 2024. Given that negotiations are ongoing or have not commenced, 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 all members of the AHS Board. The viability of AHS' operations depends on transfers from AH. Transactions between AHS and AH are reported and disclosed in the Consolidated Statement of Operations, the Consolidated Statement of Financial Position, and the Notes to the Consolidated Financial Statements, and are therefore excluded from the tables below.

Related parties also include key management personnel of AHS. AHS has defined key management personnel to include those disclosed in Schedules 2A and 2B of these consolidated financial statements, 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	
	2024	2023	2024	2023
Alberta Advanced Education[b]	$ 57,875	$ 59,994	$ 184,077	$ 181,312
Alberta Infrastructure[c]	312,158	289,460	12,064	17,310
Alberta Mental Health and Addiction[d]	121,779	90,695	-	-
Other ministries[e]	33,157	29,113	31,749	33,112
Total for the year	**$ 524,969**	**$ 469,262**	**$ 227,890**	**$ 231,734**

	Receivable from		Payable to	
	2024	2023	2024	2023
Alberta Advanced Education[b]	$ 11,435	$ 7,597	$ 33,399	$ 45,006
Alberta Infrastructure[c]	69,725	67,236	6,144	1,000
Alberta Mental Health and Addiction[d]	28,419	22,641	1,288	-
Other ministries[e]	8,928	3,635	419,112	437,593
Balance, end of year	**$ 118,507**	**$ 101,109**	**$ 459,943**	**$ 483,599**

Note 23 Related Parties (continued)

(a) Revenues with Province of Alberta ministries include other government transfers of $492,963 (2023 – $433,722), (Note 4), other income of $29,791 (2023 – $31,307) (Note 6), and fees and charges of $2,214 (2023 – $4,233).

(b) The majority 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.

(c) The transactions with AI relate to the construction of tangible capital assets on behalf of AHS. These transactions include operating transfers of $98,110 (2023 – $99,542) and recognition of expended deferred capital revenue of $214,048 (2023 – $189,918) 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 $198,774 (2023 – $262,429).

(d) The transactions with Alberta Mental Health and Addiction relate to initiatives to support Albertans experiencing addiction and mental health challenges.

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

At March 31, 2024, AHS has recorded deferred revenue from other ministries within the Province of Alberta, excluding AH, of $109,380 (2023 – $96,218) related to unexpended deferred operating revenue (Note 14(a)), $2,524 (2023 – $8,442) related to unexpended deferred capital revenue (Note 15(a)) and $7,876,146 (2023 – $7,705,605) 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.

	2024	2023
Financial assets (portfolio investments, accounts receivable, other assets)	$ 83,417	$ 67,995
Liabilities (trade accounts payable, unexpended deferred operating revenue)	83,417	67,995
Accumulated surplus	**$ -**	**$ -**
Total revenues	$ 279,160	$ 263,082
Total expenses	279,160	263,082
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 employee life and health 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:

	2024	2023
Financial assets	$ 232,932	$ 125,630
Liabilities	23,983	34,644
Net financial assets	208,949	90,986
Non-financial assets	-	5
Net assets	**$ 208,949**	**$ 90,991**

AHS has included in prepaid expenses $142,539 (2023 – $59,712) representing in substance a prepayment of future premiums to the HBTA. For the fiscal year ended March 31, 2024, AHS paid premiums of $632,746 (2023 – $552,232) which is approximately 98% (2023 – 98%) of the total premiums received by the HBTA.

(b) Other Trust Funds

AHS holds funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to appropriate the funds or to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2024, the balance of funds held in trust by AHS for research and development is $100 (2023 – $100).

AHS holds funds in trust from continuing care residents for personal expenses. As at March 31, 2024, the balance of these funds is $2,185 (2023 – $1,855). 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, 2024, there are $25,176 in plan assets (2023 – $26,547). 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, palliative, 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.

Note 26 Segment Disclosure (continued)

(a) Home care

Home care is comprised of home nursing and support.

(b) 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.

(c) 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.

(d) 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, rehabilitation services such as physiotherapy, occupational therapy, respiratory therapy, and speech language pathology.

(e) 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, outbreaks, screening programs, and disease surveillance. This segment excludes activities associated with treatment of communicable diseases.

(f) 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.

(g) 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.

(h) 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.

(i) 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 Acquisition of DynaLIFEDX

On August 18, 2023, the government announced that AHS, through Alberta Precision Laboratories, would be the sole provider of community laboratory services in Alberta, to improve service delivery to Albertans. This was accomplished by AHS' acquisition of the operations, including specific assets, liabilities, and workforce of DynaLIFEDX (DLDX) through the Asset Purchase and Transition Agreements executed on August 31, 2023. The previous Services Agreement and Ancillary Agreements with DLDX including the related commitment, was cancelled effective August 31, 2023 (Note 22(b)).

The purchase price allocation of assets and liabilities on the basis of fair value was as follows:

	August 31, 2023
Financial assets:	
Cash	$ 2,112
Accounts receivable	7,173
	9,285
Liabilities:	
Accounts payable and accrued liabilities	39,468
Employee future benefits	10,421
	49,889
Non-financial assets:	
Tangible capital assets	71,760
Inventories of supplies	7,886
Prepaid expenses	4,959
	84,605
Purchase price before settlement of balances due from DLDX	(47,795)
Net balances due from DLDX settled at acquisition	16,295
Cash purchase consideration paid	**(31,500)**
Purchase premium before transaction costs	**(3,794)**
Transaction costs	(912)
Purchase premium	**$ (4,706)**

Note 28 Corresponding Amounts

Certain corresponding amounts have been reclassified to conform with 2024 presentation.

