**Title: Tuesday, September 11, 2007 Public Accounts Committee**
Date: 07/09/11
Time: 9:00 a.m.
[Mr. MacDonald in the chair]
**The Chair:** Good morning, everyone. I would like to call this Standing Committee on Public Accounts to order, please.
I would now ask for an approval of the agenda that was circulated.

**Mr. Strang:** So moved, Mr. Chairman.

**The Chair:** Thank you, Mr. Strang. Before we do that, I would like to remind all members that we received the link to the agenda and the materials on August 31, and there were several updates since. It's moved by Mr. Strang that the agenda for the September 11, 2007, meeting of the Standing Committee on Public Accounts be approved as circulated. All those in favour? None opposed. Thank you very much.
Also, item 3 is the adoption of the minutes from May 30, 2007, June 6, 2007, and June 13, 2007. Moved by Mr. Chase that the minutes of the May 30, June 6, and June 13 meetings of the Standing Committee on Public Accounts be approved as circulated. Thank you.
Item 4 on our agenda this morning is a briefing meeting with the Auditor General, Mr. Fred Dunn, and committee research co-ordinator, Dr. Philip Massolin. Now, as the rest of this hour is to be an internal briefing from our Auditor General and research co-ordinator, I would like at this time to call for a motion to move in camera, please.

**Mr. Eggen:** I would like to move as such.

**The Chair:** Thank you. Moved by David Eggen that the meeting move in camera. All those in favour? Opposed? Seeing none, carried.

[The committee met in camera from 9:03 a.m. to 10 a.m.]

**The Chair:** Good morning, everyone. I would like to call this meeting of the Standing Committee on Public Accounts to order, please. Perhaps we can quickly go around the table and introduce ourselves. We'll start with the hon. Member for West Yellowhead.

**Mr. Strang:** Good morning. Ivan Strang, West Yellowhead.

**Mrs. Forsyth:** Hi there. I'm Heather Forsyth, Calgary-Fish Creek.

**Mr. Webber:** Hello. Len Webber, Calgary-Foothills.

**Mr. Cardinal:** Good morning. Mike Cardinal, Athabasca-Redwater.

**Mr. Cenaiko:** Good morning. Harvey Cenaiko, Calgary-Buffalo.

**Mr. Dunford:** Well, good morning on a historic day for openness and accountability in Alberta. I'm Clint Dunford, Lethbridge-West.

**Ms White:** Good morning. Ronda White with the office of the Auditor General.

**Mr. Dunn:** Fred Dunn, Auditor General.

**Ms Staples:** Jane Staples with the office of the Auditor General.

**Mr. Dickson:** Good morning. I'm Mark Dickson. I'm director of finance for East Central health.

**Mr. Stevenson:** Good morning. I'm Brian Stevenson, chief corporate services officer with East Central health.

**Mr. Kirkland:** Good morning. Malcolm Kirkland, vice-president of operations with East Central health.

**Dr. Olson:** Good morning. Odell Olson, vice-president of medical services, East Central health.

**Mr. Bonko:** Good morning. Bill Bonko, MLA, Edmonton-Decore.

**Mr. R. Miller:** Good morning. Rick Miller, MLA, Edmonton-Rutherford.

**Mr. Chase:** Good morning. Harry Chase, Calgary-Varsity. On behalf of my colleague Laurie Blakeman welcome to Edmonton-Centre.

**Mr. Johnston:** Good morning. Art Johnston, Calgary-Hays.

**Mr. Herard:** Good morning. Denis Herard, Calgary-Egmont. Welcome.

**Mr. Rodney:** Welcome from Dave Rodney, Calgary-Lougheed.

**Mr. Eggen:** Good morning. My name is Dave Eggen. I'm the MLA for Edmonton-Calder.

**Dr. Massolin:** Good morning. Philip Massolin. I'm the committee research co-ordinator for the Legislative Assembly Office.

**Mr. Saunders:** Yes. Good morning. My name is Jim Saunders, one of two official administrators for East Central health.

**Mr. Prins:** Ray Prins, Lacombe-Ponoka.

**The Chair:** Hugh MacDonald, Edmonton-Gold Bar.

**Mrs. Dacyshyn:** Corinne Dacyshyn, committee clerk.

**The Chair:** Mr. Kirkland, would you like to introduce your colleague that's sitting over to the side, please?

**Mr. Kirkland:** Okay. Good morning. Conrad Quist, budget officer with East Central health.

**The Chair:** Okay. He's quite welcome to participate, clarify information or supplement a question if you so desire.
I would also like to introduce colleague Laurie Blakeman, who is sitting this morning observing the proceedings. She is our official spokesman on health matters.
We look forward to discussing, Mr. Kirkland, your 2005-06 and 2006-07 annual reports. We would like to thank you formally for getting that material to us in a timely fashion.
Again, I would like to remind you that you do not have to touch the microphones. The *Hansard* staff will turn them on and off for you.
I understand now that you have a brief opening statement, followed by a PowerPoint presentation. You can proceed, please.

**Mr. Saunders:** Thank you very much. It's a great privilege for East

Central health to be here this morning. We appreciate the tremendous responsibility that you're undertaking, and we really applaud the initiative and the leadership that you're showing by this open accountability opportunity. We believe also that it's an opportunity for East Central health to share some of the events that are going on in East Central health and some of the things that we're very proud of in that regional health authority.

We're here with a team this morning, and our intent is to share the responsibilities to respond to any of the areas that may be of question. We will respond fully, openly, and quite transparently in any areas of question, whether that be with regard to our financial operation or any part of the services that are provided throughout East Central health.

East Central health has recently gone through a fairly significant change at the board level.

**Mrs. Dacyshyn:** We're having a technical difficulty for a few minutes. I'm sorry.

**The Chair:** Mr. Saunders, I believe all members have a copy of this. Please, just proceed. We got along in this world quite well before we had PowerPoint presentations.

**Mr. Saunders:** That's right. That's, in fact, why you have copies in front of you, for this very reason.

Just to give you a very brief background. On July 25 of this year Minister Hancock replaced the board and CEO of East Central health with two official administrators, myself and Paddy Meade. My background has been health administration for in excess of 30 years, and it was an honour for me to be asked to come in and assist East Central health in the transition process as we work through a number of the issues with regard to the findings of the Health Quality Council. I began my function formally on July 25 but actually appeared on-site about August 13.

Paddy Meade, the deputy minister, extends her regrets for not being here this morning. We discussed the opportunity, and we decided that I would carry that responsibility forward. I'm sure everyone is aware, but the role and function and authority level of an official administrator carries the full responsibility of the board as well as the CEO. That position is shared with Paddy Meade and myself. We confer on a regular basis and have fully engaged the management team and the staff throughout East Central health in, I think, a very constructive change process.

It's very difficult on the organization. It was a major change to see the board and the CEO leave, but I want to commend the East Central health management team, the medical community, and the staff throughout the organization for their resilience and their ability to come forward and constructively look at what the issues are and develop a priority plan to move forward in a constructive way. The organization is dealing with the change very effectively. I am very confident that they'll be able to handle the responsibilities in the forthcoming months very successfully.

East Central health is a very large rural health region with a very dispersed population. We serve about 110,000 residents spread out between two cities, 15 towns, 33 villages, and 34 hamlets. We have 17 health centres or care centres made up of 13 hospitals and four continuing care facilities, 16 community offices, and nine mental health clinics.

I want to tell you that my experience in the past has been in urban health regions as well as in the not too distant past the WestView regional health authority. The challenges that relate to the operation of a large rural health region are very significant: the need to balance priorities, quality, service. There is a premium to pay for maintaining the health services throughout the rural communities throughout Alberta. It's very difficult to be everything to everybody, and it's a constant challenge for the management team and the medical leadership team to make the correct decisions. Fundamentally – and I think it's been reinforced both provincially as well as probably nationally – as we look at the quality and safety issues that everyone is facing, those in fact are the greatest areas of responsibility that we have as we go into the future.

Our 110,000 population is also unique. Like many areas we're in aging communities, but in East Central health we actually have an elderly population which exceeds the provincial average. As you can see from the brief graph here, the percentage of residents that we serve over the age of 65 is about 15.5 per cent versus the provincial average of 11.1 per cent, upward to the 85-plus in East Central health at 2.4 per cent versus 1.4 per cent on the provincial average. What this really tells you is, as you're probably well aware, the utilization of health services rises extremely quickly with an aging population, and it just exemplifies the challenge that East Central health has as we look into the future and we look for ways to make sure that we're providing high-quality, safe, and an appropriate range of health services.

