A healthier future.
Together.

ALBERTA HEALTH SERVICES
Annual Report
2017-18

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

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

Every day in communities across the province, we work with our partners to transform how healthcare is being delivered in Alberta and will be delivered in the years ahead. We commit ourselves to improving the quality of healthcare we provide and to address the challenges we face by fostering a culture of continuous improvement, research and innovation across the organization.

Every day for almost 10 years, patients and families have been at the centre of everything we do. Together, our achievements have made us a national and international leader in many areas of healthcare, in addition to being recognized as a top employer in Canada.

We strive to provide care Albertans trust. And we do so by being compassionate, accountable and respectful. We are focused on always improving the way we treat and prevent illness and injury, and how we care for Albertans where they are – hospitals, communities and even in their homes. From the boardroom to the front lines, through our staff, physicians and volunteers, we are dedicated to providing our patients and families the healthcare they deserve with respect, fairness and dignity. We connect and listen to our people and Albertans because what they say matters.

This year has been no different as our teams continually work to protect the health of Albertans and respond to their needs. For example, last fall we broke ground on the new Calgary Cancer Centre, a world-class facility that will double the capacity to treat patients with the best technology. We are providing more support for people in their communities through initiatives such as the Community Paramedic Program, which allows seniors in long-term care to be cared for in their home setting avoiding trips to the hospital. This reduces stress for seniors, increases their comfort and reduces unnecessary patient transports to hospitals. We've also increased the number of continuing care spaces available to Albertans. These are just some of the ways we are investing dollars where it matters most to Albertans.

AHS will remain committed to finding ways to work more efficiently and effectively for the people we serve. We will continue to focus on strengthening the health and wellness of our people and Albertans, while improving access, flow and community-based options. We want Albertans to be partners in health to achieve better health outcomes for themselves, their families and their communities for the years to come.

We are proud to share this report to the community and some of the highlights of 2017-18. Together, we are doing amazing things every day.

[Original Signed By]

Linda Hughes
Chair, Alberta Health Services Board

[Original Signed By]

Dr. Verna Yiu
President and CEO, Alberta Health Services

The 2017-18 AHS Annual Report was prepared in accordance with the *Fiscal Management Act*, *Regional Health Authorities Act* and instructions as provided by Alberta Health. All material economic and fiscal implications known as of May 31, 2018 have been considered in preparing the Report.

About Alberta Health Services

Who We Are

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

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

AHS made the list for Alberta's Top 70 Employers, Canada's Top Employers for Young People and Canada's Top 100 employers.

Throughout AHS, people are working together to create a culture where we all feel safe, healthy, valued and included, with opportunities to reach our full potential.

Alberta's population growth remains ahead of the national average. Alberta's population reached just over 4.3 million in 2017 and is expected to be over five million by 2028 and six million by 2042.

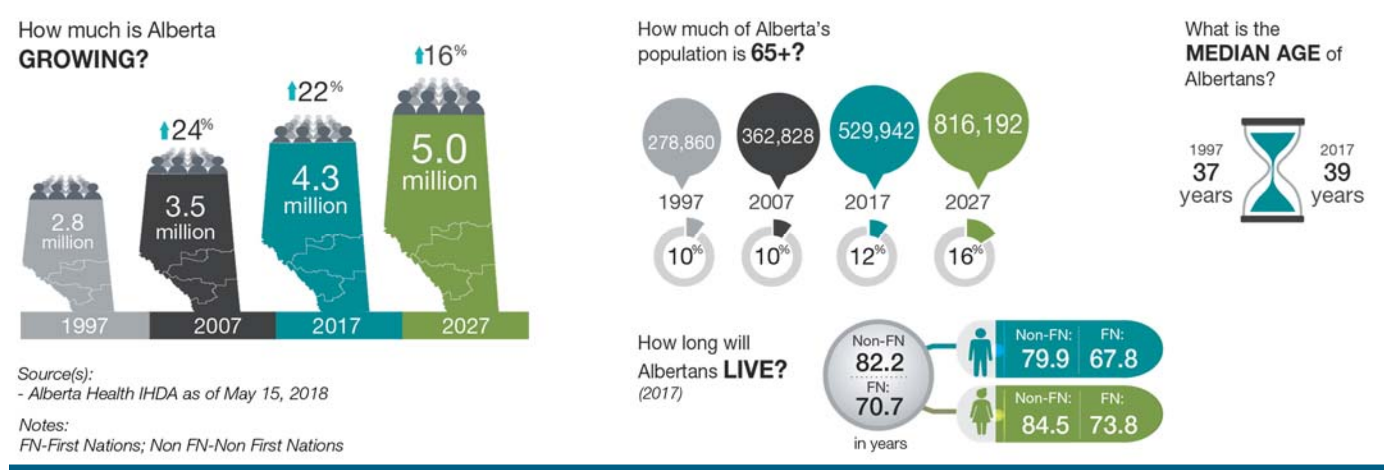
Alberta has urban, rural and remote populations. Certain geographical areas within our province are home to unique population and health needs requiring tailored approaches to healthcare delivery.

AHS has more than 110,000 employees, including 102,000 direct AHS employees (excluding Covenant Health staff). Over 8,300 staff work in AHS' wholly-owned subsidiaries, such as Carewest, CapitalCare Group and Calgary Laboratory Services. We are also supported by more than 10,300 physicians, 8,400 of whom are members of the AHS medical staff (physicians, dentists, podiatrists, oral and maxillofacial surgeons).

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

AHS programs and services are offered at more than 650 facilities throughout the province, including hospitals, clinics, continuing care facilities, cancer centres, mental health facilities and community health sites. Community-based services are also provided to help Albertans maintain and/or improve their health status.

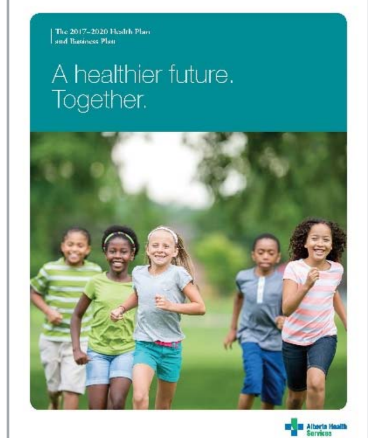
All facilities and programs are operated in compliance with specific sections of program legislation.



AHS Health Plan & Business Plan

The AHS 2017-2020 Health Plan and Business Plan is a public accountability document spanning a three-year time frame.

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



This annual report reflects Year One (2017-18) results based on actions and priorities identified in the AHS 2017-2020 Health Plan and Business Plan.

Vision, Mission & Values

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

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

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

Foundational Strategies

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

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

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

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

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

Our Volunteers

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

AHS has over 14,300 volunteers (which includes nearly 1,200 patient and family advisors) who have contributed over one million volunteer hours this past year to help keep Albertans safe and healthy.

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

Governance

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

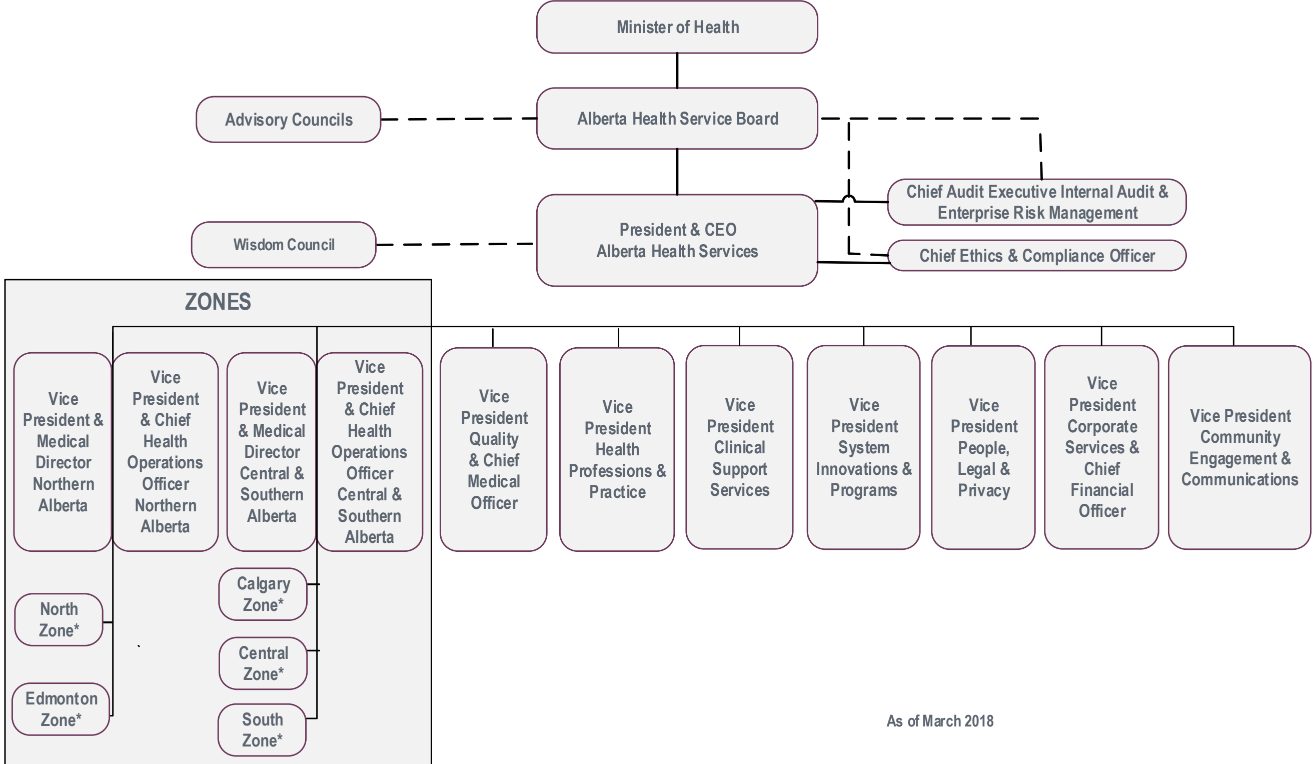
The AHS Board has established committees to assist in governing AHS and overseeing the management of AHS' business and affairs: Audit & Risk Committee, Community Engagement Committee, Finance Committee, Governance Committee, Human Resources Committee and Quality & Safety Committee. The purpose and scope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

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

*Appointment effective April 12, 2018

Organizational Structure

Dr. Verna Yiu is President and Chief Executive Officer (CEO) of AHS and leads over 110,000 caring and dedicated individuals who make up the AHS workforce. With leaders and staff in the organization, AHS is proud to have a culture that exemplifies its values, takes a provincial perspective on issues and ensures good ideas developed in one part of the province are shared across the province. AHS' organizational structure is represented below, arranged under the AHS Executive Leadership Team reporting directly to the President and CEO.



Advisory Councils – *Working Together to Improve Lives*

Advisory councils bring the voice of Albertans to better address the health needs of Albertans and bring decision-making to the local level. AHS has established the following councils to support ongoing collaboration and engagement.

Health Advisory Councils (HACs) engage the public in communities throughout Alberta and provide advice and feedback from a local perspective. The HACs report to the AHS Board Chair. Each HAC represents a different geographical area within the province.

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

Wisdom Council provides guidance and recommendations on the development and implementation of culturally appropriate and innovative health service delivery for Indigenous Peoples. It is comprised of Indigenous Peoples with wide-ranging backgrounds, including traditional knowledge-holders, youth, nursing professionals and health consultants.

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

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

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

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

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

Seniors & Continuing Care Provincial Advisory Council was launched in January 2018. It aims to improve the delivery of services to seniors and those in continuing care (long-term care and designated supportive living) across Alberta. The new council has 15 members from across the province who have personal interactions with, or who are caregivers, for clients in continuing care.

AHS received a new "accredited" designation and an updated certificate of accreditation for the final on-site survey of the 2014-2017 cycle with **Accreditation Canada** in May 2017. Health Standards Organization, the new parent organization to Accreditation Canada, is now responsible for developing standards and assessment methodologies used to assess organizations against the standards. An agreement was made with AHS to co-design processes to apply the new methodologies to a large complex health system. This work will achieve a more integrated approach to assessment of services and make improvements to quality of care through accreditation. Given the breadth of work required for this co-design, the 2018 survey assessment was deferred and a new four-year accreditation cycle will commence in 2019.

AHS Map

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

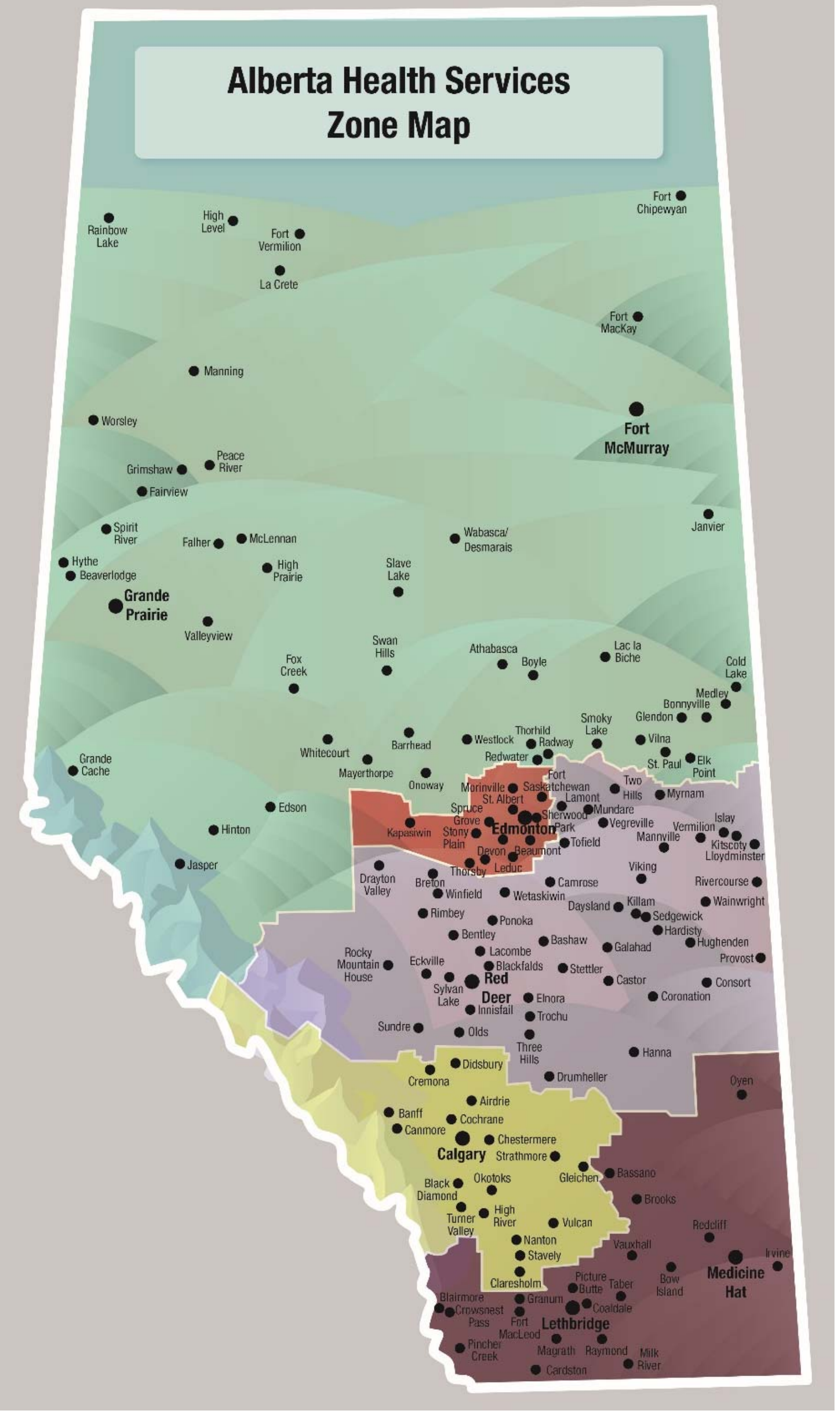
Province-wide services, such as Emergency Medical Services; population, public and Indigenous health; diagnostic imaging; quality and safety; and so on, work together with the zones to deliver care.

The next section includes an overview and highlights about each zone.

legend

		Population (2017)
	North Zone	492,946
	Edmonton Zone	1,366,982
	Central Zone	484,308
	Calgary Zone	1,634,393
	South Zone	305,343
	Alberta	4,283,973

Alberta Health Services



Quick Facts

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

Alberta Health Services	2014-15	2015-16	2016-17	2017-18	% change from previous year
Primary Care / Population Health					
Ambulatory Care Visits	6,238,753	6,421,309	6,569,162	Not available	2.3%
Number of Unique Home Care Clients	113,778	116,415	118,774	121,021	1.9%
Number of People Placed in Continuing Care	7,810	7,879	7,963	7,927	-0.5%
Health Link Calls	813,471	755,334	744,278	706,280	-5.1%
Poison Information Calls (PADIS)	35,080	36,375	39,467	39,281	-0.5%
Seasonal Influenza Immunizations	1,254,950	1,146,569	1,171,728	1,229,350	4.9%
EMS Events	503,769	517,640	512,167	544,744	6.4%
Food Safety Inspections	92,723	92,857	82,482	78,311	-5.1%
Acute Care					
Emergency Department Visits (all sites)	2,181,369	2,134,945	2,079,688	2,100,498	1.0%
Urgent Care Visits	195,312	189,775	187,519	197,963	5.6%
Hospital Discharges	401,331	404,514	403,958	400,902	-0.8%
Births	54,203	55,283	53,647	51,691	-3.6%
Total Hospital Days	2,808,990	2,812,244	2,837,865	2,864,120	0.9%
Average Length of Stay (in days)	7.0	7.0	7.0	7.1	-1.4%
Diagnostic / Specific Procedures					
Hip Replacements (scheduled and emergency)	5,397	5,564	6,004	6,190	3.1%
Knee Replacements (scheduled and emergency)	6,377	6,645	6,692	6,552	-2.1%
Cataract Surgery	36,583	36,807	38,053	38,498	1.2%
Main Operating Room Activity	277,134	282,720	288,198	291,247	1.1%
MRI Exams	199,928	195,419	192,375	195,017	1.4%
CT Exams	387,116	391,600	405,332	415,755	2.6%
X-rays	1,868,044	1,874,879	1,843,076	1,857,946	0.8%
Lab Tests	73,994,032	75,512,771	76,282,777	76,973,607	0.9%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	578,005	616,237	641,856	639,449	-0.4%
Unique Cancer Patients	52,288	55,020	57,549	58,409	1.5%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care sites)	21,260	22,646	24,183	24,457	1.1%
Community Treatment Orders (CTOs) Issued	443	452	462	368 (Q3 YTD)	pending
Addiction Residential Treatment & Detoxification Admissions	10,342	10,919	10,591	11,007	3.9%

NOTES: Data updated as of May 23, 2018.

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

Bed Numbers

AHS is committed to providing community-based options for Albertans, including long-term care, supportive living, palliative care, and home care. A key objective is to shift services from acute care hospital and facility living to the community – bringing care closer to home for patients.

In 2017-18, AHS opened 572 net new continuing care beds – more than the entire 2016-17 year (376 new beds). Since 2010, AHS has opened 6,196 new beds to support individuals who need community-based care and supports (including palliative). Additional detail on continuing care bed capacity can be found in the Appendix.

Number of Beds/Spaces	March 31, 2017	March 31, 2018	Difference	% Change
ACUTE & SUB-ACUTE CARE				
Acute Care	8,427	8,448	21	0.2%
Sub-acute in Auxiliary Hospitals	510	490	-20	-3.9%
TOTAL ACUTE & SUB-ACUTE CARE	**8,937**	**8,938**	**1**	**0.0%**
CONTINUING CARE				
Auxiliary Hospital	5,606	5,616	10	0.2%
Nursing Home	9,139	9,230	91	1.0%
Long-Term Care (LTC) Subtotal	**14,745**	**14,846**	**101**	**0.7%**
Supportive Living 4 - Dementia	2,904	3,056	152	5.2%
Supportive Living 4	5,915	6,237	322	5.4%
Supportive Living 3	1,517	1,514	-3	-0.2%
Supportive Living (SL) Subtotal	**10,336**	**10,807**	**471**	**4.6%**
LONG-TERM CARE & SUPPORTIVE LIVING SUBTOTAL	**25,081**	**25,653**	**572**	**2.3%**
Community Palliative and Hospice (out of hospital)	243	243	0	0.0%
TOTAL CONTINUING CARE (LTC, SL and Palliative)	**25,324**	**25,896**	**572**	**2.3%**
ADDITION & MENTAL HEALTH				
Psychiatric (standalone facilities)	955	928	-27	-2.8%
Addiction Treatment	968	993	25	2.6%
Community Mental Health	746	802	56	7.5%
TOTAL ADDICTION & MENTAL HEALTH	**2,669**	**2,723**	**54**	2.0%
ALBERTA TOTAL	**36,930**	**37,557**	**627**	**1.7%**

South Zone Overview

Population Statistics (2017)

Overall **Population**

305,343

46,697
Aging Population
(over 65 years)

Life
Expectancy *(2017)*
80.5 years

Median Age
40 years

Source: Alberta Health IHDA

Facts at Your Fingertips

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

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

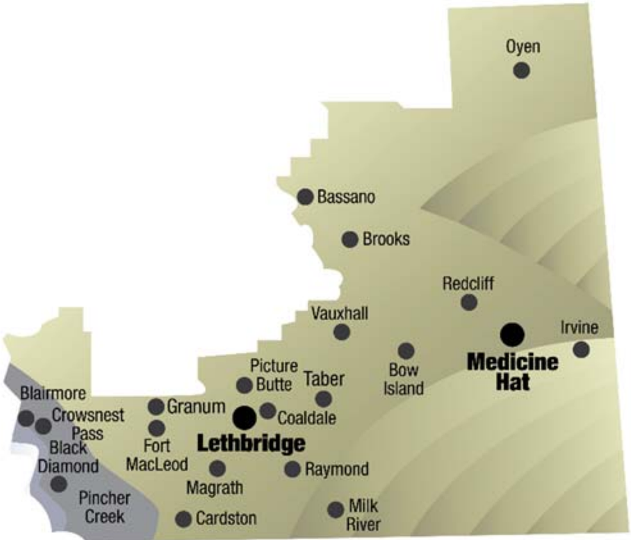
58%
are **active** or moderately active

15%
smoke everyday

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

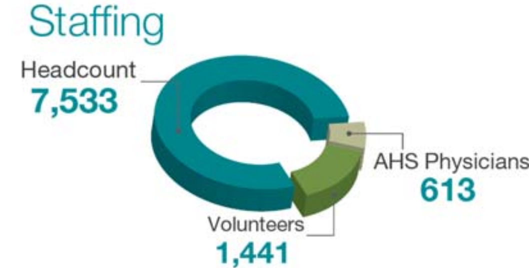
32%
are **obese**

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



Land Mass: 65,500 km²

Staffing



South Zone 2017-18 Highlights

- Two sessions of Indigenous cultural awareness and sensitivity training were held in Lethbridge and Medicine Hat in January 2018, followed by a blanket exercise. With this training and online training, South Zone surpassed its goal (10 per cent) by having nearly 20 per cent of staff trained.
- New and enhanced community resources in Medicine Hat increased care options, which will reduce duplication and costs, while maintaining quality services for patients. The new 100-bed Masterpiece Southland Meadows opened as a combined long-term care and supportive living facility. It includes transition beds to accommodate convalescent and respite care. In addition, Covenant Health's St. Joseph's Home (Hospice) will see more patients with end-of life and convalescent needs – instead of admitting these patients to hospitals.
- In the fall of 2017, the zone experienced one of the worst wildfire seasons on record, including the fire that devastated Waterton National Park. On October 17, 2017 there were eight out-of-control wildfires affecting different corners of the zone including the Crowsnest Pass, Cypress County, and the Oyen area. Staff, physicians and volunteers were faced with immense challenges as they dealt with poor air quality, assisted in evacuations, worked to keep patients safe and provided care and support to communities.
- The newly implemented Police and Crisis Team (PACT) in Medicine Hat began providing interventions and support for vulnerable individuals with addiction and mental health concerns with police. PACT is also being piloted with the Lethbridge Police Service.

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

SOUTH ZONE QUICK FACTS	2014-15	2015-16	2016-17	2017-18	% change from previous year
Primary Care / Population Health					
Ambulatory Care Visits	365,293	376,743	406,163	Not available	7.8%
Number of Unique Home Care Clients	11,860	12,064	12,380	12,568	1.5%
Number of People Placed in Continuing Care	866	887	925	905	-2.2%
Health Link Calls	32,108	34,773	34,061	32,644	-4.2%
Seasonal Influenza Immunizations	96,663	88,172	90,273	92,391	2.3%
Food Safety Inspections	8,609	7,866	7,707	6,401	-16.9%
Acute Care					
Emergency Department Visits (all sites)	194,352	194,257	192,083	193,467	0.7%
Hospital Discharges	31,125	30,485	30,521	29,905	-2.0%
Births	4,156	4,217	3,940	3,865	-1.9%
Total Hospital Days	212,020	219,218	228,308	222,761	-2.4%
Average Length of Stay (in days)	6.8	7.2	7.5	7.4	1.3%
Diagnostic / Specific Procedures					
Hip Replacements (scheduled and emergency)	571	578	591	569	-3.7%
Knee Replacements (scheduled and emergency)	822	838	784	778	-0.8%
Cataract Surgery	2,878	2,847	2,955	2,920	-1.2%
Main Operating Room Activity	23,501	23,209	23,352	22,491	-3.7%
MRI Exams	14,227	14,288	13,809	13,601	-1.5%
CT Exams	26,185	26,964	28,926	30,418	5.2%
X-rays	163,095	166,251	165,091	162,358	-1.7%
Lab Tests	5,085,305	5,263,114	5,195,905	5,200,813	0.1%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	30,277	32,144	34,055	31,067	-8.8%
Unique Cancer Patients	4,349	4,273	4,379	3,733	-14.8%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care sites)	2,014	2,052	2,166	2,228	2.9%
Staffing					
Head Count	7,238	7,280	7,431	7,533	1.4%
Volunteers	1,933	1,746	1,632	1,441	-11.7%
AHS Physicians	613	569	578	613	6.1%

NOTES: Data updated as of May 23, 2018.

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

Calgary Zone Overview

Population Statistics (2017)

Overall **Population**

1,634,393

189,605
Aging Population
(over 65 years)

Life
Expectancy *(2017)*
83.0 years

Median Age
39 years

Source: Alberta Health IHDA

Facts at Your Fingertips

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

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

62% are **active** or moderately active

9% **smoke** everyday

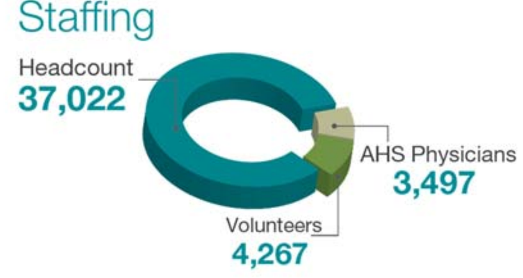
18% are **heavy drinkers** (5+ drinks on one occasion, at least once a month)

25% are **obese**

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

Land Mass: 39,300 km²

Staffing



Calgary Zone 2017-18 Highlights

- In April 2017, Airdrie Urgent Care Centre began providing 24-hour access to care to the community for unexpected, but non-life-threatening health concerns, which require same-day treatment.
- The Complex Care Hub at Rockyview General Hospital became operational in February 2018 with the goal to reduce hospital admissions for frail elderly patients through enhancing community supports with an Internal Medicine/Community Paramedic partnership.
- A new neonatal intensive care unit at the Peter Lougheed Centre was opened in spring 2017, providing more space and privacy for the most fragile newborns from Calgary and southern Alberta.
- The Calgary Police Service has provided in-kind space to AHS for the Safe Communities Opportunity and Resource Centre (SORCe). SORCe provides on-site addiction and mental health services to clients and acts as a single point of referral and access that connects people to services, programs and support that currently exist within Calgary.
- The Calgary Zone Community Paramedic Program created its City Centre Team mobile paramedic program to provide better access to health services for people living with homelessness. This program coordinates a specially trained, mobile paramedic service with existing healthcare resources to deliver timely, individualized care.

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

CALGARY ZONE QUICK FACTS	2014-15	2015-16	2016-17	2017-18	% change from previous year
Primary Care / Population Health					
Ambulatory Care Visits	2,573,583	2,646,960	2,661,944	Not available	0.6%
Number of Unique Home Care Clients	33,504	34,680	35,834	37,318	4.1%
Number of People Placed in Continuing Care	2,548	2,722	2,438	2,632	8.0%
Health Link Calls	325,566	318,422	310,333	292,109	-5.9%
Seasonal Influenza Immunizations	511,151	467,942	491,931	525,652	6.9%
Food Safety Inspections	31,121	30,496	27,093	26,494	-2.2%
Acute Care					
Emergency Department Visits (all sites)	493,861	487,862	475,485	475,434	0.0%
Urgent Care Visits	183,230	179,832	176,120	185,710	5.4%
Hospital Discharges	140,563	143,063	143,659	144,349	0.5%
Births	19,554	19,720	19,394	18,883	-2.6%
Total Hospital Days	1,025,776	1,030,612	1,024,174	1,021,425	-0.3%
Average Length of Stay (in days)	7.3	7.2	7.1	7.1	0.0%
Diagnostic / Specific Procedures					
Hip Replacements (scheduled and emergency)	1,960	2,099	2,184	2,275	4.2%
Knee Replacements (scheduled and emergency)	2,388	2,511	2,490	2,353	-5.5%
Cataract Surgery	13,378	13,578	13,490	13,797	2.3%
Main Operating Room Activity	98,386	101,016	101,850	102,641	0.8%
MRI Exams	78,175	76,850	77,116	77,502	0.5%
CT Exams	143,496	142,863	145,678	151,370	3.9%
X-rays	541,087	546,546	537,800	546,543	1.6%
Lab Tests	28,407,412	28,800,108	29,212,267	29,637,101	1.5%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	180,811	200,599	213,828	214,536	0.3%
Unique Cancer Patients	21,717	22,934	23,792	24,651	3.6%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care sites)	8,081	9,022	9,499	9,666	1.8%
Staffing					
Head Count	37,000	37,023	36,887	37,022	0.4%
Volunteers	4,623	5,100	4,206	4,267	1.5%
AHS Physicians	3,497	3,326	3,439	3,497	1.7%

NOTES: Data updated as of May 23, 2018.

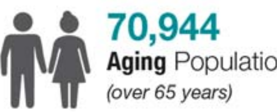
- HealthLink: The lower call volumes may be due to the number of online options Albertans can use to obtain or self-serve for this type of information, including the MyHealthAlberta site.
- Surgery volumes are dependent on funding available.

Central Zone Overview

Population Statistics (2017)

Overall **Population**

484,308



70,944
Aging Population
(over 65 years)

Life
Expectancy *(2017)*
80.3 years

Median Age
40 years

Source: Alberta Health IHDA

Facts at Your Fingertips

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

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

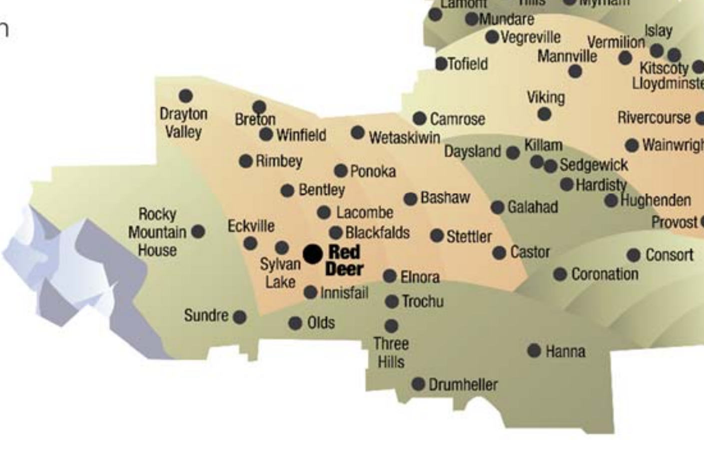
61%
are **active** or moderately active

17%
smoke everyday

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

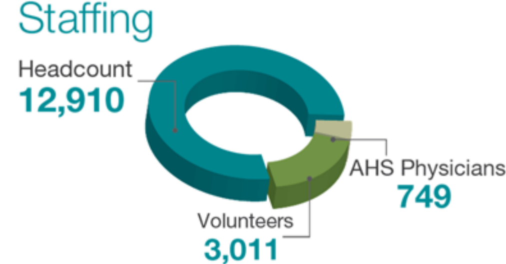
32%
are **obese**

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



Land Mass: 95,000 km²

Staffing



Central Zone 2017-18 Highlights

- The first Indigenous Cree naming ceremony was held at the Red Deer Regional Hospital Centre in the hospital's Indigenous Culture room. This room opened in 2014 and provides a space where people can balance traditional medicine with spiritual healing.
- Medically-supported detox beds opened in April 2017 at the Safe Harbour Society in Red Deer in November 2017. These beds provide support and access to on-site registered nurses and on-call physicians for adult patients with complex addiction and substance abuse. The Rural Opioid Dependency Program expanded access to 40 rural communities across Central Zone.
- Two new obstetrical operating rooms opened at the Red Deer Regional Hospital Centre, adjacent to the existing labour and delivery unit and neonatal intensive care unit. This allows patients needing obstetrical procedures or caesarean sections to move seamlessly into the obstetrical operating room instead of being transported to the main operating room via public hallways.
- A new and bigger heliport at the Rocky Mountain House Health Centre became operational in August 2017. The ability to have all medevac helicopters land directly at the Rocky Mountain House Health Centre will improve access for patients who need critical care transport.
- In partnership with Saddle Lake Cree Nation and Health Canada, a cultural awareness liaison role was implemented at the Two Hills Health Centre.

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

CENTRAL ZONE QUICK FACTS	2014-15	2015-16	2016-17	2017-18	% change from previous year
Primary Care / Population Health					
Ambulatory Care Visits	471,526	479,723	501,083	Not available	4.5%
Number of Unique Home Care Clients	17,973	18,408	18,802	19,105	1.6%
Number of People Placed in Continuing Care	1,259	1,060	1,352	1,236	-8.6%
Health Link Calls	62,035	68,388	61,431	56,996	-7.2%
Seasonal Influenza Immunizations	115,539	105,872	106,934	112,629	5.3%
Food Safety Inspections	11,234	11,390	9,944	9,508	-4.4%
Acute Care					
Emergency Department Visits (all sites)	380,367	360,966	344,993	346,669	0.5%
Hospital Discharges	45,691	45,577	45,265	43,982	-2.8%
Births	4,926	5,037	4,765	4,433	-7.0%
Total Hospital Days	330,752	323,983	338,305	328,939	-2.8%
Average Length of Stay (in days)	7.2	7.1	7.5	7.5	0.0%
Diagnostic / Specific Procedures					
Hip Replacements (scheduled and emergency)	569	585	632	646	2.2%
Knee Replacements (scheduled and emergency)	654	616	678	621	-8.4%
Cataract Surgery	3,722	3,782	3,859	3,748	-2.9%
Main Operating Room Activity	29,330	29,999	30,930	29,337	-5.2%
MRI Exams	12,610	12,406	11,034	12,058	9.3%
CT Exams	36,143	37,485	38,679	38,310	-1.0%
X-rays	256,595	255,147	251,374	251,082	-0.1%
Lab Tests	6,187,163	6,374,514	6,426,497	6,385,971	-0.6%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	27,298	32,098	33,366	33,856	1.5%
Unique Cancer Patients	2,461	2,762	2,970	3,038	2.3%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care sites)	2,260	2,497	2,633	2,613	-0.8%
Staffing					
Head Count	12,631	12,772	12,813	12,910	0.8%
Volunteers	3,292	3,409	2,852	3,011	5.6%
AHS Physicians	749	710	725	749	3.3%

NOTES: Data updated as of May 23, 2018.

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

Edmonton Zone Overview

Population Statistics (2017)

Overall **Population**

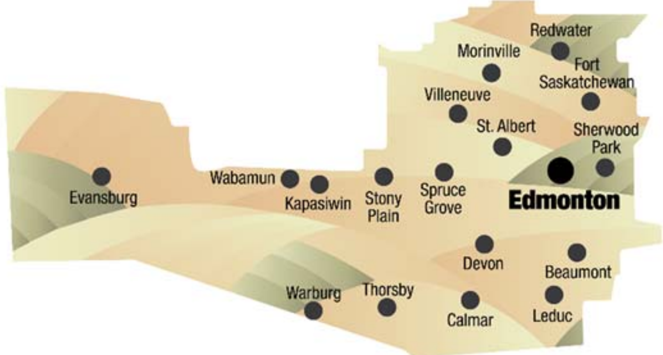
1,366,982

170,948
Aging Population
(over 65 years)

Life
Expectancy *(2017)*
82.1 years

Median Age
37 years

Source: Alberta Health IHDA



Land Mass: 11,800 km²

Facts at Your Fingertips

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

13%
smoke everyday

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

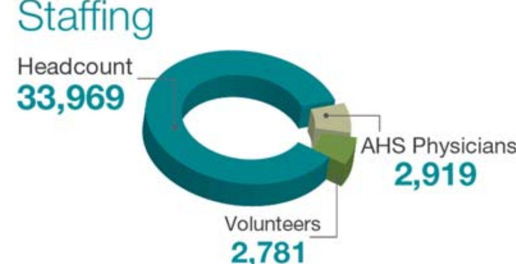
30%
eat **5 or more servings** of fruit or vegetables daily

58%
are **active** or moderately active

26%
are **obese**

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

Staffing



Edmonton Zone 2017-18 Highlights

- Colorectal cancer screening wait times decreased from 10.6 months to five weeks due to increased screening procedures made possible by strong collaborative care between the SCOPE (Stop Colorectal Cancer through Prevention and Education) program staff and endoscopy physicians.
- The Stollery Children's Hospital's Pediatric Cardiac Intensive Care Unit opened in December 2017. This new unit offers 16 single-patient rooms with enhanced infection-control measures and improved privacy for patients and families.
- Albertans have improved access to painless, scalpel-free brain surgery for certain conditions with the opening of the Gamma Knife suite at the University of Alberta Hospital. The Gamma Knife delivers a highly accurate dose of radiation to certain tumours and other lesions without a scalpel and without the usual risks of open neurosurgery.
- Access Open Minds clinic was opened in the spring of 2017 and offers a centralized option for addiction and mental health services for residents aged 11 to 25. Clinicians screen clients to determine what services are needed and then co-ordinate those services. Psychiatric services can be provided within the clinic; other services may be provided at other AHS or community-based sites.

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

EDMONTON ZONE QUICK FACTS	2014-15	2015-16	2016-17	2017-18	% change from previous year
Primary Care / Population Health					
Ambulatory Care Visits	2,410,006	2,490,807	2,581,917	Not available	3.7%
Number of Unique Home Care Clients	37,675	37,509	37,992	37,820	-0.5%
Number of People Placed in Continuing Care	2,443	2,506	2,575	2,388	-7.3%
Health Link Calls	325,440	269,205	278,755	267,218	-4.1%
Seasonal Influenza Immunizations	417,388	384,723	389,918	406,229	4.2%
Food Safety Inspections	26,170	27,788	23,188	20,484	-11.7%
Acute Care					
Emergency Department Visits (all sites)	535,146	541,451	545,147	552,857	1.4%
Urgent Care Visits	12,082	9,943	11,399	12,253	7.5%
Hospital Discharges	139,052	141,279	142,584	140,224	-1.7%
Births	19,258	19,751	19,849	18,758	-5.5%
Total Hospital Days	984,395	975,054	995,740	1,009,001	1.3%
Average Length of Stay (in days)	7.1	6.9	7.0	7.2	-2.9%
Diagnostic / Specific Procedures					
Hip Replacements (scheduled and emergency)	1,957	1,987	2,270	2,345	3.3%
Knee Replacements (scheduled and emergency)	2,068	2,166	2,191	2,241	2.3%
Cataract Surgery	14,411	14,458	15,751	16,013	1.7%
Main Operating Room Activity	102,467	102,463	107,015	111,249	4.0%
MRI Exams	81,945	78,254	77,523	79,087	2.0%
CT Exams	147,226	149,237	157,225	159,512	1.5%
X-rays	609,179	613,135	603,962	609,941	1.0%
Lab Tests	27,278,431	27,781,396	28,233,276	28,671,512	1.6%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	325,538	337,234	344,170	343,539	-0.2%
Unique Cancer Patients	23,868	25,074	26,442	27,150	2.7%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care sites)	5,992	6,195	6,909	6,805	-1.5%
Staffing					
Head Count	32,657	32,921	33,473	33,969	1.5%
Volunteers	2,680	2,903	2,771	2,781	0.4%
AHS Physicians	2,919	2,714	2,824	2,919	3.4%

NOTES: Data updated as of May 23, 2018.

- Number of People Placed in Continuing Care declined due to a high number of outbreaks which impacted vacancy filling.
- HealthLink: The lower call volumes may be due to the number of online options Albertans can use to obtain or self-serve for this type of information, including the MyHealthAlberta site.
- Food inspections decreased due to focused efforts on more difficult establishments which required longer inspections.
- The decrease in the number of births may be due to the economic downturn.