Note 29 Subsequent Events and Restructuring/Refocusing of AHS

On November 8, 2023, the Premier of Alberta announced that AHS will shift its primary focus from being the regional health authority in Alberta to focusing on acute care. Implementation of these changes will be introduced in a staged approach, resulting in the restructuring of AHS and the creation of four new agencies focusing on primary care, acute care, continuing care, and mental health and addiction.

On April 2, 2024, the Premier of Alberta announced that Recovery Alberta will be the new provincial health agency responsible for the delivery and oversight of mental health and addiction services. The annual budget for these services is estimated at approximately $1 billion and is expected to be transitioned from Alberta Health to the ministry of Mental Health and Addiction.

On May 30, 2024, the *Health Statutes Amendment Act*, 2024, received Royal Assent, enabling the transition from one regional health authority, AHS, to an integrated system of four sector-based provincial health agencies. The *Regional Health Authorities Act*, now renamed the *Provincial Health Agencies Act*, clarifies the Minister of Health's authority, the roles and responsibilities of the provincial health agencies, and enables the transfer of staff from AHS to the new agencies.

Recovery Alberta will begin operating in the summer of 2024, while the remaining three provincial health agencies are expected to be established in the fall of 2024. The full financial effect of the restructuring, including the impact on AHS' assets, liabilities and operations is currently unknown.

Note 30 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on June 3, 2024 and submitted to the Ministry of Health.

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

	2024		2023
	Budget (Note 3)	Actual	Actual
Salaries and benefits	$ 9,408,967	$ 9,839,465	$ 9,155,665
Contracts with health service providers	3,790,600	3,466,333	3,328,374
Contracts under the Health Facilities Act	59,300	55,824	28,587
Drugs and gases[(i)]	827,300	738,881	679,210
Medical supplies[(i)]	707,000	815,353	828,438
Other contracted services	1,559,300	1,688,175	1,533,975
Other[(a)]	1,590,500	1,685,083	1,595,887
Amortization and loss on disposals/write-downs of tangible capital assets (Note 19)	527,500	555,033	514,897
	$ 18,470,467	**$ 18,844,147**	**$ 17,665,033**
(a) Significant amounts included in Other are:			
Equipment expense	$ 320,900	$ 295,346	$ 272,979
Utilities	180,400	230,705	209,283
Building and ground expenses	163,300	174,780	164,886
Housekeeping, laundry and linen, staff wearing apparel, plant maintenance and biomedical engineering supplies[(i)] [(ii)]	159,300	163,538	222,813
Building rent	133,500	125,766	128,547
Minor equipment purchases	75,000	103,351	75,540
Food and dietary supplies	88,800	86,029	86,604
Fundraising and grants awarded	52,000	65,734	56,600
Office supplies and courier	54,400	64,347	68,685
Insurance and liability claims	51,500	58,656	35,860
Travel	30,000	46,165	35,486
Telecommunications	36,400	34,250	30,936
Licenses, fees and memberships	30,630	26,139	27,390
Education	12,000	14,994	11,802
Other	202,370	195,283	168,476
	$ 1,590,500	**$ 1,685,083**	**$ 1,595,887**

[(i)] Demand has reduced for inventories purchased to support public health emergencies in prior years, resulting in a valuation adjustment of $78,997 (2023 – $71,419) (Note 20).

[(ii)] Includes personal protective equipment, such as procedural masks, N95s, gowns, face shields and goggles, as well as other supplies such as hand sanitizers, disinfecting wipes and other cleaning supplies.

SCHEDULE 2 - SCHEDULES OF REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2024

SCHEDULE 2A – BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2024

	Term	2024 Committees	2024 Remuneration	2023 Remuneration
Board Chair[f]				
Dr. Lyle Oberg	Since Nov 8, 2023	FARC, FC, GCHRC	$ 155	$ -
Board Members				
Sandy Edmonstone (Vice Chair)	Since Nov 8, 2023	FC (Chair), GCHRC	14	-
Cynthia Farmer [g]	Since Nov 8, 2023	-	-	-
Angela Fong	Since Nov 21, 2023	GCHRC (Chair)	12	-
Paul George Haggis	Since Nov 8, 2023	FARC (Chair), FC	14	-
Evan Romanow[g]	Since Nov 8, 2023	FC	-	-
Andre Tremblay[g]	Since Nov 8, 2023	FARC, FC, GCHRC	-	-
Total Board			**$ 195**	**$ -**

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

Board committees were established by the Board to assist in governing AHS and overseeing the management of AHS' business and affairs.

Committee legend: FARC = Finance, Audit and Risk Committee, FC = Foundations Committee, GCHRC = Governance, Compliance and Human Resources Committee

SCHEDULE 2B – FORMER OFFICIAL ADMINISTRATOR / FORMER OFFICIAL ADMINISTRATOR COMMITTEE REMUNERATION FOR THE YEAR ENDED MARCH 31, 2024

	Term	2024 Committees	2024 Remuneration	2023 Remuneration
Former Official Administrator				
Dr. John Cowell	Nov 17, 2022 to Nov 8, 2023	OAAC	$ 436	$ 267
Former Official Administrator Committee Participants[h]				
Tara Lockyer	Nov 24, 2022 to Nov 8, 2023	OAAC	2	4
Gregory Turnbull	Nov 24, 2022 to Nov 8, 2023	OAAC	3	4
Tyler White	Jul 12, 2023 to Nov 8, 2023	OAAC	1	-
Gord Winkel	Nov 24, 2022 to Nov 8, 2023	OAAC	3	4
Total Former Official Administrator / Former Official Administrator Committee			**$ 445**	**$ 279**

The tenure of the Official Administrator was in lieu of a Board at AHS.