East Central health is responsible for the full continuum of care, which includes all of the things that are listed on the slide. I won't go through each one, but it's more than hospitals. It is the full continuum, which includes all of the ambulatory services, continuing care services, and others. The ability to co-ordinate those services is a tremendous advantage. I think one of the things that Alberta has achieved through the regionalization is the ability to centralize all of the levels of care under the government structures in each of the nine health regions plus the Cancer Board. It is a tremendous responsibility, but by looking at it on a regional basis and then tying that regional responsibility into the provincial responsibility, I think Alberta has been a leader in Canada and has been successful in making the transition to that responsibility.

***10:10***

This is just a brief map. If you're not familiar with it, this is East Central health. Really, our cornerstones are Lamont on the northwest down to Bashaw on the southwest over to Kitscoty on the northeast and Provost on the southeast. It's a large, diverse area. The driving distances are up to three hours in any one direction, and just the communication aspect of the co-ordination of services is a major challenge. In fact, on our way up here this morning one of the comments shared was that Dr. Olson indicated that he puts on over 40,000 kilometres a year driving back and forth to the various sites in his responsibilities in his chief medical officer role.

Another table. Again, I won't go into it in detail, but it just gives you an overview of the demographics, the range of services, and the complexity that East Central health operates with. All of those different symbols indicate the services that are available in the various communities. If you want to come back to any of those, we would be pleased to do so as we get into more detailed discussions.

One of the fundamental challenges that East Central health has is being both an operator and a contractor. We operate a series of programs in the areas that are noted there, from Bashaw to Wainwright, and we contract out services, although the word "contract" is up for debate at this point in time. The current terminology is that we have associate partners – various religious organizations, nonprofit voluntary groups – providing management, oversight, and service to a series of communities within East Central health. This is a very complex environment. We're into discussions that we'll probably talk about a little bit later, but what you need to know is that we're both an operator and a contractor. The communities are

listed there, both that we operate as well as the ones that are contracted out. We are using the term "contracted service providers," but that's synonymous, if you're familiar, with the term "associate partner."

We have about 4,200 staff, which is more or less an equal distribution between East Central direct staff and the staff that are employed by our contractors. The responsibilities that we have in working with our associate partners. Just to give you an overview, you can see by this short table that contracted service providers operate about 58 per cent of the acute care beds within East Central health, whereas we manage directly only about 42 per cent of that. This is highly unusual and not common to other health regions in Alberta or outside of Alberta. Long-term care beds we operate about 48 per cent versus 52 per cent by our contractors.

The interesting aspect of this as we looked inside East Central health – and this is a core fundamental discussion around accountability – is that East Central health actually owns all the land, buildings, and equipment for all sites except the Lamont health centre and the Viking extended care centre as well as the other one that maybe doesn't show up on that slide, Lloydminster. We own it, but we don't necessarily directly operate it or control it.

Financial statements of operations. Now you can see everything. We're not hiding anything. We have our financial staff here, who will get into any of the detailed questions that you have about it. Looking at our 2005-06, we just want to indicate that on the information that you have, we recognize that there's about a million dollar deficit that is visible in '05 and '06. I would say, after spending some time with the staff, that East Central health has a history of responsible financial management.

I think the challenges are very specific, though, with regard to the introduction of some of the medical technology, such as the CT scans. What's known as RSHIP, the regional shared health information program, which is a partnership of seven non-urban health regions who have joined together to create an information system which began in 2003, has been a significant financial investment. I use the word "investment" as: a realistic knowledge that we need information in order to operate successfully, and in order to get that information, we need the ability to move into an electronic world. To do that is very expensive. We've used a combination of funding: about $64 million was provided by Alberta Health and Wellness; the remaining funding is expected to come from regional health authority operating budgets. Again, we believe it's an investment. We believe it's essential to our operations to be able to operate on a good business model as well as to provide the information that is so essential to the operation of the health system in Alberta.

We, like all other health regions, have looked at our long-term capital plan, that was submitted in '06-07. You can see that we've been successful in getting approval for a number of different projects. Part of the plan, also, looking at the transition: what's the best level of care? How can we do it most efficiently and most effectively to provide the level of service that is so essential?

This is just a brief summary of what's been approved: about $14 million in Vegreville, again, converting from 90 long-term care beds to 60 beds, but it's a bit misleading because in addition to the 60 beds, we've also created 40 designated assisted-living beds. Similarly, in Vermilion we've gone from 65 basically nursing home beds to 48 beds plus 40 designated assisted-living beds. So the investment that Alberta is making in East Central health is commendable. I can't say that it's enough, but then, again, I can say that whatever the amount of money that could be put into health care, it would never be enough.

We have several functional programs that have been approved. All have been completed on that list except Wainwright. They were submitted to Health and Wellness in June of this year. So St. Mary's, Dr. Cooke, and Lloydminster have all been submitted. The plan for Wainwright will be submitted in December of this year. Also, we're doing a feasibility study at St. Joseph's in Vegreville. That was approved just last month, in August. It's currently out for an RFP by invitation. That RFP closes in the middle of September.

East Central health is more than a health provider. I think it's important that you know that we're a good participant in the educational system. We're a good partner with education. We have formal affiliation agreements established with all of the partners that are noted on the slide. In addition, we have a memorandum of understanding with the University of Alberta that relates to education and to research. We believe that there's a strong opportunity, and so does the University of Alberta, to invest more to look seriously at the research and learn more about rural health care and how it contributes more effectively to the future of the Alberta health care system.

Innovation. East Central health has been very proactive. They've been a leader, I think, in rural health care. Some of the examples of that include some of the work that's gone on in diagnostic imaging, most recently the CT scanner, which opened in July of last year in Camrose and in Lloydminster in January of '06. PACS, which is the diagnostic imaging system across all sites, went live in November of '06. A very exciting opportunity, a very unique opportunity: we have gone into partnership with Aspen and have purchased a mobile MRI, which will be shared between Aspen and East Central health and will be able to locate in different communities, move around, so accessibility to MRI technology by residents across both our regions will be far greater than it ever has been before.

***10:20***

In the continuing care strategy there is implementation of the Eden alternative, and we'll look to our staff to give you some more details if you would like some more information there. Also work in rehabilitation in the pediatric program and a number of initiatives in clinical care.

In addition – I know that we are going to talk about quality today – there's been a high emphasis within East Central health regarding incident reporting, disclosure program, and the MORE and ACoRN programs, similar initiatives in pharmacy, some good beginning work in primary care networks, and some good work in palliative care.

We have some major challenges, and that won't come as a surprise to you. I think every health region might share a similar list of challenges, not only in Alberta but throughout Canada. But very specific to East Central health: quality in patient safety standards. These words are going to be around for a long time. The Health Quality Council report that was tabled this summer is going to have a major ripple effect throughout health care in Canada not so much for the very specific findings but for the demand for accountability, for the clarification of who has the final authority who has the final accountability to make sure that the quality standards are met.

You know, we have debated in Alberta for a number of years, especially when we look at our rural health care settings, the terminology of "hospital," what's provided by the H sign on the highway. The ability to sustain operations in small communities across this province is going to be redebated because of the requirement and, I think, the acknowledged importance, certainly within East Central health but also in other sectors as well, that quality and standards need to supercede any debate regarding economic development. The sustainability of our health system is going to depend on that quality and safety, and if they've done anything, they've opened a box, a very appropriate box, that we are support-

ing. East Central health will be a leader in ensuring that those standards and safety aspects are fully acknowledged and that all of the issues that are brought up in the Health Quality Council report are answered.

Our next challenge is the contracted service provider. Roles and accountabilities: I mentioned very briefly that one of our responsibilities there really impacts who has the final responsibility. It was brought to light in the Vegreville issue, but there are many other aspects of it. At the provincial level I know that the minister is looking seriously at the master agreement. Internally, within East Central health, we're working with our contractors, our voluntary groups. They've been very open to looking at changes that would bring the clarity so that everyone is assured of what those expectations are and how the system will function in an appropriate, safe, and high-quality manner.

The third one will not surprise you: recruitment and retention. We have in the physician areas about nine physician vacancies now. We've been quite successful. I think the work that they've done to ensure, I guess, that physicians are aware of the opportunities in rural Alberta – Dr. Olson has done an outstanding job of ensuring that that's well communicated. We have about four of those nine vacancies in final status, or confirmed status, for individuals coming into the region.

In the nursing areas, like everybody else we face vacancies although, again, East Central health themselves, not counting our partners, have been quite successful. We really just have five vacancies in that area now. All totalled, if you add in all vacancies, including full-time, part-time, casual, and term positions, we have about 136 vacancies.

Operating capital budgets: a major challenge. You will see from our report that in '05-06 that we had a million dollar deficit. I don't know if you have access to the '06-07 year-end, but we faced additional challenges there and are facing additional challenges in '07-08. We're trying to balance that accountability – and providing the kind of cross-section of services in the continuum of care has been a major challenge – while at the same time trying to bring ourselves up to standards through the RSHIP group and the introduction of new information technology, which, again, is an investment into the future. This is a major challenge. I can't avoid, obviously, the accountability that the health region has back to this government and to the people for its financial operation. It is both a business as well as a health care organization, and we are doing our utmost to make sure that we are as accountable as possible for all those dollars that are spent.