North Zone Overview

Population Statistics (2017)

Overall **Population**

492,946

48,747
Aging Population
(over 65 years)

Life
Expectancy *(2017)*
79.8 years

Median Age
38 years

Source: Alberta Health IHDA

Facts at Your Fingertips

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

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

58%
are **active** or moderately active

20%
smoke everyday

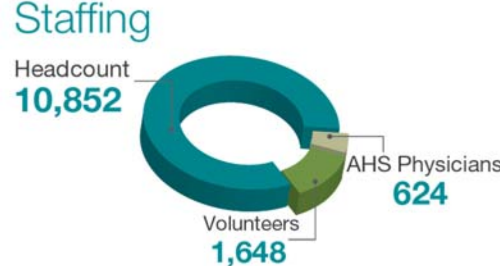
23%
are **heavy drinkers** (5+ drinks on one occasion, at least once a month)

38%
are **obese**

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

Land Mass: 448,500 km²

Staffing



North Zone 2017-18 Highlights

- The High Prairie Community Health and Wellness Clinic moved into a new building in June 2017, located at the new High Prairie Health Complex. The clinic will continue to provide convenient access to primary care services with a collaborative healthcare team within a new, modern facility.
- A new Emergency Medical Services (EMS) station opened in Wabasca-Desmarais to better support EMS staff so they can provide the best possible service in the community.
- Residents living in Lac La Biche and Edson and surrounding areas have access to improved dialysis treatment with the opening of a new, permanent renal dialysis unit at the William J. Cadzow – Lac La Biche Healthcare Centre and a new permanent dialysis clinic in the Edson Healthcare Centre.
- A new Opioid Dependency Program, operated by AHS, opened in Grande Prairie in May 2017, increasing access to opioid replacement therapy, treatment and counselling services.
- An Indigenous Health Leadership –Truth Always event was held, which was attended by approximately 100 leaders. Learning was through the sharing of personal and powerful stories, experiences and historical teachings.

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

NORTH ZONE QUICK FACTS	2014-15	2015-16	2016-17	2017-18	% change from previous year
Primary Care / Population Health					
Ambulatory Care Visits	418,345	427,076	418,055	Not available	-2.1%
Number of Unique Home Care Clients	12,766	13,754	13,766	14,210	3.2%
Number of People Placed in Continuing Care	694	704	673	766	13.8%
Health Link Calls	68,322	64,546	59,698	57,313	-4.0%
Seasonal Influenza Immunizations	114,209	99,860	92,672	92,449	-0.2%
Food Safety Inspections	15,589	15,317	14,550	15,424	6.0%
Acute Care					
Emergency Department Visits (all sites)	577,643	550,409	521,980	532,071	1.9%
Hospital Discharges	44,900	44,110	41,929	42,442	1.2%
Births	6,309	6,558	5,699	5,752	0.9%
Total Hospital Days	256,047	263,377	251,338	281,994	12.2%
Average Length of Stay (in days)	5.7	6.0	6.0	6.6	-10.0%
Diagnostic / Specific Procedures					
Hip Replacements (scheduled and emergency)	340	315	327	355	8.6%
Knee Replacements (scheduled and emergency)	445	514	549	559	1.8%
Cataract Surgery	2,194	2,142	1,998	2,020	1.1%
Main Operating Room Activity	23,450	26,033	25,051	25,529	1.9%
MRI Exams	12,971	13,621	12,893	12,769	-1.0%
CT Exams	34,066	35,051	34,824	36,145	3.8%
X-rays	298,088	293,800	284,849	288,022	1.1%
Lab Tests	4,883,055	5,038,109	4,937,068	4,819,741	-2.4%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	14,081	14,162	16,437	16,451	0.1%
Unique Cancer Patients	2,199	2,318	2,378	2,297	-3.4%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care sites)	2,913	2,880	2,976	3,145	5.7%
Staffing					
Head Count	10,411	10,403	10,574	10,852	2.6%
Volunteers	3,083	2,774	1,626	1,648	1.4%
AHS Physicians	624	607	594	624	5.1%

NOTES: Data updated as of May 23, 2018.

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

Our Performance

Leading in Health

The following indicators were developed by the Canadian Institute for Health Information (CIHI) and measure the health of Canadians and health system performance in Canada. These indicators help inform AHS and Albertans on how we perform nationally.

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

> AHS spent 3.3 per cent of its total expenses on administration, which is among the lowest of all provinces and territories in Canada, according to the latest Canadian Institute for Health Information. The national average is 4.5 per cent (2016-17).

Source: Canadian Institute of Health Information (CIHI) 2017, 2018

Alberta is first in the country for:

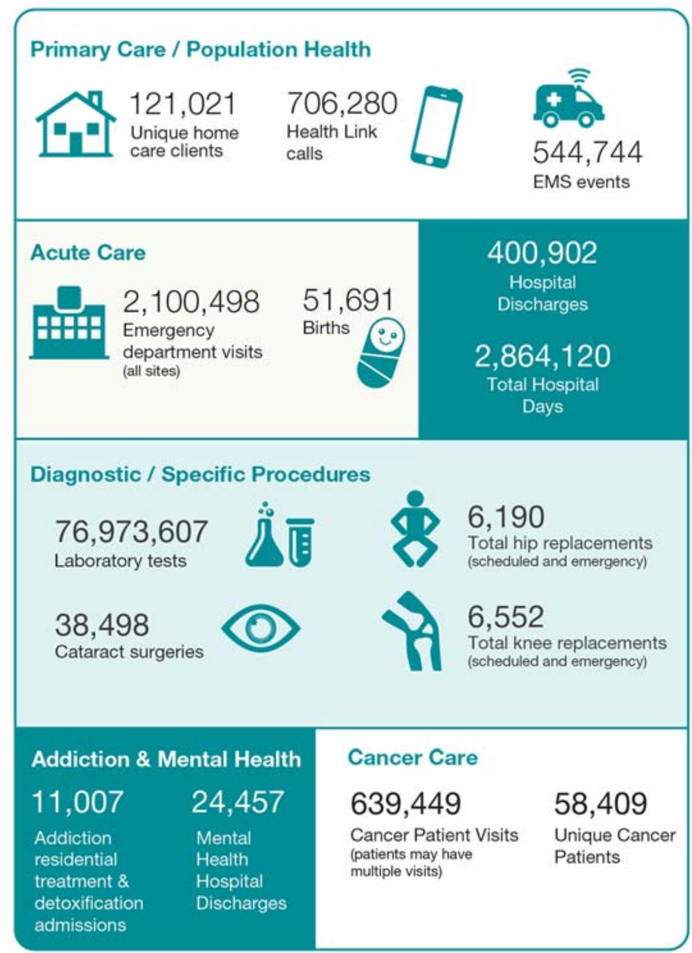
- Lowest total time spent in emergency department for admitted patients
- Lowest potentially inappropriate use of antipsychotics in long-term care
- Lowest administrative expense
- Best perceived health

Alberta is second in the country for:

- Highest percent of hip fracture surgeries within 48 hours
- Fewest repeat hospital stays for mental illness
- Lowest restraint use in long-term care
- Fewest hospitalized heart attacks
- Fewest residents experiencing pain in long-term care
- Highest physical activity (age 18 and older)

Alberta is third in the country for:

- Lowest number of obstetric patients readmitted to hospital
- Highest life expectancy at age 65 (tied)
- Fewest hospitalized strokes (tied)
- Highest percent of knee replacements within national benchmark of 26 weeks
- Highest percent of patients receiving radiation therapy within national benchmark of 28 days



Source: AHS Quick Facts

2017-18 Performance Results

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

During 2017-18, AHS continued to pursue the four goals as outlined in the 2017-2020 Health Plan and Business Plan:

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

AHS is now in the second year of its Health Plan, following an inaugural year in which significant progress was made on a number of key initiatives.

Enhancing Care is a cornerstone of the Health Plan and a driver of patient- and family-centred care throughout the health system. Enhancing Care in the Community involves moving some services out of hospitals and into the community when it's safe to do so, and also to expand existing community services, especially home care. The goal is to ensure Albertans get the right care at the right time by the right mix of healthcare providers, as close to home as possible. By doing so, AHS is shifting from a hospital-based health system focused on illness and injury to a community-based health system focused on health, wellness, and injury and illness prevention. Hospitals remain a key component of the health system but AHS recognizes they should support Albertans who truly need that high-level of care.

Additional investments were made to bolster home care, continuing care (long-term and designated supportive living) and opioid dependency services, while the Community Paramedic Program — which brings select hospital services to patients where they live — was expanded from Calgary and Edmonton to more communities across the province. Enhanced Care in the Community also involves a renewed focus on community-based wellness advice, injury and illness prevention, addiction and mental health support, restorative care, caregiver respite and home-based palliative care.

The Health Plan acknowledges enhanced community-based care requires improved health system integration, especially with primary care providers. AHS made progress on this front throughout 2017-18.

Connect Care met major milestones in 2017-18 including reaching an agreement with Epic Systems Corporation to help build a single, shared electronic system to store health information, so it moves with patients from site to site, service to service. For instance, with a provincial clinical information system, a family doctor can see what tests a specialist ordered for his patient, a specialist can know what medication a family doctor has prescribed, and an emergency department physician can see a patient's medical history at a glance.

Another major development was the Government of Alberta's announcement of a new provincial laboratory services entity that will help to improve the quality and timeliness of care for Albertans.

The organization's efforts to improve the experience and safety of staff, physicians and volunteers were recognized when AHS was named one of Canada's 100 Employers for 2018, as well as one of Canada's Top Employers for Young People and one of Alberta's Top 70 Employers.

As AHS works to transform the health system, the organization continues to reach out to partners, stakeholders and Albertans; listen to their thoughts and ideas about healthcare delivery; and ensure this feedback is considered during AHS decision-making.

Healthcare transformation cannot and should not be foisted on Albertans. AHS wants Albertans to be involved in their health and in their health system, so we can jointly move toward the AHS vision of 'Healthy Albertans. Healthy Communities. Together.'

Summary of Performance Measure Results

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

The 13 performance measures are reported as follows:

Two measures are not reported quarterly but are reported at different times based on when the data is available:

- Perinatal Mortality among First Nations (reported annually)
- AHS Workforce Engagement (reported every two years)

Eleven measures are reported quarterly:

- Seven measures include the most current data available with comparable historical data.
- One measure is a cumulative measure (eReferrals) and cannot be compared to previous period.
- Three measures rely on patient follow-up, generally after they have been discharged from care. These measures are updated after each quarter has ended and are therefore posted in subsequent quarters (Q3 year-to-date provided).

Results 2017-18 for the eleven performance measures available are as follows:

- 82 per cent (9 out of 11) of the performance measures are better or stable from the same period last year with two measures achieving target (Timely Access to Specialty Care and Percentage of Nursing Units Achieving Best Practice Targets).
- 18 per cent (2 out of 11) of the performance measures did not improve from the same period as last year. Percentage placed in continuing care in 30 days and the percentage of alternate level of care patient days – deteriorated due to slower than expected growth in mental health, home care, continuing care and community care.

Further explanations are noted in the following sections.

GOALS	OBJECTIVES (We will...)	PUBLIC PERFORMANCE MEASURES
Improve patients' and families' experiences.	Make the transition from hospital to community-based care options more seamless. Make it easier for patients to move between primary, specialty, and hospital care. Respect, inform and involve patients and families in their care while in hospital. Improve access to community and hospital addiction and mental health services for adults, children and families.	• People Placed in Continuing Care within 30 Days • Percentage of Alternate Level of Care Patient Days • Timely Access to Specialty Care (eReferrals) • Patient Satisfaction with Hospital Experience • Wait Time for Addiction Outpatient Treatment
Improve patient and population health outcomes.	Improve health outcomes through clinical best practices. Improve the health outcomes of Indigenous People in areas where AHS has influence. Reduce and prevent incidents of preventable harm to patients in our facilities. Focus on health promotion and disease and injury prevention with an emphasis on childhood immunization.	• Unplanned Medical Readmissions • Perinatal Mortality Rate Among First Nations • Hand Hygiene Compliance • Childhood Immunization – Diphtheria / Tetanus / acellular Pertussis, Polio, Hib • Childhood Immunization – Measles / Mumps / Rubella
Improve the experience and safety of our people.	Improve our workforce engagement. Reduce disabling injuries in our workforce.	• Workforce Engagement Rate • Disabling Injury Rate
Improve financial health and value for money.	Improve efficiencies through implementation of operational and clinical best practices while maintaining or improving quality and safety. Work toward integrating clinical information systems to create common, comprehensive patient records.	• Nursing Units Achieving Best Practice Targets

Improve Patients' and Families Experiences

51.8% of people were **Placed in Continuing Care within 30 days**

2017-18 Trend: ⬇ — Target 56%

17.4% of bed days were used by people whose care needs could be met by an **Alternate Level of Care**

2017-18 Trend: ⬇ — Target 14%

12 physician specialty services with **eReferral Advice Request** were implemented

2017-18 Trend: ★ — Target 10

81.7% of patients said they were **Satisfied with their Hospital Experience**

Q3YTD 2017-18 Trend: ➡ — Target 85%

90% of people received their first appointment to **Addiction Outpatient Treatment** within **13 Days**

Q3YTD 2017-18 Trend: ⬆ — Target 12 days

Improve Patient and Population Outcomes

13.7% **Unplanned Medical Readmissions** to hospital within 30 days of being discharged

Q3YTD 2017-18 Trend: ➡ — Target 13.4%

8.4 **Perinatal Mortality** rate among **First Nations**

5.5 per 1,000 births **Perinatal Mortality** rate among **Non First Nations**

Gap-> 2016: **4.94** 2017: **2.90**

2017 Trend: ⬆ — AHS' focus is to reduce the gap between First Nations and non-First Nations

85% **Hand Hygiene compliance rate** for AHS Healthcare Workers

2017-18 Trend: ⬆ — Target 90%

77.7% of children received the required dose of **DTaP-IPV-Hib* immunization** by age 2

2017-18 Trend: ➡ — Target 80%

86.9% of children received the required dose of **MMR* immunization** by age 2

2017-18 Trend: ➡ — Target 88%

Improve the Experience and Safety of Our People

3.46 out of 5 Our **Engagement Rates** were above average compared to other Canadian workplaces

2016-17 Next survey in 2019-20

3.88 per 200,000 hours **Disabling injury rate** for the province remained stable from the same period last year

2017-18 Trend: ➡ — Target 3.5

Improve Financial Health and Value for Money

38% of Nursing Units at AHS' 16 largest sites were **Achieving Best Practice Targets**

2017-18 Trend: ★ — Target 35%

Connect Care

Major milestones for Connect Care were met in 2017-18 including CIS contract, governance framework and system design.

Legend - Annual Comparison Trend:

- ★ Target Achieved
- ⬆ Improvement
- ➡ Stable: ≤3% change between compared periods
- ⬇ Area requires additional focus

Annual Comparison compares data from the most recent period to the same time period last year and may or may not indicate statistical significance of the results.

* DTaP-IPV-Hib=Diphtheria / Tetanus /acellular Pertussis, Polio, Haemophilus influenzae type b

* MMR=Measles, mumps, rubella

YTD=Year to date

Improve Patients' and Families' Experiences

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

By improving timely and appropriate access to home care and continuing care living options in Alberta, AHS can improve flow throughout the system, provide more client-centred care, decrease wait time and deliver care in a more cost-effective manner. Timely placement can also reduce the stress on clients and family members.

Enhancing Care in the Community (ECC) is an initiative that focuses on the health and wellness of Albertans and improves access to health services and community-based care. By enhancing care in communities, we can ease pressures on hospitals and build the right services to support our growing and aging population.

AHS, with the support of Alberta Health and a broad stakeholder group, approved and set in motion the ECC strategy and action plan in 2017-18. Projects initiated in the fall of 2017 to support this work, include:

- The expansion of home care programs and services will continue in 2018-19 to enable people to remain safely in their homes for longer.
- The expansion of palliative home care service expansion across the province, including the addition of new teams and programs. In Alberta on average, over 65 people die each day; these programs help support people and their loved-ones to receive supportive palliative and end-of-life care services in all settings.
- An increase in the availability of respite services and adult day program supports through new adult day programs added in Grande Prairie and enhanced respite day programs in communities across the North Zone. AHS implemented a caregiver support and respite program in the Edmonton Zone aimed at providing flexible and meaningful supports.
- Across Alberta, the number of respite home care clients served was 6,018 in 2017-18 (5,861 in 2016-17) and the number of adult day program clients served was 3,843 in 2017-18 (3,716 in 2016-17).
- Implementation of emergency medical service programs to improve access to care in the community and at home (i.e., Community Paramedic Teams, and Assess, Treat and Refer processes).
- The development of Intensive Home Care programs designed to support clients in their homes while awaiting an alternate level of care.
- The Edmonton Zone Virtual Hospital project is incorporating a new operational model for the delivery of specialized transitional care by moving patients and families from hospitals to community in an integrated, collaborative and systematic way.
- The Complex Care Hub at the Rockyview General Hospital in Calgary became operational in February 2018. Its focus is a Hospital at Home-like program with inpatient admission, case management, and collaboration with patients' health home. The model aims to promote collaboration with acute care, the Community Paramedic Program, home care and primary care.
- A palliative home care program was established in the Calgary Zone which focuses on rural areas. This program supports families and caregivers by ensuring resources are available to support end of life care in client's homes.
- Community Support Teams were created to provide urgent care and consultation to complex clients and their care teams living in the community and requiring more intensive services.

As part of ECC, AHS is amending its policies to encourage more rapid discharge into home care for clients who might otherwise be placed on a waitlist for long-term care or designated supportive living. Several zones have begun implementing the policy suite.

In partnership and consultation with First Nations and Métis representatives and the Government of Alberta (Ministries of Health, Indigenous Relations, Seniors and Housing), AHS developed and launched the Continuing Care in Indigenous Communities Guidebook. AHS is committed to supporting Métis and First Nations communities in the development of continuing care services that meet their unique needs.

In 2017-18, there were 121,021 clients with unique needs who received home care, an increase of 1.9 per cent from 2016-17 (118,774 clients).

AHS strives to improve quality of care for continuing care residents and those living with dementia. To support the Alberta Dementia Strategy and Action Plan, AHS continues to implement the following actions.

- Seniors & Continuing Care Provincial Advisory Council was launched in January 2018 to strengthen community engagement and improve the delivery of services to seniors and those in continuing care across Alberta.

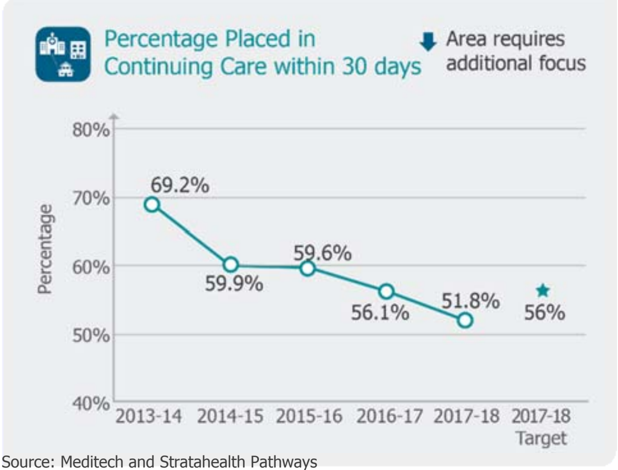
- The Appropriate Use of Antipsychotics initiative, which reduces inappropriate antipsychotic medication use for continuing care residents, was rolled out to all supportive living sites across Alberta.

- AHS is increasing availability and awareness of GPS locator technology for home care clients living with dementia.

- The provincial Housing and Health Services Steering Committee was established to address gaps and opportunities in the quality of residential continuing care services.

Measuring our Progress

People Placed in Continuing Care within 30 Days is the percentage of clients admitted to a Continuing Care Living Option (i.e., designated supportive living levels 3, 4, and 4-dementia or long-term care) from hospital and community within 30 days of the assessed and approved date the client is placed on the waitlist. It monitors the percentage of people moved from hospitals and communities into community-based continuing care settings. The higher the percentage, the better.



Source: Meditech and Stratahealth Pathways

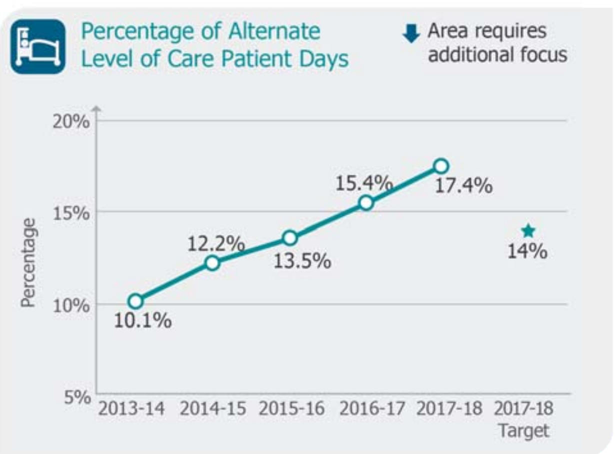
This measure continues to trend downward due to slower than required growth in home care, and continuing care and community living options.

To keep pace with population growth and aging, AHS needs to target increasing community capacity by approximately 1,000 designated spaces annually. In 2017-18, AHS opened 572 net new continuing care beds – more than the entire 2016-17 year (376 new beds).

Since 2010, AHS has opened 6,196 new beds to support individuals who need community-based care and supports (including palliative). Additional continuing care beds were opened in Medicine Hat in October 2017 (100+ beds) and Calgary in April 2017 (200+ beds). *Details on continuing care bed capacity across the province can be found in the Appendix.*

It's expected that new continuing care beds will be filled initially with clients who have been waiting for longer periods of time. As a result, the measure may show a deterioration before improving over the longer term.

Percentage of Alternate Level of Care Patient Days is the percentage of all hospital inpatient days when a patient no longer requires the intensity of care provided in a hospital setting and the patient's care could be provided in an alternate setting. This is referred to as alternate level of care (ALC). If the percentage is high, there may be a need to focus on ensuring timely accessible options for support or care for ALC patients. Therefore, the lower the percentage, the better.



Source: Discharge Abstract Data (DAD) – AHS Provincial

This measure shows a long-term trend towards deterioration year-over-year. The reasons for deterioration are multi-faceted and generally related to challenges in finding appropriate placement or services following hospital discharge. In some areas, this is due to slower than required growth in mental health, home care, continuing care or community care capacity.

By opening new capacity, we have seen an increase in discharges that inflate this rate. Increases in ALC percentage may also be due to a relative increase in patients needing supportive services when discharged to home.

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

Working with our partners, AHS is making changes to improve how patients and their information move throughout the healthcare system.

Primary Healthcare

In September 2017, AHS launched the Primary Health Care Integration Network (PHCIN) – the 15th Strategic Clinical Network (SCN)™ in Alberta. The PHCIN is creating an integrated system across Alberta through supporting home to hospital to home transitions, accessing specialty care and back, keeping care in the community and the system foundations required to make this successful.

PHCIN partnered with the Seniors SCN for a pilot project with five Primary Care Networks (PCNs) in eight communities focused on managing care of those living with dementia in the community.

- The Coalition for Integration was established to stimulate innovative thinking and solutions for integration challenges faced in Alberta. A total of three in-person sessions were held in 2017-18.
- An Integrated Care Partnership (ICP) is a formation of stakeholders who address key challenges and opportunities in health service delivery and work together to achieve a shared outcome. Learning and experiences help inform service provision for PHCIN projects.

> **PCNs** develop solutions to meet the primary healthcare needs of the local communities they serve. There are now 42 PCNs operating throughout Alberta with more than 3,700 family physicians, and more than 1,100 other health practitioners.

Patients Collaborating with Teams (PaCT), a partnership between AHS, the Alberta Medical Association, the Health Quality Council of Alberta and the Alberta Cancer Prevention Legacy Fund, was designed to help primary care teams better support patients to maintain their health. In 2017-18, seven innovation hubs (PCNs that have volunteered to test new ideas) were created.

Alberta Health is working with the Alberta Medical Association and AHS to implement the new PCN Governance Framework to improve integration of PCN services. This includes a Provincial PCN Committee to provide leadership, strategic direction and priorities for five Zone PCN Committees. This framework aligns PCNs and zones to allow for improved system planning.

CancerControl Alberta

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

- Calgary Cancer Centre (Phase 2) is near completion and commencement of Phase 3 will begin in June 2018. The new healthcare facility and academic centre will provide cancer services in southern Alberta.
- Grande Prairie Cancer Centre construction continues as part of the new Grande Prairie Regional Hospital project.
- Construction of the Jack Ady Cancer Centre (Phases 2 and 3) in Lethbridge was completed.
- A replacement linear accelerator (Linac) was installed and operationalized to support cancer treatment in spring 2017 at both the Tom Baker Cancer Centre (TBCC) in Calgary and the Cross Cancer Institute (CCI) in Edmonton. A second Linac was also installed at CCI in March 2018. Construction was completed at TBCC for its second Linac and it is expected to be operational by summer 2018.

Recruitment to support expansion of cancer hematology services was completed in the Central Zone (Central Alberta Cancer Centre) with increased capacity is expected to start in summer 2018. Recruitment at the Jack Ady Cancer Centre and Margery E Yuill Cancer Centre in Medicine Hat is underway.

Improvements were made in end of treatment and transition of care processes for patients who have completed cancer treatment and are returning to a family physician. Improved transition processes were implemented in eight, early stage curative intent populations: breast, prostate, testicular, cervical, endometrial, Hodgkin lymphoma, B Cell, and colorectal cancer.

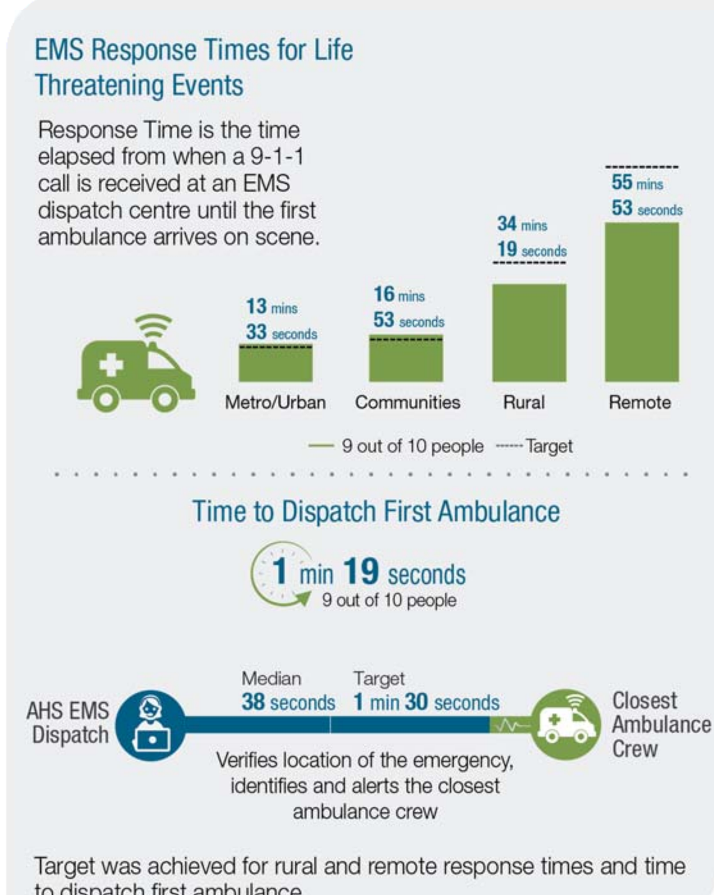
Emergency Medical Services (EMS)

EMS works with health, community and public safety partners to provide quality service in Alberta. Emergency Response and Inter-Facility Transfers are provided by ground ambulance, non-ambulance transfer vehicles, and rotary and fixed-wing air ambulance with service co-ordinated through calltaking and dispatch resources.

EMS highlights in 2017-18 include:

- Electronic Patient Care Record (ePCR) was implemented for all contract operators and direct delivery operators (baseline 15 per cent). ePCR links patient ambulance data with previous patient medical information.
- A helipad upgrade was completed at Rocky Mountain House (August 2017). Jasper, Fort McMurray, and Medicine Hat Regional Hospital upgrades are scheduled for completion in 2018.
- In June 2017, an air ambulance team of AHS and its partners developed Canada's first mobile flight simulation trailer to enable learners to practise and master individual and team skills.
- All ground ambulances are now equipped with power stretchers and load systems. Repetitive patient lifting is one the leading causes of injury to paramedics.
- The Collaborative Dispatch Model was completed in February 2018. The project links AHS-managed dispatch centres with existing dispatch facilities in the Regional Municipality of Wood Buffalo, Red Deer, Calgary and Lethbridge to form a fully integrated dispatch system.
- The new Psychological Awareness and Wellness Support (PAWS) program uses canines to assist EMS responders who experience psychological stress. The team promotes mental wellness to help decrease stigma, increase resiliency and raise awareness about available resources to support employees experiencing a psychological injury.

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



Measuring our Progress

TIMELY ACCESS TO SPECIALTY CARE (EREFERRALS) is the number of implemented physician specialty services with Alberta Netcare eReferral Advice Request. It provides primary care physicians with the ability to request advice from other physicians or specialty services, allowing for better support and timely access to the most appropriate specialist.

The number of specialties using eReferral Advice Request is a cumulative measure. With zone engagement, eight specialty services implemented eReferral Advice Request in 2017-18, for a total of 12 specialties to date.

The 12 specialty services implemented are:

1. Orthopedics – hip and knee (Provincial)
2. Breast Cancer (Provincial)
3. Lung Cancer (Provincial)
4. Nephrology (Edmonton, Calgary)
5. Addiction Mental Health - Opiate Agonist Therapy (Provincial)
6. Endocrinology (Calgary)
7. Gastroenterology (North, Edmonton, Calgary, South)
8. General Internal Medicine (Calgary)
9. Obstetrical/Gynecology (Calgary)
10. Pulmonary (Calgary)
11. Spinal Neurosurgery (Calgary)
12. Urology (Adult) (Edmonton)

In 2017-18, nearly 5,000 eReferral Advice Requests were received by triage facilities. Of the advice requests completed, 38 per cent were provided with advice to continue managing in the community, 60.8 per cent required a referral and 1.2 per cent did not have sufficient information to receive advice.

This work will continue into 2018-19 with a focus on increasing awareness, training new users and implementing additional specialties.

Having more specialties providing advice for non-urgent questions and doing so in an electronic format, may prevent patients from waiting for an appointment they don't need, provide them with care sooner, and support them better while they are waiting for an appointment.

Alberta Netcare eReferral is Alberta's first paperless referral solution and offers healthcare providers the ability to create, submit, track and manage referrals throughout the referral process.

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

AHS strives to make every patient's experience positive and inclusive. AHS continues to apply the Patient First Strategy by empowering and supporting Albertans to be the centre of their healthcare teams. Patient- and family-centred care initiatives were implemented across Alberta to increase the patient voice and participation in care delivery.

- AHS Quality and Safety Summit received the Patients Included designation based on a demonstrated commitment to incorporating patient and family experiences and to co-designing health services together with patient and family advisors.
- Patient First Proclamation was finalized, which illustrates AHS' commitment to patient experiences.
- Leader Rounding Campaign involved AHS management attending clinical rounds to understand how staff are serving patients. Over 85 AHS leaders participated in the challenge and over 100 participants attended a dedicated coaching session to prepare for effective leader rounding.
- Digital Storytelling workshop was hosted in September 2017 where patient advisors crafted digital stories to promote patient- and family-centred care and quality improvement across AHS.
- AHS provides interpretation and translation services to support Albertans whose first language is not English. Usage of telephone interpretation services in 2017-18 increased by 7 per cent compared to last year. Over 1.2 million minutes of over-the-phone interpretation services in 116 languages were accessed.
- Zones rolled-out the Visitation Policy and Family Presence Policy which guides visitation and family presence and recognizes patients and families as partners in care.
- The Alberta Children's Hospital in Calgary participated in the Video Remote Interpretation project which allows patients, clinicians and interpreters to see each other during virtual meetings. This project will be used to inform how best to make this technology available to patients and care teams in other locations across Alberta.

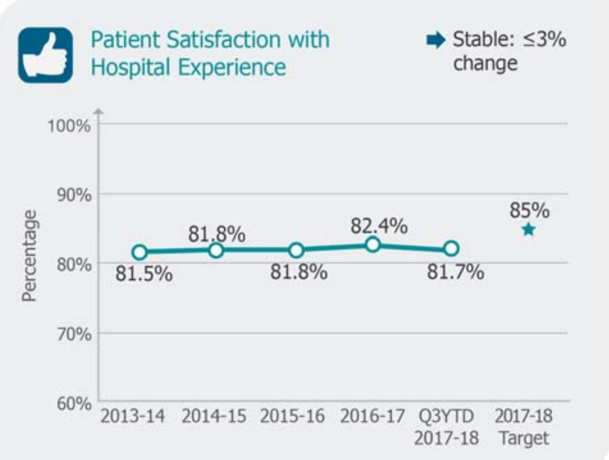
- Commitment to Comfort quality initiative was rolled out to all emergency departments to improve outcomes in pain management and reduce distress for pediatric patients.

- Collaborative Care (CoACT) refers to inter-professional teams working together with patients and families to achieve optimal health outcomes. This work continues to be implemented on over 160 surgery, medicine and mental health units.

- AHS joined the What Matters to You international event that encourages patients, families and clinicians to have conversations about what matters most to them in regard to their healthcare. In June 2017, AHS hosted a live and interactive blog, featuring nine guest bloggers from AHS. Planning for the second event is underway with an emphasis on social media.

Measuring our Progress

Patient Satisfaction with Hospital Experience is the percentage of patients rating hospital care as 8, 9, or 10 on a scale from 0-10, where 10 is the best possible rating. This measure reflects patients' overall perceptions associated with the hospital where they received care. The survey is conducted by telephone on a sample of adults within six weeks of discharge from hospital. The higher the number, the better, as it demonstrates more patients are satisfied. This measure is reported a quarter later due to follow-up with patients.



Source: Canadian Hospital Assessment of Healthcare Providers and Systems Survey (CHCAHPS) responses

This measure has remained stable year-over-year but did not meet target. There are a number of contributing factors that influence performance, such as high occupancies, ALC patients that drive increases in transfers, off-service patients and co-ed patients and staff vacancies. Historically, these issues result in lower satisfaction with care. AHS continues to monitor results and work on team engagement and quality improvement.

AHS has processes in place to review and respond to feedback from patients and families. If a resolution is not possible, a concern will be forwarded to the Patient Concerns Officer (PCO) for review. All reported concerns and commendations are tracked in the Feedback and Concerns Tracking (FACT) database and monitored to identify areas for broader improvement. The table below summarizes the types of feedback and the number of concerns and commendations escalated to the PCO.

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

Includes Covenant Health

AHS measures patient satisfaction in other areas of our healthcare system:

- New surveys for children, youth and their families were designed to help staff better understand emergency room experiences and provide better patient- and family-centred care.

- All cancer sites are using 2017 Patient Reported Outcomes (PRO) and Ambulatory Oncology Patient Experience Survey data to enhance cancer patient experiences.

- Emergency Medical Services (EMS) has a measure patient experience survey. In 2017, 96 per cent of patients agreed with the statement: "Overall, I was satisfied with my experience with EMS."

- A survey was conducted with adult accessing community addiction and mental health services. Results will be released in 2018-19.

- The Health Quality Council of Alberta (HQCA) collaborates with AHS in conducting surveys on Long-Term Care Family Experience (2017), Designated Supportive Living Family & Residents Experience (2016) and Home Care Client Experience (2015). Visit HQCA's website for survey results.

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

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

- In 2017-18, AHS added 54 addiction and mental health spaces in the community to support placement for vulnerable Albertans.
- Diversion refers to the redirection of individuals with mental illness from the criminal justice system, whenever appropriate, to mental health, social and support services. Provincial Mental Health Diversion Standards were completed and will be implemented in ten locations.
- Primary care physicians and nurse practitioners helping Albertans with problematic opioid use can now consult with an on-call specialist for advice on treatment and prescription alternatives, as well as treating patients with existing opioid dependency.
- The Calgary Zone Community Paramedic Program created the City Centre Team mobile paramedic program to provide better access to health services for people living with homelessness. The number of patient events in 2017-18 was 1,743, compared to 886 events in 2016-17.
- Construction is underway to implement a new 24/7 addiction and mental health Urgent Care Centre on a designated hospital site, including centralized intake for adult clients in the Edmonton Zone. It is expected to be completed in fall 2018.

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

- New Opioid Dependency Treatment clinics were opened in Grande Prairie, Centennial Centre for Mental Health and Brain Injury in Ponoka, High Prairie, Sherwood Park, Northgate (Edmonton). In addition, expansion plans are already underway new services in High Prairie, Bonnyville and Edmonton.
- Mental Health Virtual Health provides a variety of clinical mental health services to clients using technology. These services include consultation, case review, treatment, counselling, and other supportive care. The number of patient encounters within Mental Health Virtual Health for 2017-18 was 11,326, a slight increase from 2016-17 (11,179).
- The Centennial Centre for Mental Health and Brain Injury, which operates a Rural Opioid Dependency Program, provides access to opioid dependency treatment to 56 communities across rural and suburban Alberta as a telehealth service.
- The expansion of existing programs in Fort McMurray, Calgary and Edmonton are underway. Services are also provided in Cardston and through Telehealth in Ponoka, Wetaskiwin, Rocky Mountain House, Stettler, Camrose, Wainwright, Sylvan Lake, Olds and Drayton Valley.
- The number of unique clients in AHS Opioid Dependency Programs increased by almost 50 per cent from 1,664 in 2016-17 to 2,464 in 2017-18.
- Provincially, there are 1,500 sites distributing naloxone, including community pharmacies, harm reduction agencies, emergency departments and urgent care. More than 42,000 naloxone kits were dispensed in 2017-18 (nearly 11,000 kits dispensed in 2016-17).
- Based on AHS data collected since January 2016, over 3,600 overdose reversals (naloxone administered to reverse effects of an opioid overdose) were voluntarily reported in Alberta.

- A national guideline was released that described strategies for treatment of opioid use disorders and recommended Suboxone® as the preferred treatment. To align with the guideline, the Emergency SCN™ is developing a province-wide strategy that will enable effective transfers to community or primary healthcare providers for follow-up and patient care.

- In response to the opioid crisis, work on a pan-SCN™ pathway (opioid dependency treatment, acute pain management and chronic non-cancer pain management) is underway. Funding from Health Canada was awarded and work will commence in the fall of 2018.

The percentage of children offered scheduled community mental health treatment within 30 days dropped to 74 per cent in 2017-18 compared to 81 per cent in 2016-17. Time is measured from referral to first offered appointment with a mental health therapist. Many initiatives are underway to enhance access to children's addiction and mental health services, including:

- In addition to the opening of the Access Open Minds clinic, zones are recruiting mental health therapists for services in schools and child psychiatrists in community clinics to enhance access to psychiatric consultations for children.

- Rural areas are investigating the use of alternative methods, such as telehealth and peer support networks, to provide and support children's mental health services.

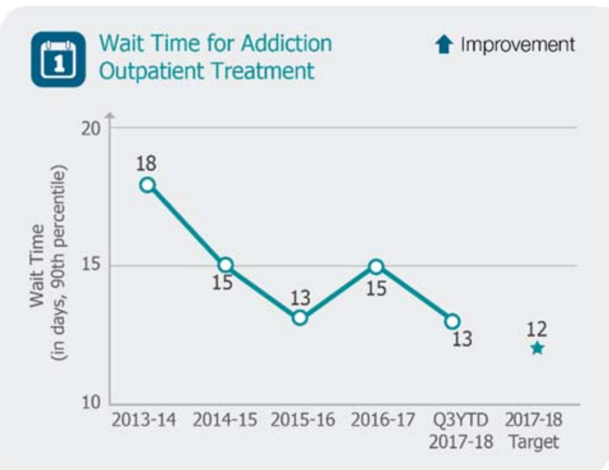
- Mental Health Capacity Building in Schools provides services to over 65,000 students in 182 schools and 85 communities. Over 3,800 referrals were made to community-based services and over 900 to intensive treatment since September 2017.

- SCNs™ are creating a 'journey map' of what children, youth and their families with addiction and/or mental health issues experience in the emergency department to identify areas of improvement.

- SCNs™ are also working across ministries on a full-continuum model of school mental health.

Measuring our Progress

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



Source: AHS Addiction and Mental Health

For this measure, the lower the number, the better, as it demonstrates people are waiting a shorter time to receive adult addiction outpatient services. The most recent data is a quarter behind the reporting period due to various reporting system timelines.

Wait times for outpatient addiction treatment has shown improvement compared to last year. Work continues to address issues related to the complexity and acuity of cases referred and wait times in areas without walk-in clinics.

Wait times can be influenced significantly by service models used, particularly in rural and remote areas. For example, the use of traveling clinics and services that are not operated five days a week can result in shorter wait times. Additionally, wait times can increase with staff vacancies. Although, there are challenges with recruiting and retaining staff in remote communities, active recruitment is underway.

Improve Patient and Population Health Outcomes

Improving health outcomes through clinical best practices.

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

Strategic Clinical Networks™

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

This year, SCNs™ celebrated their five-year anniversary of health innovation. Since 2013, AHS has expanded from six to 15 SCNs™.