Dr. John Cowell was appointed to the position of Official Administrator effective November 17, 2022 per Ministerial Order 319/2022 for a six month term. The incumbent was reappointed to the position of Official Administrator effective May 17, 2023 as per Ministerial Order 305/2023 with a term to end on June 30, 2023, and then subsequently reappointed effective July 1, 2023 as per Ministerial Order 307/2023 with a term to end on December 31, 2023. The incumbent's term ended November 8, 2023 when Ministerial Order 307/2023 was repealed by Ministerial Order 314/2023.

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 were eligible to receive honoraria for meetings attended.

Committee legend: OAAC = Official Administrator Advisory Committee

SCHEDULE 2C – FORMER BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2023

	Term	2023 Remuneration
Former Board Chair		
Gregory Turnbull	Dec 8, 2021 to Nov 17, 2022	$ 43
Former Board Members		
Dr. Sayeh Zielke (Vice Chair)	Sep 28, 2020 to Nov 17, 2022	31
Deborah Apps	Jan 19, 2021 to Oct 7, 2022	18
Tony Dagnone	Jan 19, 2021 to Nov 17, 2022	21
Sherri Fountain	Jan 19, 2021 to Nov 17, 2022	23
Hartley Harris	Aug 9, 2021 to Nov 17, 2022	21
Tara Lockyer	Aug 17, 2022 to Nov 17, 2022	7
Jack Mintz	Jun 3, 2021 to Nov 17, 2022	17
Heidi Overguard	Sep 25, 2019 to Nov 17, 2022	23
Natalia Reiman	Jan 19, 2021 to Nov 17, 2022	18
Brian Vaasjo	Aug 20, 2019 to Nov 17, 2022	19
Vicki Yellow Old Woman	Sep 28, 2020 to Nov 17, 2022	19
Former Board Committee Participants		
Dr. William Ghali	Oct 1, 2021 to Nov 17, 2022	1
Stephen Livergant	Apr 9, 2021 to Sep 15, 2022	-
Gord Winkel	Nov 27, 2015 to Nov 17, 2022	1
Total Former Board		**$ 262**

Former Board members were remunerated with monthly honoraria. In addition, they received remuneration for attendance at Board and committee meetings. Former Board members did not serve however in the fiscal year ended March 31, 2024, having been dismissed effective November 17, 2022.

SCHEDULE 2D - EXECUTIVE REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2024

	2024						
For the Current Fiscal Year	**FTE [a]**	**Base Salary [b, i]**	**Other Cash Benefits [c]**	**Other Non-Cash Benefits [d]**	**Subtotal**	**Severance [e]**	**Total**
Board / Former Official Administrator Direct Reports							
Athana Mentzelopoulos – President and Chief Executive Officer[j, dd]	0.31	$ 179	$ -	$ 88	$ 267	$ -	$ 267
Sean Chilton – Interim President and Chief Executive Officer[k, ee]	0.06	35	-	6	41	-	41
Mauro Chies – President and Chief Executive Officer[l]	0.63	374	-	85	459	1,386	1,845
Ronda White – Chief Audit Executive[m, ff]	1.00	313	2	73	388	-	388
Athana Mentzelopoulos – Official Administrator Advisor/ Provisional Lead, Emergency Medical Services[j, dd]	0.33	119	-	44	163	-	163
CEO Direct Reports							
Sean Chilton – Interim VP and Chief Operating Officer, Clinical Operations/VP, People, Health Professions and Information Technology[k, ee]	0.94	410	19	102	531	-	531
Lori Anderson – Acting VP and Chief Operating Officer, Clinical Operations[n]	0.03	10	3	2	15	-	15
Deb Gordon – VP and Chief Operating Officer, Clinical Operations[o, hh]	0.52	212	-	7	219	970	1,189
Dr. Sid Viner – VP and Medical Director, Clinical Operations[ff]	0.90	436	22	102	560	-	560
Dr. Peter Jamieson – Interim VP, Quality and Chief Medical Officer[p, gg]	0.33	177	-	-	177	-	177
Dr. Francois Belanger – VP, Quality and Chief Medical Officer[q, hh]	0.63	316	-	85	401	1,071	1,472
Susan McGillivray – Interim VP, People and Health Professions[r, ee]	0.60	229	-	61	290	-	290
Karen Horon – VP, Cancer Care Alberta and Clinical Support Services[s, ff]	1.00	331	1	96	428	-	428
Natalie McMurtry – Interim VP, Provincial Clinical Excellence[t, ff]	0.81	219	-	48	267	-	267
Dr. Braden Manns – Interim VP, Provincial Clinical Excellence[u]	0.19	107	2	7	116	-	116
Kerry Bales – Chief Program Officer, Addiction and Mental Health and Correctional Health Services[ff]	1.00	328	-	99	427	-	427
Holly Budd – Acting Senior Program Officer, Community Engagement and Communications[v, ff]	0.33	60	12	18	90	-	90
Gail Fredrickson – Interim VP, Community Engagement and Communications[w]	0.07	18	2	3	23	-	23
Colleen Turner – VP, Community Engagement and Communications[x, hh]	0.60	233	-	103	336	792	1,128
Michael Lam – Interim VP, Corporate Services and Chief Financial Officer[y, ff]	0.33	97	12	29	138	-	138
Colleen Purdy – VP, Corporate Services and Chief Financial Officer[z, hh]	0.63	273	-	57	330	504	834
Andrea Beckwith-Ferraton – Interim General Counsel and Corporate Secretary[aa, ff]	0.37	86	10	23	119	-	119
Tina Giesbrecht – General Counsel[bb, hh]	0.63	165	5	49	219	356	575
Geoffrey Pradella – Chief Strategy Officer[cc]	0.35	105	-	26	131	144	275
Total Executive	**12.59**	**$ 4,832**	**$ 90**	**$ 1,213**	**$ 6,135**	**$ 5,223**	**$ 11,358**
Management Reporting to CEO Direct Reports	**59.68**	**$ 14,938**	**$ 468**	**$ 2,844**	**$ 18,250**	**$ 388**	**$ 18,638**