The final slide, and we'll move to your agenda: just some key opportunities. We think the introduction of provincial quality standards in reporting is a very positive opportunity for all of us. We think it's good for East Central health. We think it's good for the health care system. We think the clarity with our associate partners or our contractors is going to be a key opportunity which will in fact drive many of the changes in East Central. If you've gone through the report that the quality council tabled, I mean, one of their number one issues and statements is that there was full accountability by both the voluntaries and by East Central health. Not one organization appeared by legislation to have the final authority. I think that it's very clear now that the health region has the final authority and the accountability, and we're working with our partners to make sure that that is the continuing strategy and that we all move forward together. So clear accountabilities and expectations.

Shared services efficiencies and effectiveness we're looking for. You know, we don't need to do everything. Our core business is provision of health services to the East Central health population. If we can save money by sharing services, if we can improve quality and effectiveness by sharing services or working with others, we will undertake that.

Finally, managing public expectations. This is huge. For each one of you around the table with responsibilities, if you have any, in East Central health – but it really doesn't matter because you'll have responsibilities elsewhere – health is a very high-profile expectation. Just to manage those public expectations within the financial resources and the people resources we have is a huge challenge.

Mr. Chairman, thank you for this opportunity to make an opening statement. We will address any areas of question that you and your committee might have.

**The Chair:** Thank you very much, Mr. Saunders. I suspect that the first question may be on the use of information technology, but before we go any further, Mr. Dunn, would you like to make a brief statement?

**Mr. Dunn:** Very, very briefly. Our work on the authority over the last two years has focused mainly on the audit of their financial statements, and we issued unqualified audit opinions on both the March 31, '06, and the March 31, '07, financial statements. As discussed previously, our annual report includes recommendations that will relate to all health authorities around the areas of food safety, RHA global funding, and Seniors Care and Programs, which is the 2005 report that we did, with our update in the 2006 annual report.

Certainly, myself and my staff will answer any questions that are directed to us by the committee. Thank you, Mr. Chairman.

*10:30*

**The Chair:** Thank you very much. We will proceed, then, quickly to questions. There is a quite a long list already, and I would ask for the patience of the members and their consideration, please. Keep your questions as brief as possible and direct because we do have a long list. We will start this morning with Mr. Bonko, followed by Ivan Strang.

**Mr. Bonko:** Thanks, Mr. Chairman. The closure of the St. Joseph's hospital was due to an inadequate sterilization of medical equipment and a failure to stop the spread of the MRSA. These two areas were reported as problems in the 2005-06 report, but the situation only got worse. On August 27 the minister announced $15 million for a new infection prevention practice. Some of the questions here that I wanted to know are: how does the region determine how much of that $15 million St. Joseph's hospital in Vegreville is going to receive? That's my first question.

**Mr. Saunders:** I'd ask if Dr. Olson could respond.

**Dr. Olson:** Okay. We have been developing our infection control program for the last five years. As we stated, you know, with the diffuse number of facilities it's hard to assign this to one particular hospital because our staff service everywhere. What we have done around the infection prevention and control program is: we started out with one infection control nurse five years ago, we added a second one about two years ago although we had to train her because we can't recruit already-trained IPC nurses, and we're in the process of hiring two more. Now, it's hard to assign how much time they'll spend at each facility because it depends on what outbreaks are there, what problems they experience. Because of the problems at St. Joseph's I would estimate that it will probably receive the services of a half-time IPC nurse over the next year.

**Mr. Bonko:** Okay. Then the follow-up would be: has the infection prevention problem been resolved in the region, and what more needs to be done to ensure that it has and doesn't occur again?

**Dr. Olson:** I don't think you can say that infection prevention and control problems are ever totally resolved. This is a matter of ongoing staff education over such simple things as handwashing. I know that Iris Evans in the past was very keen on handwashing as an infection prevention and control measure. But there are always new issues.

We certainly have been active with our IPC staff. I told you that there'll be four in total when we finish hiring. We interviewed yesterday, so we should have those in place. In addition, we have IPC staff at each site that are in charge of surveillance. They undertake surveillance programs, looking for problems, particularly problems that occur as a result of our treatments, iatrogenic infections. So we're looking for them. We've had several programs in the past, and we'll continue to respond, to program to needs.

To give you one example, two years ago we had a number of norovirus outbreaks in our lodges. This is the gastrointestinal vomiting- and diarrhea-causing virus. This caused a lot of stress on our acute care facilities because these people would be admitted to acute care, not to mention distress for the patients.

What we did was: between our IPC staff and our public health staff we went on an education campaign for the lodge owners and with their staff so that they would recognize when there was an outbreak occurring – and we define an outbreak as two cases – so that they would notify our IPC staff. When the IPC staff go out, it's remarkable because – we keep graphs – the outbreak stops almost immediately. This is over such simple things as changing cleaning techniques, making sure that staff wash hands between use, making sure that the residents wash their hands before and after eating. Simple things like that can cause cessation of outbreaks almost immediately.

**The Chair:** Thank you, Dr. Olson.

Mr. Strang, please, followed by Harry Chase.

**Mr. Strang:** Thanks, Mr. Chairman. I'll give my two questions right off the bat. I really was intrigued when I saw the aspect of East Central health having their own acute beds and then working with associate partners. When I look at the associate partners on the acute side, it runs around 58 per cent, and then you operate the 42 per cent. I'm just wondering how you've worked to look at the aspect on cost factors and how they work compared to the associate and to your own.

I guess the other thing is that we've got the other seven rural health authorities. I notice that in your March 31, 2007, you have the regional shared health information program. I'm just wondering if that's up and running and if that is connected to the one, I guess, closest to here, and it would be with Capital health. If you could give me an insight on that, I'd appreciate it.

Thank you.

**The Chair:** Are those your two questions?

**Mr. Strang:** Yes, sir.

**Mr. Saunders:** I'll address the one on our partnerships and then ask Brian if he could look at the health information program initiative. Our partnership is an historical event. The volunteer providers have owned and operated the health facilities across East Central health for many years. The accountability for operations has never been clear, but there are many issues related to the understanding of the responsibility for quality as well as the financial understanding.

To directly answer your question, the cost factors really are brought about by presentation by the voluntary groups to East Central health. Once approved, there should be a clear accountability for those voluntary organizations to balance the budgets that they were provided on an annual basis. That has not been the case, and the ability to acknowledge what the financial situation is at any one point in time, at least on a quarterly basis, is part of the discussions that we've opened up with the voluntary groups now. In fairness, they also are seeking that clarity and are quite willing to work with us to assure that we negotiate a fair and reasonable budget, but the accountability, then, to live within them has to be as strong between East Central health and the voluntary groups as it is between the health region and Alberta Health and Wellness. We will make that happen. We have the commitment, certainly, within this group as well as our voluntary groups.

You know, we looked at it globally and said: could we run it more efficiently if we ran everything ourselves? We have an imbalance, I think, in reference to our own operated facilities versus those of our voluntaries. I don't think it's a question of efficiency at this point in time; it's a question of re-evaluating our working relationship and moving forward with a new and clear understanding.

**Mr. Stevenson:** Just so I'm clear, the second question: did that have to do with the RSHIP or the Health Information Act? I wasn't quite clear on that.

**Mr. Strang:** It's the regional shared health information.

**Mr. Stevenson:** Okay. RSHIP, yes.

**Mr. Strang:** Yes.

**Mr. Stevenson:** Okay. Just a history there. Again, this is an undertaking of the seven rural regions, the nonmetro. Calgary and Edmonton have their own information systems, but certainly there is, you know, discussion and a plan to interphase. I think it's all part of the Infoway plan, which is a national plan.

The regions have a steering committee that works closely with government on the RSHIP initiative, and personally our region went live both with the administration suites and many of the clinical suites in '06, April for the administration and June for the clinical, I think it was.

Now, along with that, there are additional phases where there are other modules that are being implemented. There is an attempt by the regions to try to be consistent in implementing, but some are at a different place and have different pressures, so that creates some real challenges as far as the implementation of the different modules.

The costs certainly have increased. As Jim had indicated, the RSHIP costs for the electronic health record, both capital and operating, are much greater than was originally projected. A lot of the challenges that it's created for the region are that a lot of our staff actually are service providers, and we need their expertise in helping develop a lot of the modules. In taking them from the clinical practice to help develop the electronic models, it's been very difficult to backfill and to find staff to, you know, support the services while that's being developed.

***10:40***

I think we still believe that, you know, from a service delivery in both quality and efficiency, this electronic record will be very helpful once it's implemented across the province. It's a road we've

gone down that I don't think we can detract from. It involves all the staff. We've gone through extensive training of not only professional staff but support staff. I think change is very difficult. This is major change, but I think staff are coping with it.