1. Addiction and Mental Health
2. Bone and Joint Health
3. Cancer
4. Cardiovascular Health and Stroke
5. Critical Care
6. Diabetes, Obesity And Nutrition
7. Digestive Health
8. Emergency
9. Kidney Health
10. Maternal Newborn Child & Youth
11. Population, Public and Indigenous Health
12. Primary Health Care Integration Network (New!)
13. Respiratory Health
14. Seniors Health
15. Surgery

SCNs™ are continually embarking on innovative initiatives to help reduce inappropriate variation, apply consistent clinical standards and improve health outcomes. Many of these are cited throughout this report; additional highlights for 2017-18 include:

- The Provincial Breast Health Initiative improves breast cancer care through the use of provincial pathways (diagnostic assessment, same-day mastectomies and breast reconstruction surgery). This work included completing an education package, launching a patient experience survey, and implementing a pathway to expedite referrals and consults for highly suspicious breast lesions. Performance in the third quarter of 2017-18 indicates the percentage of mastectomies performed as same-day surgery improved to 41 per cent (from 27 per cent in Q3 2016-17).
- Starting Dialysis on Time at Home on the Right Therapy Project (START) aims to maximize the safe and effective use of peritoneal dialysis, ensure patients are starting dialysis at the appropriate time, improve outcomes and experiences and reduce healthcare costs. Thirty-two per cent of new patients received peritoneal dialysis within six months of starting dialysis therapy.
- Many Primary Care Networks and Alberta Kidney Care North are implementing the diabetes foot care clinical pathway which aims to improve diabetes foot screening rates, early identification and treatment of foot problems and patient self-care recommendations thereby reducing risks of developing a diabetic foot ulcer and amputations.

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

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

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

Research and Innovation

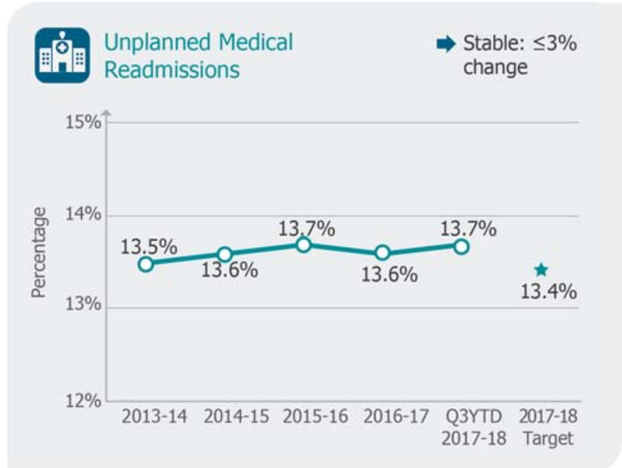
AHS continues to increase capacity for evidence-informed practice and policy through enhanced data sharing, research, innovation, health technology assessment and knowledge translation.

- To date, 39 per cent of Partnership for Research and Innovation in the Health System (PRIHS) funding was allocated to care in the community (Enhancing Care in the Community).
- Release 1 of the Health Analytic Portal (HAP) went live in August 2017 to allow stakeholders to register and interact with selected published reports. The next release was also completed, allowing authorized users to upload client data to the HAP and have data from the Discharge Abstract Database (DAD) and National Ambulatory Care Reporting System (NACRS) made available for download.
- The Strategic Clinical Networks™ supported multiple projects in the new innovative Strategy for Patient Orientated Research (SPOR) CIHR Rewarding Success Initiatives. Three of these projects have moved forward to the next round of the competition. All three have the potential to improve the health system in Alberta through implementation of patient oriented system changes.

AHS supports a tremendous amount of research studies across Alberta to generate the evidence needed to deliver patient-focused, quality care. AHS and its partners at Alberta's academic institutions and affiliated research institutes work together to implement an integrated model of health research. This past year, Alberta's ethics board approved 1,650 studies that needed access to AHS patients, data or services, such as laboratory tests. Our partnerships with Alberta's universities is critical to delivering the best care to our patients and families, both today and tomorrow.

Measuring our Progress

Unplanned Medical Readmissions is the percentage of medical patients with unplanned readmission to hospital within 30 days of leaving the hospital. This excludes admissions for surgery, pregnancy, childbirth, mental health diseases and disorders, palliative care and chemotherapy for cancer. The lower the percentage, the better as it demonstrates that fewer people are being readmitted shortly after discharge. The most recent data is a quarter behind the reporting period due to various reporting system timelines.



Source: Discharge Abstract Data (DAD) – AHS Provincial

Unplanned medical hospital readmission rates remain stable year-over-year.

In most cases, medical readmissions are primarily driven by patients with complex health needs, such as chronic obstructive pulmonary disease (COPD), heart failure and pneumonia. AHS is working on several initiatives to help reduce these types of readmissions.

- AHS works with Primary Care Networks to ensure services are in place for complex patients, such as Patients Collaborating with Teams (PACT) and Bridging the Gap which determines solutions for discharge and transition of patients with complex health needs to community family practices.
- The following clinical pathways were implemented in the zones: COPD and heart failure, Enhanced Recovery After Surgery (ERAS), hip and knee replacement pathway, and delirium in intensive care units.

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

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

Working together with the AHS Wisdom Council, Indigenous communities and government, Indigenous health services are delivered throughout the province with the goal of providing an effective, patient-centred approach to improving care to First Nations, Métis and Inuit Peoples and communities.

Engagement and Cultural Sensitivity

Community engagement sessions were held with Indigenous groups in Alberta to support the enhancement of the Indigenous Health Program, the Indigenous Wellness Clinic in Edmonton and the Elbow River Healing Lodge in Calgary.

Recruitment of teams is underway to focus on process improvement strategies on the High Prairie Health Complex project to improve cultural safety for First Nations, Métis and Inuit patients, families and communities.

As of March 31, 2018, 31 physicians in three urban settings and 11 communities are part of the Alternate Relationship Plan which provides physician services and increases access to primary care in First Nations and Métis communities.

AHS leadership was encouraged to complete cultural competency training sessions to gain better awareness on how to appropriately provide care to Indigenous patients and families.

In 2017-18, 37 per cent of senior leaders completed the Indigenous Awareness and Sensitivity training and 20 per cent completed the Indigenous Peoples in Alberta Introduction. Additional curriculum on Indigenous Peoples and history was also developed for new employee orientation.

AHS is promoting the implementation of the Truth and Reconciliation Commission Calls to Action and United Nations Declaration on the Rights of Indigenous Peoples across AHS. Approximately 225 AHS senior leaders attended the Truth Always session in October 2017 and participated in a blanket ceremony that helped create awareness about Canadian history from an Indigenous perspective. In addition, four listening day sessions were held.

Program Development

AHS and the Alberta Cancer Prevention Legacy Fund (ACPLF) continue to work together with Indigenous partners to promote prevention and screening initiatives for Indigenous Peoples.

- The First Nations Cancer Prevention and Screening Practices Project, the Alberta First Nations Information Governance Centre and the ACPLF are supporting First Nations communities to develop, implement and evaluate comprehensive prevention and screening plans. Three communities (Peerless Trout, Maskwacis, and Blood Tribe) are working on actions to improve cancer prevention awareness and screening. Evaluation results indicate that all partners and team members are confident the approach has strengthened relationships.

- Alberta Healthy Communities Approach (AHCA) supports communities to plan, implement and evaluate comprehensive prevention and screening interventions. To date, three Métis Settlements have joined the 16 Alberta communities already implementing AHCA. The ACPLF is working with Alberta's Métis Tri-Settlements to pilot the community assessment and planning tools for culturally appropriate and safe application. All Tri-Settlements are also working collaboratively through the creation of a community wellness team that delivers training and provides new opportunities to share knowledge and learnings.

- With support from the ACPLF and Toward Optimized Practice, the Elbow River Healing Lodge has successfully implemented an adapted version of the Alberta Screening and Prevention (ASaP) Program. Improvements were demonstrated including increased cancer screening rates for colorectal cancer (42 per cent), mammography (16 per cent) and Pap tests (6 per cent). Plans are in place to expand ASaP to three additional sites in 2018.

- Zone Comprehensive Prevention and Screening Approach is piloting a framework to reduce cancer risks and promote health across the North Zone. Central to the coordinated approach is mobile outreach to remote and isolated communities to bring prevention and screening services to the communities, as well as to strengthen health promotion and prevention in culturally safe ways. As a result, 10 community outreach visits were provided to Indigenous and non-Indigenous communities where more than 10 per cent of the population self-identified as Indigenous in the North Zone.

AHS also supports improvement of women's health and of maternal, infant, child and youth health including Indigenous Peoples and vulnerable populations.

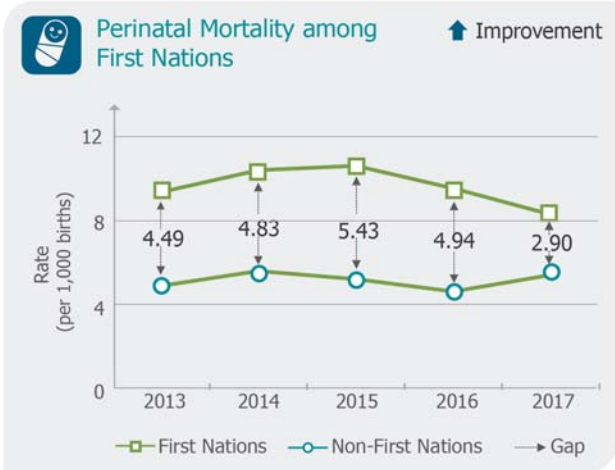
- Normal Postpartum and Newborn Clinical Pathway was implemented at 47 out of 50 acute care hospitals in Alberta that provide obstetrical services.

- Police and Crisis Team (PACT) program provides clinical assessment and interventions for vulnerable individuals presenting to police with addiction and mental health concerns.

- AHS is supporting the design and implementation of MyCHILD Alberta to increase data capacity to improve outcomes and optimize public sector policies for women and children.

Measuring our Progress

Perinatal Mortality among First Nations is the number of perinatal deaths per 1,000 total births among First Nations. A perinatal death is a fetal death (stillbirth) or an early neonatal death. This indicator provides important information on the health status of First Nations pregnant women, new mothers and newborns and enables AHS to develop and adapt population health initiatives and services. The measure does not include all Indigenous populations, such as Inuit and Métis residents.



Source: Alberta Vital Statistics and Alberta First Nations Registry

As demonstrated in the graph, results for 2017 indicate that AHS is reducing the gap in perinatal mortality among First Nations compared to Non-First Nations from 4.94 deaths in 2016 to 2.90 deaths (per 1,000 births) in 2017.

Examples of projects that support improving perinatal mortality among First Nations:

- Merck for Mothers uses community-based ways to enhance the support of pregnant Indigenous women to overcome barriers to prenatal care. Three initiatives are underway: Maskwacis in the Central Zone focuses on building resilience, promoting positive images of the community, celebrating birth and sharing Indigenous knowledge on pregnancy; Pregnancy Pathways in Inner City Edmonton provides safe housing and support services for pregnant Indigenous homeless women; and Little Red River Cree in the North Zone provides a community-based support model for maternal health.

- The development of an antenatal care pathway is underway to support the maternity services corridors of care initiative so expectant mothers can access evidence-based consistent antenatal care across the province.

- Work continues to support development of midwifery care service models for Indigenous and vulnerable populations through community and stakeholder engagement.

- The establishment of midwifery privileges at the Elbow River Healing Lodge in Calgary supports access to obstetrical services for Indigenous, vulnerable and rural populations.

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

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

Work is underway to finalize the Patient Safety Strategy that will articulate how to make significant improvement in patient safety. A policy suite was completed with a focus on recognizing and responding to hazards, close calls and clinical adverse events.

AHS is working to complete the implementation of all of the recommendations by the Health Quality Council of Alberta (HQCA) related to parenteral nutrition. Parenteral nutrition (intravenous feeding) is given to vulnerable patients and is classified as a high-alert medication because significant harm may occur when used incorrectly or without regard for accepted leading practice standards.

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

AHS continues to monitor the rates of hospital-acquired infections to ensure appropriate actions are taken when rates increase. In 2017-18, rates for Hospital-acquired *Clostridium difficile (C-diff)* infection (3.0 per 10,000 patient-days in 2017-18 compared to 3.4 in 2016-17) and Methicillin-resistant *Staphylococcus aureus* Bloodstream Infection (0.15 per 10,000 days in 2017-18 compared to 0.19 in 2016-17) saw improvement.

There was an overall reduction in Defined Daily Doses (DDD)/100 patient days for the aggregate of 14 select antimicrobials associated with high risk of *Clostridium difficile (C-diff)* Infection at select sites (from a three-year baseline of 22.36 to 21.35 in Q3 2017-18).

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

- The Antimicrobial Stewardship program includes the use of standardized physician-patient care orders implemented at the time of *C-diff* diagnosis to ensure appropriate treatment.
- Infection prevention and control standards support front-line healthcare workers to promote the use of order sets, follow-up on case severity, and provide feedback on case management.
- Zones continue to implement initiatives targeted at reducing utilization of the 14 select antimicrobials associated with a high risk of *C-diff* infection.
- AHS launched a provincial initiative targeted to optimize urine tests and reduce antibiotic use.
- Roll-out of standardized hospital disinfectant products began in January 2018 with the Central Zone.
- Infection Prevention and Control continually works collaboratively with clinical partners to assess individual *C-diff* cases with a focus on improving care management.

Measuring our Progress

Hand Hygiene Compliance is the percentage of opportunities in which healthcare workers clean their hands during the course of patient care. Healthcare workers are observed by trained personnel to see if they are compliant with routine hand hygiene practices according to the Canadian Patient Safety Institute's "4 Moments of Hand Hygiene". The higher the percentage, the better, as it demonstrates more healthcare workers are complying with appropriate hand hygiene practices.

Source: AHS Infection, Prevention and Control Databasse

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

Overall, there was continued and sustained improvement in provincial hand hygiene rates in 2017-18 compared to last year. While normal fluctuations in compliance are anticipated, downward trends in compliance rates are monitored and investigated. In some cases, the drop in compliance at a site is due to an increased proportion of observations occurring within a unit or program identified to be struggling with hand hygiene compliance.

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

- AHS Infection Prevention and Control Hand Hygiene program launched a call to action on Global Handwashing Day in October 2017 to increase hand hygiene awareness and shift the focus to site-based reviewers.
- Staff were asked to submit videos of coworkers who go above and beyond the call of duty for hand hygiene. The videos will be used to create a video montage, which will be released on Stop! Clean Your Hands Day in May 2018.
- A leadership toolkit was approved and is expected to be released early 2018-19 to provide leaders with a framework that aims to connect hand hygiene improvement initiatives with existing AHS resources.
- Zones continue to recruit site-based hand hygiene reviewers to foster ownership and accountability for hand hygiene improvement in healthcare workers.

Focusing on health promotion & disease and injury prevention.

Screening

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

- Screen Test Mobile Clinics offered screening mammography services to over 18,000 women in 110 communities, including 20 First Nations communities and five Metis settlements in 2017-18.
- Overall, over 800,000 Albertans were screened for breast, cervical or colorectal cancer.

AHS also plays an important role in supporting screening initiatives across the province.

- Early Hearing Detection and Intervention (EHDI) was implemented in all 13 neonatal intensive care units. EHDI offers screening to newborns for hearing prior to discharge.
- The Surfacing Population, Public and Indigenous Health Data for Action project makes cancer screening status available on Netcare for primary care providers to rapidly identify and support Albertans who are under-screened.

Environmental Risks and Hazards

AHS has completed the first year of a three-year project to streamline meat processing facility inspections. As of March 31, 2018, 74 per cent of meat processing facilities were inspected using the new baseline assessment and inspection tool: North Zone (46 per cent), Edmonton Zone (84 per cent), Central Zone (61 per cent), Calgary Zone (80 per cent), and South Zone (100 per cent).

Outbreak Management

AHS and Alberta Health are working with the zones to ensure a consistent approach to disease outbreak notification, management and reporting including:

- Participating on a national Outbreak Investigation Co-ordinating Committee, contributing unique surveillance data to help identify contamination of flour with E. coli which led to a nation-wide recall.

- Revising the provincial food-borne illness outbreak protocol with partners (i.e., Alberta Agriculture and Forestry, Alberta Health, and Canadian Food Inspection Agency).
- Participating on the Outbreak Investigation Co-ordinating Committee to manage assessment calls associated with raw oyster consumption and norovirus; frozen breaded chicken and salmonellosis; and outbreaks relating to E coli and foods containing pork from a single producer.
- Consultations with sites that experienced outbreaks helped inform revisions to AHS' Department Standard Operating Procedures and Outbreak Guidelines. Some of the communicable disease outbreaks managed were for infectious gastroenteritis, influenza-like illness, mumps and pertussis.

Chronic Disease Prevention and Management

The Chronic Condition and Disease Prevention and Management vision was completed, including holding webinars with approximately 130 attendees. AHS is working on developing an Alberta Chronic Disease Inventory, which is a searchable listing of programs, services and resources focused on chronic disease prevention and management.

Reporting on the Chronic Disease Management Office of the Auditor General (OAG) was submitted with over 100 documents. An action plan for completing the current phase of the audit is under development. Progress continues on the OAG recommendations.

Promotion and Prevention

AHS provides consultation, facilitation, planning support and resource development to prevent addiction.

- AHS supported 30 funded community coalitions across the province to focus on preventing and reducing substance use harms.
- AHS and its partners provided 294 workshops to 3,417 participants to support psychosocial recovery for those affected by recent disasters, which included train-the-trainer sessions and versions for schools and Indigenous communities. The AHS Provincial Mental Health Promotion and Illness Prevention team was recognized nationally for this work.
- A refresh of AHS' Harm Reduction for Psychoactive Substance Abuse policy was completed.
- A total of 11 Developmental Pathways InRoads training modules were developed for AHS and external providers.

Immunization

The influenza immunization rate for AHS healthcare workers for 2017-18 was 66 per cent, an increase of 1.7 per cent from the previous year. The overall influenza immunization rate for Albertans is 29 per cent in 2017-18 – an increase of 1.1 per cent.

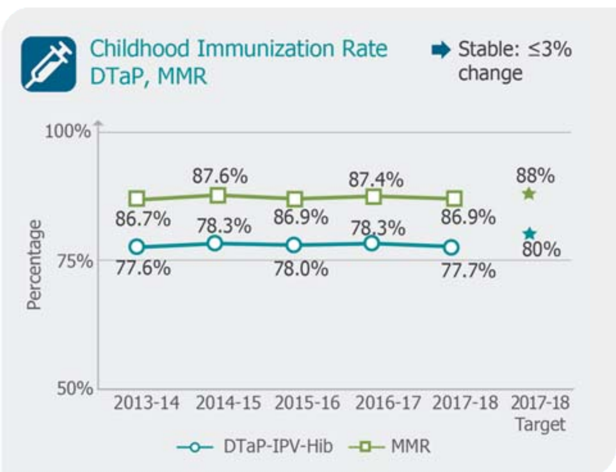
The 2016-2020 Alberta Sexually Transmitted Blood-Borne Infections (STBBI) Operational Strategy and Action Plan began development in spring 2016, engaging over 350 stakeholders across the province including First Nations' communities and Metis settlements. The STBBI will increase awareness and accessibility of STBBI treatment services across the province. Five work streams have been established to develop recommendations.

> Rotavirus immunization coverage rates in infants was 81 per cent in 2017-18 (compared to 80 per cent in 2016-17).
>
> Human Papilloma Virus (HPV) vaccine administration (2016-17).
> - Grade 5 – boys 67 per cent, girls 67 per cent
> - Grade 9 – boys 70 per cent, girls 82 per cent

Measuring our Progress

Childhood Immunization is the percentage of children who have received the required number of vaccine doses by two years of age. The higher the percentage, the better, as it demonstrates more children are vaccinated and protected from preventable childhood diseases.

- Diphtheria / Tetanus /acellular Pertussis, Polio, Hib (DTaP-IPV-Hib) - 4 doses
- Measles / Mumps / Rubella (MMR) - 1 dose



Source: Province-wide Immunization Program, Communicable Disease Control

Immunization rates in 2017-18 were steady. AHS continues to raise awareness on the importance of immunization in geographical areas where immunization rates are low.

Improve the Experience and Safety of our People

Improving our workforce engagement.

Our People Strategy guides how we put our people first, thereby improving patient and family experiences.

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

- A Diversity and Inclusion initiative was launched with training, communication materials, networking opportunities, consultation and changes to physical environments.
- AHS has developed information and resources for patients, families and healthcare providers about sexual and gender minority, including the Guide to Creating Safe and Welcoming Places for Sexual and Gender Minorities (LGBTQ+) People. The guide is available on the LGBTQ+/Sexual and Gender Diversity page on the AHS website.
- A new online forum, Your Voice Matters, was launched for staff to share thoughts and provide input on topics, such as the AHS Diversity & Inclusion Plan.

Measuring our Progress

AHS Workforce Engagement is calculated as the average score of our workforce's responses to AHS' Our People Survey.

Monitoring workforce engagement enables us to determine the effectiveness of processes/programs that support employee engagement and strengthen a patient safety culture.

The rate shows the commitment level the workforce has to AHS, their work, and their manager and co-workers. The higher the rate, the more employees are positive about their work.

More than 46,000 individuals – including nurses, Emergency Medical Services, support staff, physicians, midwives and volunteers – participated in the Our People Survey in 2016. AHS' workforce engagement was 3.46 on a five-point scale (5 indicates highly engaged). Based on a question asking how satisfied people are with AHS as a place to work: 57 per cent of respondents felt positively, 40 per cent felt neutral, and 3 per cent felt negatively.

An "accountability" pulse survey (Our People Pulse Survey) was conducted in November 2017. This survey did not measure engagement but assessed use of the 2016 Our People Survey results to identify and act on ways to improve engagement locally. While generally positive, our employees indicated there is room for improvement.

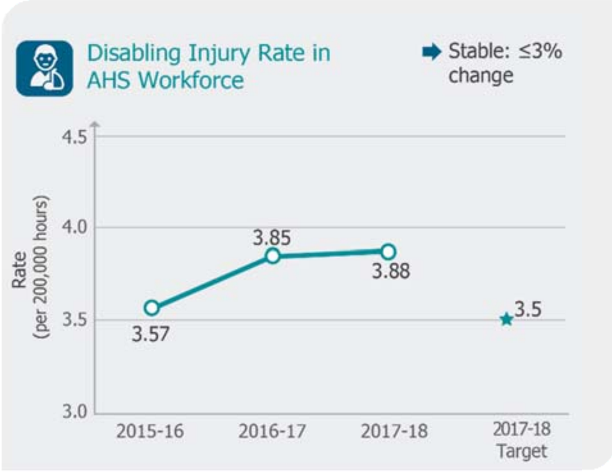
Reducing disabling injuries in our workforce.

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

All new leaders are required to complete Leading Health and Safety in the Workplace: Fundamentals training. This course supports Our People Strategy, equipping leaders with the knowledge to create safe, healthy and inclusive workplaces. As of March 31, 2018, 22 per cent of AHS leaders have completed the course.

Measuring our Progress

Disabling Injury Rate (DIR) is the number of AHS workers injured seriously enough to require modified work or time loss from work per 200,000 paid hours (approximately 100 full-time equivalent workers). This rate indicates the extent to which AHS experiences injury in the workplace and enables us to identify health and safety programs that engage our people in creating a safe, healthy and inclusive workplace. The lower the rate, the fewer disabling injuries are occurring at work.



Source: AHS Workplace Health and Safety

DIR remains stable when compared to last year but several zones deteriorated largely due to an increase in occupational related exposures in a more severe influenza (flu) season.

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

- Power cots and load systems were installed in all ambulances to reduce the frequency of front-line crews having to physically lift patients.
- AHS supports operational areas to ensure staff are appropriately trained on It's Your Move and Move Safe ergonomic programs, which aim to prevent lifting and handling injuries.
- The Communicable Disease Assessment policy was implemented for new AHS employees on April 1, 2017, to ensure employees are assessed for their risk of communicable disease. Uptake and compliance has been positive.

AHS is also committed to providing psychological safety with an increased focus on aggression and violence in the workplace.

- There were over 3,400 workplace violent incidents reported in 2017-18 (56 per cent increase from 2016-17). Of all violent incidents, 97 per cent were patient-to-worker and 7 per cent resulted in a lost time injury at the time of reporting. AHS expects to see a continuing rise in reported incidents of violence due to increased efforts to ensure incidents are reported.
- A psychological safety toolkit and resources are available to help leaders work with their teams to feel safe. AHS piloted communication tools across 16 units in September 2017 for teams that care for patients who pose a higher risk of aggression or violence.
- Road to Mental Readiness (R2MR) was developed by the Mental Health Commission of Canada, the Canadian Armed Forces, and the Calgary Police Service. R2MR addresses the stigma related to mental illness and establishes resiliency among employees and leaders. In 2017-18, 97 per cent of EMS staff completed R2MR training.
- Opioids: Illicit Fentanyl Awareness is a new online course that was made available to staff in December 2017 to help employees recognize fentanyl and other illicit opioids and assess risk of exposure and response, as well as determine appropriate personal protective equipment.

Improve Financial Health and Value for Money

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

AHS supports strategies to improve clinical appropriateness of care, support service delivery, and focus on operational best practices to gain efficiencies while maintaining or increasing quality of care.

Appropriateness of Care

Advanced diagnostic imaging tests, such as CT scans, MRIs and ultrasounds have dramatically changed the way patients are diagnosed and treated. These advancements have resulted in improved, more efficient, and more effective patient care.

AHS has implemented a number of projects aimed at promoting clinical appropriateness. Examples include:

- AHS saw a 13 per cent decrease in CT lumbar spine exams performed in 2017-18 compared to 2016-17. A lower value demonstrates improved efficiencies.
- Dose banding/rounding of tinzaparin (rounding the prescribed dose to a safe, effective dose that can be delivered by pre-filled syringes) reduces the need for multi-dose vials which reduces waste.
- AHS is working with medical staff to develop quality metrics which will allow clinicians to get a snapshot of their medical practice and see how they compare with their peers.

Strategic Clinical Networks™ (SCNs™) have demonstrated increased efficiencies, improved health outcomes, and reduced costs across Alberta by generating innovation and implementing best evidence into practice. Some of these projects and their successes are outlined in the table below.

SCN™ Project	Benefits/Outcomes
Access for Referral & Triage e-Referral	Improved efficiency in scheduled health services, increasing accessibility and reducing wait times for scheduled services.
Adult Coding Access Targets for Surgery (aCATS)	Positive impact on surgical demand improving access, ensuring more efficient utilization of operating room time.
Appropriate Use of Antipsychotics (AUA)	Reduction in inappropriate use of antipsychotic drugs in long-term care facilities.
Enhance Recovery after Surgery (ERAS)	Reduction in post-surgical complications rate and severity; earlier patient mobilization and improved patient nutrition status all leading to net reduction in system cost per surgical case.
Fragility and Stability	Designed to support the use of Primary Care Network and family physician model to keep patients in their communities and to provide co-ordination of care and prevention strategies.
National Surgery Quality Improvement Program (NSQIP)	Improvements in post-operative outcomes including a reduction in complication rates and re-admission rates, and improved patient safety. As a result, there was a reduction in healthcare costs.
Safe Surgery Checklist	Reduction in the number of preventable errors and adverse events during surgical procedures.
Stroke Action Plan	Improvement in use of stroke order sets, decrease in length of stay for acute stroke patients and increased access for rural areas.
Vascular Risk Reduction	Reduction of overall cardiovascular risk due to improved capacity building with community pharmacies, primary healthcare providers and physicians.

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

Provincial Laboratory Services

The Government of Alberta announced in December 2017 a new provincial laboratory services entity that will help improve the quality and timeliness of care for Albertans. A provincial lab system is a cost-effective, efficient model that will bring together similar diagnostic services and research under one organization for better collaboration and improved integration.

The consolidation of lab services (which includes Calgary Lab Services, Covenant Health, the Provincial Laboratory for Public Health, Lamont Health Care Centre and eventually Dynalife) into an AHS wholly-owned subsidiary will leverage existing infrastructure, accounting systems and corporate services, while optimizing innovation in laboratory diagnostics to accommodate growing demands.

To support this transition, an interim board and CEO has been established. This approach to lab governance was one of the recommendations made by the Health Quality Council of Alberta to improve lab services.

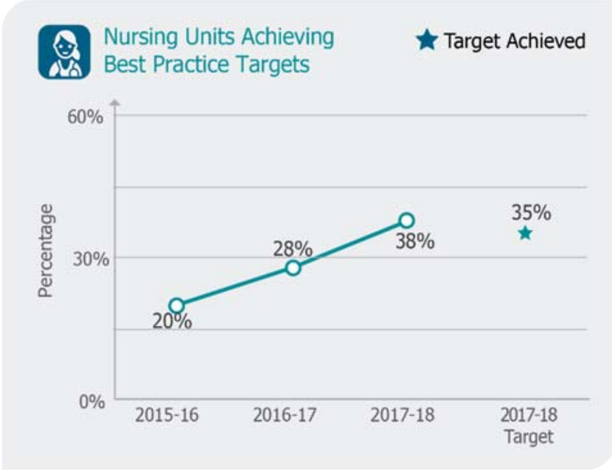
Service Planning

AHS was engaged in a number of planning activities in 2017-18 to support service delivery, for example:

- Zone Healthcare Plans for Calgary and Central Zones were completed and will be formally submitted to Alberta Health in 2018-19. A Red Deer Regional Hospital Centre capital needs assessment is in development, in alignment with the Central Zone Healthcare Plan.
- Through a joint Alberta Health/AHS agreement, the Service and Access Guidelines initiative has been put on formal pause due to competing priorities related to Connect Care, Enhancing Care in the Community and PCN Governance.
- Provincial Interventional Cardiac Service Plan identifies the need for cardiac services in a co-ordinated and evidence-based approach. A needs assessment and options analysis overview were completed.

Measuring our Progress

Nursing Units Achieving Best Practice Targets is the percentage of nursing units at the 16 busiest sites meeting labour targets. Using comparative data from across the country, targets were designed to achieve more equitable service delivery across the province. This measure helps to monitor leadership's ability to meet targets and reduce variations in the cost of delivering high quality services at AHS sites.



Source: AHS Finance Statistical General Ledger (STAT GL)

Operational Best Practice compares healthcare delivery costs within Alberta, as well as with healthcare systems across Canada, to ensure we are efficient and focused on quality care.

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

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

Connect Care is the bridge between information, healthcare teams, patients – and the future. The foundation of Connect Care is a common clinical information system, which will directly impact everyone who provides patient care within AHS. It will be implemented provincially over time in order to allow our facilities time to prepare for this transformation.

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

Measuring our Progress

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

- AHS Board approved a contract agreement with Epic Systems Corporation, which came into effect in October 2017.
- A new governance structure was established with a Terms of Reference.

Connect Care met its major milestones for 2017-18. This includes high-level completion of scoping, groundwork, direction setting, technical training and much of the core clinical system design. Next year will be focused on building and configuring the system.

Connect Care – Direction Setting

In February 2018, more than 2,400 AHS staff, physicians, volunteers and patient advisors from across Alberta came together in Edmonton to start designing the CIS at the first of a series of Direction Setting sessions. The second session took place in March and the third and final session was in April.

The sessions helped decide how Connect Care will support commonly used workflows (tasks performed when providing patient care). Participants representing programs, care settings, and clinical and operations teams were guided through a series of questions and made decisions on how these workflows and processes are designed into the CIS.

Significant progress was made at the session in February; the aim was to have approximately 65 per cent of the decisions needed on workflows made by the participants. In fact, consensus was reached on 79 per cent of the decisions presented.

After six years of committed effort, the Meditech Optimization Program was completed in a collaborative effort with many stakeholders, including physicians. The project involved the implementation of eight platforms (e.g. operating room scheduling) to support better access to information between providers, improved efficiency and increased savings in paper and storage costs. This work also helped position thousands of end-users to be better prepared for the transition to Connect Care.

AHS is supporting Alberta Health in enhancing and expanding Alberta Netcare and the Personal Health Portal to assist Albertans in taking an active role in managing their health. Alberta Netcare is a secure and confidential electronic system of Alberta patient health information collected through a point of service in hospitals, laboratories, testing facilities, pharmacies and clinics. Access is restricted to registered healthcare providers working as an accredited Alberta healthcare provider. In 2017-18, the number of enabled sign-ons increased by 19 per cent (50,477 users) compared to 2016-17.

MyHealth.Alberta.ca is an online website available for public access to healthcare information about health conditions, healthy living, medications, tests and treatments. In 2013-14, there were 1.5 million online visits. This has grown to 8.5 million visits in 2017-18.

Financial Information

- Financial Statement Discussion and Analysis
- Consolidated Financial Statements
- Compensation Analysis and Discussion

Financial Statement Discussion and Analysis For the year ended March 31, 2018

This Financial Statement Discussion and Analysis (FSD&A) provides a financial overview of the results of Alberta Health Services' (AHS) operations and financial condition for the year ended March 31, 2018. In particular, the FSD&A reports to stakeholders how financial resources are being managed to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans. It serves as an opportunity to communicate with stakeholders and other report users regarding AHS' 2017-18 financial performance, as well as cost drivers, strategies, and plans to address financial risk and sustainability.

This FSD&A has been prepared by and is the responsibility of Management and should be read in conjunction with the March 31, 2018 audited consolidated financial statements, notes, and schedules.

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

2017-18 Highlights

During fiscal 2017-18, in line with the 2017-2020 Health and Business Plan, AHS continued to focus on sharing knowledge and best practices across Alberta, harnessing our shared expertise to drive innovation, reducing costs through efficiencies and consolidated business functions, and adjusting operations to ensure a stronger, sustainable health care system in Alberta. AHS has taken significant steps in leveraging the advantages of a province-wide health system so that Albertans can get the care they need, when they need it.

Fiscal 2017-18 marks the year when AHS took another important step in the transformation of health care with the initiation of Connect Care. Connect Care will benefit all Albertans, no matter where they live or receive care. Considered a catalyst for health care transformation, this province-wide system will improve patient experience, quality and safety of patient care, by creating common clinical standards and processes to manage and share information across the continuum of health care. As a significant investment in the future of health care in Alberta, Connect Care will take time to put in place.

Another major development during 2017-18 is the Government of Alberta's announcement of a new provincial clinical laboratory services entity that will help to improve the quality and timeliness of care for Albertans. The consolidation of all laboratory services in Alberta into an AHS wholly owned subsidiary will be aimed at optimizing innovation in laboratory diagnostics to accommodate growing demand. The overall financial impact to AHS during 2017-18 was nominal, with transition of employees and operations to the subsidiary set to occur in fiscal 2018-19.

As outlined in the Health and Business Plan, by enhancing care in the community and focusing on the health and wellness of Albertans, AHS will be more sustainable over time. While it will take time to transform how health care is delivered, AHS has begun to implement a number of initiatives to change the way of meeting the health needs of Albertans. These initiatives include Enhancing Care in the Community, which is a program to prioritize home care initiatives that will enhance care in the community and reduce reliance on emergency and acute care services, and the Continuing Care Capacity Plan, which will ease pressure on hospitals by addressing the needs of patients waiting in community and acute care for a continuing care space. AHS is committed to these initiatives, and despite some delays, new beds continued to open and the number of clients receiving home care increased in 2017-18. These plans will continue into the future, reflecting both AHS' and the Government's vision of a health system that is patient-centered, and delivers care closer to the home and community.

AHS continued to work together with Alberta Health, health professionals, first responders, law enforcement, and community organizations to address the opioid crisis and offer programs, services and support for Albertans. With additional funding from Alberta Health, AHS has supported the expansion of the naloxone program, as well as the expansion of existing opioid dependency treatment programs, the opening of supervised consumption sites, and the future opening of new treatment clinics.

The 2017-18 budget was established with the understanding that AHS must continue to find cost savings and efficiencies in order to be financially sustainable in the long-term. Improving efficiencies through the implementation of operational best practices (OBP) is key to achieving AHS' goal of improving financial health and value for money. AHS continued to expand OBP during 2017-18. OBP is the practice of comparing AHS' cost of providing health care services within Alberta, as well as externally, to ensure overall efficiency and quality care. While adapting to a changing system with increasing demands, AHS continued its efforts to manage expenditure growth and spend within available resources. The implementation of OBP operates under the principles of no reduction in core front-line services, an attrition only strategy, adherence to union collective agreements, and the commitment to quality and continuous improvement in the health care system.

2017-18 Financial Highlights

The 2017-18 Health and Business Plan supports AHS' four goals of improving patients' and families' experiences, patient and population health outcomes, experience and safety of our people, and financial health and value for money. AHS continued to support current services to meet the health care needs of Albertans, and focused on addressing service pressures and strategic priorities.

AHS operates in an environment of rising health care costs and increasing demand and expectations for services, resulting in the need to find cost savings and efficiencies. Focusing on how care is provided to patients and working to ensure clinical best practices and clinical appropriateness, AHS has allocated resources to where care is needed most and made strategic investments within the principles described above.

AHS finished 2017-18 with a $91 million annual operating surplus which is 0.6 per cent of total expenses, or approximately two days' worth of expenses. The operating surplus is mainly attributable to the timing of implementation of certain initiatives and vacancies. Increased fees and charges, unbudgeted other income, as well as a decrease in employee benefit premiums expense have further contributed to the operating surplus.

Initiatives identified in the various phases of OBP continued to be implemented in 2017-18 with savings achieved in some areas, while other areas of the organization experienced some delays in the realization of these savings, partially due to low attrition rates.

During the year, Alberta Health transferred the Academic Medicine and Health Services Program (AMHSP) grant for the North Sector from the University of Alberta to AHS. This grant ensures that physicians are compensated for services that are non-billable under the fee-for-service model by providing clinical and non-clinical funding, including support for research, education, and administrative activities. The transfer resulted in $154 million of unbudgeted revenue and expenses for AHS, primarily within acute care, and education and research. The transfer of this grant had no impact on AHS' operating surplus. The impact of this grant on revenues and expenses was significant and is explained further in the financial analysis section of this report. The AMHSP South Sector grant has always been managed by AHS.

AHS' net assets increased over the prior year mainly due to the 2017-18 operating surplus. Although AHS finished the year with a small operating surplus, it in effect provided for an opportunity to increase investments in internally funded tangible capital assets of $103 million with a corresponding decrease to AHS' unrestricted surplus. The management and maintenance of tangible capital assets is essential for AHS as clinical services depend heavily on them.

AHS saw its net debt ratio of liabilities to financial assets increase slightly to 1.07 (2016-17 – 1.01), mainly due to an increase in Connect Care obligations. However, the ratio of total assets to total liabilities remained positive and stable at 1.14 (2016-17 – 1.14), mainly due to the current year operating surplus.

2017-18 Key Trending

SELECT ANNUAL FINANCIAL INFORMATION (in millions)					
	2017-18	2016-17	2015-16	2014-15	2013-14
Revenue	14,856	14,470	13,955	13,828	13,221
Expenses	14,765	14,403	14,100	13,827	13,062
Annual surplus (deficit)	**91**	**67**	**(145)**	**1**	**159**
Accumulated surplus	1,317	1,226	1,159	1,304	1,303

Annual Surplus

AHS' overall financial position has remained relatively stable over the past five years as annual operating surpluses and deficits have averaged less than one per cent of total expenses.

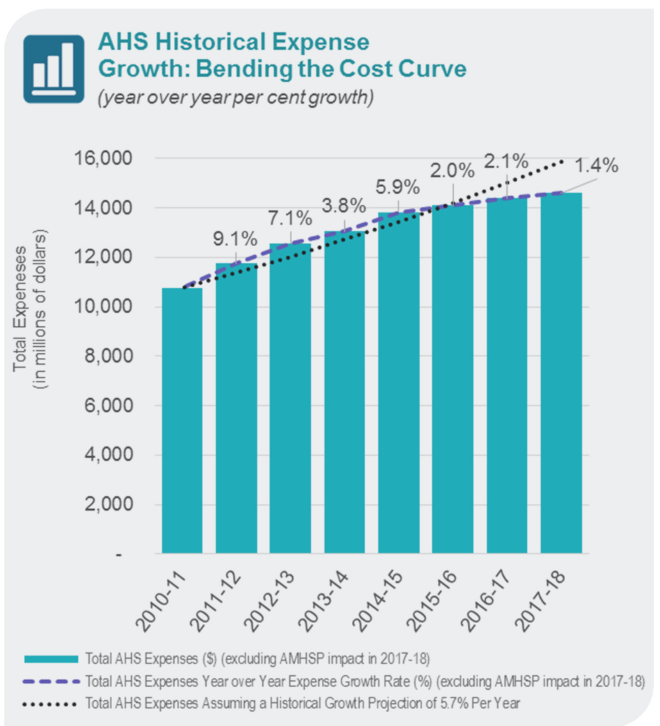
AHS is dependent upon transfers from Alberta Health and must operate within the budget approved by the AHS Board of Directors and the Minister of Health. As the provincial fiscal environment has been challenging in recent years, with lower provincial revenues, rising health care costs, and increasing demand for services, AHS has strived to find cost savings and efficiencies in order to remain financially sustainable in the long-term. With 2016-17 being the first full year of OBP, AHS has slowed the rate of spending increases while maintaining a focus on delivering innovative, high-quality health care services.

Accumulated Surplus

The accumulated surplus has been increasing over the last three years, reflecting the amount by which assets exceed liabilities. AHS has continued to invest in its tangible capital assets in order to continue to support the objectives of the health plan and deliver effective programs and services. Internal funds are a key source of funding when it comes to AHS' investment in tangible capital assets, which includes supporting the development of Connect Care, equipment purchases and replacements, facility enhancements and upgrades, and information technology investments in equipment, infrastructure and systems.