SCHEDULE 2D - EXECUTIVE REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2024 (CONTINUED)

	2023						
For the Prior Fiscal Year	**FTE [a]**	**Base Salary [b, i]**	**Other Cash Benefits [c]**	**Other Non-Cash Benefits [d]**	**Subtotal**	**Severance [e]**	**Total**
Official Administrator / Former Board Direct Reports							
Mauro Chies – President and Chief Executive Officer	0.99	$ 490	$ 13	$ 143	$ 646	$ -	$ 646
Dr. Verna Yiu – President and Chief Executive Officer	0.01	4	-	4	8	660	668
Ronda White – Chief Audit Executive	1.00	291	1	45	337	-	337
Athana Mentzelopoulos – Official Administrator Advisor/ Provisional Lead, Emergency Medical Services	0.37	139	-	57	196	-	196
CEO Direct Reports							
Deb Gordon – VP and Chief Operating Officer, Clinical Operations	1.00	389	-	51	440	-	440
Dr. Sid Viner – VP and Medical Director, Clinical Operations	0.90	415	22	110	547	-	547
Dr. Francois Belanger – VP, Quality and Chief Medical Officer	1.00	477	-	59	536	-	536
Sean Chilton – VP, People, Health Professions and Information Technology	1.00	365	1	81	447	-	447
Karen Horon – Interim VP, Cancer Care Alberta and Clinical Support Services	0.98	255	3	63	321	-	321
Mauro Chies – VP, Cancer Care Alberta and Clinical Support Services	0.01	4	-	1	5	-	5
Dr. Braden Manns – Interim VP, Provincial Clinical Excellence	0.83	454	6	34	494	-	494
Kathryn Todd – VP, Provincial Clinical Excellence	0.08	24	5	5	34	-	34
Dr. Mark Joffe – VP and Medical Director, Cancer Care Alberta, Clinical Support Services and Provincial Clinical Excellence	0.62	288	20	29	337	-	337
Kerry Bales – Chief Program Officer, Addiction and Mental Health and Correctional Health Services	0.79	242	-	57	299	-	299
Colleen Turner – VP, Community Engagement and Communications	1.00	356	-	88	444	-	444
Colleen Purdy – VP, Corporate Services and Chief Financial Officer	1.00	412	3	78	493	-	493
Tina Giesbrecht – General Counsel	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 2E - 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 2D are prorated for the period of time the individual was in their position directly reporting to the Board / former Official Administrator or directly reporting to the President and Chief Executive Officer. Only individuals holding a position directly reporting to the Board / former Official Administrator or President and Chief Executive Officer during the current fiscal year are disclosed.

	2024			2023			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2023	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2024
Athana Mentzelopoulos - President and Chief Executive Officer	$ 14	$ -	$ 14	$ -	$ -	$ 14	$ 14
Sean Chilton - Interim President and Chief Executive Officer/Interim VP and Chief Operating Officer, Clinical Operations/VP, People, Health Professions and Information Technology	30	-	30	21	265	60	325
Mauro Chies - President and Chief Executive Officer	49	-	49	36	217	73	290
Ronda White - Chief Audit Executive	14	-	14	12	159	32	191
Lori Anderson - Acting VP and Chief Operating Officer, Clinical Operations	17	-	17	15	135	32	167
Deb Gordon - VP and Chief Operating Officer, Clinical Operations							
SERP	-	(4)	(4)	(42)	560	(560)	-
SPP	13	-	13	23	307	(307)	-
Dr. Sid Viner - VP and Medical Director, Clinical Operations	31	-	31	29	152	51	203
Dr. Peter Jamieson - Interim VP, Quality and Chief Medical Officer [5]	-	-	-	-	-	-	-
Dr. Francois Belanger - VP, Quality and Chief Medical Officer	23	-	23	34	469	(469)	-
Susan McGillivray - Interim VP, People and Health Professions							
SERP	-	(1)	(1)	(9)	147	2	149
SPP	18	-	18	12	148	20	168
Karen Horon - VP, Cancer Care Alberta and Clinical Support Services	16	-	16	8	48	20	68
Natalie McMurtry - Interim VP, Provincial Clinical Excellence	7	-	7	1	5	8	13
Dr. Braden Manns - Interim VP, Provincial Clinical Excellence [5]	-	-	-	-	-	-	-
Kerry Bales - Chief Program Officer, Addiction and Mental Health and Correctional Health Services	16	-	16	13	211	40	251
Holly Budd – Acting Senior Program Officer, Community Engagement and Communications [6]	-	-	-	-	-	-	-
Gail Fredrickson - Interim VP, Community Engagement and Communications	6	-	6	7	34	(34)	-

SCHEDULE 2E - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (CONTINUED)

	2024			2023			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2023	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2024
Colleen Turner - VP, Community Engagement and Communications	14	-	14	20	220	(220)	-
Michael Lam - Interim VP, Corporate Services and Chief Financial Officer	12	-	12	9	79	22	101
Colleen Purdy - VP, Corporate Services and Chief Financial Officer	18	-	18	26	74	(74)	-
Andrea Beckwith-Ferraton - Interim General Counsel and Corporate Secretary	4	-	4	3	39	9	48
Tina Giesbrecht - General Counsel	5	-	5	8	91	(91)	-
Geoffrey Pradella - Chief Strategy Officer [7]	-	-	-	-	-	-	-

(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.
(5) The incumbent is not an employee of AHS, and therefore not eligible for enrollment in the SPP.
(6) The incumbent's pensionable earnings were below the threshold for enrollment in the SPP.
(7) The SPP had not fully vested at the time of the incumbent's departure, and as a result no current period benefit costs were incurred.