**The Chair:** Thank you.
Mr. Chase, please, followed by Len Webber.

**Mr. Chase:** Thank you very much. MRSA is a very invasive problem, and it's not restricted to the East Central health region, but one of the ways of combating a problem is improving communications, which includes change of command, accountability, who's responsible for what, and how that responsibility is shared and communicated. That's my first question.

My second question. Whenever a problem surfaces, it's felt all the way down the line, and the people who are most often affected are those on the front lines: the nurses, the doctors, the orderlies. What has the region done to support, empower, enact internal whistle-blower rules to make the employees feel supported and valued?

So the first one: what is the chain of command? Is it now clear whose responsibility it is for what various measures are there? That seemed to lead to the initial problems as to whose job it is.

**Dr. Olson:** It's obvious that the responsibility is East Central health's to make sure that MRSA is controlled. As Jim has alluded to, there was this difficulty over who was accountable. It was obvious that we were responsible, but we felt that there was limited authority in the contracting sites. So I think that's been resolved now through this episode. I don't think there's any doubt that they're prepared to listen to us now over MRSA issues.

As to what we're doing around MRSA, we did start a surveillance program about five years ago. Now, there was debate at that time whether surveillance was useful. For instance, in the province of Quebec they did not start surveillance, and some of the regions here didn't start surveillance. We did. A surveillance program means that we swab from the groin and nares, from the nose and groin, anybody who comes from a high-risk institution. That includes big-city hospitals, where MRSA is often started. We also take it from sites that have high incidence in our region. So we do that surveillance program.

Just as a point here I think I should mention that MRSA in most cases is colonization only. This means that the patient has MRSA, methicillin-resistant staphylococcus aureus, on the skin, but it's not a pathogen. It's not causing any illness at that point. It's just there. The risk is that if that patient has a wound, whether it's surgical or otherwise, that will then move from a colonization to causing an active infection. It's that active infection that we're trying to avoid. The program is to first identify people that are colonized – and that's predominantly so we can prevent other people from being colonized – and to prevent active infections. So we have a surveillance program.

The other thing is that we have active staff education. So the IPC nurses conduct every two years a site-by-site education program that includes two lectures, if you like, at each site. They've also developed self-education modules, which is a book that the staff read through. There's a self-examination at the end. For people who can't attend the lectures or between the lectures, this is put in place. Then, because of surveillance, if we have a high incidence of MRSA occurring at a site, we send the IPC nurses there to see what the problem is. Again, in most cases we get back to such simple things as handwashing, cleaning techniques, because this stuff can be transmitted by direct contact, meaning that if you touch a patient then touch another patient without washing your hands, you can transmit it. Similarly, if you touch a patient and then touch a surface, like a tabletop, and somebody else comes along and touches the same tabletop while treating another patient, there's a risk of transmission. So cleaning and such simple things as handwashing become important, and of course that is a management function, both to make sure staff are doing that by doing audits and also education. We do both.

**The Chair:** Thank you, Dr. Odell Olson.

**Mr. Chase:** The second part of my question wasn't answered.

**The Chair:** No. I'm sorry, Mr. Chase.

**Mr. Chase:** Okay.

**The Chair:** Perhaps in the future you could ask one question and then another if you want, but we're going to continue to the next person, please.
Mr. Webber, followed by Rick Miller.

**Mr. Webber:** Thank you, Mr. Chair, and thank you, Mr. Saunders, for coming out today. Your presentation was quite interesting. I would like to refer to volume 1 of the annual report of the Auditor General, page 76, at his recommendation 6, which states that he recommends that "the regional health authorities improve their food establishment inspection programs. In particular, regional health authorities should . . ." Mr. Chair, if you don't mind, I would like to read out the entire recommendation.

**The Chair:** You go ahead.

**Mr. Webber:** Thank you, sir. They should

- Inspect food establishments following generally accepted risk assessment and inspection frequency standards;
- Ensure that inspections are consistently administered and documented;
- Follow up critical violations promptly to ensure that food establishments have corrected those violations;
- Use their enforcement powers to protect Albertans from the highest risk food establishments;
- Periodically reinforce independence and conflict of interest policies amongst public health inspectors.

Now, I guess what I would like to ask is: what actions have you taken as an RHA following the release of Mr. Dunn's recommendations?

**Mr. Saunders:** Dr. Olson, please.

**Dr. Olson:** Yes. We have hired an additional two public health inspectors and have advanced our inspections, including food, water, and things like public swimming pools to the blue book standards as requested by Alberta Health.

**Mr. Webber:** Are these the new standards that have been implemented recently?

**Dr. Olson:** That's right.

**Mr. Webber:** I guess that would be my second question, wouldn't it, Mr. Chair? Well, actually, you just answered the second one with

regard to the public health inspectors and whether or not you feel you have enough.

**Dr. Olson:** Well, we've hired two and one on contract, so actually three. Our public health officer has requested over the next two years that we hire an additional three to do some education and other things related to public health inspection, but we are meeting targets at this point with the staff we've hired.

**Mr. Webber:** Great. Thank you, Doctor.

**The Chair:** Thank you very much.
Mr. Miller, please, followed by Mr. Rodney.

**Mr. R. Miller:** Thank you very much, Mr. Chairman. My question references pages 104 and 105 of your 2005-06 annual report. In reading the report, this is the only place I can find in the report that refers to pandemic planning, and it's actually the Bethany Auxiliary Hospital Board of Management and the Bethany Group who state a commitment to develop a pandemic planning response with East Central health and other stakeholders. My question for you would be: what specific co-ordination procedures are in place with your local facilities, including your associate partners, municipalities, and the province, when it comes to pandemic planning?

**Mr. Saunders:** Dr. Olson again.

**Mr. R. Miller:** He's a busy guy.

**Dr. Olson:** It's just that the medical officer of health reports to me. That's why.
We started this some time ago, and the medical officer of health is in charge of disaster planning. We've been working with our facilities and the communities. We have had training sessions for all of our communities in public health or in disaster planning issues. Dr. Benade is meeting with our communities and the facilities that we operate in those communities to develop disaster plans, which includes pandemic planning.

***10:50***

**Mr. R. Miller:** Based on that, then, my supplemental would be: you're not complete yet; what still needs to be done until you're comfortable that you've got the plans in place that would be necessary?

**Dr. Olson:** We have submitted a plan, and we've received suggestions back. The major thing is around specific planning within the community for things like auxiliary facilities in case of large demand, specific plans regarding personnel.

**Mr. R. Miller:** Thank you, Mr. Chairman.

**The Chair:** Thank you.
Mr. Rodney, please, followed by David Eggen.

**Mr. Rodney:** Thank you, Mr. Chair. Just one question if you are okay with that, but I expect there may be many answers. On behalf of the Alberta taxpayer – that's why we're here, and the Alberta taxpayer includes you and me – I think it's very fair to ask this. What procedures have you had in place to ensure that we're all receiving the biggest possible bang for our health care buck? That could include infrastructure or services or resources or anything else on the expense side of the ledger that you'd like to share with us. An open-ended question.

**Mr. Saunders:** I'll ask Brian Stevenson.

**Mr. Stevenson:** I'll certainly respond in regard to the infrastructure. Since regionalization in 1994 we've worked very closely both with Alberta Health and Infrastructure to determine kind of a baseline assessment of all of our infrastructure across the region, and every region undertook that through the conserve process back in the late 1990s. Since that time we've established a database, and we continue to work with them in updating that database. It helps us, one, determine on an ongoing basis how to prioritize our capital projects, and it also helps us determine the viability of programs to start converting.
For example, in the early years of regionalization we had several acute-care facilities that were converted to long-term care. As well, there were long-term care facilities that had been converted to community health service spaces. So we are getting good, efficient use out of our facilities. Now, it's not always the best appropriate type of space for some of them, but it's using existing infrastructure wisely.
I think also that when we look at projects, we have a prioritization process. So we always look first of all in our capital projects at health- and safety-related issues. Those become our number one priorities as far as projects. The second would be your basic maintenance – mechanical, electrical, nurse call, fire alarms – setting up schedules for replacement, again, based on the condition. Then the third would be the functional ones. That's where there would be, you know, major costs in converting existing space into other program space. Those are kind of a third priority, but we always try to include at least a couple of those types of projects in each year.
The other thing, I think, that has been a little challenging is that because of the access-to-service issues, we do have a lot of smaller facilities. I mean, that's what rural health service is about, access. Sometimes you pay a premium, you know, for a service in running smaller facilities. But, I think, again, we try to keep our upgrades in regard to infrastructure up to standard as much as possible. Again, anything that becomes urgent, we work very closely with Health and Infrastructure and prioritize them.