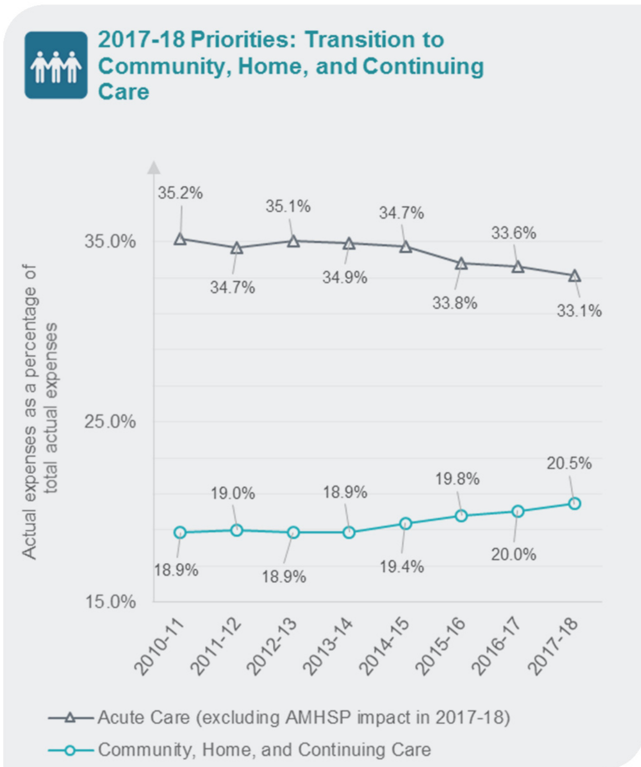
Expense Growth

Alberta's population growth has continued to be higher than the national average, which continues to put pressure on the province's health care system and front line services. Between 2013 and 2017, Alberta's population grew 7.2 per cent, while all the other provinces grew an average of 3.4 per cent during the same period. Through various organization-wide and local initiatives, AHS has been able to slow the rate of spending growth. Expenses have increased by an average of 2.2 per cent per year since 2015-16, while historically, expenses were growing an average of 5.7 per cent per year. Total expenses grew by 2.5 per cent from the prior year, however when excluding expenses related to the AMHSP North Sector grant, the growth in expenses decreases to 1.4 per cent in 2017-18.



Community, Home and Continuing Care

One of the key priorities for 2017-18 continued to be to enhance community and home care options for Albertans. AHS is working towards a shift to community, home, and continuing care in order to ease pressures on hospitals so that resources can be utilized in areas that will better support health care in the long-term for Albertans.



Community, home, and continuing care expenses increased $134 million from the prior year, representing 20.5 per cent of total expenses in 2017-18. Excluding costs related to the AMHSP North Sector grant, acute care expenses decreased $1 million from the prior year and were 33.1 per cent of total expenses.

With a shift towards promoting wellness in the community, AHS' acute care expense growth has slowed, increasing by approximately 9 per cent since 2013-14 while spending related to community, home and continuing care services has increased approximately 22 per cent during the same period.

Workforce

To support the transition from hospital to the community, there is a need for trained health care workers to shift from a hospital setting to community and home care settings. AHS is committed to using an attrition-based approach to achieve this objective.

Since 2013-14, AHS' salaries and benefits expense has increased an average of 3.6 per cent per year. AHS is currently working with its physician and employee groups to negotiate sustainable contracts extending into 2019-20. Additionally, a wage freeze for management and non-union employees has been in place since 2014 and continued through 2017-18. Through ongoing efforts, AHS has managed to maintain steady staffing levels, with headcount increasing by 0.9 per cent from the prior year.

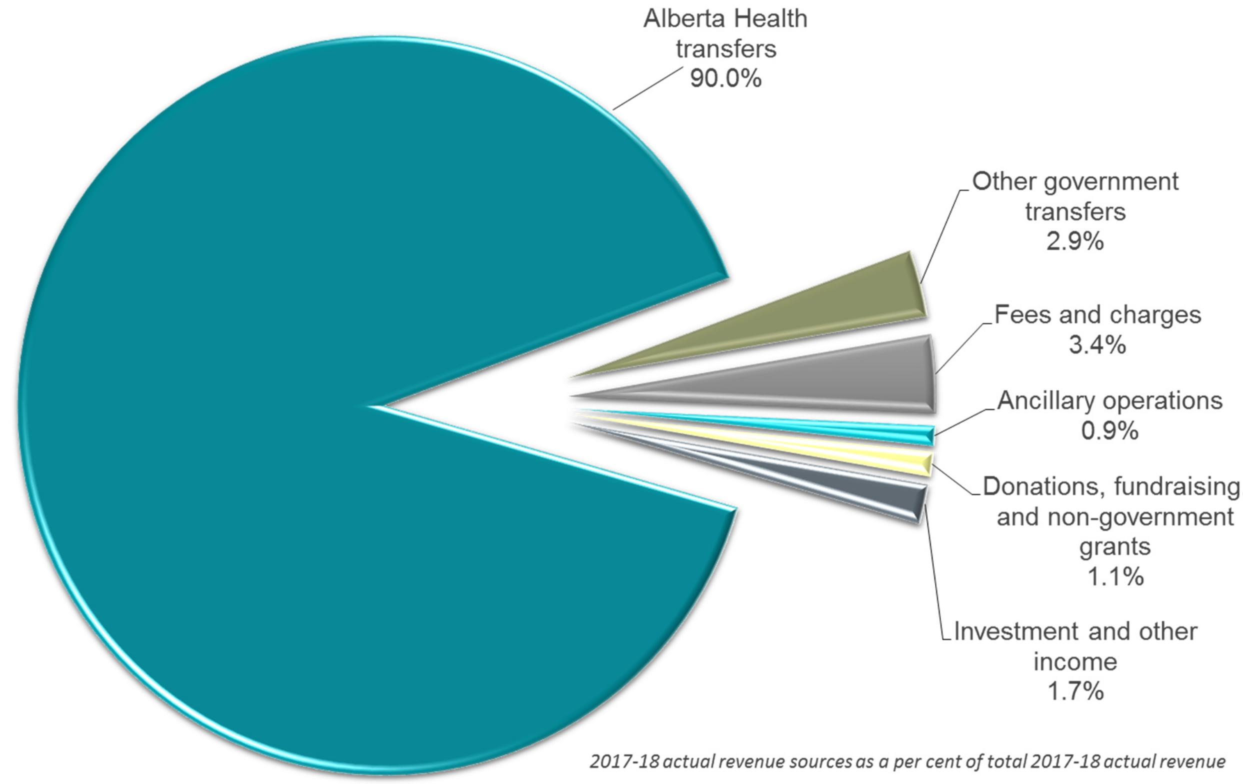
Calculated Full Time Equivalents (FTE) amounted to 79,442 FTE compared to the prior year of 78,434 FTE, representing an increase of 1,008 FTE or 1.3 per cent. Calculated FTE are determined by actual hours earned divided by 2,022.75 annual base hours for fiscal 2018. The overall increase was primarily due to increased worked hours. Clinical positions, including medical doctors, regulated nurses, health technical and professional staff, and unregulated health service providers account for 49,643 FTE, an increase of 1.4 per cent compared to the prior year. Other staff, which includes support services such as food services, facilities and maintenance, clerical staff, and secretarial support, account for 26,738 FTE, an increase of 1.3 percent compared to the prior year. Total management decreased 0.5 per cent compared to the prior year.

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 2017-18 operations are analyzed in comparison to the budget and the prior year separately in this report. A glossary of financial statement line definitions can be found at the end of this report. An analysis of AHS' financial position compared to prior year is also discussed in this section.

Operations – Comparison to Budget

Revenues



2017-18 actual revenue sources as a per cent of total 2017-18 actual revenue

The overall distribution of revenues remained consistent with the prior year. Alberta Health transfers accounted for 90.0 per cent of AHS total revenues (2016-17 - 89.6 per cent). AHS' total revenues amounted to $14,856 million, which was $187 million or 1.3 per cent higher than the budget of $14,669 million, mainly due to unbudgeted Alberta Health transfers related to the Academic Medicine and Health Services Program (AMHSP) North Sector grant. Excluding the unbudgeted Alberta Health transfers related to the AMHSP North Sector grant of $154 million, AHS' total revenues were $33 million higher than budget, mainly due to higher than budgeted investment and other income.

REVENUES (in millions)				
	2017-18 Budget	2017-18 Actual	Variance $	Variance %
Alberta Health transfers	$ 13,245	$ 13,363	$ 118	0.9%
Other government transfers	451	438	(13)	(2.9%)
Fees and charges	475	502	27	5.7%
Ancillary operations	147	133	(14)	(9.5%)
Donations, fundraising and non-government contributions	144	160	16	11.1%
Investment and other income	207	260	53	25.6%
Total revenues	**$ 14,669**	**$ 14,856**	**$ 187**	**1.3%**

Alberta Health transfers was $118 million or 0.9 per cent higher than budget mainly due to the unbudgeted AMHSP North Sector grant from Alberta Health. Excluding the impact of the unbudgeted grant of $154 million, Alberta Health transfers were $36 million lower than the budget mainly due to a lower volume of specialized high cost drugs and outpatient cancer drugs provided at no cost to patients, vacancies and compensation rate differences in physician services programs, and delayed implementation of various grant funded initiatives.

Other government transfers was $13 million or 2.9 per cent lower than budget mainly due to a change in accounting policy wherein space provided rent free by Alberta Infrastructure is no longer recognized as revenue in AHS' consolidated financial statements. The offsetting expense is also no longer recognized and therefore, there is no impact to AHS' operating surplus as a result of this change. The overall variance was partially offset by higher unexpended deferred capital revenue recognized for the amortization of tangible capital asset additions funded by Alberta Infrastructure.

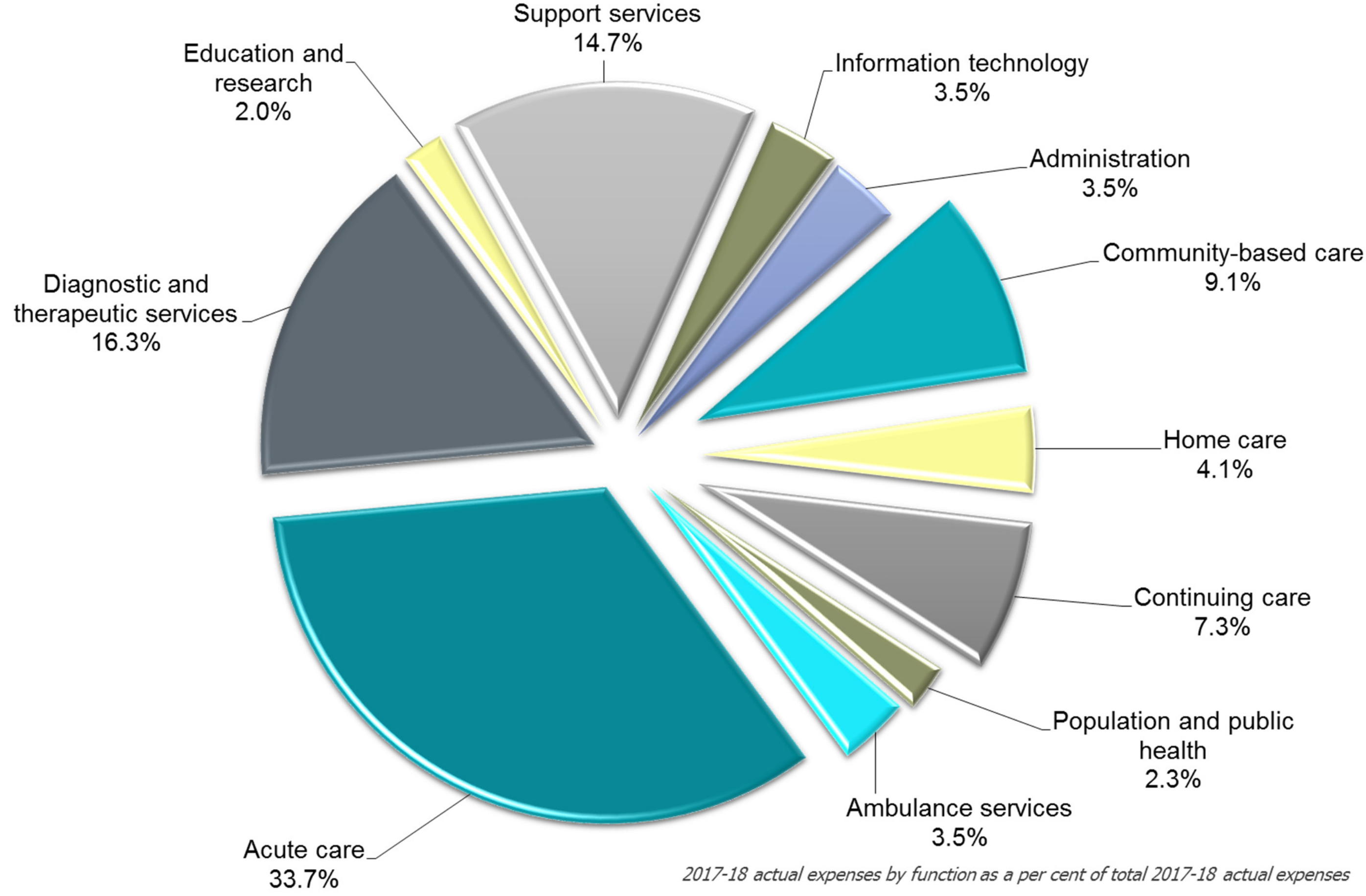
Fees and charges was $27 million or 5.7 per cent higher than budget mainly due to higher activity and patient acuity involving services billable to the Workers' Compensation Board (WCB), non-residents of Canada, other Canadian jurisdictions, and long-term care residents.

Ancillary operations was $14 million or 9.5 per cent lower than budget mainly due to lower than anticipated revenue from parking services and ancillary laboratory services.

Donations, fundraising and non-government contributions was $16 million or 11.1 per cent higher than budget mainly due to unbudgeted revenue related to spending for various initiatives funded by donations and non-government grants, and higher than anticipated unexpended deferred capital revenue recognized for the amortization of externally funded tangible capital assets.

Investment and other income was $53 million or 25.6 per cent higher than budget mainly due to unbudgeted other income including a WCB surplus distribution, outpatient cancer drugs received at no cost, and higher than anticipated recoveries for services provided to external entities, such as labour unions, contracted health service providers, WCB, and physicians.

Expenses by Function



2017-18 actual expenses by function as a per cent of total 2017-18 actual expenses

The overall distribution of expenses by function remained consistent with the prior year, with acute care and diagnostic and therapeutic services making up 50.0 per cent of total expenses (2016-17 – 50.3 per cent). Operating expenses amounted to $14,765 million, which was $96 million or 0.7 per cent higher than the budget of $14,669 million mainly due to unbudgeted expenses related to the Academic Medicine and Health Services Program (AMHSP) North Sector grant. Excluding the impact of the unbudgeted AMHSP North Sector grant, operating expenses were $58 million or 0.4 per cent lower than budget. The AMHSP North Sector grant is fully offset by corresponding grant revenues.

An overall net increase in activity, primarily within acute care, ambulance services, and diagnostic and therapeutic services contributed to the overall expense variance. Savings to be realized through AHS' focus on promoting community health and wellness and the strategic shift from "hospital to community" will take time, partly due to AHS' commitment to an attrition based approach to re-allocate staff. As a result, the need for staffing levels that were higher than budgeted and differences in budgeted savings assumptions further contributed to the overall expense variance.

AHS continued to have a significant number of vacant positions throughout the organization in 2017-18, including physician vacancies and vacancies related to the timing of implementation of various planned initiatives, such as Enhancing Care in the Community and the Continuing Care Capacity Plan, which partially offset the overall expense variance.

EXPENSES BY FUNCTION (in millions)	2017-18 Budget	2017-18 Actual	Variance $	Variance %
Community-based care	$ 1,362	$ 1,338	$ 24	1.8%
Home care	689	611	78	11.3%
Continuing care	1,096	1,072	24	2.2%
Population and public health	365	338	27	7.4%
Ambulance services	480	512	(32)	(6.7%)
Acute care	4,773	4,981	(208)	(4.4%)
Diagnostic and therapeutic services	2,385	2,411	(26)	(1.1%)
Education and research	305	298	7	2.3%
Support services	2,211	2,182	29	1.3%
Information technology	512	510	2	0.4%
Administration	491	512	(21)	(4.3%)
Total expenses by function	**$ 14,669**	**$ 14,765**	**$ (96)**	**(0.7%)**

Community-based care was $24 million or 1.8 per cent lower than budget mainly due to the timing of implementation of the Continuing Care Capacity Plan and Enhancing Care in the Community. Unanticipated delays in the construction of new care facilities and related vacancies contributed to lower spending compared to budget. Higher than budgeted expenses relating to new addiction and mental health initiatives in the year, including the Fort McMurray Wellness Recovery initiative, which is part of the continued Fort McMurray wildfire recovery efforts, and the Opioid Crisis Dependency Treatment initiative, which aims to improve access to addiction treatment and increase public awareness, partially offset the variance.

Home care was $78 million or 11.3 per cent lower than budget mainly due to the timing of implementation of Enhancing Care in the Community, and related recruitment delays.

Continuing care was $24 million or 2.2 per cent lower than budget mainly due to the timing of implementation of the Continuing Care Capacity Plan, partially due to unanticipated delays in the construction of new care facilities, as well as vacancies.

Population and public health was $27 million or 7.4 per cent lower than budget mainly due to vacancies and lower than planned spending related to the Alberta Cancer Prevention Legacy Fund, which supports multiple cancer screening and prevention initiatives, and the Indigenous Wellness Program. Lower than budgeted respiratory syncytial virus vaccine purchases, partially due to a surplus of supply from the prior year and lower activity, contributed to the variance. Travel vaccine activity was also lower than anticipated in the year. Increased demand for take-home naloxone kits and public health inspections partially offset the variance.

Ambulance services was $32 million or 6.7 per cent higher than budget of $480 million partially due to increased ambulances on the road in response to ongoing capacity and patient flow challenges, which has led to higher than budgeted overtime and relief costs. There was also higher than anticipated minor equipment purchases, and higher amortization expense related to ambulances purchased during the year. Vacancies partially offset the variance.

Acute Care was $208 million or 4.4 per cent higher than budget of $4,773 million mainly due to unbudgeted expenses related to the AMHSP North Sector grant of $141 million.

Excluding the impact of the unbudgeted grant, acute care expenses were $67 million or 1.4 per cent higher than budget. This variance is primarily due to the need for staffing levels that were higher than budgeted, partially related to low attrition rates combined with increased activity throughout the province.

Higher than budgeted activity for acute care services included higher elapsed patient days than anticipated, increased patient acuity, higher costs related to the influenza season, and an increased number of surgeries, which was an area of focus in order to address surgery wait times. Drugs provided at no cost to patients, as well as differences in budgeted savings assumptions also contributed to the variance.

The overall variance is partially offset by lower employee benefit premiums expense, physician vacancies, and lower

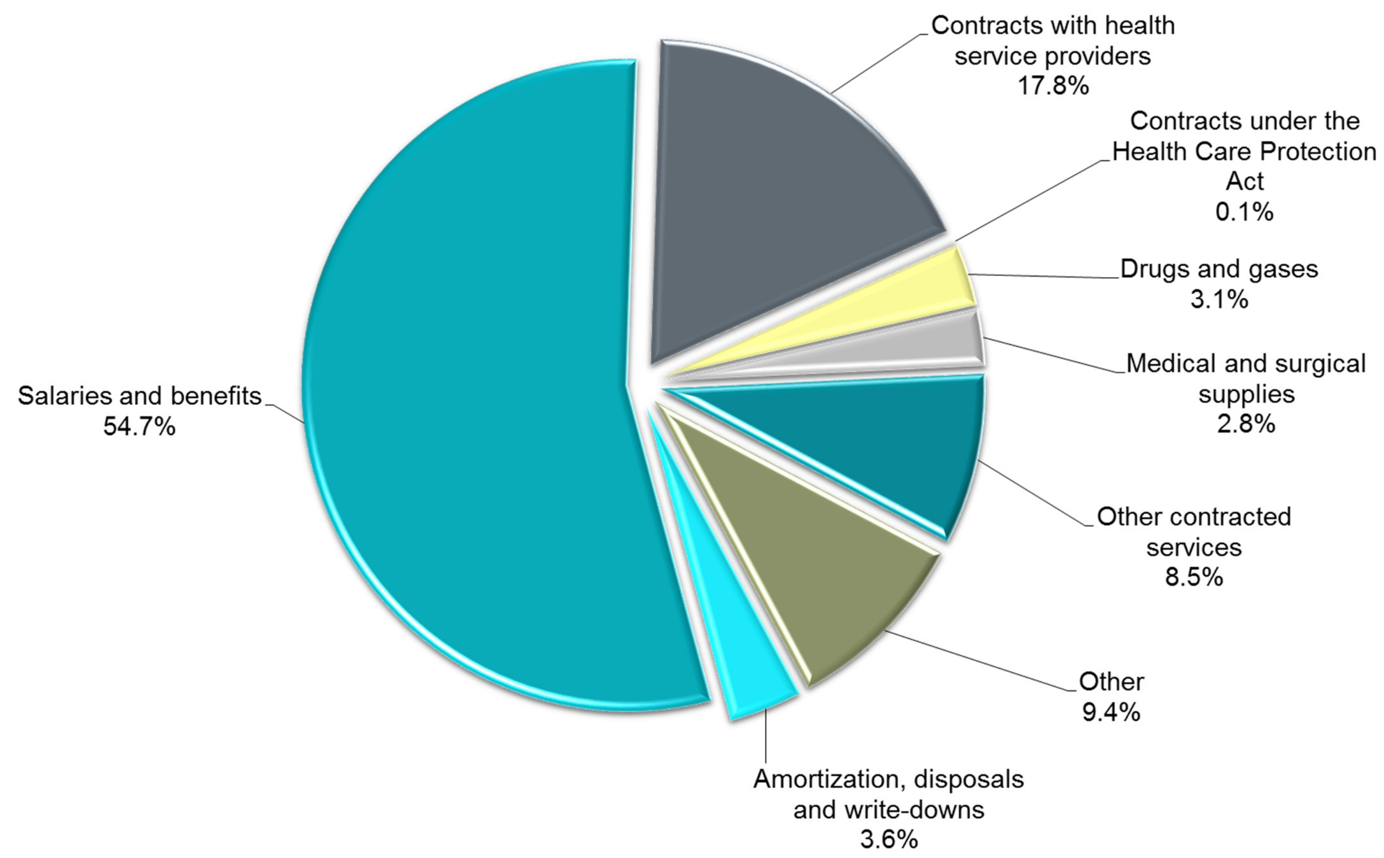
than budgeted activity in some areas, partially due to renovations and hard to recruit positions.

Diagnostic and therapeutic services was $26 million or 1.1 per cent higher than budget mainly due to differences in budgeted savings assumptions, increased demand for laboratory services, and the need for staffing levels that were higher than budgeted, partially related to lower attrition rates. Lower than budgeted expenses relating to the timing of implementation of various initiatives, vacancies, including physician vacancies, and lower costs of certain diagnostic imaging exams, partially offset the overall variance.

Support services was $29 million or 1.3 per cent lower than the budget of $2,211 million mainly due to vacancies and lower amortization expense due to the timing and nature of tangible capital asset purchases. The accounting policy change wherein space provided rent free to AHS is no longer recognized as an expense further contributed to the variance. Differences in budgeted savings assumptions and higher than budgeted utility costs primarily as a result of the carbon levy partially offset the variance.

Administration was $21 million or 4.3 per cent higher than the budget partially due to increased expenses related to Strategic Clinical Networks (SCNs) and data analytics. Increased liability insurance claims and actuarial estimates for future claims further contributed to the increase. Vacancies partially offset the overall variance.

Expenses by Object



2017-18 actual expenses by object as a per cent of total 2017-18 actual expenses

The overall distribution of expenses by object remained consistent with prior years, with salaries and benefits making up 54.7 per cent (2017 - 55.4 per cent) of total expenses. When the employees of AHS' contracted health service providers are included, the largest of which is Covenant Health, the percentage increases to approximately 70 per cent.

The overall budget to actual expense variance, excluding the impact of the AMHSP North Sector grant, was primarily driven by the need for staffing levels that were higher than budgeted, higher net activity within the province resulting in increased relief costs, and compensation rate variances, which was offset by a reduction in employee benefit premiums expense and vacancies. Higher minor equipment purchases and medical and surgical supplies usage also contributed to the variance.

EXPENSES BY OBJECT (in millions)							
	2017-18 Budget		2017-18 Actual		Variance $		Variance %
Salaries and benefits	$	8,092	$	8,070	$	22	0.3%
Contracts with health service providers		2,642		2,621		21	0.8%
Contracts under the Health Care Protection Act		18		18		-	-
Drugs and gases		462		457		5	1.1%
Medical and surgical supplies		403		414		(11)	(2.7%)
Other contracted services		1,136		1,253		(117)	(10.3%)
Other expenses		1,368		1,393		(25)	(1.8%)
Amortization and disposals of tangible capital assets		548		539		9	1.6%
Total expenses by object	**$**	**14,669**		**14,765**	**$**	**(96)**	**(0.7%)**

Salaries and benefits was $22 million or 0.3 per cent lower than the budget of $8,092 million. Lower employee benefit premiums expense and vacancies, including physician vacancies and vacancies resulting from delays and recruitment challenges related to Enhancing Care in the Community and the Continuing Care Capacity plan, were the main drivers of the positive variance.

The need for staffing levels that were higher than budgeted, partially related to low attrition rates combined with increased net activity, primarily within acute care settings, partially offset the variance. Other offsets included compensation rate variances, differences in budgeted savings assumptions, and the insourcing of previously contracted out services.

Contracts with health service providers was $21 million or 0.8 per cent lower than budget mainly due to the timing of implementation of Enhancing Care in the Community and the Continuing Care Capacity Plan, and the insourcing of previously contracted out services. Increased activity, primarily related to AHS' acute and home care service providers, and differences in budgeted saving assumptions partially offset the variance.

Medical and surgical supplies was $11 million or 2.7 per cent higher than budget mainly due to increased surgical activity, which was an area of focus in order to address surgery wait times, increased patient acuity, and increased demand for take-home naloxone kits. Vendor rebates for medical and surgical supplies partially offset the variance.

Other contracted services was $117 million or 10.3 per cent higher than budget of $1,136 million mainly due to unbudgeted expenses related to the AMHSP North Sector grant of $148 million.

Excluding the impact of the unbudgeted grant, other contracted services were $31 million or 2.7 per cent lower than the budget. This was mainly due to physician vacancies, partially offset by differences in budgeted savings assumptions and higher than planned spending related to various other restricted grants including the Academic Medicine and Health Services Program – South Sector grant.

Other expenses was $25 million or 1.8 per cent higher than budget mainly due to increased information technology and other minor equipment purchases and services, higher than budgeted utility costs primarily as a result of the carbon levy, increased liability insurance claims and actuarial estimates for future claims, higher than budgeted bad debt expense related to non-residents of Canada patients, and unbudgeted AMHSP North Sector grant expenses. Partially offsetting the variance was a reduction in spending due to cost mitigation and the accounting policy change wherein space provided rent free to AHS is no longer recognized as an expense.

Operations – Comparison to Prior Year

Revenues

Total 2017-18 revenues increased by $386 million or 2.7 per cent from $14,470 million to $14,856 million in 2017-18. The transfer of the Academic Medicine and Health Services Program (AMHSP) North Sector grant, which was previously funded through the University of Alberta, contributed most significantly to the increase in revenues year over year. Excluding the new AMHSP North Sector grant, year over year revenues increased 1.6 per cent. The overall increase is mainly attributable to a base funding increase from Alberta Health.

REVENUES (in millions)				
	2017-18 Actual	2016-17 Actual	Change $	Change %
Alberta Health transfers	$ 13,363	$ 12,965	$ 398	3.1%
Other government transfers	438	456	(18)	(3.9%)
Fees and charges	502	479	23	4.8%
Ancillary operations	133	136	(3)	(2.2%)
Donations, fundraising and non-government contributions	160	164	(4)	(2.4%)
Investment and other income	260	270	(10)	(3.7%)
Total revenue	**$ 14,856**	**$ 14,470**	**$ 386**	**2.7%**

Alberta Health transfers increased $398 million or 3.1 per cent mainly due to a base funding increase, as well as new or increased funding in 2017-18 for the AMHSP North Sector grant and various addiction and mental health grants to address the opioid crisis.

Other government transfers decreased $18 million or 3.9 per cent, mainly due to the accounting policy change wherein space provided rent free to AHS is no longer recognized as revenue. Externally funded tangible capital assets that were fully amortized in 2017-18, lower operating expenses incurred for infrastructure maintenance projects, and one-time revenue recognized in the prior year for the reimbursement of Fort McMurray wildfire costs, also contributed to the decrease from the prior year. Increased amortization of tangible capital asset additions funded by Alberta Infrastructure, as well as an in-kind contribution of land from Alberta Infrastructure, partially offset the variance.

Fees and charges increased $23 million or 4.8 per cent mainly due to higher activity and patient acuity involving services billable to non-residents of Canada, Workers' Compensation Board (WCB), long-term care residents, and other Canadian jurisdictions.

Investment and other income decreased $10 million or 3.7 per cent mainly due to the Fort McMurray wildfire insurance proceeds accrued in the prior year, lower recoveries for services provided to external entities, and reduced surplus distribution revenue WCB.

Expenses by Function

Expenses increased $362 million or 2.5 per cent from $14,403 million to $14,765 million in 2017-18. This was mainly due to increased activity throughout the province, including new expenses in 2017-18 related to the Academic Medicine and Health Services Program (AMHSP) North Sector grant. Excluding costs related to the AMHSP North Sector grant, expenses grew by $208 million, or 1.4 per cent from the prior year. This was mainly due to increased spending related to various new initiatives in the year to improve health care in Alberta, including Enhancing Care in the Community and the Continuing Care Capacity Plan.

EXPENSES BY FUNCTION (in millions)				
	2017-18 Actual	2016-17 Actual	Change $	Change %
Community-based care	$ 1,338	$ 1,249	$ 89	7.1%
Home care	611	585	26	4.4%
Continuing care	1,072	1,053	19	1.8%
Population and public health	338	355	(17)	(4.8%)
Ambulance services	512	498	14	2.8%
Acute care	4,981	4,841	140	2.9%
Diagnostic and therapeutic services	2,411	2,400	11	0.5%
Education and research	298	285	13	4.6%
Support services	2,182	2,146	36	1.7%
Information technology	510	513	(3)	(0.6%)
Administration	512	478	34	7.1%
Total expenses by function	**$ 14,765**	**$ 14,403**	**$ 362**	**2.5%**

Community-based care increased $89 million or 7.1 per cent from the prior year mainly due to increased spending related to various new priority initiatives, including the Continuing Care Capacity Plan, Enhancing Care in the Community, the Fort McMurray Wellness Recovery initiative, and the Opioid Crisis Dependency Treatment initiative, as well as clinical contract inflation.

Home care increased $26 million or 4.4 per cent mainly due to new spending related to Enhancing Care in the Community. AHS also saw the number of home care clients cared for increase 1.9 per cent in 2017-18.

Continuing care increased $19 million or 1.8 per cent mainly due to health service provider contract inflation and new spending in the current year related to the Continuing Care Capacity Plan.

Population and public health decreased $17 million or 4.8 per cent from the prior year. This is primarily due to an increased number of vacancies, lower employee benefit premiums expense, current year cost mitigation, and a reduction in certain vaccine purchases, partially due to a surplus in supply from the prior year and lower activity. Higher spending in 2016-17 related to the Fort McMurray wildfire also contributed to the decreased spending as compared to the prior year. Partially offsetting the decrease were increased costs related to new initiatives, including increased distribution and availability of naloxone kits and the Indigenous Wellness Program.

Ambulance services increased $14 million or 2.8 per cent from the prior year. This is partially a result of increased ambulances on the road in response to higher demand, partially related to ongoing capacity and patient flow challenges, which resulted in increased overtime and relief. Increased expenses in the current year related to minor equipment purchases, the Enhancing Care in the Community Mobile Integrated Health initiative, increased amortization related to new ambulances, new air ambulance contracts, and the higher cost of fuel also contributed to the increase. A reduction in uniform replacement and patients being air

lifted to other medical facilities in Canada and abroad, and higher costs in the prior year related to the Fort McMurray wildfire partially offset the increase.

Acute Care increased $140 million or 2.9 per cent from the prior year mainly due to higher expenses related to the AMHSP North Sector grant of $141 million. Excluding the impact of this grant, acute care decreased $1 million from prior year. Fewer vacancies, increased patient acuity, and increased activity from the prior year, such as increased emergency room visits and an increased number of surgeries, were offset by lower employee benefit premiums expense and achieved savings related to OBP initiatives.

Diagnostic and therapeutic services increased $11 million or 0.5 per cent from the prior year mainly due to a change to health service provider contracts regarding workload and inflation, and an increased number of lab tests and diagnostic exams from the prior year. Partially offsetting the increase was a decrease in employee benefit premiums expense and lower amortization due to various assets that have been fully amortized.

Education and research increased $13 million or 4.6 per cent mainly due to activity related to the AMHSP North Sector grant of $13 million. Excluding the impact of this grant, education and research was consistent with prior year.

Support services increased $36 million or 1.7 per cent from the prior year mainly due to higher amortization expense in the current year due to new facility projects, including the expansion and redevelopment of the Chinook Regional Hospital in Lethbridge and Medicine Hat Regional Hospital. Increased demand for healthcare across the province, resulting in the additional support staff and supplies, and higher utility costs partially due to the impact of the carbon levy, also contributed to higher expenses from the prior year. Partially offsetting the increase was the accounting policy change wherein space provided rent free to AHS is no longer recognized as an expense.

Administration increased $34 million or 7.1 per cent from the prior year partially due to increased expenses related to Strategic Clinical Networks™ (SCNs™) and data analytics. Increased liability insurance claims and actuarial estimates for future claims further contributed to the increase. Lower employee benefit premiums expense partially offset the increase.

Expenses by Object

The overall increase to expenses in 2017-18 as compared to the prior year was the result of new expenses related to the Academic Medicine and Health Services Program (AMHSP) North Sector grant, which mainly impacted payments to physicians within other contracted services. Fewer vacancies compared to the prior year combined with contract inflation also contributed to higher expenses in 2017-18. Lower employee benefit premiums expense partially offset the overall increase.

EXPENSES BY OBJECT (in millions)				
	2017-18 Actual	2016-17 Actual	Change $	Change %
Salaries and benefits	$ 8,070	$ 7,983	$ 87	1.1%
Contracts with health service providers	2,621	2,540	81	3.2%
Contracts under the Health Care Protection Act	18	20	(2)	(10.0%)
Drugs and gases	457	450	7	1.6%
Medical and surgical supplies	414	385	29	7.5%
Other contracted services	1,253	1,107	146	13.2%
Other expenses	1,393	1,367	26	1.9%
Amortization and disposals of tangible capital assets	539	551	(12)	(2.2%)
Total expenses by object	**$ 14,765**	**$ 14,403**	**$ 362**	**2.5%**

Salaries and benefits increased $87 million or 1.1 per cent mainly due to higher demand for health care services across the province, including increased demand for various acute care, laboratory, diagnostic and ambulance services. An increased number of clients within community, home, and continuing care settings, partially related to new initiatives in the year, such as Enhancing Care in the Community, the Continuing Care Capacity Plan, and the Opioid Crisis Dependency Treatment initiative, also contributed to the increase. The increased demand also impacted the need for additional support services, as well as new and existing human resources, quality assurance, and utilization management initiatives in the current year. The increased activity resulted in a 0.7 per cent increase in worked hours from the prior year, including a 3.0 per cent increase in relief. The realization of efficiencies related to OBP initiatives in the current year partially offset the increase.

The insourcing of various previously contracted services, a lower number of vacancies than in the prior year, and compensation rate variances also contributed to the increase to salaries and benefits expense.

Payroll deduction expenses decreased as a result of retroactive payments paid in the prior year for the ratification of collective agreements, which partially offset the increase in salaries and benefits. Lower employee benefit premiums expense further offset the overall increase.

Contracts with health service providers increased $81 million or 3.2 per cent mainly due to contract inflation, primarily related to various community, home, and continuing care providers and laboratory services. Increased activity, including new initiatives in the year, such as the Continuing Care Capacity Plan, contributed to the increase. The insourcing of various previously contracted services partially offset the increase.

Medical and surgical supplies increased $29 million or 7.5 per cent primarily due to increased surgical activity during the year, which was prioritized as an initiative to reduce wait times, and higher vendor rebates recognized in the prior year.

Other contracted services increased $146 million or 13.2 per cent from the prior year mainly due to the AMHSP North Sector grant of $148 million. Excluding the impact of this grant, other contracted services decreased $2 million mainly due to achieved savings.

Other expenses increased $26 million or 1.9 per cent mainly due to increased information technology and other minor equipment purchases, including costs related to Connect Care, as well as increased renovation and maintenance projects. Higher utility costs partially due to the impact of the carbon levy, AMHSP North Sector grant expenses, and increased liability insurance claims and actuarial estimates for future claims also contributed to the increase. Higher one-time expenses in the prior year, such as information technology hardware and infrastructure costs and higher costs related to the Fort McMurray wildfire, partially offset the increase. The accounting policy change wherein space provided rent free to AHS is no longer recognized as an expense further offset the increase in other expenses.

Amortization and disposals of tangible capital assets decreased $12 million or 2.2 per cent mainly due to information technology and diagnostic and therapeutic services assets that have been fully amortized. Partially offsetting the decrease was increased amortization related to various new facility projects, including expansion and redevelopments projects at the Chinook Regional Hospital in Lethbridge and Medicine Hat Regional Hospital.

Financial Position - Comparison to Prior Year

AHS ended the year with an overall net asset position of $1,338 million reflecting a 6.6 per cent increase over the prior year. AHS's net assets are mainly comprised of its investment in tangible capital assets, internally restricted surplus for future purposes, and unrestricted surplus.

FINANCIAL POSITION (in millions)		
Actual 2017-18	Actual 2016-17	Increase (Decrease)
Total financial assets		
2,810	2,697	113
Total liabilities		
3,030	2,732	298
Net debt		
(220)	(35)	185
Total non-financial assets		
8,294	7,839	455
Expended deferred capital revenue		
6,736	6,549	187
Net assets		
1,338	1,255	83

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

Net assets represents the extent to which total assets exceed total liabilities, including expended deferred capital revenue. While AHS remains in an overall net asset position, the additional investment in tangible capital assets has resulted in an increase in net debt as AHS' liabilities increased to cover the purchases. As a result, AHS' ratio of financial assets to liabilities has decreased from 0.99 to 0.93.

Financial Assets

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

Investments

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

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

Investments increased during the year by $52 million, or 2.3 per cent to $2,317 million primarily due to the timing of cash inflows and outflows at year-end. These financial assets are used to fund AHS' liabilities, both short and medium term, including accounts payable, accrued liabilities, employee future benefits, and debt.

AHS' investment portfolio generated a return of 2.7 per cent during 2017-18 (2016-17 - 2.7 per cent), benefitting from stronger returns from its equity investments, offset by lower yielding fixed income investments.

Accounts receivable

AHS' accounts receivable include amounts related to patient receivables, such as uninsured services, services provided to non-residents, and EMS services, as well as the Workers' Compensation Board and GST. Amounts owed to AHS by Alberta Health, Alberta Infrastructure, and other government organizations are also included in this category.

Accounts receivable increased by 10.4 per cent to $427 million during the year, mainly due to an increase in Alberta Health capital grants related to the Connect Care project, as well as other general operating increases in patient receivables, other receivables, and other capital grants. The overall increase in accounts receivables was partially offset by a decrease in Alberta Health and other operating grants.

Liabilities

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

Accounts payable and accrued liabilities

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

Accounts payable and accrued liabilities increased by $203 million to $1,413 million mainly due to the timing of payments related to various trade accounts payable, as well as vendor invoices related mainly to the purchase of capital equipment. Further increasing the year-end balance are obligations related to the building of the Connect Care provincial clinical information system, as well as an increase in the provision for unpaid liability claims, which is based on actuarial estimates.

Debt

AHS' debt is primarily comprised of debentures issued to Alberta Capital Financing Authority (ACFA) to finance the construction of parking facilities, and for Energy Savings initiatives.

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

The Energy Savings initiative is a pilot project at the Alberta Hospital and Royal Alexandra Hospital in Edmonton and is expected to result in lower AHS utility and energy costs at these facilities. The cost savings from these initiatives will be applied against the loan repayments in a cost neutral strategy. For the Energy Savings loan, land at the respective sites has been pledged as security.

During the year, AHS received loan proceeds of $67 million from ACFA, $46 million related to the construction of a parking facility at the Foothills Medical Centre in Calgary, in anticipation of the Calgary Cancer Centre development and $21 million related to the Energy Savings initiatives. The construction of this parkade is expected to be completed in 2019 and the Energy Savings initiatives are expected to be completed later in 2018. The net principal repayments during the year on all outstanding debt amounted to $18 million.

AHS also has access to a $220 million revolving demand loan facility with a Canadian chartered bank, which may be used for operating purposes. This facility was not utilized during the year. AHS also has access to a $33 million revolving demand letter of credit facility of which $5 million in letters of credit were outstanding at March 31, 2018.

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

Expended deferred capital revenue

Expended deferred capital revenue represents external resources spent in the acquisition of tangible capital assets, stipulated for use in the provision of services over their useful lives. Revenue is recognized over the useful lives of the assets. The assets include hospitals and other related facilities, equipment, and information systems. Funding from the Government of Alberta, mainly Alberta Infrastructure, represents $6,545 million, or 97.2 per cent of the $6,736 million total balance.

Non-Financial Assets

Non-financial assets are assets that AHS uses when providing services to the public and are not intended to be monetized for settling its liabilities. While tangible capital assets is the most significant non-financial asset, it also includes inventories and prepaid expenses.