FOOTNOTES TO THE SCHEDULES OF REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2024

Definitions

a. For this schedule, full time equivalents (FTE) are determined by actual hours earned divided by 2,030.50 annual base hours (2023 – 2,022.75 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 2E
- Employer's share of employee benefit contributions and payments made on behalf of employees including pension, health care, dental and vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, and long and short-term disability plans
- Vacation accruals, and
- Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

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

Board

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

g. These individuals did not claim honoraria.

Former Official Administrator and Former Official Administrator Committee Participants

h. These individuals were participants of Official Administrator committees but are not AHS employees.

Executive

i. Base salary reported for executives are the actual payments earned during the year, and is therefore contingent on the number of AHS' work days in the year. For the year ended March 31, 2024, the number of work days at AHS was 260 (2023 – 261 work days).

j. Athana Mentzelopoulos held management positions as both Official Administrator Advisor and Provisional Lead, Emergency Medical Services until July 28, 2023 at which time she left AHS. During this tenure, the incumbent was on temporary secondment from the Government of Alberta, and AHS reimbursed the Government of Alberta for the incumbent's base salary and benefits. The incumbent was subsequently appointed to the position of President and Chief Executive Officer effective December 11, 2023.

k. Sean Chilton held the position of Vice President, People, Health Professions and Information Technology until August 28, 2023 at which time he was appointed to Interim Vice President and Chief Operating Officer, Clinical Operations. The incumbent held the position of Interim Vice President and Chief Operating Officer, Clinical Operations until November 16, 2023 at which time the incumbent was appointed to Interim President and Chief Executive Officer and became a direct report to the Board. The incumbent held the position of Interim President and Chief Executive Officer until December 11, 2023 at which time the incumbent resumed the role of Interim Vice President and Chief Operating Officer, Clinical Operations and resumed being a direct report to the President and Chief Executive Officer.

l. Mauro Chies held the position of President and Chief Executive Officer until November 16, 2023 at which time he left AHS from a leadership capacity. The incumbent's severance is to be paid by way of salary continuance which will terminate, without a requirement of further notice or compensation from AHS, effective November 15, 2025. The reported severance includes 24 months base salary plus accrued entitlements to pension and other benefits, as well as $21 in lieu of the loss of employee benefits. In addition, the incumbent received a vacation payout of $174 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

m. Ronda White received a vacation payout of $18 for unused accrued vacation earned in prior periods; accrued vacation has been recorded in the compensation as a non-cash benefit in the period it was earned.

n. Lori Anderson held the position of Chief Zone Officer, Calgary Zone until November 30, 2023 at which time she was appointed to Acting Vice President and Chief Operating Officer, Clinical Operations and became a direct report to the President and Chief Executive Officer. The incumbent held the position of Acting Vice President and Chief Operating Officer, Clinical Operations until December 11, 2023 at which time the incumbent resumed the role of Chief Zone Officer, Calgary Zone and was no longer a direct report to the President and Chief Executive Officer.

o. Deb Gordon held the position of Vice President and Chief Operating Officer, Clinical Operations until October 6, 2023 at which time she left AHS. The incumbent received salary and other accrued entitlements to the date of departure, as well as the reported severance. In addition, the incumbent received a vacation payout of $164 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.

FOOTNOTES TO THE SCHEDULES OF REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2024 (CONTINUED)

p. Dr. Peter Jamieson held the position of Interim Associate Medical Director, Clinical Operations until November 21, 2023 at which time he was appointed to Interim Vice President, Quality and Chief Medical Officer and became a direct report to the President and Chief Executive Officer. The incumbent's remuneration is as per the terms of a Medical Administrative Services Agreement.

q. Dr. Francois Belanger held the position of Vice President, Quality and Chief Medical Officer until November 16, 2023 at which time he left AHS. The incumbent received salary and other accrued entitlements to the date of departure. The reported severance included 22 months base salary at the rate in effect at the date of departure, and 15% of the severance in lieu of benefits. In addition, the incumbent received a vacation payout of $106 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.

r. Susan McGillivray held the position of Senior Program Officer, HR Talent and Workforce Strategies until August 28, 2023 at which time she was appointed to Interim Vice President, People and Health Professions and became a direct report to the President and Chief Executive Officer.

s. Karen Horon held the position of Interim Vice President, Cancer Care Alberta and Clinical Support Services until October 2, 2023 at which time she was appointed to Vice President, Cancer Care Alberta and Clinical Support Services.

t. Natalie McMurtry held the position of Senior Program Officer, Sustainability Program Office until June 12, 2023 at which time she was appointed to Interim Vice President, Provincial Clinical Excellence and became a direct report to the President and Chief Executive Officer. Effective November 30, 2023, the incumbent took on the additional responsibilities as AHS Transition Lead. In addition, the incumbent received a vacation payout of $13 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.

u. Dr. Braden Manns held the position of Interim Vice President, Provincial Clinical Excellence until June 9, 2023 at which time he left AHS from a leadership capacity. 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.

v. Holly Budd held the position of Executive Director, Communications until November 30, 2023 at which time she was appointed to Acting Senior Program Officer, Community Engagement and Communications and became a direct report to the President and Chief Executive Officer.

w. Gail Fredrickson held the position of Senior Program Officer, Communications until November 6, 2023 at which time she was appointed to Interim Vice President, Community Engagement and Communications and became a direct report to the President and Chief Executive Officer. The incumbent held the position of Interim Vice President, Community Engagement and Communications until November 30, 2023 at which time the incumbent resumed the role of Senior Program Officer, Communications and was no longer a direct report to the President and Chief Executive Officer.