**Mr. Rodney:** I thought I had one question, but there are different parts within it. Maybe other members would care to comment on other than infrastructure; maybe it would be services or resources or personnel, you know. What I'm really getting at is: do you speak with other regional health authorities in Alberta or beyond? Do you find: oh, well, we could get a better deal on this, that, or the other thing? I think the Alberta taxpayer would really love to know what you do in those regards.

**Mr. Stevenson:** Yeah. Certainly in program areas there is a lot of partnering or efficiencies in group purchasing. A lot of the regional health authorities work together, both with Capital and as a group of rural regions, in group purchasing. As was mentioned before, the RSHIP is a major initiative where there is, you know, a combined partnership and sharing in developing services. We did mention the mobile MRI service that we're bringing to our region in partnership with Aspen. There are all kinds of partnerships in regard to pharmacy, drug purchasing, all of those types of things.
Program services. In our region we have developed program leads in many of our clinical areas. Again, those program leads are shared with our contracted service providers so that they don't need to duplicate that. We do believe that there's a lot more area for efficiencies in relation to our contracted services.
We're working throughout our region and with our associate partners in developing a regional laundry service. Again, the

challenge of recruiting staff across the region, even in support services, is becoming very difficult, so we are working with one of our contracted service providers who actually will be the provider of the regional laundry service. We've taken the initiative to work with them to develop that to get some efficiencies in that area.

So that's just a few of several that we do.

**The Chair:** Thank you.

David Eggen, please, followed by Mr. Cenaiko.

**Mr. Eggen:** Well, thanks, Mr. Chair, and thanks, too, to the members of the East Central health region that are here today. We're breaking some new ground, and we appreciate your support.

When looking at your long-term capital plan that you submitted to us, I noted that in at least two locations you are reducing your long-term care beds, in one instance from 65 to 48 and on page 10 from 90 to 60. I have a serious concern about that in regard to two issues. First of all, I'm wondering if this is a reflection of a cost-saving measure. And is it a reflection of the difficulty that you're having in meeting the long-term care hours, that you expressed in your report somewhere else?

**Mr. Saunders:** Brian Stevenson.

**Mr. Stevenson:** Yes. I can respond to that. We had, along with a lot of the other regions, about four or five years ago developed a 10-year continuing care plan. When it was initiated, it would have been right around the time that the long-term care review, the Broda report, came out. You'll see in our annual report that we really support that philosophy of the development of supportive housing. Where you see the reduction of long-term care beds, it's all part of our regional plan for continuing care to expand and develop other options, and what we believe are more appropriate options, for seniors who have in the past been placed in long-term care simply because there have been no other options available. Where you will see reductions in long-term care is where we will also have increased capacity within the community by working with housing partners in developing the designated assisted living. So in most of those cases capacity has increased, and now we're working very closely.

The challenge over the years has been that the program for supportive housing has moved from Health to Seniors. Infrastructure was involved for a while, but now it is strictly with Seniors. We are continuing on our continuing care plan to develop more designated assisted living. There is construction taking place with a partner in Lloydminster, a project ready to begin in Wainwright. Again, based on a needs assessment that's done in each community and projections, we believe that we are meeting the needs of our seniors by developing these other options for continuing care. It's a broader spectrum now than what we've been used to in the past, and it's going again to that philosophy where it's residential, homelike, not institutional. It has been proven to be working very well in the communities where it's been developed.

**Mr. Saunders:** Just on that point, though, it's going to be a major, ongoing challenge. We have to be more creative, more in tune with what the alternatives are. Our current system of continuing care will not sustain us going into the future. We need to find new, alternate ways to provide the quality of care for our seniors throughout Alberta and do a much better job of it in the future than we are doing today.

**Mr. Eggen:** Absolutely. I concur with that. Unfortunately, I don't follow the logic. Certainly, it's commendable to provide more options for seniors' care and different possibilities, including daily assisted living, but you're not creating more options by closing long-term care beds. I mean, these two don't have to follow one another. You know, when I look at the Auditor General's report on long-term care, there are several serious deficiencies in regard to seniors' care. I'm asking, then, if closing long-term care beds isn't going to make it more difficult to meet the deficiencies that were identified in the Auditor General's report in regard to long-term care for seniors in the East Central and, in fact, across the province.

***11:00***

**Mr. Saunders:** Our only response there would be that in looking for the innovative ways to care for the seniors, what we're looking for is to find ways to put them in appropriate housing that will provide them with the level of care that they require without treating everybody in the same manner, as we have done over the past number of years in our nursing home systems and, previous to that, our auxiliary hospitals. It's a challenge to try to do that in an economic framework that is efficient and effective both for the consumer or the resident plus the health care system.

**Mr. Eggen:** Thank you.

**The Chair:** Mr. Cenaiko, followed by Bill Bonko, please.

**Mr. Cenaiko:** Thank you very much, Mr. Chair. It's indeed a pleasure to be here today and as well to welcome the officials from the East Central health region. I want to first of all state that it's a pleasure to see Jim Saunders again. Jim and I had the opportunity to work together when I was a board member on the Calgary health region. Jim was at that time, '95-96 I believe, the president and CEO of the Calgary health region, and that was the start-up of the regional health authorities. Obviously, Jim played an integral part in developing the region's service of providing health care. With his background of more than 30 years it's a pleasure to see him again and to see him in an official capacity with the East Central health region.

The question that I have, though, is more generic. Jim, with your background and experience regarding health care throughout Canada, does the innovation that you're looking at in some of the programs that you've provided for us today include working, for example, in a closer relationship with the Capital health region, and the fact that we have nine health regions, is that eight too many?

**Mr. Saunders:** I won't cast judgment on what the right number of health regions is. I mean, the opportunity to work more effectively between the health regions is clearly an opportunity. I think we have a very good relationship with Capital health. They were very helpful, as was David Thompson, actually, in the evaluation of our CSRs all across the region immediately following the release of the Health Quality report. They came to bat. They gave us their staff and their highest level of expertise on a very high-priority nature and produced a report that is invaluable to us as we go forward with the plans. That also holds true, actually, for our ability to pick up the phone and talk to any one of the other health regions and get straight answers, get information, whether that be financial, program, quality related, or standards. The ability to come together with CEOs and medical directors and financial people all across the province on a regular basis through the health boards of Alberta organization and through our RSHIP organization, which is really more appropriate to our individual operating needs, is critical.

I think we can do more. I think the opportunity to look at what's critical to our core services, how we can make sure of the dollars to

address that, how you get the biggest bang for the buck issues – we're always looking for innovative ways to do that. We need information to do that. That's why we're investing in the RSHIP group. We're the last bastion of major industry in the world, I think, to embrace information technology and to use it effectively, and we're still not there. So we have a long way to go there.

I think the increased knowledge and the ability to operate as a business as well as provide the balance of accountability for quality is essential. I think that in the future as we look for ways that we can outsource things, where we can share services more effectively, the door is open. It's just a matter of bringing it up to the priority level of entering into serious discussions about what we would like to decant or what others could do more efficiently or more effectively than we do.

**Mr. Cenaiko:** My second question, Mr. Chairman, follows a similar line. Again, Jim, with your experience and leadership in the health care industry throughout Canada, when you look at East Central and the small population of 110,000 residents and you look at areas, for example, in Saskatchewan or northern British Columbia, from having reviewed the business plans and in your short time there, what's your opinion regarding the provision of services that we're providing there compared to some of those remote areas and/or smaller areas, for example in Manitoba, Saskatchewan, or B.C.?

**Mr. Saunders:** Actually, it's a good question. I mean, I had been comparing since I got there. First of all, the responsiveness of the management team and the medical group has been tremendous. They are open minded to considering whatever would help our final delivery of services to the population that we're serving.

The short answer is that I think East Central has been doing some very creative things, things like the mobile MRI and bringing in the CAT scan opportunity. I think our challenge in the future is whether or not we can sustain the breadth and the number of health care operations that we have in all of the communities across the region. It's just a realistic fact that it's a number of different operations, and to do it within a financial framework of accountability, it's very difficult to measure it from an efficiency perspective. It's not efficient. It's simply an opportunity that we have now to provide our health system in a way – I think it's evolved very successfully with regionalization. I think it still has a long way to go. I think the recent initiatives around demanding quality and safety and a more active and accurate reporting system is going to be critical to the future.

I think that compared to the facilities that I've experienced in British Columbia and Saskatchewan, East Central measures up very well.

**The Chair:** Thank you.

Mr. Bonko, please, followed by Mr. Dunford.

**Mr. Bonko:** Thank you, Mr. Chairman. On page 4 of the annual report the former board chair stated that the board lost two members through resignations, and more recently the entire board and the CEO resigned once the news of inadequate sterilization problems surfaced. How have the costs increased with replacement of the entire board and the management team as a result of severance packages and the training of new members?