TANGIBLE CAPITAL ASSETS (in millions)

	Actual 2017-18	Actual 2016-17	Increase
Cost	$ 15,509	$ 14,606	$ 903
Accumulated amortization	7,478	6,987	491
Net book value	**$ 8,031**	**$ 7,619**	**$ 412**

Tangible capital assets

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

In the current year, tangible capital assets increased by $412 million, mainly within work in progress (WIP), equipment, and information systems. Several capital projects totaling $417 million previously included within WIP were brought into service. Notable projects included the Windows Desktop 7 project, Lethbridge Chinook Regional Hospital, Fort McMurray Detox Treatment Centre, Peter Lougheed Vascular and Women's Health Units, the Northern Alberta Urology Centre and the Medicine Hat Detox Treatment Centre.

The remaining WIP balance of $1,179 million includes infrastructure and information technology capital expenditures that support the following initiatives:

- Grande Prairie Regional Hospital Development
- Calgary Cancer Centre Development
- Connect Care Wireless Program
- Foothills Medical Centre Parkade

While certain tangible capital assets are internally funded from AHS's net assets, AHS receives significant external funding for capital expenditures, primarily from Alberta Government ministries. In 2017-18, tangible capital asset additions amounted to $951 million, of which 75 per cent were externally funded (2016-17 – 72 per cent).

Net Assets

NET ASSETS (in millions)			
	Actual 2017-18	Actual 2016-17	Increase (Decrease)
Unrestricted Surplus	$ 188	$ 212	$ (24)
Invested in tangible capital assets	817	714	103
Internally restricted surplus for future purposes	237	225	12
Endowments	75	75	-
Accumulated Surplus	**$ 1,317**	**$ 1,226**	**$ 91**
Accumulated Remeasurement Gains	21	29	(8)
Total Net Assets	**$ 1,338**	**$ 1,255**	**$ 83**

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

The unrestricted surplus of $188 million at March 31, 2018 does not have any restrictions attached to its future use and may be used at AHS' discretion for operating or capital purposes. The decrease in the current year mainly relates to the purchase of tangible capital assets with internal funds, partially offset by the current annual operating surplus.

The accumulated surplus invested in tangible capital assets at March 31, 2018 of $817 million represents the net book value of tangible capital assets that have previously been purchased with AHS' unrestricted surplus. AHS has no plans to monetize these assets to cover future operations.

The internally restricted surplus for future purposes at March 31, 2018 of $237 million has been approved by the Board for various requirements.

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

Financial Reporting, Control and Accountability

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

AHS performance measures are aligned with the Alberta Quality Matrix for Health, a framework that provides a common language, understanding and approach for thinking about quality among health-care organizations, professionals and other stakeholders.

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

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

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

The Audit & Risk Committee has the responsibility to assist in fulfilling the oversight responsibilities of the Board with respect to management and compliance, external financial reporting, internal controls over financial reporting, internal audit, and the external audit. The Finance Committee has responsibility to assist in fulfilling the financial oversight responsibilities of the Board such as including those pertaining to the Health Plan, Business Plan, budget, and its investment portfolio.

AHS has established an Internal Audit function with the mandate of providing independent advisory and assurance services to management and the Board on AHS operations. The scope of Internal Audit's work is to determine whether AHS' risk management, control and governance processes are adequate and functioning effectively. The Chief Audit Executive is also responsible for coordinating AHS' Enterprise Risk Management function including development and implementation of policies and processes for identifying, monitoring, and reporting risks within the organization.

As a component of the Internal Audit function, AHS has an Internal Controls over Financial Reporting (ICOFR) group, which is tasked with ensuring the financial reporting environment mitigates the risk of material misstatements by establishing a sustainable framework of internal controls over financial reporting. In fulfilling its mandate, ICOFR continues to work on the implementation of its plan to ensure appropriate internal controls are designed, implemented, and documented within AHS.

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 to the legislature recommendations related to AHS along with other government entities. The Auditor General of Alberta's reports are available at **www.oag.ab.ca** under public reports.

Forward-Looking Statements Disclosure

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

Budget Outlook

AHS must enhance and improve health services and operate within the budget approved by the AHS' Board of Directors and the Minister of Health. Over the next three years, expenses are budgeted to grow by less than the population growth and inflation rates combined, which is expected to average 3.5 per cent per year over the next three years.

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

Risks

The following are risks to the budget outlook:

Population and demand

The population of Alberta continues to increase and is aging and living longer. On average, we are using more health care per person compared to previous generations. These factors are driving increased demand in many areas of the health care system. Activity will increase in targeted areas such as cancer surgery to respond to demand and wait times. In addition, AHS is looking at improvement opportunities such as more efficient use of operating rooms and reducing unnecessary tests, however these efforts will take time to implement.

Workforce

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

Multiple priorities

AHS must continue to work with Alberta Health to find the right balance of programs and services to ensure the needs of Albertans are met while working efficiently and maximizing value for money. One priority is to enhance community and home care options for Albertans. To do this successfully, AHS must continue to reduce our cost and reliance on acute care so resources can be redeployed to areas that will lead to better health outcomes and experiences for Albertans. Another priority is Connect Care which will be implemented in waves across the organization over the next five years. AHS staff and health care professionals will collaborate to ensure a smooth transition to the new provincial clinical information system.

Engagement

Enhancing care requires engagement from multiple stakeholders, including Albertans, AHS employees, physicians, other health care providers, and the Government of Alberta. AHS will need to work with key stakeholders to determine how to successfully transition the focus to placing more resources in our communities.

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

Glossary of Financial Statement Line Definitions

Revenues

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

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

Fees and charges consist of patient revenue for health services provided at rates set by the Minister of Health, and collected by AHS from individuals, Workers' Compensation Board (WCB), federal and provincial governments, and other parties, such as Alberta Blue Cross and other insurance companies.

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

Donations, fundraising and non-government contributions are comprised of revenue that can be unrestricted or restricted for operating or capital purposes.

Investment and other income is comprised of interest income, dividends, net realized gains and losses on disposal of investments, and recoveries from external sources other than ancillary operations. Included are revenues from third parties, such as drug and medical supply companies, and universities (for purposes other than research).

Expenses by Function

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

Home care is comprised of home nursing and support.

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

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

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

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

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

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

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

Information technology is comprised of costs pertaining to the provision of services to design, develop, implement, and maintain effective and efficient management support systems in the areas of data processing, systems engineering, technical support, and systems research and development. This includes clinical and corporate enterprise systems and infrastructure, as well as support of provincial systems.

Administration is comprised of human resources, finance, communications and general administration, as well as a share of administration of certain contracted health service providers. General administration includes senior executives

and many functions such as planning and development, infection control, quality assurance, patient safety, insurance, privacy, risk management, internal audit, and legal. Activities and costs directly supporting clinical activities are excluded.

Expenses by Object

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

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

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

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

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

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

Other expenses relate to those expenses not classified elsewhere.

Amortization, disposals and write-downs relates to the periodic charges to expenses representing the estimated portion of the cost of the respective tangible capital asset that expired through use and age during the period.

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2018

Management's Responsibility for Financial Reporting

Independent Auditor's Report

Consolidated Statement of Operations

Consolidated Statement of Financial Position

Consolidated Statement of Change in Net Debt

Consolidated Statement of Remeasurement Gains and Losses

Consolidated Statement of Cash Flows

Notes to the Consolidated Financial Statements

Schedule 1 – Consolidated Schedule of Expenses by Object

Schedule 2 – Consolidated Schedule of Salaries and Benefits

Schedule 3 – Consolidated Schedule of Segment Disclosures

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the year ended March 31, 2018 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Public Sector Accounting Standards and the financial directives issued by Alberta Health, and of necessity include some amounts based on estimates and judgment.

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

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

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

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

[Original Signed By]

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

[Original Signed By]

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

May 31, 2018

Independent Auditor's Report

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

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of Alberta Health Services, which comprise the consolidated statement of financial position as at March 31, 2018, the consolidated statements of operations, remeasurement gains and losses, change in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these consolidated financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements 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 entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

I believe that the audit evidence I have obtained in my audit is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2018, 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.

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

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

May 31, 2018
Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS YEAR ENDED MARCH 31	2018		2017
	Budget (Note 3)	Actual	Actual
Revenues:			
Alberta Health transfers			
Base operating	$ 12,160,000	$ 12,147,985	$ 11,859,923
One-time base operating	-	14,683	50,000
Grant funding transferred to one-time base operating	-	-	14,515
Other operating	1,009,000	1,134,483	953,328
Recognition of expended deferred capital revenue	76,000	66,085	86,784
Other government transfers (Note 4)	451,000	438,127	456,152
Fees and charges	475,000	502,230	479,180
Ancillary operations	147,000	132,661	135,660
Donations, fundraising, and non-government contributions (Note 5)	144,000	160,076	164,016
Investment and other income (Note 6)	207,000	259,513	270,410
TOTAL REVENUE	**14,669,000**	**14,855,843**	**14,469,968**
Expenses:			
Community-based care	1,362,000	1,337,646	1,249,031
Home care	689,000	610,515	585,313
Continuing care	1,096,000	1,071,676	1,053,118
Population and public health	365,000	338,451	354,700
Ambulance services	480,000	512,410	497,686
Acute care	4,773,000	4,981,290	4,841,007
Diagnostic and therapeutic services	2,385,000	2,410,972	2,400,242
Education and research	305,000	298,160	285,300
Support services (Note 7)	2,211,000	2,181,641	2,145,541
Information technology	512,000	509,989	513,420
Administration (Note 8)	491,000	511,697	478,074
TOTAL EXPENSES (Schedules 1 and 3)	**14,669,000**	**14,764,447**	**14,403,432**
ANNUAL OPERATING SURPLUS	**-**	**91,396**	**66,536**
Accumulated surplus, beginning of year	1,226,000	1,225,659	1,159,123
Accumulated surplus, end of year (Note 19)	**$ 1,226,000**	**$ 1,317,055**	**$ 1,225,659**

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

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31		
	2018 **Actual**	**2017** **Actual**
Financial Assets:		
Cash	$ 66,253	$ 46,103
Investments (Note 10)	2,316,752	2,264,866
Accounts receivable (Note 11)	426,558	386,292
	2,809,563	2,697,261
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,412,913	1,209,974
Employee future benefits (Note 13)	673,136	653,037
Unexpended deferred operating revenue (Note 14)	420,245	411,079
Unexpended deferred capital revenue (Note 15)	153,751	137,806
Debt (Note 17)	369,775	320,087
	3,029,820	2,731,983
NET DEBT	**(220,257)**	**(34,722)**
Non-Financial Assets:		
Tangible capital assets (Note 18)	8,031,307	7,619,077
Inventories for consumption	96,573	91,882
Prepaid expenses and other non-financial assets	165,721	128,058
	8,293,601	7,839,017
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	8,073,344	7,804,295
Expended deferred capital revenue (Note 16)	6,735,454	6,549,770
NET ASSETS	**1,337,890**	**1,254,525**
Net Assets is comprised of:		
Accumulated surplus (Note 19)	1,317,055	1,225,659
Accumulated remeasurement gains	20,835	28,866
	$ 1,337,890	**$ 1,254,525**

Contractual Obligations and Contingent Liabilities (Note 20)

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

Approved by the Board of Directors:

[Original Signed By]

Linda Hughes
Board Chair

[Original Signed By]

David Carpenter, FCPA, FCA
Audit & Risk Committee Chair

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT YEAR ENDED MARCH 31	2018		2017
	Budget (Note 3)	Actual	Actual
Annual operating surplus	$ -	$ 91,396	$ 66,536
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets (Note 18)	(1,004,000)	(950,869)	(597,021)
Amortization and disposals of tangible capital assets (Note 18)	548,000	538,639	551,015
Effect of other changes:			
Net increase (decrease) in expended deferred capital revenue	330,000	185,684	19,338
Net (increase) decrease in inventories for consumption	-	(4,691)	2,557
Net (increase) decrease in prepaid expenses and other non-financial assets	2,000	(37,663)	(115)
Net remeasurement gains (losses) for the year	1,000	(8,031)	23,844
(Increase) decrease in net debt for the year	**(123,000)**	**(185,535)**	**66,154**
Net debt, beginning of year	(35,000)	(34,722)	(100,876)
Net debt, end of year	**$ (158,000)**	**$ (220,257)**	**$ (34,722)**

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

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31	2018 Actual	2017 Actual
Unrestricted unrealized gains (losses) attributable to:		
Derivatives	$ (40)	$ 643
Portfolio investments		
Equity instruments quoted in an active market	27,873	32,926
Financial instruments designated to the fair value category	(19,143)	(194)
Amounts reclassified to the Consolidated Statement of Operations:		
Portfolio investments		
Equity instruments quoted in an active market	(20,493)	(555)
Financial instruments designated to the fair value category	3,772	(8,976)
Net remeasurement gains (losses) for the year	**(8,031)**	**23,844**
Accumulated remeasurement gains, beginning of year	28,866	5,022
Accumulated remeasurement gains, end of year (Note 10)	**$ 20,835**	**$ 28,866**

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

CONSOLIDATED STATEMENT OF CASH FLOWS YEAR ENDED MARCH 31	2018 Actual	2017 Actual
Operating transactions:		
Annual operating surplus	$ 91,396	$ 66,536
Non-cash items:		
Amortization and disposals of tangible capital assets	538,639	551,015
Recognition of expended deferred capital revenue	(384,337)	(402,887)
Revenue recognized for acquisition of land	(6,286)	(687)
Decrease (increase) in:		
Accounts receivable related to operating transactions	2,116	(26,890)
Inventories for consumption	(4,691)	2,557
Prepaid expenses and other non-financial assets	(37,663)	(115)
Increase (decrease) in:		
Accounts payable and accrued liabilities related to operating transactions	62,592	(51,771)
Employee future benefits	20,099	32,350
Unexpended deferred operating revenue	(37,555)	(70,148)
Cash provided by operating transactions	244,310	99,960
Capital transactions:		
Acquisition of tangible capital assets	(612,961)	(380,401)
Increase in accounts payable and accrued liabilities related to capital transactions	140,347	25,433
Cash applied to capital transactions	(472,614)	(354,968)
Investing transactions:		
Purchase of investments	(3,168,353)	(3,339,338)
Proceeds on disposals of investments	3,109,935	3,290,394
Cash applied to investing transactions	(58,418)	(48,944)
Financing transactions:		
Restricted capital contributions received	264,565	278,230
Unexpended deferred capital revenue returned	(7,381)	(1,220)
Proceeds from debt	67,300	10,000
Principal payments on debt	(17,612)	(16,822)
Cash provided by financing transactions	306,872	270,188
Increase (decrease) in cash	**20,150**	**(33,764)**
Cash, beginning of year	46,103	79,867
Cash, end of year	**$ 66,253**	**$ 46,103**

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2018

Note 1 Authority, Purpose and Operations

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

Pursuant to Section 5 of the *Regional Health Authorities Act* (Alberta), AHS is responsible in Alberta to:
- promote and protect the health of the population and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the population;
- determine priorities in the provision of health services and allocate resources accordingly;
- ensure that reasonable access to quality health services is provided and;
- promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities.

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

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

AHS and its contracted health service providers deliver health services at facilities and sites grouped in the following areas: addiction treatment, community mental health, standalone psychiatric facilities, acute care hospitals, sub-acute care in auxiliary hospitals, long-term care, palliative care, supportive living, cancer care, community ambulatory care centres, and urgent care centres.

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

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

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

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

(i) Controlled Entities

AHS owns majority of the Class A voting shares in the following three entities:

- Calgary Laboratory Services Ltd. (CLS) - provides medical diagnostic services in Calgary and southern Alberta. AHS owns 100% of the Class A voting shares.
- Capital Care Group Inc. (CCGI) - manages continuing care programs and facilities in the Edmonton area. AHS owns 100% of the Class A voting shares.
- Carewest - manages continuing care programs and facilities in the Calgary area. AHS owns 99% of the Class A voting shares and 1% of the Class A voting shares are held in trust by Chair of the Board of Directors.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS has majority representation on the governance boards indicating control of the following entities:

- Foundations:

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

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

- Queen Elizabeth II Hospital Child Care Centre

(ii) Government Partnerships

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

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

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

Adjustments are made for consolidated entities whose fiscal year-ends are different from AHS' fiscal year end. This only consists of LPIP with a fiscal year-end of December 31, 2017. All significant transactions in the interim period to March 31 have been recorded in the consolidated financial statements.

(iii) Trusts under Administration

These consolidated financial statements do not include trusts administered on behalf of others (Note 23).

(b) Revenue Recognition

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

(i) Government Transfers

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

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

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

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

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

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

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

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

(iii) Transfers and Donations related to Land

Transfers and donations for the purchase of land are recognized as a liability when received and as revenue when the land is purchased. AHS recognizes in-kind contributions of land as revenue at the fair value of the land when a fair value can be reasonably determined. When AHS cannot determine the fair value, it records such in-kind contributions at nominal value.

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

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

(v) Investment Income

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

(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

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

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

PSAS requires investments in equity instruments quoted in an active market to be recorded under the fair value category and AHS may choose to record other financial assets under the fair value category if there is an investment strategy to evaluate the performance of a group of these financial assets on a fair value basis. AHS has elected to record its money market securities, fixed income securities, and certain other equity investments at fair value. The three levels of information that may be used to measure fair value are:

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

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

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

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

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

(e) Cash

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

(f) Inventories For Consumption

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(g) Tangible Capital Assets

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

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

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

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

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

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

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

(h) Employee Future Benefits

(i) Registered Benefit Pension Plans

AHS participates in the following registered defined benefit pension plans: the Local Authorities Pension Plan (LAPP) and the Management Employees Pension Plan (MEPP). These multi-employer public sector defined benefit plans provide pensions for participants for each year of pensionable service based on the average salary of the highest five consecutive years, up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE), over the same five consecutive year period. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). The President of Alberta Treasury Board and Minister of Finance is the legal trustee and administrator of the plans. The Department of Treasury Board and Finance accounts for its share of obligations for these pension plans relating to former and current employees of all of the organizations included in the GOA consolidated reporting entity on a defined benefit basis. As a participating government organization, AHS accounts for these plans on a defined contribution basis. Accordingly, the pension expense recorded for these plans in these consolidated financial statements is comprised of the employer contributions that AHS is required to pay for its employees during the fiscal year, which are calculated based on actuarially pre-determined amounts that are expected to provide the plan's future benefits.

(ii) Other Defined Contribution Pension Plans

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(iii) Supplemental Retirement Plan for Designated Employees (SERP)

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

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

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

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

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

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

(iv) Supplemental Pension Plan (SPP)

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(v) Sick Leave Liability

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

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

The accumulating non-vesting sick leave liability is actuarially determined using the projected benefit method pro-rated for service and management's best estimates of expected discount rate, inflation, rate of compensation increase, termination and retirement rates, and mortality. The liability associated with these benefits is calculated as the present value of expected future payments pro-rated for service.

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

(vi) Other Benefits

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

(i) Liability for Contaminated Sites

Contaminated sites are a result of contamination being introduced into air, soil, water, or sediment of a chemical, organic or radioactive material or live organism that exceeds an environmental standard. The liability is recognized net of any expected recoveries. A liability for remediation of contaminated sites normally results from operations that are no longer in productive use and is recognized when all of the following criteria are met:

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

(j) Foreign Currency Translation

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

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

(k) Internally Restricted Surplus for Future Purposes

Certain amounts, as approved by the AHS Board, are set aside in accumulated surplus for use by AHS for future operating and capital purposes, to restrict amounts for legislatively required restricted equity and donations amounts restricted by third parties. Transfers to, or from, internally restricted surplus for future purposes are recorded to the respective reserved surplus when approved.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(l) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a difference between the recognized or disclosed amount and another reasonably possible amount. The amount recorded for amortization of tangible capital assets is based on the estimated useful life of the related tangible capital assets while the recognition of expended deferred capital revenue depends on when the terms for the use of the funding are met and, when applicable, AHS complies with its communicated use of the funding. The amounts recorded for employee future benefits are based on estimated future cash flows. The provision for unpaid claims, allowance for doubtful accounts and accrued liabilities are subject to significant management estimates and assumptions. The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals; historical precedent and trends; prevailing legal, economic, social, and regulatory trends; and expectation as to future developments. The process of determining the provision necessarily involves risks that the actual results will deviate perhaps materially from the best estimates made. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences, which may be material, could require adjustment in subsequent reporting periods.

(m) Changes in Accounting Policy

AHS has prospectively adopted the following accounting standards as of April 1, 2017:

PS 2200 Related Party Disclosures

PS 2200, Related Party Disclosures requires sufficient information be disclosed about the terms and conditions on which transactions between related parties are conducted and the relationship underlying them. The disclosure provides information necessary to assess the effect that the related party relationships have had, or, if not recognized, may have had on the entity's financial position and financial performance. The effect of adopting this standard has resulted in no changes in the accounting treatment and disclosure of AHS' related party disclosures.

PS 3420 Inter-Entity Transactions

PS 3420, Inter-Entity Transactions specifically addresses the reporting of transactions between entities controlled by a government and that comprises the government's reporting entity from both a provider and recipient perspective. The effect of adopting this standard has resulted in changes in the accounting treatment of unallocated costs with related entities. Space provided rent free by a related party has not been recognized in these consolidated financial statements effective April 1, 2017 – see Note 2(b)(i) and Note 21.

PS 3210 Assets

PS 3210, Assets provides additional guidance on the definition of assets set out in PS 1000 – Financial Statement Concepts and new disclosure requirements for those assets not recognized in the government's financial statements. The effect of adopting this standard has resulted in no changes in the accounting treatment and disclosure of AHS' assets.

PS 3320 Contingent Assets

PS 3320, Contingent Assets establishes standards on the reporting and disclosure of possible assets that may arise from existing conditions or situations involving uncertainty. The effect of adopting this standard has resulted in no changes in the disclosure of AHS' contingent assets.

PS 3380 Contractual Rights

PS 3380, Contractual Rights establishes standards on the reporting and disclosure of a government's rights to economic resources that may arise from contracts or agreements that will result in both an asset and revenue in the future. The effect of adopting this standard has resulted in no changes in the disclosure of AHS' contractual rights.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(n) Future Accounting Changes

The following accounting standards are applicable in future years:

- **PS 3430 – Restructuring Transactions (effective April 1, 2018)**
  PS 3430 provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related programs or operating responsibilities.
- **PS 3280 – Asset Retirement Obligations (effective April 1, 2021)**
  PS 3280 provides guidance on how to account for and report a liability for retirement of a tangible capital asset.

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

Note 3 Budget

The 2017-18 AHS Health Plan and Business Plan, which included the 2017-18 annual budget, was approved by the AHS Board on June 2, 2017 and by the Minister of Health on July 4, 2017.

Note 4 Other Government Transfers

	2018	2017
Unrestricted operating	$ 38,571	$ 59,737
Restricted operating (Note 14)	112,460	118,303
Recognition of expended deferred capital revenue (Note 16)	287,096	278,112
	$ 438,127	**$ 456,152**

Other government transfers include $429,855 (2017 – $449,067) transferred from the GOA and $8,272 (2017 – $7,085) from the federal government, and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

Note 5 Donations, Fundraising, and Non-Government Contributions

	2018	2017
Unrestricted operating	$ 2,281	$ 4,597
Restricted operating (Note 14)	126,311	120,120
Recognition of expended deferred capital revenue (Note 16)	31,156	37,991
Endowment contributions and reinvested income	328	1,308
	$ 160,076	**$ 164,016**

Note 6 Investment and Other Income

	2018	2017
Investment income	$ 67,988	$ 65,552
Other income:		
GOA (Note 21)	33,605	37,422
AH	16,361	19,166
Other	141,559	148,270
	$ 259,513	**$ 270,410**

Note 7 Support Services

	2018	2017
Facilities operations	$ 873,483	$ 869,181
Patient: health records, food services, and transportation	408,737	385,444
Materials management	177,090	207,661
Housekeeping, laundry, and linen	211,702	208,380
Support services expense of full-spectrum contracted health service providers	151,473	149,941
Ancillary operations	110,046	105,078
Fundraising expenses and grants awarded	46,279	42,866
Other	202,831	176,990
	$ 2,181,641	**$ 2,145,541**

Note 8 Administration

	2018	2017
General administration	$ 266,597	$ 251,703
Human resources	102,981	92,695
Finance	76,612	73,394
Communications	24,797	21,354
Administration expense of full-spectrum contracted health service Providers	40,710	38,928
	$ 511,697	**$ 478,074**

Note 9 Financial Risk Management

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

(a) Market Risk

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

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

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

AHS assesses the sensitivity of its portfolio to market risk based on historical volatility of equity and fixed income markets. Volatility is determined using a ten year average based on fixed income and equity market fluctuations and is applied to the total portfolio. Based on the volatility average of 2.85% (2017 – 2.76%) increase or decrease, with all other variables held constant, the portfolio could expect an increase or decrease in accumulated remeasurement gains and losses and unrealized net gains and losses attributable to deferred revenue and endowments of $50,819 (2017 – $48,779).

Note 9 Financial Risk Management (continued)

(i) Price Risk

Price risk relates to the possibility that equity investments will change in fair value due to future fluctuations in market prices caused by factors specific to an individual equity investment or other factors affecting all equities traded in the market. AHS is exposed to price risk associated with the underlying equity investments held in pooled funds. If equity market indices (S&P/TSX, S&P1500 and MSCI ACWI and their sectors) declined by 10%, and all other variables are held constant, the potential loss in fair value to AHS would be approximately $53,428 or 2.31% of total investments (March 31, 2017 – $51,363 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 investments by management of average duration and laddered maturity dates.

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

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

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $71,683 (March 31, 2017 – $68,009).

Fixed income securities include bonds and money market securities. The fixed income securities have the following average maturity structure ranging from 2018 and 2067:

	2018	2017
0 – 5 years	80%	78%
6 – 10 years	8%	13%
Over 10 years	12%	9%

	Effective Market Yield			Average Effective Market Yield
Asset Class	< 1 year	1-5 years	> 5 years	
Interest bearing securities	1.31%	2.18%	2.88%	2.13%

(iii) Foreign Currency Risk

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

Foreign currency risk is managed by the investment policies which limit non-Canadian equities to a maximum of 10% to 45% of the total investment portfolio, depending on the policy. At March 31, 2018, investments in non-Canadian equities represented 16.2% (March 31, 2017 – 15.3%) of total portfolio investments.

Note 9 Financial Risk Management (continued)

Foreign exchange fluctuations on cash balances are mitigated by forward contracts and holding minimal foreign currency cash balances. At March 31, 2018, AHS held US dollar forward contracts with ATB Financial to manage currency fluctuations relating to its US dollar accounts payable requirements. As at March 31, 2018, AHS held derivatives in the form of forward contracts for future settlement of $24,000 (2017 – $18,000). The fair value of these forward contracts as at March 31, 2018 was $461 (2017 – $501) and is included in investments (Note 10).

(b) Credit Risk

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

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

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

The following table summarizes AHS' investment in debt securities by counterparty credit rating at March 31, 2018.

Credit Rating	2018	2017
Investment Grade (AAA to BBB)	89%	90%
Unrated	11%	10%
	100%	**100%**

(c) Liquidity Risk

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

Note 10 Investments

	2018		2017	
	Fair Value	Cost	Fair Value	Cost
Cash held for investing purposes	**$ 118,012**	**$ 118,012**	**$ 106,666**	**$ 106,666**
Interest bearing securities:				
Money market securities	124,320	124,320	101,113	101,113
Fixed income securities	1,540,138	1,549,534	1,543,462	1,546,500
	1,664,458	**1,673,854**	**1,644,575**	**1,647,613**
Equities:				
Canadian pooled equity funds	158,030	142,929	165,068	144,026
Global pooled equity funds	376,252	326,464	348,557	304,536
	534,282	**469,393**	**513,625**	**448,562**
	$ 2,316,752	**$ 2,261,259**	**$ 2,264,866**	**$ 2,202,841**

	2018	2017
Items at Fair Value		
Financial instruments designated to the fair value category	$ 1,917,841	$ 1,886,936
Portfolio investments in equity instruments that are quoted in an active market	398,450	377,429
Derivatives	461	501
	$ 2,316,752	**$ 2,264,866**

Included in investments is $173,725 (March 31, 2017 – $161,134) that is restricted for use as per the requirements in Sections 99 and 100 of the *Insurance Act* of Alberta. Endowments included in investments amount to $74,694 (March 31, 2017 – $74,710).

The following are the total net remeasurement gains on investments:

	2018	2017
Accumulated remeasurement gains	$ 20,835	$ 28,866
Restricted unrealized net gains attributable to unexpended deferred operating revenue and endowments (Note 14(b))	34,658	32,811
Restricted unrealized net gains attributable to unexpended deferred capital revenue (Note 15(b))	-	348
	$ 55,493	**$ 62,025**

Note 10 Investments (continued)

Fair Value Hierarchy

	2018							
	Level 1		Level 2		Level 3		Total	
Cash held for investing purposes	$	118,012	$	-	$	-	$	118,012
Interest bearing securities:								
Money market securities		-		124,320		-		124,320
Fixed income securities		-		1,393,124		147,014		1,540,138
Equities:								
Canadian pooled equity funds		155,358		2,672		-		158,030
Global pooled equity funds		243,092		133,160		-		376,252
	$	**516,462**	**$**	**1,653,276**	**$**	**147,014**	**$**	**2,316,752**
Percent of total		23%		71%		6%		100%

	2017							
	Level 1		Level 2		Level 3		Total	
Cash held for investing purposes	$	106,666	$	-	$	-	$	106,666
Interest bearing securities:								
Money market securities		-		101,113		-		101,113
Fixed income securities		-		1,406,541		136,921		1,543,462
Equities:								
Canadian pooled equity funds		148,172		16,896		-		165,068
Global pooled equity funds		229,257		119,300		-		348,557
	$	**484,095**	**$**	**1,643,850**	**$**	**136,921**	**$**	**2,264,866**
Percent of total		21%		73%		6%		100%

Note 11 Accounts Receivable

	2018						2017	
	Gross		Allowance for Doubtful Accounts		Net		Net	
Patient accounts receivable	$	131,336	$	25,972	$	105,364	$	85,357
AH operating transfers receivable		81,104		-		81,104		89,247
AH capital transfers receivable		38,766		-		38,766		-
Other operating transfers receivable		30,025		-		30,025		45,810
Other capital transfers receivable		86,413		-		86,413		82,797
Other accounts receivable		84,900		14		84,886		83,081
	$	**452,544**	**$**	**25,986**	**$**	**426,558**	**$**	**386,292**

At March 31, 2017, the total allowance for doubtful accounts was $24,323.

Note 12 Accounts Payable and Accrued Liabilities

	2018	2017
Payroll remittances payable and related accrued liabilities	$ 522,604	$ 523,543
Trade accounts payable and accrued liabilities	572,282	470,126
Provision for unpaid claims[(a)]	157,583	141,233
Obligations under capital leases[(b)]	112,675	31,641
Other liabilities	47,769	43,431
	$ 1,412,913	**$ 1,209,974**

Accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $254,866 (2017 – $114,519).

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

The provision has been estimated using the discounted value of claim liabilities using a discount rate of 2.35% (2017 – 2.20%) plus a provision for adverse deviation, based on actuarial estimates.

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

The obligations expire between 2018 and 2036 and have an implicit interest rate payable ranging from 2.42% to 6.97% (2017– 1.42% to 6.91%).

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

Year ended March 31	Minimum Contract Payments
2019	$ 24,199
2020	23,349
2021	23,011
2022	23,011
2023	11,212
Thereafter	24,996
	129,778
Less: interest	(17,103)
	$ 112,675

(c) Liability for Contaminated Sites

At March 31, 2018, AHS has not identified or accepted any liability for contaminated sites (2017 – $nil).

Note 13 Employee Future Benefits

		2018		2017
Accrued vacation pay	$	553,875	$	540,547
Accumulating non-vesting sick leave liability[a]		119,261		112,490
Registered defined benefit pension plans[b] [c]		-		-
	$	**673,136**	**$**	**653,037**

(a) Accumulating Non-Vesting Sick Leave Liability

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

The AHS sick leave liability is based on an actuarial valuation as at March 31, 2015 and extrapolated to March 31, 2018.

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

		2018		2017
Change in accrued benefit obligation and funded status				
Accrued benefit obligation and funded status, beginning of year	$	115,177	$	118,969
Current service cost		10,595		10,262
Interest cost		3,779		3,621
Benefits paid		(8,870)		(8,675)
Actuarial gain		(20,683)		(9,000)
Accrued benefit obligation and funded status, end of year	**$**	**99,998**	**$**	**115,177**
Reconciliation to accrued benefit liability				
Funded status – deficit	$	99,998	$	115,177
Unamortized net actuarial gain (loss)		19,263		(2,687)
Accrued benefit liability	**$**	**119,261**	**$**	**112,490**
Components of expense				
Current service cost	$	10,595	$	10,262
Interest cost		3,779		3,621
Amortization of net actuarial loss		1,267		1,267
Net expense	**$**	**15,641**	**$**	**15,150**
Assumptions				
Discount rate – beginning of year		2.02%		2.90%
Discount rate – end of year		3.38%		2.02%
Rate of compensation increase per year		2017-2018 0.75% 2018-2019 0.75% Thereafter 2.75%		2016-2017 2.43% 2017-2018 0.75% Thereafter 2.75%

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP. AHS is not responsible for future funding of the plan deficit other than through contribution increases. As AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

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

Note 13 Employee Future Benefits (continued)

(ii) LAPP Surplus (Deficiency)

An actuarial valuation of the LAPP was carried out as at December 31, 2016 and these results were then extrapolated to December 31, 2017. The LAPP's December 31, 2017 net assets available for benefits divided by the LAPP's pension obligation shows that the LAPP is 113% (2016 – 98%) funded.

	December 31, 2017	December 31, 2016
LAPP net assets available for benefits	$ 42,728,515	$ 37,722,943
LAPP pension obligation	37,893,000	38,360,300
LAPP surplus (deficiency)	**$ 4,835,515**	**$ (637,357)**

The 2017 and 2018 LAPP contribution rates are as follows:

Calendar 2018		Calendar 2017	
Employer	Employees	Employer	Employees
10.39% of pensionable earnings up to the YMPE and 14.84% of the excess	9.39% of pensionable earnings up to the YMPE and 13.84% of the excess	11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess

(c) Pension Expense

	2018	2017
Local Authorities Pension Plan	$ 587,007	$ 595,795
Defined contribution pension plans and group RRSPs	49,021	48,397
Supplemental Pension Plan	2,303	2,230
Supplemental Executive Retirement Plans	(1,826)	2,240
Management Employees Pension Plan	393	585
	$ 636,898	**$ 649,247**

Note 14 Unexpended Deferred Operating Revenue

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

	2018				2017
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 129,855	$ 45,686	$ 235,538	$ 411,079	$ 429,515
Received or receivable during the year, net of repayments	1,131,919	40,064	185,432	1,357,415	1,139,067
Restricted investment income	282	1,450	4,869	6,601	7,716
Transferred from (to) unexpended deferred capital revenue	8,150	51,671	(14,947)	44,874	47,461
Recognized as revenue	(1,134,483)	(112,460)	(126,311)	(1,373,254)	(1,191,751)
Miscellaneous other revenue recognized	(197)	(20)	(28,100)	(28,317)	(25,182)
	135,526	**26,391**	**256,481**	**418,398**	**406,826**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	2,136	(20)	(269)	1,847	4,253
Balance, end of year	**$ 137,662**	**$ 26,371**	**$ 256,212**	**$ 420,245**	**$ 411,079**

[i] The balance at March 31, 2018 for other government includes $506 of unexpended deferred operating revenue received from the federal government (March 31, 2017 – $582). The remaining balance in other government all relates to the GOA, see Note 21.

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

	2018				2017
	AH	Other Government	Donors and Non-Government	Total	Total
Research and education	$ 19,465	$ 1,521	$ 150,309	$ 171,295	$ 157,178
Physician revenue and alternate relationship plans	38,046	1,612	-	39,658	27,241
Primary Care Networks	27,319	-	13	27,332	19,372
Long term care partnerships	-	16,735	-	16,735	17,227
Promotion, prevention and community	11,819	4,395	159	16,373	26,839
Addiction and mental health	15,888	29	335	16,252	20,912
Cancer prevention, screening and treatment	13,306	-	892	14,198	28,165
Administration and support services	1,062	761	53,267	55,090	59,374
Others less than $10,000	10,381	1,318	16,955	28,654	21,960
	137,286	**26,371**	**221,930**	**385,587**	**378,268**
Unrealized net gain (loss) attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 10)	376	-	34,282	34,658	32,811
	$ 137,662	**$ 26,371**	**$ 256,212**	**$ 420,245**	**$ 411,079**

Note 15 Unexpended Deferred Capital Revenue

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

	2018				2017
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 39,556	$ 15,958	$ 82,292	$ 137,806	$ 148,319
Received or receivable during the year	101,501	165,695	39,751	306,947	244,139
Transferred tangible capital assets (Note 18(a))	-	331,551	71	331,622	215,933
Other transfers	6,202	(6,202)	-	-	-
Unexpended deferred capital revenue returned	(7,071)	-	(310)	(7,381)	(1,220)
Transfer to expended deferred capital revenue	(83,354)	(446,473)	(40,194)	(570,021)	(422,225)
Transferred (to) from unexpended deferred operating revenue	(8,150)	(51,671)	14,947	(44,874)	(47,461)
	48,684	**8,858**	**96,557**	**154,099**	**137,485**
Changes in unrealized net gain on portfolio investments related to unexpended deferred capital revenue	(348)	-	-	(348)	321
Balance, end of year	**$ 48,336**	**$ 8,858**	**$ 96,557**	**$ 153,751**	**$ 137,806**

[(i)] The balance at March 31, 2018 for other government all relates to the GOA, see Note 21.

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

	2018	2017
AH		
Information systems less than $10,000	$ 42,132	$ 32,504
Medical Equipment Replacement Upgrade Program	147	18
Equipment less than $10,000	6,057	6,686
Total AH	**48,336**	**39,208**
Other government		
Facilities and improvements less than $10,000	8,858	15,958
Total other government	**8,858**	**15,958**
Donors and non-government		
Equipment less than $10,000	92,626	80,482
Facilities and improvements less than $10,000	3,931	1,810
Total donors and non-government	**96,557**	**82,292**
Unrealized net gain on portfolio investments related to unexpended deferred capital revenue (Note 10)	-	348
	$ 153,751	**$ 137,806**

Note 16 Expended Deferred Capital Revenue

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

	2018				2017
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 256,313	$ 6,111,388	$ 182,069	$ 6,549,770	$ 6,530,432
Transferred from unexpended deferred capital revenue	83,354	446,473	40,194	570,021	422,225
Less: amounts recognized as revenue	(66,085)	(287,096)	(31,156)	(384,337)	(402,887)
Balance, end of year	**$ 273,582**	**$ 6,270,765**	**$ 191,107**	**$ 6,735,454**	**$ 6,549,770**

[i] The balance at March 31, 2018 for other government includes $52 of expended deferred capital revenue received from the federal government (March 31, 2017 – $78). The remaining balance in other government all relates to the GOA, see Note 21.

Note 17 Debt

	2018	2017
Debentures payable[a]:		
Parkade loan #1	$ 29,424	$ 32,223
Parkade loan #2	27,951	30,278
Parkade loan #3	36,630	39,089
Parkade loan #4	140,098	147,262
Parkade loan #5	33,938	35,605
Parkade loan #6	23,505	24,418
Parkade loan #7	51,500	51,500
Energy savings initiative loan	25,800	25,800
Other	929	1,212
	369,775	**387,387**
Loan proceeds to be received[b]	-	(67,300)
	$ 369,775	**$ 320,087**

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

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

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

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

(b) During the year, loan proceeds of $46,500 were received relating to the Foothills Medical Centre Lot 1 parkade debenture (Parkade loan #7). Semi-annual principal and interest payments of $1,665 will commence September 2018. In addition, loan proceeds of $20,800 were received relating to the energy savings initiative. Semi-annual principal and interest payments of $1,162 will commence June 2018.

Note 17 Debt (continued)

AHS is committed to making payments as follows:

		Debentures Payable and Other Loans Payable
Year ended March 31		**Principal Payments**
2019	$	22,133
2020		23,091
2021		24,092
2022		24,800
2023		25,878
Thereafter		249,781
	$	**369,775**

During the year, the amount of total interest expensed, including interest related to obligations under capital leases, was $15,915 (2017 – $16,221).

As at March 31, 2018, AHS has access to a $220,000 (March 31, 2017 – $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, 2018, AHS has $nil (March 31, 2017 – $nil) draws against this facility.

AHS also has access to a $33,000 (March 31, 2017 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2018, AHS has $4,790 (March 31, 2017 – $3,469) in a letter of credit outstanding against this facility. AHS is in compliance with the terms of the agreement relating to the letter of credit, therefore no liability has been recorded.