x. Colleen Turner held the position of Vice President, Community Engagement and Communications until November 3, 2023 at which time she left AHS. The incumbent received salary and other accrued entitlements to the date of departure, as well as the reported severance. In addition, the incumbent received a vacation payout of $183 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.

y. Michael Lam held the position of Chief Program Officer, Financial Operations until November 30, 2023 at which time he was appointed to Interim Vice President, Corporate Services and Chief Financial Officer and became a direct report to the President and Chief Executive Officer.

z. Colleen Purdy held the position of Vice President, Corporate Services and Chief Financial Officer until November 16, 2023 at which time she left AHS. The incumbent received salary and other accrued entitlements to the date of departure. The reported severance included 12 months base salary at the rate in effect at the date of departure, and 15% of the severance in lieu of benefits. In addition, the incumbent received a vacation payout of $73 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.

aa. Andrea Beckwith-Ferraton held the position of Chief Ethics and Compliance Officer until November 17, 2023 at which time she was appointed to Interim General Counsel and Corporate Secretary and became a direct report to the President and Chief Executive Officer.

bb. Tina Giesbrecht held the position of General Counsel until November 16, 2023 at which time she left AHS. The incumbent received salary and other accrued entitlements to the date of departure. The reported severance included 14 months base salary at the rate in effect at the date of departure, and 15% of the severance in lieu of benefits. In addition, the incumbent received a vacation payout of $111 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.

cc. Geoffrey Pradella was appointed to the position of Chief Strategy Officer effective July 12, 2023. The incumbent held the position until November 16, 2023 at which time the incumbent left AHS. The incumbent received salary and other accrued entitlements to the date of departure. The reported severance included 5 months base salary at the rate in effect at the date of departure, and 15% of the severance in lieu of benefits. In addition, the incumbent received a vacation payout of $8 for unused accrued vacation at the time of departure.

Termination Obligations

dd. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to one month base salary for each completed month of service during the first year of the term or, after completion of one year of service of the term, 12 months base salary. Such severance will be paid in equal monthly instalments. There was no severance associated with the temporary position.

FOOTNOTES TO THE SCHEDULES OF REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2024 (CONTINUED)

ee. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to 24 months' salary and benefits.

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

gg. There is no severance associated with the Medical Administrative Services Agreement.

hh. SPP and SERP

Based on the provision of the applicable SPP and SERP, the following outlines the benefits received by individuals who terminated employment with AHS within the 2023-24 fiscal period. As a result of retirement or termination, the incumbents are entitled to the benefits accrued to them up to the date of retirement or termination. For participants of SPP, the benefit includes the account balances as at March 31, 2023 and the current period benefit costs and investment gains or losses related to the account that were incurred during the current year. For participants of SERP, the benefit includes the accrued benefit obligation as at March 31, 2023, the current period benefit cost, interest accruing on the obligations, the amortization of any actuarial gains or losses in the period, and gains or losses due to curtailment that were incurred during the current year as identified in Schedule 2E. The AHS obligations are paid through either a monthly, annual, or lump sum payment:

Incumbent [1]	Supplemental Plan Commencement Date	Benefit (not in thousands)	Frequency	Payment Terms
Deb Gordon - VP and Chief Operating Officer, Clinical Operations (SERP)	January 4, 2005	$4,156	Monthly	For a fixed term of 10 years from November 1, 2023 to October 1, 2033
Deb Gordon - VP and Chief Operating Officer, Clinical Operations (SPP)	November 1, 2012	$42,872 increasing annually to $43,300	Annually	For a fixed term of 8 years from November 2023 to January 2030
Dr. Francois Belanger - VP, Quality and Chief Medical Officer (SPP)	May 1, 2012	$136,699 increasing annually to $138,066	Annually	For a fixed term of 4 years from December 2023 to January 2026
Colleen Turner - VP, Community Engagement and Communications (SPP)	March 1, 2010	$247,986	Once	December 2023
Colleen Purdy - VP, Corporate Services and Chief Financial Officer (SPP)	July 1, 2020	$33,014 increasing annually to $33,345	Annually	For a fixed term of 3 years from December 2023 to January 2025
Tina Giesbrecht - General Counsel (SPP)	September 17, 2012	$104,072	Once	December 2023

Pertains only to those individuals for which the applicable SPP was fully vested at the time their employment with AHS ended, and in a position directly reporting to the Board / former Official Administrator or President and Chief Executive Officer at the time of departure.

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

	2024								
	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	$ 340,236	$ 951,304	$ -	$ 7,566	$ 7,657	$ 42,481	$ 23,068	$ 3,048	$ 1,375,360
Community care	927,558	945,293	-	9,574	5,428	53,219	41,622	934	1,983,628
Home care	370,243	358,439	-	199	11,593	83,992	18,683	560	843,709
Acute care	3,427,032	462,215	55,824	654,905	472,626	744,026	202,602	65,645	6,084,875
Emergency medical services	357,098	230,011	-	2,800	5,952	3,869	49,822	16,402	665,954
Diagnostic and therapeutic services	1,820,366	264,783	-	35,072	256,841	368,902	120,658	66,162	2,932,784
Population and public health	351,956	24,052	-	5,634	23,861	9,609	23,448	613	439,173
Research and education	194,329	3,229	-	108	453	119,400	35,066	122	352,707
Information technology	358,249	1,951	-	-	(32)	42,702	242,264	148,641	793,775
Support services	1,279,425	185,744	-	22,996	30,828	164,998	864,210	250,171	2,798,372
Administration	412,973	39,312	-	27	146	54,977	63,640	2,735	573, 810
Total	$ **9,839,465**	**$ 3,466,333**	**$ 55,824**	**$ 738,881**	**$ 815,353**	**$ 1,688,175**	**$ 1,685,083**	**$ 555,033**	**$ 18,844,147**