**Mr. Saunders:** All of the board costs that were previously incurred through the regular board have obviously stopped with the resignations. There were no agreements or compensation to the board members who resigned. There is no ongoing cost with regard to the board because the board is actually made up of Paddy Meade and myself in addition to our administrative responsibilities. There was some compensation to the CEO on his departure, which we believe was fair and reasonable and within the legal context of his employment contract. His ongoing salary is in fact, I guess, offsetting the consulting costs through my services on an interim basis as official administrator.

**Mr. Bonko:** Okay. With the loss of the entire board and the management team and the attention being focused primarily on infection control, which other activities, programs, or priorities were dropped as a result this year?

**Mr. Saunders:** There's a major review under way, in fact an expectation by the end of September that East Central health provide a budget reduction plan that would see the budget for East Central health balanced by March 31, 2008, for this fiscal year. We haven't completed that yet. The impacts of undertaking the changes that would be required in order to both capture the costs as well as the savings that would enable us to balance the budget by this year are an extreme challenge. The impact, we believe, would be unreasonable, but we are complying and will be submitting a balanced budget plan as an option back through the deputy minister and Alberta Health and Wellness, as we've been requested to do.

**Mr. Bonko:** Thank you.

**The Chair:** Thank you.

Mr. Dunford, please, followed by Mr. Chase.

**Mr. Dunford:** Well, thank you. So how do you like us so far? You're doing well. You're doing all right.

**Mr. Bonko:** That's your first question.

*11:10*

**Mr. Dunford:** Oops.

I'm on page 55 of your annual report for 2005-2006, rates of water- and food-borne illnesses. I tried to look up on my little BlackBerry here the definition of one of the words, and I've been unable to get it.

Here's what I'm really after. I'm a big fan of farmers' markets. I enjoy going to them. I just love the whole idea about them. Urban people think that, you know, if it's at a farmers' market and there's a sign saying organic on it, somehow it's going to be pure and healthy. Those of us that have been raised in rural areas know that there are some mean, nasty little critters out there. Given the period of time that we're here to analyze, '05-06 or '06-07, what investigations are taking place of the food at farmers' markets, and what were those results?

**Dr. Olson:** I don't think I can answer that specifically. It's one of the food establishments. The medical officer of health assesses sites by their risk, and if you actually prepare food for immediate consumption, that's considered a higher risk establishment, and those are inspected three times a year now, unless there are complaints, and then the inspection rate goes up. Specifically how many farmers' markets are inspected: I can't give you that information. Sorry; I don't have it. I can find it for you and send it to you if you like.

**The Chair:** Yes. Dr. Olson, if you could provide that information through the clerk, please – and she will it distribute it to all members – we'd be grateful.

**Mr. Dunford:** My last question is: on that chart that's provided, what is cryptosporidium?

**Dr. Olson:** It's an organism. If you remember three or four years ago the outbreak in North Battleford of a water-borne illness, that was cryptosporidium. It's a very small organism that was not caught by the standard water treatment program there. It's not killed by chlorination, and it requires very small filters to remove it from the water supply.

**Mr. Dunford:** If I had another question, it would be: why are the numbers higher in your area than in the rest of Alberta?

**Dr. Olson:** I suspect that the nasty little organisms that you say are around have to do with the rurality. Plus, for many years the water supply in rural areas relied on deep wells with no treatment.

**The Chair:** Thank you.
Mr. Chase, please, followed by Mr. Cardinal.

**Mr. Chase:** Thank you very much. In another role, as shadow minister for Infrastructure, I'm referencing page 16 of the long-term capital plan section regarding the age and condition of facilities. In Calgary half our hospitals were prematurely closed before replacements were built. While a decade has passed, we're still waiting. My first question: what has come of the feasibility review conducted on the state of St. Joseph's hospital?

**Mr. Stevenson:** I can respond to that. We are just engaging consultants to do the feasibility study. We got approval from the department of infrastructure in August, and we have proposals being submitted by mid-September. So we'll engage a consultant and begin that feasibility study.

**Mr. Chase:** Thank you.
Could you please briefly provide an update on the progress of your top three health infrastructure priorities? Have you got replacement buildings currently going up, or are you doing the repairs, that kind of thing?

**Mr. Stevenson:** The three major projects right now are the Vegreville long-term care, so that's a replacement, and this was part of this continuing care plan, where there have already been 40 designated assisted living facility beds opened in the past year. This project is going to be replacing 90 with 60 long-term care beds, and it is in a new location, and that project will be completed by December of this year.

The second one is the Vermilion Alice Keith, which is a long-term care replacement as well. It's replacing 65 beds with 48 what we call new generation long-term care. In other words, the design and the development of our new long-term care is a residential cottage model, more of a social model than the institutional model. That project will be completed by March of '08.

We just started construction on the Viking health centre, which is an expansion to the emergency outpatient ambulance area and some other renovations within the facility to do with the recovery room. That project commenced in the summer and will be completed in August of '09.

**Mr. Chase:** Thank you.

**The Chair:** Thank you very much.
Mr. Cardinal, followed by Rick Miller, please.

**Mr. Cardinal:** Thank you very much, Mr. Chairman. I'd like to also thank you for the very informative presentation you've done here and for taking the time to be here because, no doubt, health care continues to be a very important and challenging area in relation to expenditures in Alberta. I want to touch briefly on the issue of long-term planning of health care services, especially in rural Alberta. If you took a line, a two-hour drive from Edmonton, what percentage of your residents are using services in Edmonton and why? And if you compared that, say, to 10 years ago, what were the stats 10 years ago? I cover Aspen in my area pretty well. I tend to find more and more people driving to Edmonton as long as they're within two hours. Do you have any records as to what direction that's going and why it's changing?

**Mr. Saunders:** We were just conferring on the best approach to take. I think your question relates to import and export of care residents within East Central.

**Mr. Cardinal:** Yeah.

**Mr. Saunders:** I think we're just pulling some information off the computer.

**Mr. Cardinal:** Within commuting distance, though.

**Mr. Saunders:** Have you found some information, Mr. Dickson?

**Mr. Dickson:** I don't have the exact number, you know, the stats for people going from one region to the other, but comparing '04-05 to '05-06, the import/export ratio went from 17.5 per cent to 18.1 per cent. I would say that there is a slight increase each year for people getting referred into the cities for care, but to cost that out is kind of difficult as well. I think there is a little trend there where it is slightly increasing.

**Mr. Cardinal:** I wasn't referring to people that are referred by doctors. It was basically just for the general population that are at their choice going to Edmonton for services. Why is that happening? I know it's happening, but what percentage is it? It's hard to plan if you don't know.

**Mr. Stevenson:** If it's for health services, it is included in the import/export. For just general physician services maybe Dr. Olson could respond to that. It all depends, again, on how we can retain specialists in the rural areas, and he may want to comment, like, on some of the challenges we've had over the years, say, with radiologists. Part of our initiative with CT and MRI is to allow the service better access for our residents so that they don't need to go to the urban centres.

**Dr. Olson:** Yeah. There are challenges with this, and I think it has to do with technology and training. You know, if we look at the services provided in rural hospitals 10 years ago – this is when I left Daysland, Alberta, where I practised, to move to Camrose. At that time most of these rural hospitals provided some surgical services, some obstetric services, a lot of the care. But technologies advanced. If you take just about any area, if we take the area of heart attacks, when I trained, which was in 1972, we put people in intensive care units and watched them. Well, now we are to the point that we give them thrombolysis and angiograms with immediate angioplasty. So anybody who has an infarct in a rural area is transferred, almost a hundred per cent, to the city for angioplasty.

This applies to a lot of things. Surgery at the time I trained was

all open surgery. Now it's laparoscopic surgery, which requires special training and special equipment, which can only be delivered in tertiary care units. What we've been trying to do is enhance primary and secondary care so that we provide good primary care so people are referred to the right place at the right time, to allow us diagnostic access so that we don't have to send everybody to Edmonton. We've also been active in developing community cancer clinics so that we can deliver treatment locally. We think our job is primary and secondary care. We cannot deliver tertiary care, and we haven't been trying to do that. We've been trying to enhance primary and secondary care.

***11:20***

**The Chair:** Thank you, Dr. Olson.
Mr. Miller, please, followed by Mr. Herard.

**Mr. R. Miller:** Thank you. My questions would be for Mr. Saunders and Mr. Stevenson. A fair amount of discussion already about seniors and continuing care. As you mentioned in your opening presentation, page 14 of the annual report shows that your region's elderly population is substantially higher than the provincial average, and on page 15 it states that "there are currently 917 funded long term care beds in the region, and an additional 190 designated supportive housing beds." My question for you would be: how many of those long-term care beds have been transitioned into assisted-living beds over the past two years, and what is your plan in that regard over the next five years?