Note 18 Tangible Capital Assets

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

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

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

Note 18 Tangible Capital Assets (continued)

Cost	2016	Additions[a]	Transfers out of Work in Progress	Disposals	2017
Facilities and improvements	$ 8,488,610	$ -	$ 510,770	$ (2,625)	$ 8,996,755
Work in progress	1,086,124	418,267	(590,285)	-	914,106
Equipment[b]	2,179,617	153,429	1,256	(31,483)	2,302,819
Information systems	1,331,861	24,391	17,754	(11,350)	1,362,656
Building service equipment	567,261	-	43,815	(55)	611,021
Land[c]	110,069	687	-	(167)	110,589
Leased facilities and improvements	219,937	247	4,784	-	224,968
Land improvements	70,919	-	11,906	(61)	82,764
	$ 14,054,398	**$ 597,021**	**$ -**	**$ (45,741)**	**$ 14,605,678**

Accumulated Amortization	2016	Amortization Expense	Effect of Transfers	Disposals	2017
Facilities and improvements	$ 3,179,295	$ 236,203	$ -	$ (2,626)	$ 3,412,872
Work in progress	-	-	-	-	-
Equipment[b]	1,678,226	155,393	-	(31,084)	1,802,535
Information systems	1,081,472	110,696	-	(11,350)	1,180,818
Building service equipment	332,616	32,449	-	(49)	365,016
Land[c]	-	-	-	-	-
Leased facilities and improvements	149,431	12,891	-	-	162,322
Land improvements	60,287	2,812	-	(61)	63,038
	$ 6,481,327	**$ 550,444**	**$ -**	**$ (45,170)**	**$ 6,986,601**

	Net Book Value	
	2017	2016
Facilities and improvements	$ 5,583,883	$ 5,309,315
Work in progress	914,106	1,086,124
Equipment[b]	500,284	501,391
Information systems	181,838	250,389
Building service equipment	246,005	234,645
Land[c]	110,589	110,069
Leased facilities and improvements	62,646	70,506
Land improvements	19,726	10,632
	$ 7,619,077	**$ 7,573,071**

(a) Transferred Tangible Capital Assets

Additions include total transferred tangible capital assets of $331,622 (2017 – $215,933) consisting of $331,551 from AI (2017 – $215,933) and $71 from other sources (2017 – $nil).

(b) Leased Equipment

Equipment includes tangible capital assets acquired through capital leases at a cost of $13,352 (2017 – $13,417) with accumulated amortization of $11,637 (March 31, 2017 – $11,266). For the year ended March 31, 2018, leased equipment included a net increase of $494 related to vehicles under capital leases (2017 – net decrease of $1,137).

Note 18 Tangible Capital Assets (continued)

(c) Leased Land

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

Site	Leased from	Lease Expiry
Cross Cancer Institute Parkade	University of Alberta	2019
Evansburg Community Health Centre	Yellowhead County	2031
Myrnam Land	Eagle Hill Foundation	2038
Two Hills Helipad	Stella Stefiuk	2041
McConnell Place North	City of Edmonton	2044
Northeast Community Health Centre	City of Edmonton	2047
Foothills Medical Centre Parkade	University of Calgary	2054
Alberta Children's Hospital	University of Calgary	2103

Note 19 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2018					2017
	Unrestricted Surplus[a]	Internally Restricted Surplus for Future Purposes[b]	Invested in Tangible Capital Assets[c]	Endowments[d]	Total	Total
Balance, beginning of year	$ 211,715	$ 224,929	$ 714,305	$ 74,710	$ 1,225,659	$ 1,159,123
Annual operating surplus	91,396	-	-	-	91,396	66,536
Tangible capital assets acquired with internal funds	(237,934)	-	237,934	-	-	-
Amortization of internally funded tangible capital assets	154,302	-	(154,302)	-	-	-
Repayment of debt used to fund tangible capital assets	(17,612)	-	17,612	-	-	-
Payments on obligations under capital leases	(2,207)	-	2,207	-	-	-
Net receipt of life lease deposits	596	-	(596)	-	-	-
Transfer of internally restricted	(12,247)	12,247	-	-	-	-
Transfer of endowment contributions	16	-	-	(16)	-	-
Balance, end of year	**$ 188,025**	**$ 237,176**	**$ 817,160**	**$ 74,694**	**$ 1,317,055**	**$ 1,225,659**

(a) Unrestricted Surplus

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

Note 19 Accumulated Surplus (continued)

(b) Internally Restricted Surplus for Future Purposes

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

	2018		2017	
Ancillary services (i)	$	124,525	$	112,718
Insurance equity requirements (ii)		34,835		42,224
Foundations (iii)		41,395		39,987
Other (iv)		36,421		30,000
Internally restricted surplus for future purposes	**$**	**237,176**	**$**	**224,929**

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

(c) Invested in Tangible Capital Assets

The restriction of accumulated surplus is equal to the net book value of internally funded tangible capital assets as these amounts are only available to AHS for its health care mandate.

(d) 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 $328 (2017 - $1,308) of contributions and reinvested income received in the year (Note 5) offset by other transfers of $344 (2017 - $nil).

Note 20 Contractual Obligations and Contingent Liabilities

(a) Leases

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

Year ended March 31	Total Lease Payments	
2019	$	57,541
2020		48,727
2021		42,188
2022		39,702
2023		34,182
Thereafter		75,950
	$	**298,290**

(b) Contingent Liabilities

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

Accruals have been made in specific instances where it is likely that losses will be incurred based on a reasonable estimate. As at March 31, 2018, accruals have been recorded as part of the provision for unpaid claims and other liabilities (Note 12). Included in this accrual are claims in which AHS has been jointly named with the Minister. The accrual provided for these claims under the provision for unpaid claims represents AHS' portion of the liability.

AHS has been named in 223 legal claims (2017 – 186 claims) related to conditions in existence at March 31, 2018 where the likelihood of the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 208 claims have $308,012 in specified amounts and 15 have no specified amounts (2017 – 179 claims with $310,941 of specified claims and 7 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that is different than the claimed amount.

Note 20 Contractual Obligations and Contingent Liabilities (continued)

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

Note 21 Related Parties

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

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

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

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

	Revenues[(a)]		Expenses	
	2018	2017	2018	2017
Ministry of Advanced Education[(b)]	$ 55,936	$ 52,621	$ 179,759	$ 122,527
Ministry of Infrastructure[(c)]	350,196	373,253	276	24,538
Other ministries[(d)]	58,101	60,865	31,460	29,341
Total for the year	**$ 464,233**	**$ 486,739**	**$ 211,495**	**$ 176,406**

	Receivable from		Payable to	
	2018	2017	2018	2017
Ministry of Advanced Education [(b)]	$ 4,578	$ 5,536	$ 22,749	$ 26,449
Ministry of Infrastructure [(c)]	21,526	23,623	-	-
Other ministries [(d)]	16,891	30,412	378,440	322,157
Balance, end of year	**$ 42,995**	**$ 59,571**	**$ 401,189**	**$ 348,606**

(a) Revenues with GOA ministries include other government transfers of $429,855 (2017 – $449,067), (Note 4), other income of $33,605 (2017 – $37,422), (Note 6), and fees and charges of $773 (2017 – $250).

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

(c) The transactions with the Ministry of Infrastructure (AI) relate to the construction and funding of tangible capital assets. These transactions include operating transfers of $63,699 (2017 – $71,225) and recognition of expended deferred capital revenue of $286,497 (2017 – $277,660) relating to tangible capital assets with stipulations or external restrictions to utilize over their remaining useful lives. Per Note 2(b), effective April 1, 2017 unallocated costs with AI, which comprise space provided rent free, are no longer recognized (2017 - $24,368) in these consolidated financial statements. Not included in the table above but included in total amounts disclosed in Note 18(a) is the transfer of tangible capital assets from AI of $331,551 (2017 – $215,933).

Note 21 Related Parties (continued)

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

At March 31, 2018, AHS has recorded deferred revenue from other ministries within the GOA, excluding AH, of $25,865 (March 31, 2017 – $45,104) related to unexpended deferred operating revenue (Note 14), $8,858 (March 31, 2017 – $15,958) related to unexpended deferred capital revenue (Note 15) and $6,270,713 (March 31, 2017 – $6,111,310) related to expended deferred capital revenue (Note 16).

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

Note 22 Government Partnerships

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

	2018	2017
Financial assets	$ 74,306	$ 57,950
Liabilities	74,306	57,950
Accumulated surplus	$ -	$ -
Total revenues	$ 248,123	$ 231,097
Total expenses	248,123	231,097
Annual surplus	**$ -**	**$ -**

Note 23 Trusts under Administration

(a) Health Benefit Trust of Alberta (HBTA)

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

HBTA's balances as at December 31 are as follows;

	2017	2016
Financial assets	$ 131,234	$ 93,274
Liabilities	15,340	15,091
Net financial assets	$ 115,894	$ 78,183
Non- financial assets	6	-
Net assets	**$ 115,900**	**$ 78,183**

AHS has included in prepaid expenses $91,077 (March 31, 2017 – $64,317) as a share of the HBTA's net assets representing in substance a prepayment of future premiums. For the fiscal year ended March 31, 2018, AHS paid premiums of $382,090 (2017 – $340,947) to HBTA.

(b) Other Trust Funds

AHS receives funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to appropriate the funds or to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2018, the balance of funds held in trust by AHS for research and development is $150 (March 31, 2017 – $514).

Note 23 Trusts under Administration (continued)

AHS receives funds in trust from continuing care residents for personal expenses. As at March 31, 2018, the balance of these funds is $1,686 (March 31, 2017 – $1,717). These amounts are not included in the consolidated financial statements.

Note 24 Segment Disclosure

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

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

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

Segments include:

(a) Community-based care

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

(b) Home care

Home care is comprised of home nursing and support.

(c) Continuing care

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

(d) Population and public health

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

(e) Ambulance services

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

(f) Acute care

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

(g) Diagnostic and therapeutic services

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

Note 24 Segment Disclosure (continued)

(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, food services, and emergency preparedness.

(i) Information technology

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

(j) Administration

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

Note 25 Corresponding Amounts

Certain amounts have been reclassified to conform to 2018 presentation.

Note 26 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on May 31, 2018.

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

	2018		2017
	Budget (Note 3)	Actual	Actual
Salaries and benefits (Schedule 2)	$ 8,092,000	$ 8,070,000	$ 7,983,182
Contracts with health service providers	2,642,000	2,621,371	2,539,854
Contracts under the Health Care Protection Act	18,000	18,337	20,198
Drugs and gases	462,000	456,714	449,620
Medical and surgical supplies	403,000	413,840	385,213
Other contracted services	1,136,000	1,253,012	1,106,722
Other[(a)]	1,368,000	1,392,534	1,367,628
Amortization and disposals of tangible capital assets (Note 18)	548,000	538,639	551,015
	$ 14,669,000	**$ 14,764,447**	**$ 14,403,432**
(a) Significant amounts included in Other are:			
Equipment expense		$ 217,356	$ 223,364
Other clinical supplies		154,101	152,312
Building and ground expenses		119,572	121,044
Utilities		117,997	105,159
Building rent		112,318	132,080
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies		92,498	90,259
Food and dietary supplies		82,107	81,985
Office supplies		61,378	54,040
Insurance and liability claims		58,398	49,639
Fundraising and grants awarded		51,621	50,859
Minor equipment purchases		47,230	45,831
Travel		38,646	41,734
Telecommunications		38,026	39,397
Licenses, fees and memberships		30,964	28,477
Education		12,691	12,107
Other		157,631	139,341
		$ 1,392,534	**$ 1,367,628**

SCHEDULE 2 - CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2018

	2018								2017	
						Severance [e]				
	FTE[a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Number of Individuals	Amount	Total	FTE [a]	Total
Total Board (Sub-Schedule 2A)	9.25	$ -	$ 311	$ -	$ 311	-	$ -	$ 311	9.21	$ 310
Total Executive (Sub-Schedule 2B)	14.12	5,281	50	754	6,085	-	-	6,085	13.86	6,141
Management Reporting to CEO Direct Reports	72.86	16,161	432	3,115	19,708	2	361	20,069	66.06	18,691
Other Management	2,964.39	353,522	3,332	78,636	435,490	26	2,811	438,301	2,985.79	447,135
Medical Doctors not included above[f]	148.12	46,127	498	3,165	49,790	1	46	49,836	150.06	50,989
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	19,137.97	1,822,395	250,763	402,717	2,475,875	6	105	2,475,980	18,966.63	2,462,404
LPNs	4,987.54	327,262	41,251	71,217	439,730	-	-	439,730	4,836.11	422,959
Other health technical and professional	16,461.03	1,475,722	84,064	338,698	1,898,484	7	303	1,898,787	16,307.58	1,880,814
Unregulated health service providers	8,908.36	451,595	55,185	105,314	612,094	3	65	612,159	8,716.34	592,955
Other staff	26,738.08	1,670,483	91,267	365,723	2,127,473	55	1,681	2,129,154	26,382.57	2,101,209
Sub-total	**79,441.72**	**6,168,548**	**527,153**	**1,369,339**	**8,065,040**	**100**	**5,372**	**8,070,412**	**78,434.21**	**7,983,607**
Less amounts included in Other contracted services		(344)	(2)	(66)	(412)	-	-	(412)		(425)
Total		**$ 6,168,204**	**$ 527,151**	**$ 1,369,273**	**$ 8,064,628**	**100**	**$ 5,372**	**$ 8,070,000**		**$ 7,983,182**

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

SUB-SCHEDULE 2A – BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2018

	Term	2018 Committees	2018 Remuneration	2017 Remuneration
Board Chair				
Linda Hughes[g]	Since Nov 27, 2015	ARC, CEC, FC, GC, HRC, QSC	$ 67	$ 71
Board Members				
Dr. Brenda Hemmelgarn (Vice Chair)	Since Nov 27, 2015	CEC (Chair), QSC	48	51
David Carpenter	Since Nov 27, 2015	ARC (Chair), CEC, FC (Chair)	35	38
Richard Dicerni	Since Nov 27, 2015	FC, HRC (Chair)	30	30
Heather Hirsch	Since Nov 3, 2016	CEC, QSC	31	9
Hugh Sommerville	Since Nov 27, 2015	ARC, GC (Chair)	33	37
Marliss Taylor	Since Nov 27, 2015	CEC, GC, HRC	32	36
Glenda Yeates	Since Nov 27, 2015	ARC, FC, QSC (Chair)	33	33
Board Committee Participants[h]				
Dr. Thomas Feasby	Nov 27, 2015 to Jan 18, 2017	QSC	-	2
Dr. Brian Postl	Since Jan 1, 2018	QSC	-	-
Gord Winkel	Since Nov 27, 2015	QSC	2	3
Total Board			**$ 311**	**$ 310**

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

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

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

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2018

	2018						
For the Current Fiscal Year	**FTE [(a)]**	**Base Salary [(b)]**	**Other Cash Benefits [(c)]**	**Other Non-Cash Benefits [(d)]**	**Subtotal**	**Severance [(e)]**	**Total**
Board Direct Reports							
Dr. Verna Yiu – President and Chief Executive Officer[(i,w)]	1.00	$ 572	$ -	$ 104	$ 676	$ -	$ 676
Ronda White – Chief Audit Executive[(j,x)]	1.00	276	-	64	340	-	340
Andrea Beckwith-Ferraton – Chief Ethics and Compliance Officer[(k,x)]	0.79	166	-	40	206	-	206
CEO Direct Reports							
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta[(x)]	1.00	369	-	45	414	-	414
Dr. Ted Braun – VP and Medical Director, Central and Southern Alberta[(x)]	1.00	395	-	47	442	-	442
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta[(l,x)]	1.00	369	-	27	396	-	396
Dr. Mark Joffe – VP and Medical Director, Northern Alberta[(m,n,y)]	1.00	449	35	44	528	-	528
Dr. David Mador – VP and Medical Director, Northern Alberta[(o)]	0.08	36	-	4	40	-	40
Sean Chilton – VP, Collaborative Practice, Nursing and Health Professions[(x)]	1.00	329	-	72	401	-	401
Dr. Francois Belanger – VP, Quality and Chief Medical Officer[(p,x)]	1.00	462	-	43	505	-	505
Mauro Chies – VP, Clinical Support Services[(q,x)]	1.00	304	-	52	356	-	356
Karen Horon – Acting VP, Clinical Support Services[(r)]	0.19	44	-	8	52	-	52
Dr. Kathryn Todd – VP, System Innovation and Programs[(n,y)]	1.00	286	15	39	340	-	340
Todd Gilchrist – VP, People, Legal and Privacy[(s,x)]	1.00	449	-	64	513	-	513
Colleen Turner – VP, Community Engagement and Communications[(t,x)]	1.00	329	-	30	359	-	359
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer[(u,x)]	1.00	433	-	68	501	-	501
Noela Inions – Chief Ethics and Compliance Officer[(v,z)]	0.06	13	-	3	16	-	16
Total Executive	**14.12**	**$ 5,281**	**$ 50**	**$ 754**	**$ 6,085**	**$ -**	**$ 6,085**

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2018 (CONTINUED)

	2017						
For the Prior Fiscal Year	FTE [(a)]	Base Salary [(b)]	Other Cash Benefits [(c)]	Other Non-Cash Benefits [(d)]	Subtotal	Severance [(e)]	Total
Board Direct Reports							
Dr. Verna Yiu – President and Chief Executive Officer	1.00	$ 565	$ 16	$ 163	$ 744	$ -	$ 744
Ronda White – Chief Audit Executive	1.00	240	-	39	279	-	279
CEO Direct Reports							
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta	1.00	370	-	44	414	-	414
Dr. Ted Braun – VP and Medical Director, Central and Southern Alberta	1.00	383	5	69	457	-	457
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta	1.00	370	-	104	474	-	474
Dr. David Mador – VP and Medical Director, Northern Alberta	1.00	450	-	104	554	-	554
Sean Chilton – VP, Collaborative Practice, Nursing and Health Professions	0.27	89		14	103	-	103
Dave Bilan – Interim VP, Collaborative Practice, Nursing and Health Professions	0.77	130	-	2	132	-	132
Dr. Francois Belanger – VP, Quality and Chief Medical Officer	1.00	456	-	93	549	-	549
Karen Horon – Acting VP, Clinical Support Services	0.02	5	-	1	6	-	6
Mauro Chies – VP, Clinical Support Services	0.80	245		40	285	-	285
Dr. Kathryn Todd – VP, Research, Innovation and Analytics	1.00	264	13	32	309	-	309
Todd Gilchrist – VP, People, Legal and Privacy	1.00	450	-	78	528	-	528
Colleen Turner – VP, Community Engagement and Communications	1.00	314	-	81	395	-	395
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer	1.00	370	-	65	435	-	435
Noela Inions – Chief Ethics and Compliance Officer	1.00	226	-	32	258	219	477
Total Executive	**13.86**	**$ 4,927**	**$ 34**	**$ 961**	**$ 5,922**	**$ 219**	**$ 6,141**

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

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

	2018			2017			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2017	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2018
Dr. Verna Yiu - President and Chief Executive Officer	$ 49	$ -	$ 49	$ 41	$ 41	$ 49	$ 90
Ronda White - Chief Audit Executive	14	-	14	9	63	17	80
Andrea Beckwith-Ferraton - Chief Ethics and Compliance Officer	5	-	5	3	6	6	12
Brenda Huband - VP and Chief Health Operations Officer, Central and Southern Alberta							
SERP	-	(18)	(18)	23	380	9	389
SPP	24	-	24	25	125	30	155
Dr. Ted Braun - VP and Medical Director, Central and Southern Alberta							
SERP	-	(10)	(10)	12	209	6	215
SPP	28	-	28	27	85	32	117
Deb Gordon - VP and Chief Health Operations Officer, Northern Alberta							
SERP	-	(31)	(31)	35	649	17	666
SPP	24	-	24	25	116	31	147
Dr. Mark Joffe - VP and Medical Director, Northern Alberta[n]	-	-	-	-	-	-	-
Dr. David Mador - VP and Medical Director, Northern Alberta	19	-	19	35	144	24	168
Sean Chilton - VP, Collaborative Practice, Nursing and Health Professions	20	-	20	18	115	24	139
Dr. Francois Belanger - VP, Quality and Chief Medical Officer	36	-	36	35	172	47	219
Mauro Chies - VP, Clinical Support Services	17	-	17	16	67	20	87
Karen Horon - Acting VP, Clinical Support Services	4	-	4	4	16	5	21
Dr. Kathryn Todd - VP, System Innovation and Programs[n]	-	-	-	-	-	-	-
Todd Gilchrist - VP, People, Legal and Privacy	34	-	34	35	67	37	104
Colleen Turner - VP, Community Engagement and Communications	20	-	20	18	70	24	94
Deborah Rhodes - VP, Corporate Services and Chief Financial Officer	32	-	32	25	170	41	211
Noela Inions - Chief Ethics and Compliance Officer	-	-	-	8	76	(76)	-

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

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2018

Definitions

a. For this schedule, full time equivalents (FTE) are determined by actual hours earned divided by 2,022.75 annual base hours. FTE for the Board and Board committee members are prorated using the number of days in the fiscal year between either the date of appointment and the end of the year, the date of appointment and the termination date, or the beginning of the year and the termination date.

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

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

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

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

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

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

Board and Board Committee Participants

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

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

Executive

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

j. As a result of a reclassification of their position, the incumbent received an increase in base salary effective April 1, 2017.

k. The incumbent held the position of Acting Chief Ethics and Compliance Officer until June 18, 2017 at which time the incumbent was appointed Chief Ethics and Compliance Officer and became a direct report to the AHS Board. The incumbent received an increase in compensation for the new position.

l. The incumbent received a vacation payout of $15 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

m. The incumbent was appointed to the position effective April 1, 2017.

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

o. The incumbent held the position of Vice President and Medical Director, Northern Alberta until May 1, 2017 at which time the incumbent moved to a part-time consultancy position and is no longer a direct report to the President and Chief Executive Officer.

p. The incumbent received a vacation payout of $39 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

q. The incumbent returned from a temporary leave of absence on June 5, 2017, during which he received salary continuance, and resumed the role of Vice President, Clinical Support Services. The incumbent received a vacation payout of $2 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.

r. The incumbent held the position of Acting Vice President, Clinical Support Services until June 12, 2017 at which time the incumbent resumed the role of Senior Operating Officer, Pharmacy Services and is no longer a direct report to the President and Chief Executive Officer.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2018 (CONTINUED)

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

t. The incumbent received a vacation payout of $22 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.

u. A compensation review for the incumbent was finalized May 23, 2017 and as a result, the incumbent's annual compensation was adjusted retroactive to September 29, 2014. The retroactive adjustment of $19 per annum is reflected in the current year base salary amount. In addition, the incumbent received a vacation payout of $1 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.

v. The incumbent held the position until April 21, 2017, at which time the accountability and scope of the position was expanded. The employer and employee negotiated a separation agreement which resulted in the incumbent resigning her position in exchange for a severance payment. The employer allowed this resignation to be communicated as a retirement. The incumbent received salary and other accrued entitlements to the date of resignation. The reported severance included 44 weeks of base salary at the rate in effect at the date of retirement and an additional 15% of the severance in lieu of benefits. This severance was expensed in the prior year. In addition, the incumbent received a vacation payout of $39 for unused accrued vacation at the time of resignation; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

Termination Obligations

w. 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.

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

y. There is no severance associated with the secondment agreement. Upon termination of the secondment agreement, the incumbent would return to the incumbent's regular position at the University of Alberta.

z. SPP

Based on the provision of the applicable SPP, the following outlines the benefits received by individuals who terminated employment with AHS within the 2017-18 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, 2017 and the current period benefit costs and investment gains or losses related to the account that were incurred during the current year. The AHS obligations are paid through either a lump sum payment or regular instalments:

Position	Supplemental Plan Commencement Date	Benefit (not in thousands)	Frequency	Payment Terms
Chief Ethics and Compliance Officer (SPP)	April 1, 2009	$79,315	Once	May 2017

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

	2018								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Care Protection Act	Drugs and gases	Medical and surgical supplies	Other contracted services	Other	Amortization and disposals of tangible capital assets	Total
Community-based care	$ 610,867	$ 620,882	$ -	$ 3,076	$ 3,643	$ 20,961	$ 77,774	$ 443	$ 1,337,646
Home care	287,294	220,857	-	144	6,421	72,220	23,266	313	610,515
Continuing care	309,691	717,001	-	7,413	5,376	4,071	26,413	1,711	1,071,676
Population and public health	292,051	9,584	-	7,342	2,609	12,373	14,056	436	338,451
Ambulance services	283,286	167,566	-	2,185	3,021	1,376	41,592	13,384	512,410
Acute care	2,973,443	389,239	18,337	420,969	329,427	609,582	185,228	55,065	4,981,290
Diagnostic and therapeutic services	1,512,912	300,340	-	12,696	57,552	263,333	223,634	40,505	2,410,972
Education and research	180,880	3,135	-	9	88	84,733	28,965	350	298,160
Support services	1,037,413	151,473	-	2,341	5,535	104,613	559,054	321,212	2,181,641
Information technology	225,874	584	-	-	-	37,570	141,891	104,070	509,989
Administration	356,289	40,710	-	539	168	42,180	70,661	1,150	511,697
Total	**$ 8,070,000**	**$ 2,621,371**	**$ 18,337**	**$ 456,714**	**$ 413,840**	**$ 1,253,012**	**$ 1,392,534**	**$ 538,639**	**$ 14,764,447**

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

	2017								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Care Protection Act	Drugs and gases	Medical and surgical supplies	Other contracted services	Other	Amortization and disposals of tangible capital assets	Total
Community-based care	$ 563,059	$ 580,520	$ -	$ 2,897	$ 3,207	$ 27,385	$ 71,092	$ 871	$ 1,249,031
Home care	274,160	209,600		575	6,978	68,156	25,287	557	585,313
Continuing care	315,100	690,517	-	7,409	5,320	5,958	27,073	1,741	1,053,118
Population and public health	307,058	10,177	-	9,343	1,619	16,202	10,077	224	354,700
Ambulance services	270,847	171,845	-	2,004	2,563	2,329	36,514	11,584	497,686
Acute care	3,015,073	386,558	20,198	409,359	300,030	459,640	186,483	63,666	4,841,007
Diagnostic and therapeutic services	1,502,015	290,270	-	16,015	58,985	266,963	210,900	55,094	2,400,242
Education and research	184,434	3,355	-	83	202	72,865	23,903	458	285,300
Support services	1,006,376	149,941	-	1,789	6,136	100,340	577,282	303,677	2,145,541
Information technology	214,987	8,143	-	-	-	41,500	137,396	111,394	513,420
Administration	330,073	38,928	-	146	173	45,384	61,621	1,749	478,074
TOTAL	**$ 7,983,182**	**$ 2,539,854**	**$ 20,198**	**$ 449,620**	**$ 385,213**	**$ 1,106,722**	**$ 1,367,628**	**$ 551,015**	**$ 14,403,432**

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

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

Total Compensation Philosophy

AHS reinforces outstanding patient care for all Albertans by attracting, retaining and engaging talented and committed employees. We do this with competitive and fair total compensation that motivates and rewards performance while demonstrating sound fiscal management and sustainability. Principles set out in the total compensation policy guided by AHS' total compensation philosophy reflect:

- Competitive market positioning
- Internal equity
- Performance orientation
- Affordability
- Individual flexibility
- Shared employee/employer responsibility

Total Compensation Strategy

AHS ensures the process used to set total compensation, establish and maintain good governance, and incorporate best practices is transparent. The job rates for Executive and Senior Leadership salary ranges are representative of the median of the national healthcare and Alberta public sector market. To ensure total compensation remains market competitive, AHS reviews its market positioning on a regular basis and, in any event, no less than once every second year. Salary ranges are published on the AHS website. AHS is currently under a salary freeze that applies to all government agencies, boards and commissions until September 30, 2019 and consequently has not conducted a regular review of its market positioning.

AHS' Total Compensation programs and practices encourage behaviours that will promote a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Total Compensation Plan Structure

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

Direct Compensation includes pay received as wages and salaries. It integrates with the AHS Performance Management Program. AHS has no incentive, variable pay or pay at risk of any kind. Base salary ranges are intended to be competitive compared to the median (50th percentile) of the national healthcare market and the Alberta public sector market. An employee's individual base salary is set based on individual performance and salary range adjustments within AHS market comparators.

Indirect Compensation includes benefits and pension (including supplemental pension plan), terms and conditions, and employee appreciation. AHS' benefits and pension plans support the health and well-being of our employees and financial security upon retirement. AHS provides a competitive benefits program that includes pension, health and dental-care benefits, life insurance, illness and long-term disability coverage and professional memberships.

All AHS employees are eligible to participate in the Local Authorities Pension Plan (LAPP). This is a defined benefit pension plan. It provides for a pension of 1.4% for each year of pensionable service based on the average salary of the highest five consecutive years up to the Year's Maximum Pensionable Earnings under the Canada Pension Plan and 2.0% on the excess. Benefits under this plan are capped at the maximum pension benefit limit allowed under the federal *Income Tax Act*, a salary of $163,992 in 2018.

As pensionable earnings are limited under LAPP, AHS provides a Supplemental Pension Plan (SPP). Unlike the Local Authorities Pension, the SPP is a Defined Contribution plan that provides annual notional contributions that are allocated to and invested as directed by each member. The SPP allows AHS to maintain a competitive position, but at less cost and risk to the organization. AHS does not provide car allowances or perquisite allowances to its executives or employees.

Total Compensation Governance

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

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

Total Compensation Reporting

The Schedule 2 – Consolidated Schedule of Salaries and Benefits in the annual audited consolidated financial statements for the year ended March 31, 2018, provides complete disclosure of salary, benefits, and all other compensation earned for years ended March 31, 2018 and March 31, 2017 by the direct reports to the Board and direct reports to the President & CEO. The Board's compensation is disclosed in Schedule 2 – Consolidated Schedule of Salaries and Benefits in the annual audited consolidated financial statements for the year ended March 31, 2018.

The Schedule 2 Information on total compensation philosophy and practices can be found on the AHS website.

Total Compensation 2017-18 Information Updates

The *Public Service Compensation Transparency Act* requires compensation disclosure from Alberta agencies, boards and commissions including AHS. AHS was required to disclose the names and compensation of employees whose earnings were over $126,375 per year. AHS disclosure under the Act was required by June 30, 2017, and was posted on AHS' external website. For 2017-18, AHS will be disclosing the names and compensation of employees whose earnings are over $127,765. The Alberta government has frozen salaries for all non-union and exempt employees at provincial agencies, boards and commissions as part of the province's ongoing restraint measures to reduce government operating costs. AHS is among the organizations affected by the freeze. The freeze will be in effect for 18 months, beginning April 1, 2018 and expiring September 30, 2019.

A compensation regulation under the *Reform of Agencies, Boards, and Commissions Act (RABCA)* established total compensation, including salary and benefits, for Chief Executive Officers or equivalent in 23 provincial agencies that are part of the *Alberta Public Agencies Governance Act (APAGA)*. This regulation came into effect on March 16, 2017 and applied to 23 provincial agencies identified in APAGA.

AHS is exempt from this regulation and the executive compensation structure developed by the Government. Alternatively, AHS has submitted an executive compensation plan to Government, which will be an annual process. This annual compensation plan will demonstrate how AHS aligns to the key compensation principles outlined in the Regulation and help ensure scrutiny of its compensation practices. Transparency will continue to be provided through mandated salary disclosure.

Effective April 1, 2018, the Government of Alberta also enacted a new Salary Restraint Regulation which formalizes the current salary restraint measures for APAGA agencies. This regulation outlines key provisions regarding the salary restraint, extends the salary freeze for public agencies until September 30, 2019 and defines terms of the freeze. The regulation also includes a section of Permitted Adjustments that allow for base salary increases in select circumstances and in accordance with the public agency's existing policies.

Appendix

- Year-End Performance Measure Results
- Monitoring Measures
- *Public Interest Disclosure (Whistleblower Protection) Act*
- Non-Hospital Surgical Facility Contracts under the *Health Care Protection Act* (Alberta)
- AHS Facilities and Beds

Year-End Performance Measure Results

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

AHS Performance Measure	2013-14	2014-15	2015-16	2016-17	2017-18	Year-to-Year Trend	2017-18 Target
Improve Patients' and Families' Experiences							
Percentage Placed in Continuing Care within 30 Days	69.2%	59.9%	59.6%	56.1%	51.8%	⇩	56%
Percentage of Alternate Level of Care (ALC) Patient Days	10.1%	12.2%	13.5%	15.4%	17.4%	⇩	14%
Timely Access To Specialty Care (eReferrals)	Not available	3	3	4	12	☆	10
Patient Satisfaction with Hospital Experience	81.5%	81.8%	81.8%	82.4%	81.7% (Q3 YTD)	⇨	85%
Addiction Outpatient Treatment Wait Time	18	15	13	15	13 (Q3 YTD)	⇧	12 days
Improve Patient and Population Health Outcomes							
Unplanned Medical Readmissions	13.5%	13.6%	13.7%	13.6%	13.7% (Q3 YTD)	⇨	13.4%
Perinatal Mortality Rate - First Nations (Gap)	4.49 (2013)	4.83 (2014)	5.43 (2015)	4.94 (2016)	2.90 (2017)	⇧	AHS' focus is to reduce gap between First Nations and Non First Nations.
Hand Hygiene Compliance	66%	75%	80%	82%	85%	⇧	90%
Childhood Immunization Rate - DTaP-IPV-Hib	77.6%	78.3%	78.0%	78.3%	77.7%	⇨	80%
Childhood Immunization Rate - MMR	86.7%	87.6%	86.9%	87.4%	86.9%	⇨	88%
Improve the Experience and Safety of Our People							
AHS Workforce Engagement Rate	Not available			3.46	Next survey in 2019-2020.		
Disabling Injury Rate	Not available		3.57	3.85	3.88	⇨	3.5
Improve Financial Health and Value for Money							
Percentage of Nursing Units Achieving Best Practice Targets	Not available		20%	28%	38%	☆	35%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

AHS Report on Performance FY 2017-18

PEOPLE PLACED IN CONTINUING CARE WITHIN 30 DAYS

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

Percentage Placed in Continuing Care within 30 Days, FY 2017-18

Percentage Placed in Continuing Care within 30 Days Trend

Zone Name	2013-14	2014-15	2015-16	2016-17	2017-18	Trend	2017-18 Target
Provincial	**69.2%**	**59.9%**	**59.6%**	**56.1%**	**51.8%**	⇩	**56%**
South Zone	77.2%	59.5%	47.6%	45.9%	43.3%	⇩	56%
Calgary Zone	72.0%	57.1%	58.4%	57.4%	58.7%	☆	56%
Central Zone	40.7%	54.6%	61.5%	60.3%	54.6%	⇩	56%
Edmonton Zone	78.4%	66.2%	64.5%	55.8%	48.7%	⇩	56%
North Zone	62.8%	58.8%	58.7%	57.5%	43.9%	⇩	56%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total Clients Placed

Zone	2015-16	2016-17	2017-18
Provincial	7,879	7,963	7,927
South Zone	887	925	905
Calgary Zone	2,722	2,438	2,632
Central Zone	1,060	1,352	1,236
Edmonton Zone	2,506	2,575	2,388
North Zone	704	673	766

Source: AHS Seniors Health Continuing Care Living Options Report, as of April 24, 2018

AHS Report on Performance FY 2017-18

PERCENTAGE OF ALTERNATE LEVEL OF CARE PATIENT DAYS

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

Percentage of ALC Patient Days, FY 2017-18

Percentage of ALC Patient Days Trend

Zone Name	Site Name	2013-14	2014-15	2015-16	2016-17	2017-18	Trend	2017-18 Target
Provincial	**Provincial**	**10.1%**	**12.2%**	**13.5%**	**15.4%**	**17.4%**	⇩	**14%**
South Zone	**South Zone**	**6.9%**	**9.0%**	**12.6%**	**13.9%**	**15.7%**	⇩	**14%**
	Chinook Regional Hospital	5.0%	4.4%	7.8%	8.6%	12.3%	☆	14%
	Medicine Hat Regional Hospital	9.2%	14.6%	18.9%	18.9%	22.0%	⇩	14%
	Other South Hospitals	7.1%	9.4%	11.5%	17.3%	11.6%	☆	14%
Calgary Zone	**Calgary Zone**	**11.7%**	**15.2%**	**16.7%**	**16.9%**	**19.0%**	⇩	**14%**
	Alberta Children's Hospital	0.0%	0.2%	1.3%	1.2%	2.0%	☆	14%
	Foothills Medical Centre	11.5%	15.7%	14.7%	15.2%	19.0%	⇩	14%
	Peter Lougheed Centre	11.0%	14.6%	13.6%	16.8%	14.2%	☆	14%
	Rockyview General Hospital	13.7%	16.2%	21.9%	22.2%	26.0%	⇩	14%
	South Health Campus	12.1%	14.4%	20.4%	17.6%	19.1%	⇩	14%
	Other Calgary Hospitals	17.5%	26.4%	27.2%	21.0%	21.9%	⇩	14%
Central Zone	**Central Zone**	**13.0%**	**13.1%**	**12.0%**	**15.3%**	**15.9%**	⇩	**14%**
	Red Deer Regional Hospital Centre	10.3%	11.4%	8.8%	12.4%	12.2%	☆	14%
	Other Central Hospitals	14.9%	14.4%	14.3%	17.2%	18.3%	⇩	14%
Edmonton Zone	**Edmonton Zone**	**7.8%**	**9.1%**	**9.5%**	**14.0%**	**15.5%**	⇩	**14%**
	Grey Nuns Community Hospital	8.7%	10.2%	9.2%	11.1%	10.8%	☆	14%
	Misericordia Community Hospital	8.0%	10.8%	12.8%	14.7%	17.3%	⇩	14%
	Royal Alexandra Hospital	8.4%	10.6%	11.0%	18.5%	18.6%	⇨	14%
	Stollery Children's Hospital	0.1%	0.0%	1.8%	0.6%	0.2%	☆	14%
	Sturgeon Community Hospital	10.7%	12.3%	12.3%	18.9%	22.5%	⇩	14%
	University of Alberta Hospital	6.8%	6.0%	6.2%	11.7%	15.3%	⇩	14%
	Other Edmonton Hospitals	9.2%	11.8%	12.1%	12.1%	14.4%	☆	14%
North Zone	**North Zone**	**11.7%**	**13.8%**	**18.5%**	**16.4%**	**21.3%**	⇩	**14%**
	Northern Lights Regional Health Centre	9.4%	7.4%	18.5%	12.0%	8.0%	☆	14%
	Queen Elizabeth II Hospital	8.5%	14.0%	20.4%	15.2%	26.0%	⇩	14%
	Other North Hospitals	13.2%	14.9%	17.9%	17.5%	21.9%	⇩	14%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total ALC Discharges

Zone	2015-16	2016-17	2017-18
Provincial	10,254	13,513	17,040
South Zone	624	674	663
Calgary Zone	4,684	5,027	6,178
Central Zone	1,085	1,327	1,418
Edmonton Zone	3,046	5,518	7,704
North Zone	815	967	1,077

Source: AHS Provincial Discharge Abstract Database (DAD), as of May 9, 2018

AHS Report on Performance FY 2017-18

TIMELY ACCESS TO SPECIALTY CARE

Number of specialty services with eReferral Advice Request enabled.

Number of Specialty Services with eReferrals Advice Request Enabled, FY 2017-18

Provincial

2017-18 Target

Specialty Services with eReferral Advice Request Enabled, FY 2017-18

Referral Types	2014-15	2015-16	2016-17	2017-18
Provincial Total	**3**	**3**	**4**	**12**
Advice - Oncology - Breast Cancer	√	√	√	√
Advice - Oncology - Lung Cancer	√	√	√	√
Advice - Orthopaedic Surgery	√	√	√	√
Advice - Nephrology			√	√
Advice - Urology				√
Advice - Internal Medicine/Adult Gastroenterology				√
Advice - Internal Medicine/Endocrinology				√
Advice - Internal Medicine/Pulmonary Medicine				√
Advice - Neuro Surgery/Spinal Neurosurgery				√
Advice - Obstetrics and Gynecology				√
Advice - Addiction and M H/Addiction Medicine				√
Advice - Internal Medicine/General Internal Medicine				√

Source: Netcare Repository, as of March 23, 2018
2017-18 reflects Fiscal Quarter 4 YTD data, unless specified otherwise.

AHS Report on Performance FY 2017-18

PATIENT SATISFACTION WITH HOSPITAL EXPERIENCE

This measure reflects patients' overall perceptions associated with the hospital where they received care. The higher the number, the better, as it demonstrates more patients are satisfied with their care in hospital.