SCHEDULE 3 – CONSOLIDATED SCHEDULE OF SEGMENT DISCLOSURES (CONTINUED) 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[a]	Total
Continuing care	$ 328,893	$ 975,288	$ -	$ 7,711	$ 9,567	$ 35,968	$ 21,563	$ 2,504	$ 1,381,494
Community care	851,905	925,158	-	15,238	5,156	47,831	42,667	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[a]	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	**$ 9,155,665**	**$ 3,328,374**	**$ 28,587**	**$ 679,210**	**$ 828,438**	**$ 1,533,975**	**$ 1,595,887**	**$ 514,897**	**$ 17,665,033**

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	2023-24
Total Number of Commendations	1,526	1,495	2,142	2,138	2,009
Total Number of Concerns	10,773	11,602	12,728	12,689	12,469
Total Number of Concerns reviewed by PCO	20	18	19	14	9
Percent of Actions Arising from Concerns Resolved in 30 Days or Less	72%	76%	74%	71%	70%

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.

In compliance with legislated reporting requirements, from April 1, 2023 to March 31, 2024, AHS reports as follows:

- Three disclosures were received or referred by or referred to AHS' 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, 2024, and one remained ongoing as of that date.
  - In 2023-24, for an investigation that resulted in a finding of wrongdoing:

Description of the wrongdoing:	Implementing and continuing to use a database which lacked appropriate privacy and security controls.
Recommendations made or corrective measures taken:	1. Complete a Privacy Impact Assessment for the relevant application which includes: a. AHS Information Technology to provide impacted AHS program with reasonable resources such as database, server, and application technology. b. AHS Information Technology and impacted AHS program to review likelihood of any breaches of information contained in application and report, if necessary, to the Office of the Information & Privacy Commissioner. c. Establish support agreement between impacted AHS program area and AHS Information Technology 2. Implement ongoing Privacy Impact Assessment for relevant application. 3. Refer to other relevant AHS program area(s) to determine whether role of individual involved in developing, designing, and maintaining application was appropriate and if not, take steps as they determine appropriate. 4. Investigation report to be provided to AHS Chief Privacy Officer, AHS VP Provincial Clinical Excellence, and AHS Chief Information Officer. 5. Relevant program area to report back to AHS Designated Officer regarding implementation of the recommendations.
If no corrective measures taken, the reason for that:	Not applicable

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 more appropriately dealt with elsewhere.
- The allegation relates to a decision, action, or matter that results from a balanced and informed decision-making process on a public policy or operational issue.
- 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 2023-24.

Contracted Service Area	# of Contracted Operators covered under HFA	# of HFA Contracted Procedures Performed
Dermatology Edmonton Zone	1	0
General Surgery - Edmonton Zone	1	184
Ophthalmology – Calgary Zone*	2	23,157
Ophthalmology – Edmonton Zone*	3	10,099
Oral and Maxillofacial (OMF) – Calgary Zone	9	2,346
Oral and Maxillofacial (OMF) - – Edmonton Zone	11	5,139
Orthopedic – Calgary Zone	1	1,255
Orthopedic – Edmonton Zone	3	3,089
Otolaryngology (ENT) – Calgary Zone	1	659
Otolaryngology (ENT) – Edmonton Zone	3	918
Plastic Surgery – Edmonton Zone	3	1,448
Plastic Surgery – South Zone	2	14
Pregnancy Termination - – Calgary Zone	1	5,453
Pregnancy Termination - – Edmonton Zone	1	6,004

Note:

- There is one Ophthalmology operator that has one contract but is an operator for both Edmonton and Calgary zone.
- There are no surgical contracts with CSFs in the Central and North Zones.
- The # of Contracted Procedures Performed are as of May 17, 2024, and may be amended as final submissions and AHS audit occurs for the CSF sites. Audit continues through to 2023-06-30.
- Procedure totals provided by AHS Clinical Quality Metrics, Provincial CSF Procedures Dashboard. All remaining procedure totals provided by AHS Bill 11, billing system.

Glossary

Academy of Quality Improvement Sciences (AQuIS) is a series of quality and patient safety learning modules that are available to all AHS employees and contracted providers.

Acute Care Bundle Improvement (ACBI) is 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.

Alberta Surgical Initiative (ASI) is a program of interventions with a focused goal of ensuring all Albertans will receive their required surgeries within clinically appropriate timelines.

Alternate Level of Care is used to describe patients who occupy a bed but do not require the intensity of resources/services provided in that care setting. These patients are clinically stable and/or their status has plateaued, they are at low risk for rapid decline, or are not seeking new additional diagnoses by the medical team.

Anesthesia Care Team (ACT) model is when one anesthesiologist provides concurrent supervision for a qualified respiratory therapist, clinical assistant or anesthesia assistant providing anesthesia care in two or more operating room theatres when appropriate.

App Orchard is where developers can learn about Epic Systems' application programming to enable the co-development of Connect Care-compatible software solutions with AHS.

Atlas of Variation is a document that highlights geographical variation in the delivery of health services and associated health outcomes.

Bridge Healing Transitional Accommodation is a program that provides temporary, supportive accommodation for patients discharged from hospital who are unhoused.

Chartered Surgical Facilities (CSFs) are surgical facilities contracted with AHS that provide insured surgical services for dermatology, ophthalmology, oral maxillofacial, otolaryngology, plastic surgery, pregnancy terminations and podiatry.

Click Through Rate (CTR) is the number of clicks that an ad receives divided by the number of times the ad is shown. It helps gauge how well keywords and ads are performing.

Client Directed Home Care Invoicing (CDHCI) is a program that supports clients in their homes longer and waiting for designated living option to reduce pressures on acute care services.