**Mr. Stevenson:** I can give you today's numbers in regard to where our bed numbers are. With long-term care we're at 894 across the region, and with designated supportive housing or designated assisted living we're at 234. As I had mentioned, we're currently in partnership on a project in Lloydminster with a housing partner who is in construction right now for a 60-bed designated assisted-living facility.

I do want to mention that, you know, we do ongoing assessments based on placement, based on the demographics of our population on home care. Lloydminster and Camrose continue to be our pressure points for long-term care. So with the DAL being developed right now – and there is a functional program that went in for the replacement at the Dr. Cooke. Again, it's not a huge increase in numbers because we believe that there is a higher percentage of people that really would be accommodated much more appropriately in DAL if the option were available. So that's being developed in Lloydminster. We'll be adding 60 DAL by, I believe, January of '08.

In Camrose there is a project that has been approved with a housing partner to commence the construction of 42 DAL, and there's going to be other senior housing in that development as well. There were hopes that that would start by the fall, but because of the process with development it may not happen until spring now. We are also waiting to get into construction with a housing partner in Wainwright. There's a 40-bed DAL that has been approved there.

In all of our communities we do monitor on an ongoing basis people awaiting placement for long-term care. We look at not only the numbers but what the waiting period is. A more significant number is what the waiting period is. Again, it varies. It's much longer in Camrose and Lloydminster, but we believe that the new housing developments will meet the needs there.

**Mr. R. Miller:** My supplemental, then, would be exactly what you just outlined; that is, how many are on that waiting list for either continuing care or DAL, and how many of those that are on the waiting list would currently be taking up a bed in an acute-care facility?

**Mr. Stevenson:** I will maybe refer that one to either Malcolm or Odell. I think it's in the report.

**Mr. Saunders:** It's a fair question. We don't have the accurate information, but we would be pleased to provide it to you.

**Mr. R. Miller:** Thank you.

[Mr. Prins in the chair]

**The Deputy Chair:** Thank you.
Next up would be Denis Herard, followed by David Eggen.

**Mr. Herard:** Thank you very much, Mr. Chair. I wanted to try and understand what the cost escalators and cost drivers might be in your region. So I went to your website, and I had a look at your '03-04 annual report because I wanted to go back further than what this information was providing me. Overall I saw an increase of 22 per cent in total expense between '03-04 and '06-07. The three things that kind of stuck out were emergency and outpatient services, which seem to have gone up by 75 per cent, home care and community-based care, which went up by around a third, 33 per cent, and the same thing with diagnostic and therapeutic services. So I'd like to understand from your perspective what it is that either escalates or drives these costs to that extent. Really, when you look at it, 22 per cent over four years is not that much higher than inflation. It is higher than inflation but not by what we normally hear, 10 per cent a year, you know. So it sounds like you have been looking after the dollars pretty well out there. What would cause these escalations in those particular areas?

**Mr. Stevenson:** I could maybe just comment on that. In '03-04 was when the boundaries changed, and we had significant readjustment in our region: the highway 12 facilities went to David Thompson, and we acquired facilities in the north. So that kind of changed the whole financial picture. We could probably identify, you know, more detail if you required it. I know that that was a significant one in that in '03-04 we started working right away with St. Joe's to replace a lot of their diagnostic equipment, so there would have been costs associated with that. Also, utilization in some of those facilities was much higher because they provided different services than the ones that were previously within our region.

**Mr. Saunders:** If we could, Dr. Olson needs to also speak about the service aspects of it. I think your comment that 22 per cent is not unreasonable was very fair, but there's also been impact service-wise.

**Dr. Olson:** Most health care systems have a deliberate policy of increasing outpatient and home-care services, and we certainly have deliberately done that in our region. You know, if you look over the last 10 years at the change in, for instance, surgical services from in-patient to outpatient, this has been a major, deliberate move, and this has been enabled by things like limited-access surgery or laparoscopic surgery. Gallbladder surgery: people stayed for an average of five to seven days in the past; now they go home in under 24 hours in most cases. So it's been a deliberate policy. Our day-surgery programs are much larger now than our in-patient surgery programs. Similarly, with home care there's a deliberate move, for

instance, to provide as many palliative care services as we can at home, also to support the elderly at home as long as possible.

**Mr. Herard:** My second question, Mr. Chair. The second-highest increase was actually in the executive office, the chief executive officer as well as the five people that report to him. That went up by 49 per cent in four years. I guess my question is: what necessity would there be to see that huge of an increase in the executive part when overall the costs have gone up by 22 per cent? Why would these costs go up by 50 per cent?

**Mr. Saunders:** We can get additional detail that would provide a more accurate description of the 49 per cent, but we were just conferring, and one of the major changes in that time period was Dr. Olson moving from a half-time position to full-time. The value that he's added to the management of East Central health I think has been an outstanding investment, but I think that the financial burden to add him to the additional executive salaries . . .

**Mr. Dunford:** That's in *Hansard*, you know.

**Mr. Saunders:** It's a modest salary.
If you'd like a detailed description, we can provide what was added in that time period that equalled the 49 per cent difference.

**Mr. Herard:** Yeah. Thank you.

**The Deputy Chair:** Okay. Thank you very much.
Next, Dave Eggen, followed by Art Johnston.

**Mr. Eggen:** Thanks, Mr. Chair. I would like to go back, if I might, to seniors' care. This is an ongoing issue that we're having to deal with across the province, so perhaps you could outline some of the things that you've specifically done in East Central to correct the deficiencies that the Auditor General's report last year identified as being problem areas in senior long-term care. I'd really appreciate it. And how are you measuring that to identify your success?

[Mr. MacDonald in the chair]

***11:30***

**Mr. Saunders:** Are you going to take that, Malcolm?

**Mr. Kirkland:** I will. Do you have a particular page number?

**Mr. Eggen:** Page 185.

**Mr. Saunders:** I'm sorry, Mr. Chairman. Could we just get clarification on the question again as we're searching? We just want to make sure.

**Mr. Eggen:** Oh, okay. The Auditor General's report, volume 1 I think it is, page 185. Is it? Yeah. It's a list of deficiencies that the Auditor General identified for the province, all health regions, in regard to seniors' care. So I'm just asking what are some of the things you've done to correct that and measure the success of your endeavours, I guess.

**Mr. Kirkland:** Okay. I'll take a shot at seeing if I answer a question here.

**Mr. Eggen:** Sure. Yeah.

**Mr. Kirkland:** We monitor the hours of care provided inside our facilities, and those are reported on a monthly basis. As far as the care and enhancing the care to seniors in our region, we've taken measures such as adding additional discharge planners to our acute care facilities, in particular in areas that we've had placement problems or housing problems, for example Camrose. So we're now moving towards a process that would allow discharge planning at the time of admission to a site. Am I answering your question?

**Mr. Eggen:** Yeah. Absolutely. Keep going. That's great. Oh. That's it? Okay.

**The Chair:** Mr. Dunn, do you have anything to add at this time? Or Rhonda?

**Ms White:** I'll just maybe help you out a bit. On page 191 there's a progress report that we made on all RHAs and the implementation of our recommendations. When we did our previous work, we indicated there were failures to comply with standards in certain areas. They're listed on page 191: medication, medical records. Then we went on to talk about the requirement to implement the new continuing care standards. So I think that is what Mr. Eggen is talking about. What has the authority . . .

**Mr. Eggen:** I started on 185. I guess it ends on 191.

**Dr. Olson:** I can answer some of that. Starting from the more general, what we've done in some sites: we've implemented special programs like dementia programs to take better care with less medication; we monitor medication and try and reduce as much as possible all kinds of restraints, including chemical restraints. So we try by behaviour modification to deal with dementia behaviour disorders. We have also made some technical changes. We've started to implement pouch packaging of medications. This is a safer method of passing medication to the elderly. We have that in the first site in Camrose, and we have intentions over the next year to pass it out throughout all of our institutions. That's based on increased safety for the residents.
We also, as I said, monitor. One of the continuing care standards that's coming up is quarterly medication reviews. We have started doing medication monitoring, and we will be making sure that these quarterly medication reviews are done. The medication reviews have always been standard, but one of my issues has been doing them in fact and in name. We are moving with our medical staff to do them, in fact, and to try and reduce the number of medications that the elderly are consuming in our facilities.

**Mr. Eggen:** Thanks so much. I know that this is the first time we've had this particular format, but if I could just suggest, you know, that this committee takes the Auditor General's recommendations very seriously. If you can perhaps just focus on some of those things specifically or have someone do that, it makes the interaction smoother, I suppose, in the future. I appreciate your responses. Thank you.

**The Chair:** Thank you.
Mr. Johnston, followed by Mr. Bonko.

**Mr. Johnston:** Thank you, Mr. Chair. Thank you for your presentation this morning. My questions will be regarding getting better costing information. Can you tell me what steps East Central health are taking to get better cost service in their area and how long it would take?