Patient Satisfaction with Hospital Experience, Q3YTD 2017-18

Patient Satisfaction with Hospital Experience Trend

Zone Name	Site Name	2013-14	2014-15	2015-16	2016-17	Q3YTD 2016-17	Q3YTD 2017-18	Trend	2017-18 Target
Provincial	**Provincial**	**81.5%**	**81.8%**	**81.8%**	**82.4%**	**82.6%**	**81.7%**	⇨	**85%**
South Zone	**South Zone**	**81.7%**	**81.8%**	**80.9%**	**82.2%**	**82.8%**	**79.8%**	⇩	**85%**
	Chinook Regional Hospital	80.5%	76.6%	78.2%	82.3%	83.1%	79.8%	⇩	85%
	Medicine Hat Regional Hospital	80.7%	85.7%	81.3%	81.3%	81.5%	77.2%	⇩	85%
	Other South Hospitals	83.5%	88.3%	87.2%	85.5%	86.2%	85.6%	☆	85%
Calgary Zone	**Calgary Zone**	**80.1%**	**83.2%**	**82.0%**	**83.0%**	**83.1%**	**81.9%**	⇨	**85%**
	Foothills Medical Centre	76.6%	80.8%	80.8%	80.3%	80.9%	80.0%	⇨	85%
	Peter Lougheed Centre	80.9%	79.9%	77.2%	78.7%	78.7%	77.1%	⇨	85%
	Rockyview General Hospital	82.9%	85.4%	81.7%	85.1%	84.2%	82.7%	⇨	85%
	South Health Campus	91.9%	89.7%	90.1%	90.9%	91.4%	89.8%	☆	85%
	Other Calgary Hospitals	79.3%	90.3%	92.9%	92.2%	92.2%	92.7%	☆	85%
Central Zone	**Central Zone**	**83.5%**	**84.8%**	**83.4%**	**85.0%**	**85.3%**	**84.4%**	⇨	**85%**
	Red Deer Regional Hospital Centre	81.1%	83.0%	82.2%	82.7%	83.5%	83.0%	⇨	85%
	Other Central Hospitals	84.5%	86.7%	84.8%	87.0%	86.9%	85.9%	☆	85%
Edmonton Zone	**Edmonton Zone**	**81.5%**	**80.3%**	**81.6%**	**80.8%**	**80.9%**	**80.8%**	⇨	**85%**
	Grey Nuns Community Hospital	86.4%	87.2%	86.1%	86.4%	86.8%	85.4%	☆	85%
	Misericordia Community Hospital	78.5%	75.3%	77.2%	79.8%	79.8%	74.8%	⇩	85%
	Royal Alexandra Hospital	79.9%	76.5%	77.3%	76.6%	76.9%	78.2%	⇨	85%
	Sturgeon Community Hospital	89.8%	87.6%	89.8%	88.0%	88.1%	89.2%	☆	85%
	University of Alberta Hospital	77.1%	80.2%	83.5%	80.4%	80.0%	81.4%	⇨	85%
	Other Edmonton Hospitals	70.9%	85.3%	86.3%	85.7%	85.4%	84.4%	⇨	85%
North Zone	**North Zone**	**81.0%**	**80.6%**	**81.3%**	**83.2%**	**83.4%**	**82.3%**	⇨	**85%**
	Northern Lights Regional Health Centre	75.4%	74.7%	78.6%	82.2%	83.3%	82.7%	⇨	85%
	Queen Elizabeth II Hospital	76.0%	77.2%	78.6%	80.3%	81.3%	78.3%	⇩	85%
	Other North Hospitals	83.4%	83.7%	83.5%	84.8%	84.6%	83.7%	⇨	85%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total Eligible Discharges

Zone	2015-16	2016-17	Q3YTD 2016-17	Q3YTD 2017-18	Number of Completed Surveys	Margin of Error (±)
Provincial	218,546	246,917	185,622	184,636	6,300	0.96%
South Zone	19,737	19,840	14,879	14,759	526	3.42%
Calgary Zone	61,044	83,208	62,597	62,469	2,089	1.65%
Central Zone	29,272	29,531	22,156	22,048	795	2.48%
Edmonton Zone	82,559	89,005	67,141	65,829	2,159	1.68%
North Zone	25,934	25,333	18,849	19,531	731	2.68%

Source: AHS Canadian Hospital Consumer Assessment of Healthcare Providers and Systems (CH-CAHPS) Survey, as of May 1, 2018

Notes:
- *The results are reported a quarter later due to requirements to follow-up with patients after end of reporting quarter.*
- *April 27, 2018: In this reporting period quarter 3 (fiscal year 2017-18), the margin of errors were calculated using a normal estimated distribution for sample size greater than 10. If the sample size was less than 10, the Plus two & Plus four method was used.*
- *Provincial and zone level results presented here are based on weighted data.*
- *Facility level results and All Other Hospitals results presented here are based on unweighted data.*

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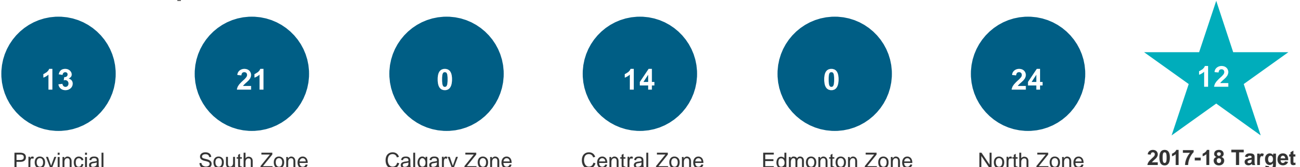
WAIT TIME FOR ADDICTION OUTPATIENT TREATMENT (in days)

This measure represents the time it takes to access adult addiction outpatient treatment services, expressed as the number of days that 9 out of 10 clients have attended their first appointment since referral or first contact. The lower the number the better, as it demonstrates people are waiting for a shorter time to receive adult addiction outpatient services.

Addiction Outpatient Treatment Wait Time, Q3YTD 2017-18



Addiction Outpatient Treatment Wait Time Trend by Zone (90th Percentile)

Wait Time Grouping	Zone Name	2013-14	2014-15	2015-16	2016-17	Q3YTD 2016-17	Q3YTD 2017-18	Trend	2017-18 Target
Provincial	**Provincial**	**18**	**15**	**13**	**15**	**15**	**13**	⇧	**12**
Urban									
	Calgary Zone	21	9	5	6	6	0	☆	12
	Edmonton Zone	17	14	0	0	0	0	☆	12
Rural									
	South Zone	13	20	21	26	27	21	⇧	12
	Central Zone	20	16	14	15	15	14	⇧	12
	North Zone	16	16	19	27	26	24	⇧	12

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Addiction Outpatient Treatment Wait Time Trend by Zone (Average)

Wait Time Grouping	Zone Name	2013-14	2014-15	2015-16	2016-17	Q3YTD 2016-17	Q3YTD 2017-18
Provincial	**Provincial**	**7.0**	**6.5**	**5.8**	**7.3**	**7.2**	**6.4**
Urban							
	Calgary Zone	7.7	7.4	7.9	11.4	11.1	9.8
	Edmonton Zone	6.4	5.1	1.2	0.9	0.8	0.4
Rural							
	South Zone	5.0	7.8	7.8	8.7	9.1	7.9
	Central Zone	7.3	6.2	6.0	6.2	6.2	5.3
	North Zone	7.5	7.3	8.2	11.1	11.0	10.6

Total Enrollments

Zone	2015-16	2016-17	Q3YTD 2016-17	Q3YTD 2017-18
Provincial	**18,329**	**18,050**	**13,215**	**13,550**
South Zone	1,760	1,819	1,305	1,276
Calgary Zone	4,617	4,457	3,286	3,283
Central Zone	3,467	3,560	2,608	2,988
Edmonton Zone	4,957	4,665	3,482	3,425
North Zone	3,528	3,549	2,534	2,578

Sources: Addiction System for Information and Service Tracking (ASIST) Data Research View for Treatment Service, Standard Data Product, Clinical Activity Reporting Application (CARA), Geriatric Mental Health Information System (GMHIS), eClinician (for results since Jun 2015) as of April 11, 2018

Notes:
- *The results are reported a quarter later due to requirements to follow-up with patients after end of reporting quarter.*
- *Average wait time is also provided to provide further context for the interpretation of the wait time performance measure. Trend and target are not applicable.*
- *Results may change due to data updates in the source information system or revisions to the measure inclusion and exclusion criteria.*

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UNPLANNED MEDICAL READMISSIONS

The measure is defined as the percentage of medical patients with unplanned readmission to hospital within 30 days of leaving the hospital. The lower the percentage the better, as it demonstrates that fewer people are being readmitted shortly after being discharged.

Unplanned Medical Readmissions, Q3YTD 2017-18

Unplanned Medical Readmissions Trend

Zone Name	Site Name	2013-14	2014-15	2015-16	2016-17	Q3YTD 2016-17	Q3YTD 2017-18	Trend	2017-18 Target
Provincial	**Provincial**	**13.5%**	**13.6%**	**13.7%**	**13.6%**	**13.7%**	**13.7%**	⇨	**13.4%**
South Zone	**South Zone**	**14.1%**	**13.5%**	**14.2%**	**13.9%**	**13.8%**	**14.2%**	⇨	**13.4%**
	Chinook Regional Hospital	13.2%	13.5%	14.1%	13.3%	13.8%	13.0%	☆	13.4%
	Medicine Hat Regional Hospital	14.4%	12.5%	14.0%	13.8%	13.4%	13.9%	⇩	13.4%
	Other South Hospitals	15.0%	14.7%	14.4%	14.9%	14.4%	15.8%	⇩	13.4%
Calgary Zone	**Calgary Zone**	**12.2%**	**12.2%**	**12.3%**	**12.3%**	**12.3%**	**12.5%**	☆	**13.4%**
	Foothills Medical Centre	12.2%	12.2%	12.3%	12.4%	12.4%	12.3%	☆	13.4%
	Peter Lougheed Centre	12.1%	12.2%	12.8%	13.1%	12.8%	12.7%	☆	13.4%
	Rockyview General Hospital	12.0%	11.9%	11.9%	12.0%	11.7%	12.7%	☆	13.4%
	South Health Campus	12.3%	12.3%	12.0%	11.3%	11.7%	12.3%	☆	13.4%
	Other Calgary Hospitals	12.8%	13.7%	12.5%	13.0%	13.0%	13.0%	☆	13.4%
Central Zone	**Central Zone**	**14.5%**	**14.9%**	**15.0%**	**14.9%**	**15.0%**	**14.5%**	⇧	**13.4%**
	Red Deer Regional Hospital Centre	14.0%	13.8%	13.9%	13.0%	13.2%	13.1%	☆	13.4%
	Other Central Hospitals	14.6%	15.3%	15.4%	15.6%	15.7%	15.0%	⇧	13.4%
Edmonton Zone	**Edmonton Zone**	**13.5%**	**13.8%**	**13.6%**	**13.6%**	**13.8%**	**13.8%**	⇨	**13.4%**
	Grey Nuns Community Hospital	12.6%	12.3%	13.2%	12.7%	12.8%	13.0%	☆	13.4%
	Misericordia Community Hospital	13.0%	13.7%	13.5%	15.0%	15.3%	14.3%	⇧	13.4%
	Royal Alexandra Hospital	13.2%	14.0%	13.7%	13.0%	13.1%	14.1%	⇩	13.4%
	Sturgeon Community Hospital	12.3%	13.7%	13.4%	13.1%	13.1%	13.6%	⇩	13.4%
	University of Alberta Hospital	14.6%	14.6%	14.2%	14.4%	14.6%	14.4%	⇨	13.4%
	Other Edmonton Hospitals	13.4%	12.8%	11.9%	12.8%	13.2%	11.8%	☆	13.4%
North Zone	**North Zone**	**15.0%**	**15.3%**	**15.3%**	**15.2%**	**15.2%**	**15.0%**	⇨	**13.4%**
	Northern Lights Regional Health Centre	13.4%	12.8%	13.4%	14.3%	13.9%	15.2%	⇩	13.4%
	Queen Elizabeth II Hospital	12.6%	11.9%	13.3%	13.3%	13.4%	11.3%	☆	13.4%
	Other North Hospitals	15.5%	16.1%	15.9%	15.5%	15.7%	15.5%	⇨	13.4%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total Discharges

Zone	2015-16	2016-17	Q3YTD 2016-17	Q3YTD 2017-18
Provincial	113,804	113,879	84,955	85,370
South Zone	9,632	9,823	7,243	7,217
Calgary Zone	35,449	35,546	26,518	27,516
Central Zone	16,826	16,738	12,550	12,109
Edmonton Zone	37,646	37,667	28,157	28,006
North Zone	14,251	14,105	10,487	10,522

Source: AHS Provincial Discharge Abstract Database (DAD), as of May 2, 2018

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

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PERINATAL MORTALITY RATE AMONG FIRST NATIONS

Number of stillbirths (at 28 or more weeks gestation) plus the number of infants dying under 7 days of age divided by the sum of the number of live births for a given calendar year; multiplied by 1,000.

Perinatal Mortality Rate Gap, 2017-18

Provincial

Perinatal Mortality Rate by Population

Population	2013	2014	2015	2016	2017	Trend	2017-18 Target
First Nations	9.47	10.52	10.73	9.65	8.40	N/A	AHS' focus is to reduce gap between First Nations and Non First Nations
Non-First Nations	4.98	5.69	5.30	4.71	5.50	N/A	
Rate Gap	**4.49**	**4.83**	**5.43**	**4.94**	**2.90**	⇧	

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Source: Alberta Health, as of April 22, 2018

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HAND HYGIENE COMPLIANCE

This measure is defined as the percentage of opportunities in which healthcare workers clean their hands during the course of patient care. Direct observation is used to assess hand hygiene compliance rates for healthcare workers. The higher the percentage the better, as it demonstrates more healthcare workers are complying with appropriate hand hygiene practices.

Hand Hygiene Compliance, FY 2017-18

Provincial

South Zone

Calgary Zone

Central Zone

Edmonton Zone

North Zone

2017-18 Target

Hand Hygiene Compliance Trend

Zone Name	Site Name	2013-14	2014-15	2015-16	2016-17	2017-18	Trend	2017-18 Target
Provincial	**Provincial**	**66%**	**75%**	**80%**	**82%**	**85%**	⇧	**90%**
South Zone	**South Zone**	**78%**	**82%**	**82%**	**84%**	**81%**	⇩	**90%**
	Chinook Regional Hospital	81%	85%	82%	83%	78%	⇩	90%
	Medicine Hat Regional Hospital	76%	77%	82%	87%	84%	⇩	90%
	Other South Hospitals	79%	85%	83%	83%	81%	⇨	90%
Calgary Zone	**Calgary Zone**	**59%**	**71%**	**78%**	**81%**	**84%**	⇧	**90%**
	Alberta Children's Hospital	57%	74%	77%	80%	79%	⇨	90%
	Foothills Medical Centre	52%	66%	76%	83%	84%	⇨	90%
	Peter Lougheed Centre	62%	77%	85%	79%	80%	⇨	90%
	Rockyview General Hospital	62%	68%	74%	84%	88%	⇧	90%
	South Health Campus	59%	59%	69%	76%	77%	⇨	90%
	Other Calgary Hospitals	61%	69%	77%	79%	83%	⇧	90%
Central Zone	**Central Zone**	**64%**	**74%**	**81%**	**78%**	**87%**	⇧	**90%**
	Red Deer Regional Hospital Centre	75%	69%	78%	78%	85%	⇧	90%
	Other Central Hospitals	57%	77%	82%	78%	87%	⇧	90%
Edmonton Zone	**Edmonton Zone**	**57%**	**74%**	**79%**	**83%**	**86%**	⇧	**90%**
	Grey Nuns Community Hospital	64%	75%	73%	83%	89%	⇧	90%
	Misericordia Community Hospital	71%	77%	75%	80%	86%	⇧	90%
	Royal Alexandra Hospital	62%	75%	81%	84%	86%	⇨	90%
	Stollery Children's Hospital	58%	75%	79%	80%	81%	⇨	90%
	Sturgeon Community Hospital	59%	81%	84%	86%	88%	⇨	90%
	University of Alberta Hospital	43%	70%	74%	85%	88%	⇧	90%
	Other Edmonton Hospitals	58%	73%	79%	82%	86%	⇧	90%
North Zone	**North Zone**	**66%**	**81%**	**87%**	**88%**	**88%**	⇨	**90%**
	Northern Lights Regional Health Centre	56%	64%	88%	87%	82%	⇩	90%
	Queen Elizabeth II Hospital	68%	91%	96%	91%	88%	⇨	90%
	Other North Hospitals	66%	74%	85%	88%	89%	⇨	90%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total Observations *(excludes Covenant Sites)*

Zone	2015-16	2016-17	2017-18
Provincial	396,272	383,975	331,530
South Zone	39,185	38,314	18,249
Calgary Zone	183,110	162,423	128,348
Central Zone	45,103	35,952	38,653
Edmonton Zone	99,795	125,281	116,610
North Zone	29,079	22,005	29,670

Source: AHS Infection, Prevention and Control Database, as of April 17, 2018

Notes:

- *Covenant sites (including Misericordia Community Hospital and Grey Nuns Hospital) use different methodologies for capturing and computing Hand Hygiene compliance rates. These are available twice a year in spring (Q1 & Q2) and fall (Q3 & Q4). These are not included in the Edmonton Zone and Provincial totals.*
- *"Other Sites" include any hand hygiene observations performed at an AHS operated program, site, or unit including acute care, continuing care, and ambulatory care settings such as Cancer Control, Corrections, EMS, hemodialysis (e.g., NARP and SARP), home care, and public health.*

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CHILDHOOD IMMUNIZATION RATE
DIPHTHERIA, TETANUS, PERTUSSIS, POLIO, HIB (DTaP-IPV-Hib)

This measure is defined as the percentage of children who have received the required number of vaccine doses by two years of age. A high rate of immunization for a population reduces the incidence of vaccine preventable childhood diseases, and controls outbreaks. Immunizations protect children and adults from a number of preventable diseases, some of which can be fatal or produce permanent disabilities. The higher the percentage the better, as it demonstrates more children are vaccinated and protected from preventable childhood diseases.

Childhood Immunization Rate: DTaP-IPV-Hib, FY 2017-18

Childhood Immunization Rate: DTaP-IPV-Hib Trend

Zone Name	2013-14	2014-15	2015-16	2016-17	2017-18	Trend	2017-18 Target
Provincial	**77.6%**	**78.3%**	**78.0%**	**78.3%**	**77.7%**	⇨	**80%**
South Zone	64.6%	67.9%	65.7%	67.8%	70.0%	⇧	80%
Calgary Zone	81.4%	82.6%	81.5%	81.4%	79.8%	☆	80%
Central Zone	71.1%	71.1%	70.9%	70.6%	70.7%	⇨	80%
Edmonton Zone	84.0%	84.0%	84.6%	84.0%	82.9%	☆	80%
North Zone	67.2%	66.6%	66.5%	67.7%	68.9%	⇨	80%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total Eligible Population

Zone	2015-16	2016-17	2017-18
Provincial	54,267	55,138	56,208
South Zone	4,104	4,157	4,271
Calgary Zone	19,602	20,424	20,862
Central Zone	6,240	5,833	5,661
Edmonton Zone	16,870	17,578	18,114
North Zone	7,451	7,146	7,300

Source: Province-wide Immunization Program, Communicable Disease Control as of April 19, 2018

Notes:
- The target represented is the AHS' 2017-18 Target. Alberta Health has higher targets for both vaccines by two years of age.

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CHILDHOOD IMMUNIZATION RATE
MEASLES, MUMPS, RUBELLA (MMR)

This measure is defined as the percentage of children who have received the required number of vaccine doses by two years of age. A high rate of immunization for a population reduces the incidence of vaccine preventable childhood diseases, and controls outbreaks. Immunizations protect children and adults from a number of preventable diseases, some of which can be fatal or produce permanent disabilities. The higher the percentage the better, as it demonstrates more children are vaccinated and protected from preventable childhood diseases.

Childhood Immunization Rate: MMR, FY 2017-18

Provincial

South Zone

Calgary Zone

Central Zone

Edmonton Zone

North Zone

2017-18 Target

Childhood Immunization Rate: MMR Trend

Zone Name	2013-14	2014-15	2015-16	2016-17	2017-18	Trend	2017-18 Target
Provincial	**86.7%**	**87.6%**	**86.9%**	**87.4%**	**86.9%**	⇨	**88%**
South Zone	81.1%	83.9%	78.8%	81.0%	82.1%	⇨	88%
Calgary Zone	88.3%	89.6%	89.2%	89.6%	87.9%	☆	88%
Central Zone	81.2%	80.8%	81.1%	82.3%	84.2%	⇨	88%
Edmonton Zone	91.7%	92.2%	91.9%	91.8%	90.5%	☆	88%
North Zone	79.6%	80.3%	78.5%	77.8%	79.6%	⇨	88%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total Eligible Population

Zone	2015-16	2016-17	2017-18
Provincial	54,267	55,138	56,208
South Zone	4,104	4,157	4,271
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North Zone	7,451	7,146	7,300

Source: Province-wide Immunization Program, Communicable Disease Control as of April 19, 2018

Notes:
- The target represented is the AHS' 2017-18 Target. Alberta Health has higher targets for both vaccines by two years of age.

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AHS WORKFORCE ENGAGEMENT RATE

Engagement refers to how committed an employee is to the organization, their role, their manager, and co-workers. High engagement correlates with higher productivity, safe patient care and willingness to give discretionary effort at work. Monitoring workforce engagement enables us to determine the effectiveness of processes/programs that support employee engagement and strengthen a patient safety culture.

The Engagement Rate is the mean score of the responses to the AHS' 'Our People Survey' which utilized a five-point scale, with one being 'strongly disagree' and five being 'strongly agree'. More than 46,000 individuals – including nurses, emergency medical services, support staff, midwives, physicians and volunteers – participated in the Our People Survey in 2016.

Monitoring workforce engagement enables us to determine the effectiveness of processes/programs that support employee engagement and strengthen a patient safety culture.

Our People Survey Results

AHS' workforce engagement was 3.46 on a five-point scale (5 indicates highly engaged). Based on a question asking how satisfied people are with AHS as a place to work: 57 per cent of respondents felt positively, 40 per cent felt neutral, and 3 per cent felt negatively.

Employees	Volunteers	Physicians
57% were positive about the work they do at AHS and chose a 4 or 5 for overall satisfaction.	**90%** were positive about the work they do at AHS and chose a 4 or 5 for overall satisfaction.	**48%** were positive about the work they do at AHS and chose a 4 or 5 for overall satisfaction.

Source: AHS People, Legal, Privacy

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DISABLING INJURIES IN AHS WORKFORCE

This measure is defined as the number of AHS workers injured seriously to require modified work or time loss from work per 200,000 paid hours (approximately 100 full time equivalent workers). Our disabling injury rate enables us to identify Workplace Health & Safety (WHS) programs that provide AHS employees, volunteers and physicians with a safe and healthy work environment and keep them free from injury. The lower the rate, the fewer disabling injuries are occurring at work.

Disabling Injury Rate: FY 2017-18

Provincial

2017-18 Target

Disabling Injury Rate by AHS Portfolio

Level of Portfolio	Portfolio or Departments	2015-16	2016-17	2017-18	Trend	2017-18 Target
Province	**Provincial**	**3.57**	**3.85**	**3.88**	⇨	**3.5**
Zone	South Zone Clinical Operations	3.54	3.50	3.65	⇩	3.5
	Calgary Zone Clinical Operations	3.54	3.89	4.24	⇩	3.5
	Central Zone Clinical Operations	4.00	4.18	4.73	⇩	3.5
	Edmonton Zone Clinical Operations	3.49	3.73	3.90	⇩	3.5
	North Zone Clinical Operations	4.34	3.75	3.84	⇨	3.5
Provincial Portfolios	Cancer Control	1.67	1.47	1.04	☆	3.5
	Capital Management	2.13	2.65	2.08	☆	3.5
	Collaborative Practice, Nursing & Health Profession	7.24	6.64	7.23	⇩	3.5
	Community Engagement and Communications	0.00	0.00	0.00	☆	3.5
	Contracting, Procurement & Supply Management	2.70	3.85	3.02	☆	3.5
	Diagnostic Imaging	1.86	2.89	3.16	☆	3.5
	Emergency Medical Services	12.91	15.09	14.23	⇧	3.5
	Finance	0.16	0.33	0.50	☆	3.5
	Health Information Management	1.29	2.19	1.64	☆	3.5
	Information Technology (IT)	0.25	0.16	0.21	☆	3.5
	Internal Audit and Enterprise Risk Management	0.00	0.00	0.00	☆	3.5
	Laboratory Services	1.26	1.63	2.12	☆	3.5
	Linen & Environmental Services	7.64	8.02	6.72	⇧	3.5
	Nutrition Food Services	5.81	5.29	5.13	⇧	3.5
	People, Legal, and Privacy	1.50	2.88	2.83	☆	3.5
	Pharmacy Services	1.09	1.69	1.05	☆	3.5
	Population Public & Indigenous Health	1.29	1.13	0.82	☆	3.5
	Research, Innovation and Analytics	0.26	0.25	0.48	☆	3.5

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Source: WCB Alberta and e-Manager Payroll Analytics (EPA), 2017-18 March YTD data is as of March 31, 2018; Data retrieval date: April 16, 2018

Notes:

- *AHS Community Engagement & Communications and Internal Audit & Enterprise Risk Management reporting of "0.00" is accurate and reflects these two portfolios having very safe and healthy work environments.*

AHS Report on Performance FY 2017-18

NURSING UNITS ACHIEVING BEST PRACTICE TARGETS

This measure is defined as the percentage of nursing units at the 16 busiest sites meeting Operational Best Practice (OBP) labour targets. A higher percentage means more efficiencies have been achieved across AHS.

Percentage of Nursing Units Achieving Best Practice Targets, FY 2017-18

Percentage of Nursing Units Achieving Best Practice Targets

Zone Name	2015-16	2016-17	2017-18	Trend	2017-18 Target
Provincial	**20%**	**28%**	**38%**	☆	**35%**
South Zone	63%	58%	61%	☆	35%
Calgary Zone	15%	20%	25%	⇧	35%
Central Zone	7%	14%	47%	☆	35%
Edmonton Zone	14%	29%	42%	☆	35%
North Zone	33%	33%	36%	☆	35%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Source(s): AHS General Ledger (no allocations); Worked Hours - Finance consolidated trial balance, Patient Days – Adult & Child - Finance statistical General Ledger, as of April 30, 2018

Notes:

- *Data quality issues were identified in historical data which potentially over-stated efficiencies. Work continues in data quality but historical data cannot be retroactively corrected.*

Monitoring Measures

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

The trend column indicates comparison of the most recent available data over the earliest data available for each measure. An upward arrow (⇧) indicates improvement by more than three per cent; a horizontal arrow (⇨) indicates stability (current results are within three per cent of prior results), and a downward arrow (⇩) indicates measure is declining by more than three per cent and requires additional focus. Data updated as of May 22, 2018.

LIFE EXPECTANCY	2013	2014	2015	2016	2017	Trend
The number of years a person would be expected to live, starting at birth, on the basis of mortality statistics.						
Provincial	81.7	81.8	81.8	81.9	81.8	⇨
Females	83.7	83.9	84.1	84.2	84.1	⇨
Males	79.6	79.7	79.5	79.7	79.5	⇨
First Nations	71.9	70.9	69.9	70.9	70.7	⇨
Non-First Nations	82.0	82.2	82.2	82.3	82.2	⇨

POTENTIAL YEARS OF LIFE LOST	2013	2014	2015	2016	2017	Trend
The total number of years not lived (per 1,000 population) by an individual who died before their 75th birthday.						
Both	48.3	49.6	50.1	49.1	50.2	⇨
Females	38.3	38.8	38.1	37.9	38.0	⇨
Males	57.7	59.7	61.6	59.9	61.8	⇩

CANCER SCREENING	2014-15	2015-16	2016-17	2017-18	Trend
Breast Cancer Participating Rate	62.7%	63.4%	63.7%	Not available	⇨
Colorectal Cancer Participating Rate	39.2%	38.0%	37.7%	Not available	⇨
Cervical Cancer Participating Rate	66.8% (2012-2014)	65.8% (2013-15)	65.3% (2014-16)	64.4% (2015-17)	⇨
Early Detection of Cancers	69.0% (2014)	70.0% (2015)	69.9% (2016)	Not available	⇨

INFLUENZA IMMUNIZATION	2014-15	2015-16	2016-17	2017-18	Trend
Rates of seasonal influenza immunization by age group.					
Adults 65+ years	60.5%	62.7%	60.2%*	60.1%	⇨
Children 6 to 23 months	35.6%	35.9%	35.3%	34.6%	⇨
AHS healthcare workers	63.9%	60.9%	62.5%	66.0%	⇧

* *Adults 65+ results were recalculated for 2016-17 to be comparable to 2017-18.*

PRIMARY HEALTH CARE	2014-15	2015-16	2016-17	2017-18	Trend
Albertans enrolled in a Primary Care Network	78%	79%	80%	n/a	⇨
Ambulatory care sensitive conditions: rate of hospital admissions for health conditions that may be prevented or managed by appropriate primary healthcare.	288	281	271	260	⇧
Family practice sensitive conditions: percentage of emergency department or urgent care visits for health conditions that may be appropriately managed at a family physician's office.	24.4%	23.1%	22.2%	21.3%	⇧
Percentage of Health Link calls answered within two minutes	77%	76%	74%	73%	⇨

CHILDREN'S MENTAL HEALTH SERVICES	2014-15	2015-16	2016-17	2017-18	Trend
Percentage of children aged 0 to 17 years *offered* scheduled mental health treatment	89%	85%	81%	74%	⇩
Percentage of children aged 0 to 17 years *receiving* scheduled mental health treatment	82%	73%	73%	67%	⇩

EMERGENCY DEPARTMENT (ED) *	2014-15	2015-16	2016-17	2017-18	Trend
Percentage of patients treated and admitted to hospital within 8 hours (all sites)	46.0%	46.9%	46.1%	43.9%	⇩
Percentage of patients treated and admitted to hospital within 8 hours (busiest sites)	36.1%	37.9%	37.3%	35.5%	⇩
Percentage of patients treated and discharged within 4 hours (all sites)	78.5%	78.3%	77.8%	76.0%	⇨
Percentage of patients treated and discharged within 4 hours (busiest sites)	63.3%	62.9%	62.6%	60.1%	⇩
ED time to Physician Initial Assessment (median in hours at busiest sites)	1.4	1.3	1.3	1.4	⇩
Percentage of patients left without being seen and left against medical advice	4.3%	3.9%	3.9%	4.3%	⇩

* ED historical values were restated to ensure consistent information over time based on the NACRS database.

ACUTE CARE	2014-15	2015-16	2016-17	2017-18	Trend
Acute Care Occupancy: Percentage of patient days in hospital compared to available bed days in the reporting period for top 16 AHS sites.	97.2%	95.8%	96.7%	97.7%	⇨
Acute Length of Stay to Expected Length of Stay Ratio	1.04	1.02	1.01	0.99	⇨
Hospital-Acquired *Clostridium difficile* Infection Rate (per 10,000 patient days)	3.5	3.6	3.4	3.0	⇧
Hospital Standardized Mortality Ratio (HSMR)	93	93	93	93	⇨
Mental Health Readmissions within 30 days (risk adjusted)	8.8%	8.6%	8.8%	8.6%*	⇨
Surgical Readmissions within 30 days (risk adjusted)	6.5%	6.5%	6.7%	6.7%*	⇨
Heart Attack (AMI) in Hospital Mortality within 30 days (risk adjusted)	5.9%	6.1%	5.5%	5.3%*	⇧
Stroke in Hospital Mortality within 30 days (risk adjusted)	13.8%	14.0%	12.5%	12.0%*	⇧

*Results reflect Q3 year-to-date only.

CANCER CARE in weeks, 90th percentile	2014-15	2015-16	2016-17	2017-18	Trend
Radiation oncology access: referral to first consult (from referral to the time of their first appointment with a radiation oncologist).	4.9	5.0	5.0	5.3	⇩
Medical oncology access: referral to first consult (from referral to the time of their first appointment with a medical oncologist).	5.6	5.6	5.1	5.7	⇩
Radiation therapy access: ready to treat to first therapy.	3.1	2.9	2.7	2.7	⇨

SURGERY WAIT TIMES in weeks	2014-15	2015-16	2016-17	2017-18	Trend
Coronary Artery Bypass Graft (CABG) Ready To Treat (RTT) Urgency III – Scheduled	14.9	12.1	10.7	22.2	⇩
Cataract Surgery RTT	29.9	33.0	34.0	38.4	⇩
Hip Replacement RTT	28.7	31.4	32.9	36.7	⇩
Knee Replacement RTT	33.0	34.7	36.9	40.7	⇩
Hip Fracture Repair: Percentage within 48 hours	86.2%	90.1%	91.8%	92.8%	⇨

CONTINUING CARE	2014-15	2015-16	2016-17	2017-18	Trend
Total number of people placed into continuing care	7,810	7,879	7,963	7,927	⇨
Number of patients placed from acute / subacute hospital bed into continuing care	5,548	5,405	5,395	5,218	⇩
Number of clients placed from community (at home) into continuing care	2,262	2,474	2,568	2,709	⇧
Average wait time in acute / subacute care hospital bed for continuing care placement (in days)	42	44	46	51	⇩
Total number waiting for continuing care placement	1,544	1,411	1,873	1,937	⇨
Number of persons waiting in acute / subacute hospital bed for continuing care placement	690	628	846	676	⇧
Number of persons waiting in community (at home) for continuing care placement	854	783	1,027	1,261	⇩
Number of unique home care clients	113,778	116,415	118,744	121,021	⇨

Public Interest Disclosure (Whistleblower Protection) Act (PIDA)

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

Its purpose is to:

- Facilitate the disclosure and investigation of wrongdoing.
- Protect those who make a disclosure from reprisal.
- Implement recommendations arising from investigations.
- Provide for the determination of appropriate remedies arising from reprisals.
- Promote confidence in the public sector.

Over the past year, AHS has:

- Monitored legislative amendments to PIDA that came into effect on March 1, 2018.
- Updated resources for managers and staff about PIDA and the internal disclosure process.

In compliance with legislated reporting requirements, from April 1, 2017 to March 31, 2018, AHS reports as follows:

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

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

Non-Hospital Surgical Facility Contracts under the Health Care Protection Act (Alberta)

AHS contracts services with multiple Non-Hospital Surgical Facilities (NHSF) to provide insured surgical services for dermatology, ophthalmology, oral maxillofacial, otolaryngology, plastic surgery and pregnancy terminations. The use of NHSFs enables AHS to obtain quality services to enhance surgical access and alleviate capacity pressures within AHS main operating rooms.

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

AHS determines if the contract is appropriate by assessing sustainability of the public system, access to services, patient safety, appropriateness, effectiveness, cost and public benefit. Contracts with NHSFs provide increased choice of service provider for patients and supplement the resources available in hospitals, while providing good value for public dollars.

2017-18 NON-HOSPITAL SURGICAL FACILITIES ACTIVITY

Contracted Service Area	# of Contracted Operators	# of Contracted Procedures Performed
Dermatology – Edmonton Zone	1	41
Ophthalmology – Calgary Zone	5	17,554
Ophthalmology – Edmonton Zone	6	3,817
Ophthalmology – North Zone	1	984
Oral and Maxillofacial Surgery – Calgary Zone	8	1,046
Oral and Maxillofacial Surgery – Edmonton Zone	9	2,826
Otolaryngology (ENT) – Edmonton Zone	2	217
Plastic Surgery – Edmonton Zone	3	284
Pregnancy Termination – Calgary	1	5,075
Pregnancy Termination – Edmonton	1	5,844
Restorative Dental – South Zone	4	744
Dental Contract Surgical Service – Calgary	1	400
Restorative Dental – Edmonton	3	347
Podiatry Contract Surgical Service – Calgary	1	973

There are no surgical contracts with NHSF in the Central Zone that fall under the *Health Care Protection Act.*

Calgary Zone contracts more ophthalmology procedures outside AHS hospitals compared to Edmonton Zone, which performs more ophthalmology procedures within AHS hospitals.

AHS Facilities and Beds

Each year, AHS tracks beds and facilities across Alberta to support AHS operations, corporate reporting and accountability requirements to Alberta Health.

The AHS Bed Bi-Annual Bed Survey reports beds staffed and in operation (previously known as "funded beds") that are operated and contracted by AHS. This includes:

- Inpatient acute care
- Addiction & mental health (community mental health, standalone psychiatric facilities)
- Long-term care and supportive living beds (continuing care)

AHS prepares the AHS Bi-Annual Bed Survey twice a year as required by Alberta Health, Health Facilities Planning Branch at the end of September and March. The survey is used for all external reporting throughout the year.

Alberta Health requires this information for reviewing and planning of continuing care services, capital planning, informing the *Canada Health Act* Annual Report, and responding to general enquiries regarding provincial bed capacity.

AHS Planning and Performance fulfills a leadership role in AHS that works closely with Alberta Health and AHS Operations to determine the appropriate designation for new facilities and any changes in service/program delivery.

Facility Designation requirements are based on the scope of services outlined for each facility. It affects a multitude of operational components which includes, but is not limited to: physician fees for service, ambulance drop off, out-of-province billing, patient location identification, electronic health records, city zoning bylaws, budgets and funding.

This work is done in accordance with the following legislation:

- *Hospital Act*
- *Nursing Home Act*
- *Mental Health Regulation*
- Provincial Framework for Advanced Ambulatory Care Centres and Urgent Care Centres

AHS Planning and Performance is the primary "point of contact" for ensuring all facility designation and registration is in place prior to the facilities opening. This area is responsible for:

- Working with the AHS CEO Office, Zone Executive Leadership and provincial programs;
- Acting as a liaison between AHS and Alberta Health;
- Ensuring contracts are complete; and,
- Distributing new facility numbers from Alberta Health for billing and facility operations.

For more information about designation of new facilities and/or changes to services/programs, please contact AHS Planning and Performance.

The next section is an overview of AHS' bed and facilities as of March 31, 2018. It includes information on the following:

- Facility Definitions
- Facility by Zone
- Provincial Overview of Community-Based Capacity (notes new facilities that opened in 2017-18)
- Number of Continuing Care Facilities by Provider by Zone (new!)
- Zone Overview of Bed Numbers by Facility
- Beds by Facility
- Change in Bed Numbers by Zone from 2016-17 to 2017-18

AHS Facilities

Facility Definitions

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

Facility by Zone

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

Number of Facilities	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
Community Ambulatory Care						
Urgent Care Centres		5		2		**7**
Ambulatory Care Centres	2	1	2		2	**7**
Family Care Clinics		1		1	1	**3**
Primary Care Networks	2	7	12	9	12	**42**
Public Health Centres	17	22	34	21	45	**139**
Addiction and Mental Health						
Addiction	5	12	5	10	7	**39**
Community Mental Health	3	11	2	19	1	**36**
** The number of facilities for Community Mental Health does not include contracted sites with multiple locations. These facilities are noted in Zone Beds by Facility.*		3		3		
Standalone Psychiatric		2	1	2		**5**
Acute Care						
Urban		5		5		**10**
Regional	2		1		2	**5**
Community	10	8	29	7	31	**85**
Standalone Emergency Departments	1			2	1	**4**
Ambulatory Endoscopy or Surgical Centre Hospital	1	1				**2**
TOTAL DESIGNATED HOSPITALS	**14**	**14**	**30**	**14**	**34**	**106**
Cancer Care						
Cancer Centres	2	3	5	1	6	**17**
Community-Based Care						
Long-Term Care & Supportive Living (3, 4, Dementia, Mental Health and Restorative Care)	48	68	78	86	56	**336**
Additional contracted care sites not included in above number reflect the number of personal care, special care and family care homes		53		55		**108**
Community Hospice, Palliative & End-of-Life Care	2	8	1	5	4	**20**

Source: AHS Bi-Annual Bed Survey as of March 31, 2018.

Notes:

- In April 2018, West Peace Primary Care Network and Sexsmith / Spirit River Primary Care Network in the North Zone merged.
- Refer to definition and explanation of facilities on previous page.

Provincial Overview of Community-Based Capacity

Continued growth in community and home care capacity is the key to efficient system flow in emergency departments, acute care and community; it also allows patients to receive the most appropriate care in the most appropriate setting by the most appropriate care provider. Since March 2010, 6,196 net new continuing care beds have been added to the system.

As of...	Long-Term Care (LTC)	Supportive Living (SL)	Total Continuing Care	Net New LTC & SL Beds	Net New Palliative Beds	Total Net New Continuing Care Beds
March 2010	14,429	5,089	19,518			
March 2011	14,569	6,104	20,673	1,155		**1,155**
March 2012	14,734	6,941	21,675	1,002		**1,002**
March 2013	14,553	7,979	22,532	857	20	**877**
March 2014	14,370	8,497	22,867	335		**335**
March 2015	14,523	9,218	23,741	874	6	**880**
March 2016	14,768	9,937	24,705	964	35	**999**
March 2017	14,745	10,336	25,081	376		**376**
March 2018	14,846	10,807	25,653	572		**572**
Total Net New Beds	**417**	**5,718**	**6,135**	**6,135**	**61**	**6,196**

Source: AHS Bi-Annual Bed Survey as of March 31, 2018.
Note: Bed numbers have been updated with revised data.

The number of beds above reflects AHS new capacity which has been staffed and in operation (patient placed into beds) during 2017-18. AHS is working with Alberta Health on several projects for additional capacity that did not open in 2017-18 but are planned to open in 2018-19. AHS does not include future capacity in any bed reporting.

In 2017-18, new continuing care capacity (seven beds) was added at existing facilities in all zones, as well as new facilities (565 beds) in South, Calgary, Central and North zones. All new capacity was built to accommodate clients needing long-term care and dementia care. The table below reflects where clients were placed from the AHS waitlists into the new facilities that opened.

New Facilities Opened in 2017-18	Zone	Location	Date Opened	Long-term care	Dementia Supportive Living 4	Supportive Living 4	Total
Masterpiece Southland Meadows	South	Medicine Hat	October 2017	50	35	15	**100**
St. Teresa Place	Calgary	Calgary	April 2017		52	198	**250**
Pioneer House	Central	Lloydminster	April 2017		23	21	**44**
Timberstone Mews	Central	Red Deer	May 2017		20	40	**60**
Wild Rose Assisted Living	North	Boyle	January 2018	22	8	14	**44**
J.B. Wood Continuing Care Centre	North	High Prairie	April 2017	27	14	26	**67**
TOTAL				**99**	**152**	**314**	**565**

Source: AHS Bi-Annual Bed Survey as of March 31, 2018.

Number of Continuing Care Facilities by Provider

As of March 31, 2018, there were 25,653 Designated Long Term Care (LTC) and Designated Supportive Living (SL) spaces staffed and in operation in the province in over 300 facilities. These facilities encompass AHS, AHS subsidiaries (Carewest and CapitalCare), voluntary (non-profit includes Covenant, Good Samaritan, etc.), private (Extendicare, Agecare, etc.) and Regional Health Authority (RHA) ownership. AHS will continue to improve the system and access to care and supports in the community. Collaboration with our valued service providers is integral to this effort.