Community Information Integration (CII) is a system that transfers select patient information between community Electronic Medical Records (EMRs) and other members of the patient's care team through Alberta Netcare.

Community Safety Team is joint initiative between the Healthy Street Operations Center (HSOC) and the Edmonton Police, Edmonton Fire, Community Standards Peace Officers, Sheriffs and AHS Paramedics to provide enhanced services to vulnerable communities including pairing an EMS paramedic with a police officer to do proactive work to care for individuals at risk.

Central Patient Attachment Registry (CPAR) is a provincial system that captures the confirmed relationship of a primary provider and their paneled patients.

Comprehensive School Health Approach is a framework for building healthy school communities that support students in reaching their full potential as learners.

Connect Care is 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.

Digital Remote Patient Monitoring (dRPM) allows Albertans to receive hospital-level care in their homes, using digital devices such as a blood pressure monitors, weigh scales, pulse oximeters and thermometers.

ED Fast Track is a process to effectively manage patients admitted to emergency departments with non-urgent complaints. It consists of a separate pathway for patients with less serious conditions who can be treated and discharged more quickly. Triage nurses use specific inclusion criteria based on presenting problems and the triage category.

ED Park is used by sites when there are no available emergency department beds or staff, and it is known that an EMS crew will not be able to handover patient care. The patient then remains under the care of the EMS crew in the hospital hallway.

EMS/811 Shared Response occurs when EMS calls are assessed by EMS dispatch as being low-acuity or non-emergency and may not require an ambulance. Calls are transferred to Health Link 811 for further assessment, guidance, and connection to care.

Enhanced Recovery After Surgery (ERAS) helps patients get back to normal as quickly as possible by providing new and consistent ways of managing care before, during and after surgery.

eSIM™ (Educate, Simulate, Innovate, Motivate) is an educational simulation program in which clinical events are recreated to engage individuals, teams, systems and communities in an interactive, immersive and meaningful "real-world" experience, often through self-reflection and guided facilitation.

Facilitated Access to Specialized Treatment (FAST) model is a new central access and intake program for managing referrals in specialty surgeries.

Healthier Together is a community-based partnership that guides cities/municipalities toward healthier ways of living, working, learning, and healing to give everyone a fair chance for health.

Health Link 811 is a telephone line for health advice and information.

Health Quality Council of Alberta (HQCA) is 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.

Home to Hospital to Home (H2H2H) is Alberta's first provincial guideline on how patients can best transition from their communities to hospitals and then back home.

Institute for Healthcare Optimization (IHO) is a non-profit organization that works with hospitals and health systems to refine classification of urgent surgical cases, optimize scheduled and urgent surgeries, and improve placement of surgical patients to a surgical bed. IHO methodologies can drive improvements in surgical flow and outcomes.

Integration Operation Centres (IOC) have trained paramedics that assign locations to EMS crews based on patient need, appropriateness of service and site capacity. Decisions are made based on the information provided by the paramedic on scene and real-time data from the sites.

LACE is a tool that identifies readmission risk through the following variables: length of stay, acuity, co-morbidities, and past emergency department visits.

Learn Improve Together (LIT) is a model that aligns and integrates multiple existing structures and committees into new Program Improvement Networks (PIN) that comprise a singular governance model for quality improvement, research and innovation.

Mobile Integrated Health (MIH) Units provide responsive urgent mobile healthcare by facilitating in community assessment, treatment, and diagnostics in collaboration with the patients care providers.

MyAHS Connect is 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.

My Recovery Plan (MRP) is an online tool to help those living with addiction identify and understand the personal, social, and community supports to build treatment plans and enter and sustain recovery.

National Surgical Quality Improvement Program (NSQIP) uses clinical data to measure and improve performance thereby reducing the rate of preventable surgical complications.

Partnership for Research and Innovation in the Health System (PRIHS) is part of Alberta Innovates. Through grant-enabled innovative projects, it strengthens health research capacity in Alberta by encouraging collaboration and partnerships between academic institutions, health and clinician researchers, patients, and AHS operations.

Police and Crisis Team (PACT) is a joint mental health/police team that responds to mental health and addiction crises in the community to decrease potential escalation and/or criminal charges. The **Regional Police and Crisis Team (RPACT)** provides the same services as PACT but operate in rural areas of the province.

Primary Care Network (PCN) is a model of team-based primary health care delivery in Alberta. Partnerships between a group of family physicians and AHS provide interdisciplinary programming and services.

Quarterly year-to-date (YTD) is 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).

Rapid Access Clinics (RACs) is a multidisciplinary surgical triage facility.

Referral, Access, Advice, Placement, Information & Destination (RAAPID) is an AHS call centre that serves as a single point of contact for care providers to facilitate the return of patients to a health care facility closest to their home that best meets their health care needs.

Right Care Alberta is 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.

Shared Commitments support patient involvement in their care through meaningful and diverse engagement which will improve patient experience.

Violence Aggression Screening Tool (VAST) is a training course that prepares staff who interact with patients/clients and families. The training has tools to screen for potential patient-to-worker violence and aggression, a plan using universal safety precautions, and risk and safety plans.

Virtual Home Hospital is the use of technology and integrated care teams to provide hospital-level care for patients in their own homes. Care providers interact with patients and caregivers by phone or video to help manage their care in their home rather than in a hospital bed.

Virtual Opioid Dependency Program (VODP) uses technology to serve clients in smaller communities by providing same-day access to opioid addiction treatment including medications, Narcotic Transition Services as well as recovery-oriented referrals and supports to meet the individualized needs of the client

Wrap-Around Services are multi-disciplinary follow-up programs or teams for patients originating from inpatient or ED referral who require continued, close follow-up following acute level of care.