Continuing Care Facilities by Operator	Number of Facilities as of March 31, 2018								
	LTC (Facilities)	LTC (Spaces)	SL (Facilities)	SL (Spaces)	Campus of Care (Facilities)	Campus of Care (LTC Spaces)	Campus of Care (SL Spaces)	Total Facilities	Total Spaces
AHS Operated	**81**	**4,349**	**11**	**439**	**4**	**263**	**127**	**96**	**5,178**
South	11	229						11	229
Calgary	14	1,117	1	10	1	175	30	16	1,332
Central	24	1,154	2	32	1	23	19	27	1,228
Edmonton	8	1,059	6	280				14	1,339
North	24	790	2	117	2	65	78	28	1,050
Private	**36**	**4,533**	**69**	**4,836**	**11**	**705**	**981**	**116**	**11,055**
South	3	288	9	563	3	130	91	15	1,072
Calgary	14	2,280	13	978	4	223	640	31	4,121
Central	2	133	18	985	1	220	60	21	1,398
Edmonton	13	1,606	24	2,144				37	3,750
North	4	226	5	166	3	132	190	12	714
Non-Profit	**33**	**4,047**	**78**	**3,946**	**11**	**839**	**478**	**122**	**9,310**
South	1	10	18	1,076	3	252	144	22	1,482
Calgary	9	1,423	10	929	2	167	113	21	2,632
Central	9	519	16	515	3	145	90	28	1,269
Edmonton	13	2,065	19	1,085	3	275	131	35	3,556
North	1	30	15	341				16	371
Prairie North RHA - Lloydminster	**2**	**110**	**0**	**0**	**0**	**0**	**0**	**2**	**110**
Total	**152**	**13,039**	**158**	**9,221**	**26**	**1,807**	**1,586**	**336**	**25,653**

Source: AHS Bi-Annual Bed Survey as of March 31, 2018.

Notes: The number of facilities does not include the over 100 Personal Care Homes which are considered Private Supportive Living. The beds for these facilities are included in the spaces total. The table also does not include beds in standalone palliative/hospice facilities.

Zone Overview of Bed Numbers

Summary of Bed Numbers by Zone and Detailed Facility Listing

Number of Beds/Spaces as of March 31, 2018	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
Hospital & Sub-Acute Care						
Hospital Acute Care	517	2,169	933	2,399	839	6,857
Psychiatric in Acute Care	72	287	50	236	34	679
Neonatal Intensive Care (NICU Levels II and III)	23	126	17	133	10	309
Intensive Care (includes ICU, SCU, CCU, CVICU and PICU)	24	136	21	193	19	393
Sub-acute in Acute Care	9	32	32	22	0	95
Palliative beds in Acute Care	0	29	45	20	21	115
HOSPITAL ACUTE CARE SUBTOTAL	**645**	**2,779**	**1,098**	**3,003**	**923**	**8,448**
Sub-acute in Auxiliary Hospital (includes transition, rehab, community support beds, etc.)*	24	280	0	168	18	490
TOTAL HOSPITAL ACUTE AND SUB-ACUTE CARE	**669**	**3,059**	**1,098**	**3,171**	**941**	**8,938**
Continuing Care						
Auxiliary Hospital	258	1,072	1,413	2,234	639	5,616
Nursing Home	651	4,313	891	2,771	604	9,230
Long-Term Care (LTC) Subtotal	**909**	**5,385**	**2,304**	**5,005**	**1,243**	**14,846**
Supportive Living Level 4 - Dementia	548	730	444	1,118	216	3,056
Supportive Living Level 4	1,027	1,737	872	2,123	478	6,237
Supportive Living Level 3	299	233	385	399	198	1,514
Supportive Living (SL) Subtotal	**1,874**	**2,700**	**1,701**	**3,640**	**892**	**10,807**
LONG-TERM CARE & SUPPORTIVE LIVING SUBTOTAL	**2,783**	**8,085**	**4,005**	**8,645**	**2,135**	**25,653**
Community Palliative and Hospice (out-of-hospital) PEOLC	20	121	10	79	13	243
TOTAL CONTINUING CARE (includes LTC, SL and PEOLC)	**2,803**	**8,206**	**4,015**	**8,724**	**2,148**	**25,896**
Addiction and Mental Health						
Psychiatric (standalone facilities)	0	153	330	445	0	928
Addiction Treatment	74	301	66	409	143	993
Community Mental Health	37	423	31	306	5	802
TOTAL ADDICTION & MENTAL HEALTH	**111**	**877**	**427**	**1,160**	**148**	**2,723**
Alberta Total	**3,583**	**12,142**	**5,540**	**13,055**	**3,237**	**37,557**

Source: AHS Bi-Annual Bed Survey as of March 31, 2018.
* This includes restorative beds located in long-term care. Restorative beds are reported where they are located (auxiliary hospital, nursing home and supportive living).

SOUTH ZONE – Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Bassano Health Centre	X	Bassano				4			8		12		
Crowsnest Pass Health Centre	X	Blairmore				16			58		74		
York Creek Lodge		Blairmore								20	20		
Bow Island Health Centre	X	Bow Island				10			20		30		
Pleasant View Lodge		Bow Island								20	20		
Brooks Health Centre	X	Brooks				37			15		52		
Orchard Manor		Brooks								25	25		
Sunrise Gardens		Brooks								84	84		
Cardston Health Centre	X	Cardston				19			12		31		
Chinook Lodge		Cardston								20	20		
Good Samaritan Lee Crest		Cardston								95	95		
Coaldale Health Centre	X	Coaldale				OP			44		44		
Sunny South Lodge		Coaldale								45	45		
Extendicare Fort Macleod		Fort Macleod							50		50		
Foothills Detox Centre		Fort Macleod	14								14		
Fort Macleod Health Centre	X	Fort Macleod				4					4		
Chinook Regional Hospital	X	Lethbridge				288					288		
Jack Ady Cancer Centre	X	Lethbridge	Co-located on same campus as Chinook Regional Hospital									Ca	
CMHA Crisis Beds		Lethbridge		5							5		
CMHA Laura House		Lethbridge		7							7		
Columbia Care Centre		Lethbridge								50	50		
Edith Cavell Care Centre		Lethbridge							120		120		
Extendicare Fairmont Park		Lethbridge								140	140		
Golden Acres Lodge		Lethbridge								45	45		
Good Samaritan Park Meadows Village		Lethbridge								121	121		
Good Samaritan West Highlands		Lethbridge								100	100		
Legacy Lodge		Lethbridge								104	104		
SASHA Group Home		Lethbridge		25							25		
South Country Treatment Centre		Lethbridge	21								21		
Southern Alcare Manor		Lethbridge	13								13		
St Michael's Health Centre		Lethbridge					24	10	72	72	178		
St. Therese Villa		Lethbridge								200	200		
Youth Residential Services	X	Lethbridge	8								8		

SOUTH ZONE – Beds by Facility continued

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Good Samaritan Garden Vista		Magrath								35	35		
Magrath Health Centre	X	Magrath											CACC
Cypress View		Medicine Hat								45	45		
Good Samaritan South Ridge Village		Medicine Hat							80	48	128		
Leisure Way		Medicine Hat								16	16		
Masterpiece Southland Meadows		Medicine Hat							50	50	100		
Meadowlands Retirement Residence		Medicine Hat								10	10		
Meadow Ridge Seniors Village		Medicine Hat								84	84		
Medicine Hat Recovery Centre	X	Medicine Hat	18								18		
Medicine Hat Regional Hospital	X	Medicine Hat				210					210		
Margery E. Yuill Cancer Centre	X	Medicine Hat	Co-located same campus Medicine Hat Regional Hospital									Ca	
River Ridge Seniors Village		Medicine Hat							50	36	86		
Riverview Care Centre		Medicine Hat							118		118		
St. Joseph's Home Carmel Hospice		Medicine Hat						10	10		20		
Sunnyside Care Centre		Medicine Hat							100	24	124		
The Wellington Retirement Residence		Medicine Hat								50	50		
Valleyview		Medicine Hat							30	5	35		
Milk River Health Centre	X	Milk River				ED			24		24		
Prairie Rose Lodge		Milk River								10	10		
Big Country Hospital	X	Oyen				10			30		40		
Piyami Health Centre	X	Picture Butte											CACC
Piyami Lodge		Picture Butte								20	20		
Piyami Place		Picture Butte								15	15		
Good Samaritan Vista Village		Pincher Creek								75	75		
Pincher Creek Health Centre	X	Pincher Creek				16			3		19		
Good Samaritan Prairie Ridge		Raymond								85	85		
Raymond Health Centre	X	Raymond				12			5		17		
Clearview Lodge		Taber								20	20		
Good Samaritan Linden View		Taber								105	105		
Taber Health Centre	X	Taber				19			10		29		
Total South Zone			**74**	**37**	**0**	**645**	**24**	**20**	**909**	**1,874**	**3,583**		

CALGARY ZONE – Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Airdrie Regional Community Health Centre	X	Airdrie											UCC
Bethany Airdrie		Airdrie							74		74		
Mineral Springs Hospital		Banff				22			25		47		
Oilfields General Hospital	X	Black Diamond				15			30		45		
Agape Hospice		Calgary						20			20		
Alberta Children's Hospital	X	Calgary				141					141		
Alcove Addictions Recovery for Women		Calgary	1								1		
Alpha House		Calgary	48								48		
Approved Homes - Mental Health		Calgary		117							117		
Aspen Family and Community Network		Calgary		3							3		
Aventa Addiction Treatment for Women		Calgary	48								48		
Bethany Calgary		Calgary							446		446		
Bethany Harvest Hills		Calgary							60		60		
Beverly Centre Glenmore		Calgary							208		208		
Beverly Centre Lake Midnapore		Calgary							270		270		
Bow Crest Care Centre		Calgary							150		150		
Bow View Manor		Calgary							231		231		
Calgary Community Rehab Program		Calgary		6							6		
Calgary Homeless Foundation		Calgary		26							26		
Canadian Mental Health Association		Calgary		123							123		
Canadian Mental Health Association (Hamilton House)		Calgary		8							8		
Canadian Mental Health Association (Robert's House)		Calgary		9							9		
Carewest Colonel Belcher	X	Calgary							175	30	205		
Carewest Dr. Vernon Fanning Centre	X	Calgary					98		191		289		
Carewest Garrison Green	X	Calgary							200		200		
Carewest George Boyack	X	Calgary							221		221		
Carewest Glenmore Park	X	Calgary					147				147		
Carewest Nickle House	X	Calgary								10	10		
Carewest Rouleau Manor	X	Calgary							77		77		
Carewest Royal Park	X	Calgary							50		50		
Carewest Sarcee	X	Calgary					35	15	85		135		
Carewest Signal Pointe	X	Calgary							54		54		
Centre of Hope - Salvation Army		Calgary	30								30		
Clifton Manor		Calgary							250		250		

CALGARY ZONE – Beds by Facility continued

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Community Living Alternative Services Ltd - Complex Needs Client		Calgary		1							1		
Community Living Alternatives for the Mentally Disabled Association (Community LAMDA)		Calgary		62							62		
East Calgary Health Centre	X	Calgary											FCC
Eau Claire Retirement Residence		Calgary								73	73		
Edgemont Retirement Residence		Calgary								31	31		
Enviros Wilderness School Association		Calgary	10								10		
Evanston Grand Village		Calgary								102	102		
Extendicare Cedars Villa		Calgary							248		248		
Extendicare Hillcrest		Calgary							112		112		
Father Lacombe Care Centre		Calgary							114		114		
Foothills Medical Centre	X	Calgary				1081					1081		
Fresh Start Recovery Centre		Calgary	1								1		
Glamorgan Care Centre		Calgary							52		52		
Holy Cross Manor		Calgary								100	100		
Hull Homes Detox/PChaD		Calgary	15								15		
Intercare Brentwood Care Centre		Calgary							221		221		
Intercare Chinook Care Centre		Calgary						14	220		234		
Intercare Southwood Care Centre		Calgary						24	241		265		
Kerby Centre		Calgary		10							10		
Kingsland Terrace		Calgary								24	24		
Mayfair Care Centre		Calgary							142		142		
McKenzie Towne Continuing Care Centre		Calgary							150		150		
McKenzie Towne Retirement Residence		Calgary								42	42		
Millrise Place		Calgary							51	40	91		
Monterey Place		Calgary								107	107		
Mount Royal Care Centre		Calgary							93		93		
Newport Harbour Care Centre		Calgary							127		127		
Oxford House		Calgary	23								23		
Personal Care Homes - Continuing Care		Calgary								223	223		
Peter Lougheed Centre	X	Calgary				522					522		
Prince of Peace Harbour		Calgary								32	32		
Prince of Peace Manor		Calgary								30	30		
Providence Care Centre		Calgary							94	56	150		
Recovery Acres		Calgary	13								13		
Renfrew Recovery Centre		Calgary	40								40		

CALGARY ZONE – Beds by Facility continued

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Richmond Road Diagnostic & Treatment Centre	X	Calgary				OP							
Rocky Ridge Retirement Community		Calgary								29	29		
Rockyview General Hospital	X	Calgary				615					615		
Rosedale Hospice		Calgary						7			7		
Rotary Flames House	X	Calgary						7			7		
Sage Hill Retirement Residence		Calgary								72	72		
Scenic Acres Retirement Residence		Calgary								26	26		
SCOPE Hunterview House		Calgary		2							2		
Secura Bright Harbour		Calgary		4							4		
Seton Seniors Community		Calgary							59	252	311		
Sheldon M. Chumir Health Centre	X	Calgary											UCC
South Calgary Health Centre	X	Calgary											UCC
South Health Campus	X	Calgary				272					272		
Southern Alberta Foresenic Psychiatric Centre	X	Calgary			33						33		
St. Marguerite Manor		Calgary						26		102	128		
St. Teresa Place		Calgary								250	250		
Sunridge Medical Gallery	X	Calgary											CACC
Sunrise Native Addiction Services Society		Calgary	24								24		
Swan Evergreen		Calgary								48	48		
Trinity Foundation		Calgary		30							30		
Tom Baker Cancer Centre	X	Calgary										Ca	
Walden Heights Seniors Community		Calgary							58	238	296		
Wentworth Manor/The Residence and The Court		Calgary							73	57	130		
Whitehorn Village		Calgary								53	53		
Wing Kei Care Centre		Calgary							145		145		
Wing Kei Greenview		Calgary								95	95		
Woods Homes		Calgary		22							22		
Bow Valley Community Cancer Centre	X	Canmore	Co-located on same campus as Canmore General Hospital									Ca	
Canmore General Hospital	X	Canmore				21			23		44		
Claresholm Centre for Mental Health and Addictions	X	Claresholm			120						120		
Claresholm General Hospital	X	Claresholm				16					16		
Lander Treatment Centre	X	Claresholm	48								48		
Willow Creek Continuing Care Centre	X	Claresholm							100		100		
Bethany Cochrane		Cochrane							78		78		

CALGARY ZONE – Beds by Facility continued

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Cochrane Community Health Centre	X	Cochrane											UCC
Aspen Ridge Lodge		Didsbury								30	30		
Bethany Didsbury		Didsbury								100	100		
Didsbury District Health Services	X	Didsbury				16			21		37		
High River General Hospital	X	High River				27			50		77		
High River Community Cancer Centre	X	High River	Co-located on same campus as High River General Hospital									Ca	
Sunrise Village High River		High River								108	108		
Silver Willow Lodge		Nanton								38	38		
Foothills Country Hospice		Okotoks						8			8		
Okotoks Health and Wellness Centre	X	Okotoks											UCC
Revera Heartland		Okotoks								40	40		
Strafford Foundation Tudor Manor		Okotoks								152	152		
Agecare Sagewood Seniors Community		Strathmore							55	110	165		
Strathmore District Health Services	X	Strathmore				23					23		
Extendicare Vulcan		Vulcan							46		46		
Vulcan Community Health Centre	X	Vulcan				8			15		23		
Total Calgary Zone			**301**	**423**	**153**	**2,779**	**280**	**121**	**5,385**	**2,700**	**12,142**		

CENTRAL ZONE – Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Bashaw Care Centre	X	Bashaw											CACC
Bashaw Meadows		Bashaw								30	30		
Bentley Care Centre	X	Bentley							16		16		
Slim Thorpe Recovery Centre		Blackfoot	6								6		
Breton Health Centre	X	Breton							23		23		
Bethany Meadows		Camrose							65	30	95		
Faith House		Camrose								20	20		
Louise Jensen Care Centre		Camrose							65		65		
Memory Lane		Camrose								25	25		
Rosehaven Care Centre		Camrose							75		75		
St Mary's Hospital		Camrose				76					76		
Camrose Community Cancer Centre		Camrose	Co-located on same campus as St. Mary's Hospital									Ca	
Sunrise Village Camrose		Camrose								82	82		
Viewpoint		Camrose								20	20		
Our Lady of the Rosary Hospital		Castor				5			22		27		
Consort Hospital and Care Centre	X	Consort				5			15		20		
Coronation Hospital and Care Centre	X	Coronation				10			23	19	52		
Daysland Health Centre	X	Daysland				26					26		
Providence Place		Daysland								16	16		
Drayton Valley Hospital and Care Centre	X	Drayton Valley				32			50		82		
Drayton Valley Community Cancer Centre	X	Drayton Valley	Co-located on same campus as Drayton Valley Hospital and Care Centre									Ca	
Serenity House	X	Drayton Valley								12	12		
Sunrise Village Drayton Valley		Drayton Valley								16	16		
Drumheller Health Centre	X	Drumheller				37			96		133		
Drumheller Community Cancer Centre	X	Drumheller	Co-located on same campus as Drumheller Health Centre									Ca	
Grace House		Drumheller	5								5		
Hillview Lodge		Drumheller								36	36		
Eckville Manor House		Eckville								15	15		
Galahad Care Centre	X	Galahad							20		20		
Hanna Health Centre	X	Hanna				17			61		78		
Hardisty Health Centre	X	Hardisty				5			15		20		
Innisfail Health Centre	X	Innisfail				28			78		106		
Sunset Manor		Innisfail								102	102		
Islay Assisted Living	X	Islay								20	20		

CENTRAL ZONE – Beds by Facility continued

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Killam Health Care Centre		Killam				5			45		50		
Lacombe Hospital and Care Centre	X	Lacombe				35			75		110		
Royal Oak Manor		Lacombe								111	111		
Lamont Health Care Centre		Lamont				15			105		120		
Westview Care Community		Linden							37		37		
Points West Living Lloydminster		Lloydminster								60	60		
Dr. Cooke Extended Care Centre		Lloydminster							50		50		
Lloydminster Continuing Care Centre		Lloydminster							60		60		
Lloydminster Hospital (Saskatchewan)		Lloydminster				39					39		
Lloydminster Community Cancer Centre (Sask.)		Lloydminster	Co-located on same campus as Lloydminster Hospital									Ca	
Pioneer House		Lloydminster								44	44		
Mannville Care Centre	X	Mannville							23		23		
Mary Immaculate Hospital		Mundare							30		30		
Eagle View Lodge		Myrnam								9	9		
Enviros Wilderness School (Shunda Creek)		Nordegg	10								10		
Olds Hospital and Care Centre	X	Olds				33			50		83		
Sunrise Encore Olds		Olds								60	60		
Sunrise Village Olds		Olds								20	20		
Centennial Centre for Mental Health & Brain Injury	X	Ponoka			330						330		
Northcott Care Centre (Ponoka)		Ponoka							73		73		
Ponoka Hospital and Care Centre	X	Ponoka				29			28		57		
Sunrise Village Ponoka		Ponoka								20	20		
Provost Health Centre	X	Provost				15			47		62		
Addiction Counselling & Prevention Services	X	Red Deer	5								5		
Bethany CollegeSide (Red Deer)		Red Deer							112		112		
Extendicare Michener Hill		Red Deer							220	60	280		
Kentwood Place	X	Red Deer		25							25		
Pines Lodge		Red Deer								10	10		
Points West Living Red Deer		Red Deer								114	114		
Red Deer Hospice		Red Deer						10			10		
Red Deer Regional Hospital Centre	X	Red Deer				370					370		
Central Alberta Cancer Centre	X	Red Deer	Co-located on same campus as Red Deer Regional Hospital									Ca	
Safe Harbour Society		Red Deer	40								40		
Timberstone Mews		Red Deer								60	60		
Villa Marie		Red Deer								100	100		

CENTRAL ZONE – Beds by Facility continued

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
West Park Lodge		Red Deer								36	36		
Rimbey Hospital and Care Centre	X	Rimbey				23			84		107		
Clearwater Centre		Rocky Mountain House							40	39	79		
Park Avenue at Creekside		Rocky Mountain House								40	40		
Rocky Mountain House Health Centre	X	Rocky Mountain House				31					31		
Points West Living Stettler		Stettler								88	88		
Stettler Hospital and Care Centre	X	Stettler				26			50		76		
Sundre Hospital and Care Centre	X	Sundre				14			9		23		
Sundre Seniors Supportive Living		Sundre								40	40		
Bethany Sylvan Lake		Sylvan Lake							40	21	61		
Sylvan Lake Community Health Centre	X	Sylvan Lake											CACC
Chateau Three Hills		Three Hills								15	15		
Three Hills Health Centre	X	Three Hills				21			24		45		
Tofield Health Centre	X	Tofield				16			50		66		
St. Mary's Health Care Centre		Trochu							28		28		
Two Hills Health Centre	X	Two Hills				27			56		83		
Century Park		Vegreville								40	40		
Heritage House		Vegreville								42	42		
St. Joseph's General Hospital		Vegreville				23					23		
Vegreville Care Centre	X	Vegreville							60		60		
Vegreville Manor		Vegreville								15	15		
Vermilion Health Centre	X	Vermilion				25			48		73		
Vermilion Valley Lodge		Vermilion								40	40		
Extendicare Viking		Viking							60		60		
Viking Health Centre	X	Viking				16					16		
Points West Living Wainwright		Wainwright								59	59		
Wainwright Health Centre	X	Wainwright				25			69		94		
Good Samaritan Good Shepherd Lutheran Home		Wetaskiwin								69	69		
Sunrise Village Wetaskiwin		Wetaskiwin								20	20		
Wetaskiwin Hospital and Care Centre	X	Wetaskiwin				69			107		176		
Wetaskiwin Meadows		Wetaskiwin								26	26		
Wetaskiwin Serenity House (Bosco)		Wetaskiwin		6							6		
Total Central Zone			**66**	**31**	**330**	**1,098**	**0**	**10**	**2,304**	**1,701**	**5,540**		

EDMONTON ZONE – Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Kipohtakawmik Elders Lodge		Alexander Reserve								17	17		
Chateau Vitaline		Beaumont								46	46		
Devon General Hospital	X	Devon				10			14		24		
Addiction Recovery Centre	X	Edmonton	42								42		
Alberta Hospital Edmonton	X	Edmonton			295						295		
Allen Gray Continuing Care Centre		Edmonton							156		156		
Allendale House		Edmonton		10							10		
Ambrose Place		Edmonton		42							42		
Anderson Hall	X	Edmonton		16							16		
Aspire Homes - Newton	X	Edmonton		5							5		
Aspire Homes - Mount Rose	X	Edmonton		5							5		
Aspire Homes - Elmwood Park	X	Edmonton		5							5		
Balwin Place		Edmonton		25							25		
Balwin Villa (Excel Society)		Edmonton								104	104		
CapitalCare Dickinsfield	X	Edmonton							275		275		
CapitalCare Dickinsfield Duplexes	X	Edmonton								14	14		
CapitalCare Grandview	X	Edmonton					34		147		181		
The Dianne and Irvings Kipnes Centre for Veterans	X	Edmonton							120		120		
CapitalCare Laurier House Lynnwood	X	Edmonton								80	80		
CapitalCare Lynnwood	X	Edmonton							284		284		
CapitalCare McConnell Place North	X	Edmonton								36	36		
CapitalCare McConnell Place West	X	Edmonton								36	36		
CapitalCare Norwood	X	Edmonton					114	23	68		205		
Churchill Retirement Community		Edmonton								31	31		
Cross Cancer Institute	X	Edmonton				55					55	Ca	
Devonshire Care Centre		Edmonton							132		132		
Devonshire Manor		Edmonton								59	59		
Donnelly House		Edmonton		8							8		
Diverse City Housing		Edmonton		15							15		
E4C Emerging Adults Transition Housing		Edmonton		7							7		
E4C Inner Ways		Edmonton		10							10		
E4C Inner Ways (Bear Den)		Edmonton		5							5		
E4C Inner Ways (Beaver Den)		Edmonton		5							5		
E4C Inner Ways (Complex Health Women's Housing)		Edmonton		2							2		
E4C Inner Ways (Female Harm Reduction Transitional House)		Edmonton		6							6		

EDMONTON ZONE – Beds by Facility continued

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
E4C Meadows Place		Edmonton		16							16		
E4C Our Place		Edmonton		10							10		
East Edmonton Health Centre	X	Edmonton											FCC/UCC
Edmonton Chinatown Care Centre		Edmonton							80	15	95		
Edmonton General Continuing Care Centre		Edmonton					20	26	449		495		
Edmonton People in Need #2 (SCH)		Edmonton								34	34		
Edmonton People In Need #4 - Batoma House		Edmonton								81	81		
Emmanuel Home		Edmonton								15	15		
Extendicare Eaux Claires		Edmonton							204		204		
Extendicare Holyrood		Edmonton							74		74		
Garneau Hall		Edmonton								37	37		
George Spady Centre Society		Edmonton	73								73		
Glastonbury Village		Edmonton								49	49		
Glenrose Rehabilitation Hospital	X	Edmonton				244					244		
Good Samaritan Dr. Gerald Zetter Care Centre		Edmonton							200		200		
Good Samaritan Millwoods Care Centre		Edmonton							60		60		
Good Samaritan Southgate Care Centre		Edmonton							226		226		
Good Samaritan Wedman House		Edmonton								30	30		
Good Samaritan Wedman Village Homes		Edmonton								30	30		
Grand Manor		Edmonton								102	102		
Grey Nuns Community Hospital		Edmonton				351					351		
Hardisty Care Centre		Edmonton							175		175		
Health First Strathcona	X	Edmonton											UCC
Henwood Treatment Centre	X	Edmonton	72								72		
House Next Door #1, 2, 3		Edmonton		24							24		
Jasper Place Continuing Care Centre		Edmonton							100		100		
Jellinek House		Edmonton	15								15		
Journey Home		Edmonton		6							6		
Jubilee Lodge Nursing Home		Edmonton							154		154		
Laurel Heights		Edmonton								70	70		
Lewis Estates Retirement Residence		Edmonton								87	87		
Lifestyle Options Riverbend		Edmonton								18	18		
Lifestyle Options Terra Losa		Edmonton								77	77		
Lifestyle Options Whitemud		Edmonton								79	79		
McDougall House		Edmonton	11								11		
Miller Crossing Care Centre		Edmonton							155		155		
Misericordia Community Hospital		Edmonton				312					312		

EDMONTON ZONE – Beds by Facility continued

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Northeast Community Health Centre	X	Edmonton				ED							
Ottewell Lodge		Edmonton		38							38		
Our House		Edmonton	70								70		
Our Parents' Home		Edmonton								50	50		
Recovery Acres Edmonton		Edmonton	34								34		
Recovery Acres Satellite Housing Program		Edmonton	20								20		
Riverbend Retirement Residence		Edmonton								38	38		
Rosedale at Griesbach		Edmonton								165	165		
Rosedale Estates		Edmonton								50	50		
Royal Alexandra Hospital	X	Edmonton				882					882		
Rutherford Heights Retirement Residence		Edmonton								89	89		
Saint Thomas Assisted Living Centre		Edmonton								138	138		
Salvation Army Grace Manor		Edmonton								87	87		
Salvation Army Stepping Stone Supportive Residence		Edmonton								50	50		
Shepherd's Care Ashbourne		Edmonton								0	0		
Shepherd's Care Greenfield		Edmonton								30	30		
Shepherd's Care Kensington		Edmonton							69	86	155		
Shepherd's Care Millwoods		Edmonton							147		147		
Shepherd's Care Vanguard		Edmonton								93	93		
Shepherd's Garden		Edmonton								45	45		
South Terrace Continuing Care Centre		Edmonton							107		107		
Spucewood Place		Edmonton								93	93		
St. Joseph's Auxiliary Hospital		Edmonton						14	188		202		
St. Michael's Long Term Care Centre		Edmonton							153		153		
Stollery Children's Hospital	X	Edmonton				159					159		
Touchmark at Wedgewood		Edmonton							64		64		
Tuoi Hac - Golden Age Manor		Edmonton								91	91		
University of Alberta Hospital	X	Edmonton				691					691		
Venta Care Centre		Edmonton							148		148		
Villa Caritas		Edmonton			150						150		
Villa Marguerite		Edmonton								239	239		
Wild Rose Cottage		Edmonton								27	27		
Youth Stabilization & Residential Services	X	Edmonton	21								21		
Good Samaritan Society Pembina Village		Evansburg							40		40		
Fort Saskatchewan Health Centre	X	Fort Saskatchewan				36					36		

EDMONTON ZONE – Beds by Facility continued

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Rivercrest Care Centre		Fort Saskatchewan							85		85		
Extendicare Leduc		Leduc							79		79		
Leduc Community Hospital	X	Leduc				74					74		
Lifestyle Options Leduc		Leduc								74	74		
Salem Manor Nursing Home		Leduc							102		102		
Aspen House	X	Morinville								72	72		
CapitalCare Laurier House Strathcona	X	Sherwood Park								42	42		
CapitalCare Strathcona	X	Sherwood Park							111		111		
CASA House		Sherwood Park		20							20		
Country Cottage Seniors Residence		Sherwood Park								26	26		
Sherwood Care		Sherwood Park							100		100		
Strathacona Community Hospital	X	Sherwood Park				ED							
Summerwood Village Retirement Residence		Sherwood Park								79	79		
Copper Sky Lodge		Spruce Grove								130	130		
Good Samaritan Spruce Grove Centre		Spruce Grove								30	30		
Citadel Care Centre		St. Albert							129		129		
Citadel Mews West		St. Albert								67	67		
Foyer Lacombe		St. Albert						10	12		22		
Poundmaker's Lodge Treatment Center - Youth Addiction (Safe-Com)		St. Albert	51								51		
Rosedale St Albert		St. Albert								70	70		
St. Albert Retirement Residence		St. Albert								92	92		
Sturgeon Community Hospital	X	St. Albert				166					166		
Youville Auxiliary Hospital (Grey Nuns) of St. Albert		St. Albert							232		232		
Good Samaritan George Hennig Place		Stony Plain								30	30		
Good Samaritan Stony Plain Care Centre		Stony Plain							126	30	156		
WestView Health Centre - Stony Plain Care Centre	X	Stony Plain				23		6	40		69		
Family Care Homes		Various								2	2		
Approved Mental Health Care Homes		Various		26							26		
Personal Care Homes		Various								254	254		
Special Care Homes		Various								92	92		
West Country Hearth		Villeneuve								32	32		
Total Edmonton Zone			**409**	**306**	**445**	**3,003**	**168**	**79**	**5,005**	**3,640**	**13,055**		

NORTH ZONE – Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Athabasca Healthcare Centre	X	Athabasca				27			23		50		
Extendicare Athabasca		Athabasca							50		50		
Barrhead Healthcare Centre	X	Barrhead				34					34		
Barrhead Community Cancer Centre	X	Barrhead	Co-located on same campus as Barrhead Healthcare Centre									Ca	
Dr. W.R. Keir - Barrhead Continuing Care Centre	X	Barrhead							100		100		
Mental Health Spaces		Barrhead											
Shepherd's Care Barrhead		Barrhead								42	42		
Beaverlodge Municipal Hospital	X	Beaverlodge				18					18		
Bonnyville Healthcare Centre		Bonnyville				33			30		63		
Bonnyville Community Cancer Centre		Bonnyville	Co-located same campus as Bonnyville Healthcare Centre									Ca	
Bonnyville Indian Metis Rehab Centre		Bonnyville	20								20		
Extendicare Bonnyville		Bonnyville							50		50		
Boyle Healthcare Centre	X	Boyle				20					20		
Wildrose Assisted Living		Boyle								22	22		
Cold Lake Healthcare Centre	X	Cold Lake				24			31		55		
Points West Living Cold Lake		Cold Lake								42	42		
Ridgevalley Seniors Home		Crooked Creek								15	15		
Wabasca/Desmarais Healthcare Centre	X	Desmarais				10					10		
Edson Healthcare Centre	X	Edson				24			38	38	100		
Parkland Lodge		Edson								10	10		
Elk Point Healthcare Centre	X	Elk Point				12			30		42		
Elk Point Heritage Lodge		Elk Point								10	10		
Fairview Health Complex	X	Fairview				25		1	66		92		
Fort McMurray Recovery Centre	X	Fort McMurray	16								16		
Northern Lights Regional Health Centre	X	Fort McMurray				105			31		136		
Fort McMurray Community Cancer Centre	X	Fort McMurray	Co-located same campus as Northern Lights Regional Health Centre									Ca	
Pastew Place Detox Centre		Fort McMurray	11								11		
St. Theresa General Hospital	X	Fort Vermilion				26			8		34		
Fox Creek Healthcare Centre	X	Fox Creek				4					4		
Grande Cache Community Health Complex	X	Grande Cache				12					12		
Whispering Pines Seniors Lodge		Grande Cache								15	15		
Grande Prairie Care Centre		Grande Prairie							60	60	120		
Northern Addiction Centre	X	Grande Prairie	63								63		
Points West Living Grand Prairie		Grande Prairie						10	50	95	155		
Queen Elizabeth II Hospital	X	Grande Prairie				161	10			71	242		

NORTH ZONE – Beds by Facility continued

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Grande Prairie Care Centre	X	Grande Prairie	Co-located same campus as QEII Hospital									Ca	
The Gardens at Emerald Park		Grande Prairie								15	15		
Youth Detoxification Services	X	Grande Prairie	4								4		
Grimshaw/Berwyn and District Community Health Centre	X	Grimshaw				ED		1	19		20		
Stone Brook		Grimshaw								56	56		
Action North Recovery Centre		High Level	13								13		
Northwest Health Centre	X	High Level				21			11		32		
High Prairie Health Complex	X	High Prairie				30					30		
J.B. Wood Continuing Care Centre	X	High Prairie							27	40	67		
Metis Indian Town Alcohol Association (MITAA Centre)		High Prairie	16								16		
Hinton Healthcare Centre	X	Hinton				23					23		
Hinton Community Cancer Centre	X	Hinton	Co-located same campus as Hinton Healthcare Centre									Ca	
Mountain View Centre		Hinton								52	52		
Hythe Continuing Care Centre	X	Hythe							31		31		
Jasper Alpine Summit Seniors Lodge		Jasper								16	16		
Seton - Jasper Healthcare Centre	X	Jasper				11					11		
Heimstaed Lodge		La Crete								54	54		
La Crete Continuing Care Centre	X	La Crete						1	22		23		
La Crete Health Centre	X	La Crete											AACS
William J. Cadzow - Lac La Biche Healthcare Centre	X	Lac La Biche				23			41		64		
Manning Community Health Centre	X	Manning				11			16		27		
Extendicare Mayerthorpe		Mayerthorpe							50		50		
Mayerthorpe Healthcare Centre	X	Mayerthorpe				24			30		54		
Pleasant View Lodge		Mayerthorpe								15	15		
Manoir du Lac		McLennan							22	35	57		
Sacred Heart Community Health Centre	X	McLennan				20					20		
Chateau Lac St. Anne		Onoway								15	15		
Peace River Community Health Centre	X	Peace River				31			40		71		
Peace River Community Cancer Centre	X	Peace River	Co-located same campus as Peace River Community Health Centre									Ca	
Points West Living Peace River		Peace River								42	42		
Radway Continuing Care Centre	X	Radway							30		30		
Rainbow Lake Health Centre		Rainbow Lake											CACC
Redwater Healthcare Centre	X	Redwater				14			7		21		
Points West Living Slave Lake		Slave Lake								45	45		

NORTH ZONE – Beds by Facility continued

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Slave Lake Family Care Clinic	X	Slave Lake											FCC
Slave Lake Healthcare Centre	X	Slave Lake				24			20		44		
Vanderwell Lodge		Slave Lake								8	8		
George McDougall - Smoky Lake Healthcare Centre	X	Smoky Lake				12			23		35		
Smoky Lake Continuing Care Centre	X	Smoky Lake							28		28		
Central Peace Health Complex	X	Spirit River				12			16		28		
Extendicare St. Paul		St. Paul							76		76		
St. Therese - St. Paul Healthcare Centre	X	St. Paul				40			30		70		
St. Paul Abilities Network		St. Paul		5						6	11		
Swan Hills Healthcare Centre	X	Swan Hills				4					4		
Valleyview Health Centre	X	Valleyview				20			25		45		
Vilna Villa		Vilna								12	12		
Smithfield Lodge	X	Westlock								46	46		
Westlock Healthcare Centre	X	Westlock				46	8		112		166		
Spruce View Lodge		Whitecourt								15	15		
Whitecourt Healthcare Centre	X	Whitecourt				22					22		
Total North Zone			**143**	**5**	**0**	**923**	**18**	**13**	**1,243**	**892**	**3,237**		

Source: AHS Bi-Annual Bed Survey as of March 31, 2018.

Change in Bed Numbers by Zone from 2016-17 to 2017-18

Reported Beds Staff & In Operation Summary as of March 31, 2018

Zone	Addiction and Mental Health			Acute Care		Continuing Care - Facility Living				Supportive Living				TOTAL CONTINUING CARE (LTC + SL)	TOTAL COMMUNITY BASED CARE (includes PEOLC)	TOTAL BEDS
	Addiction	Community Mental Health	Psychiatric (Stand-alone Facility)	Acute Care	Sub-Acute (Non Acute Care Facility)	Community Palliative & End of Life Care (PEOLC)	Auxiliary Hospital	Nursing Home	Long Term Care Subtotal (Auxiliary + Nursing home)	Level 3 (includes mental health)	Level 4 (includes mental health)	Level 4 Dementia	Supportive Living Subtotal (SL 3 + SL 4 + SL4D)			
South Zone	74	37	0	645	24	20	258	651	909	299	1,027	548	1,874	2,783	2,803	3,583
Calgary Zone	301	423	153	2,779	280	121	1,072	4,313	5,385	233	1,737	730	2,700	8,085	8,206	12,142
Central Zone	66	31	330	1,098	0	10	1,413	891	2,304	385	872	444	1,701	4,005	4,015	5,540
Edmonton Zone	409	306	445	3,003	168	79	2,234	2,771	5,005	399	2,123	1,118	3,640	8,645	8,724	13,055
North Zone	143	5	0	923	18	13	639	604	1,243	198	478	216	892	2,135	2,148	3,237
Alberta Total	**993**	**802**	**928**	**8,448**	**490**	**243**	**5,616**	**9,230**	**14,846**	**1,514**	**6,237**	**3,056**	**10,807**	**25,653**	**25,896**	**37,557**

Reported Beds Staff & In Operation Summary as of March 31, 2017

Zone	Addiction and Mental Health			Acute Care		Continuing Care - Facility Living				Supportive Living				TOTAL CONTINUING CARE (LTC + SL)	TOTAL COMMUNITY BASED CARE (includes PEOLC)	TOTAL BEDS
	Addiction	Community Mental Health	Psychiatric (Stand-alone Facility)	Acute Care	Sub-Acute (Non Acute Care Facility)	Community Palliative & End of Life Care (PEOLC)	Auxiliary Hospital	Nursing Home	Long Term Care Subtotal (Auxiliary + Nursing home)	Level 3 (includes mental health)	Level 4	Level 4 Dementia	Supportive Living Subtotal (SL 3 + SL 4 + SL4D)			
South Zone	74	37	0	681	24	20	248	601	849	299	1,022	513	1,834	2,683	2,703	3,519
Calgary Zone	296	418	141	2,756	280	121	1,072	4,286	5,358	233	1,555	678	2,466	7,824	7,945	11,836
Central Zone	66	31	330	1,100	0	10	1,413	891	2,304	395	811	401	1,607	3,911	3,921	5,448
Edmonton Zone	389	255	484	2,972	168	79	2,234	2,747	4,981	392	2,133	1,118	3,643	8,624	8,703	12,971
North Zone	143	5	0	918	38	13	639	614	1,253	198	394	194	786	2,039	2,052	3,156
Alberta Total	**968**	**746**	**955**	**8,427**	**510**	**243**	**5,606**	**9,139**	**14,745**	**1,517**	**5,915**	**2,904**	**10,336**	**25,081**	**25,324**	**36,930**

Change from March 31, 2017 to March 31, 2018

Zone	Addiction and Mental Health			Acute Care		Continuing Care - Facility Living				Supportive Living				TOTAL CONTINUING CARE (LTC + SL)	TOTAL COMMUNITY BASED CARE (includes PEOLC)	TOTAL BEDS
	Addiction	Community Mental Health	Psychiatric (Stand-alone Facility)	Acute Care	Sub-Acute (Non Acute Care Facility)	Community Palliative & End of Life Care (PEOLC)	Auxiliary Hospital	Nursing Home	Long Term Care Subtotal (Auxiliary + Nursing home)	Level 3 (includes mental health)	Level 4	Level 4 Dementia	Supportive Living Subtotal (SL 3 + SL 4 + SL4D)			
South Zone	0	0	0	-36	0	0	10	50	60	0	5	35	40	100	100	64
Calgary Zone	5	5	12	23	0	0	0	27	27	0	182	52	234	261	261	306
Central Zone	0	0	0	-2	0	0	0	0	-	-10	61	43	94	94	94	92
Edmonton Zone	20	51	-39	31	0	0	0	24	24	7	-10	0	(3)	21	21	84
North Zone	0	0	0	5	-20	0	0	-10	(10)	0	84	22	106	96	96	81
Alberta Total	**25**	**56**	**(27)**	**21**	**(20)**	**-**	**10**	**91**	**101**	**(3)**	**322**	**152**	**471**	**572**	**572**	**627**

Source: AHS Bi-Annual Bed Survey as of March 31, 2018.

Our appreciation and gratitude to all those who contributed to the completion of the 2017-18 Annual Report.