**Mr. Stevenson:** Okay. I'll try to address that if you could be just a little more specific. Are you talking about costs like per unit for service delivery?

**Mr. Johnston:** Yes, I am.

**Mr. Stevenson:** Okay. Again, I think some of the things that we've highlighted, the program leads where we're trying to have shared services with our contracted service providers – we still believe that there are many areas where there could be efficiencies. We know, again, for access to service that in some of our smaller sites we pay a premium for that because of minimum staffing standards, but when we look at support services like laundry and maintenance, we start developing regional programs. We can do that more cost-effectively both from a quality perspective and a service delivery perspective. We've done a business plan with the Bethany Group and know that we can get some efficiencies in a regionalized laundry. Our challenge there was that it wasn't our facility, so we had to get buy-in by the contracted service provider. So that's an area where we know we will get more efficiencies as well.

In our group purchasing we continue to work with all the other regional health authorities in group purchasing to get improved unit cost for supplies and product. I think also that when we work, again, with other regions in regard to the mobile MRI, there are efficiencies in that rather than a region trying to initiate that on their own. So there are a lot of those types of efficiencies that we believe will give us improved costs.

**Mr. Johnston:** Okay. Thank you. My final question. The new computer systems for the regional health authorities were recently implemented. Will that capture the information needed to cost service by patient?

**Mr. Dickson:** Yes. In the long run it will. Right now we're still on phase 1 of, you know, the RSHIP initiative and the Meditech program, which tracks all your admissions, discharges, transfers, and then it also tracks your costs going through the clinical systems. It would track your costs in ER, your costs in the OR, and all the way through lab, X-ray.

I think right now we're just getting into phase 2 of the Meditech system, which will give us better detail on case costing: what it would cost to run a person having their appendix removed, that type of thing. There are certain costs that go with that procedure. You know, we're getting to that point. That's phase 2, and then there's phase 3 of Meditech as well.

Those are the benefits of Meditech, or the RSHIP initiative. Looking down the road, it's probably going to be another two or three years yet. Meditech, or RSHIP, has been up and running for two years now, and we are planning on moving, you know, into the other modules, where we will get better stats and be able to track costs more efficiently and provide better information that way.

I also know that Alberta Health and Wellness has been doing some case costing in the Capital region and also the Calgary health region. Some of that information is available in the urban centres, but it could be a little bit different in the rural setting because we have different challenges with the rural health care issues and that.

**Mr. Johnston:** Thank you.

**The Chair:** Thank you.
Mr. Bonko, followed by Heather Forsyth, please.

**Mr. Bonko:** Thank you, Mr. Chairman. My concern is an issue raised by the Auditor General in the 2004-2005 report, but it's still applicable today with regard to security and handling of high-illicit-value prescription drugs in the health region pharmacies. A recommendation was made that "controls over drug procurement, inventories and dispensing could be improved," and I think that was in relation to OxyContin. What changes were made to address the Auditor General's recommendations?

**Dr. Olson:** I'm also responsible for pharmacy. Our pharmacy director made several changes. We made changes so that one person couldn't order and check the shipments at the same time. That was one of them. That's difficult in a rural area, where sometimes we only have one employee at a site, but we made changes there. He's continued to monitor through audits. Now, unfortunately, the pharmacy director just resigned, but just prior to resigning, I asked him to check one more time, and we have full compliance now with the Auditor General's recommendations for control of narcotics.

*11:40*

**Mr. Bonko:** Okay. The follow-up: how is the region currently handling the high-value illicit prescription drugs?

**Dr. Olson:** Similar issue. Now, it's not as big an issue in our sites because they're so small, and we haven't ever had a loss of the street-value drugs although we have had, as any health facility has, drugs that have disappeared, probably to staff. We have tightened up those procedures to avoid large-scale loss of drugs, which I think is what the Auditor General's report addressed.

**Mr. Bonko:** Thank you.

**The Chair:** Thank you.
Heather Forsyth, followed by Mr. Chase, please.

**Mrs. Forsyth:** Thank you, Mr. Chair, and I want to thank East Central for participating in this process. I want to focus on the question of global funding, which has been around this table since 1997 and has had debate about the issue. If I recall – Jim, you can maybe help me out – Calgary and Edmonton have been up front in regard to providing the information on medical services. However, the rural regions do not engage in such costing, and to truly get at the issue of global funding, I think it's imperative that we do that. I wonder if you could comment on that for me: when you're going to start implementing that to be accountable back to the residents of your area.

**Mr. Saunders:** Our capacity in the rural health regions is quite different than in the urbans. Our ability to collect the information and then do the comparisons which you're noting, and rightfully, are bringing us to the question about what we can produce and how we can produce it. Our ability to manage the information and use credible data sources in order to do the costing that you're requesting has not been achieved at this point in time in rural health care.

You know, part of it is looking at what the standards are, what the requirements for reporting are. I guess we would look back to Alberta Health and Wellness, at the priority of the reporting that they require each of the health regions to submit. East Central has been very diligent in responding to all of those requests in the timely manner that Health and Wellness has put forward for us. The detail costing has not been a priority that's been communicated to us at this point in time.

**Mrs. Forsyth:** On that response from you I appreciate the work that

it takes to do that, but I also think it's imperative for the people that you're serving in your region to see if they're getting the quality of standards that you alluded to when you were speaking to begin with, first of all, and then the accountability and the sustainability in the health care system. I guess I'm hoping that you will diligently work on providing that information because I think it's important, especially when you see the high percentages of seniors that you have in your region and the services. We know that all the costs escalate as we get older because of the health care that we're utilizing.

I would hope that as one of the recommendations from Public Accounts that is something that you will work on. I know that it's been mentioned by the Auditor General, and we've had some direction recently to Public Accounts that that's something that you'll put on as one of your number one priorities to get a true cost to see if you're getting the dollars that you deserve under the global funding.

**Mr. Saunders:** It's a fair question, and we would certainly support the initiative and will put resources into collecting the information that would be required. It'll be of assistance to us to be able to focus in the areas that are most important to the health system so that we can report accordingly, and we would undertake to do that.

**Mrs. Forsyth:** Thank you.

**The Chair:** Thank you.
Mr. Chase, followed by Mr. Strang.

**Mr. Chase:** Thank you. My first question, continuing on the themes of accountability, ultimate responsibility, stems from page 4 of the 2005-2006 annual report. How does the region respond to reports that a former board member, John Hunter, wrote a letter to the media and rural politicians claiming that the province and not the rural health authority is to blame for the health care issues in the region?

**Mr. Saunders:** I think part of our challenge in coming in and part of my challenge in the role of official administrator is not to try to find blame with the things that may have been identified, whether that be by Mr. Hunter or any other public source. We're moving forward to try to address the important things that were addressed in the Health Quality report.

We don't have a perfect health care system, but I think we have a very, very good health care system. The balancing of what the resources could be versus what we would like them to be: I mean, there is certainly a gap there. We could spend as much money as you would provide to us, and we would still ask for more. The prioritization around who's to blame: I think East Central health is doing a very good job and they are an accountable organization. My assessment, I can tell you quite honestly, is that there are some wonderful people that care about the services that they're providing, and they're trying to do it in the most economical manner possible. We're trying to meet the demands of all of our population as well as of government, and I think we are working in a very credible manner trying to reach and meet those expectations.

We don't blame the province. I mean, I think the funding formula does need work. I don't think it recognizes all of the factors that impact especially a large rural health care region. On the other hand, there's been a lot of work by many, many people across the country looking for the magic formula, and there is no perfect formula. Each region is different, each one of our communities is different, and the cost to provide those services is very difficult to compare. I think it's imperative that we attempt to do so in an equitable and credible manner. But we will work with the system and work with the other regions and work with Health and Wellness, and we'll continue to put in requests for additional funding, whether that be capital as well as operating, because we have huge needs out there, but we also understand that we're not going to get everything we ask for.

**The Chair:** Thank you.
Mr. Chase, please.

**Mr. Chase:** Thank you. My second question references page 9 of the 2005-06 annual report, where it is stated that "the Board conducts a regular annual self-assessment" and that "the results are used to strengthen structures and processes." So my question: given the recent somewhat sacrificial dismissal of the government-appointed board members, will the self-assessment method be amended, augmented? What happens after the self-assessment occurs? Where does the responsibility go from there?

**Mr. Saunders:** The previous board did go through a self-assessment. The final results of that assessment we don't have here with us today. In asking the question, it should be a learning opportunity for each of the boards throughout all of the different health regions that undertake their self-assessment. It's difficult for somebody else to judge them other than by the broad benchmarks of: are they meeting the service; are they meeting the budget expectations?

How they function as a board is probably equally as important. What questions do they ask, what information do they demand, what direction do they give, and how effective are they at actually governing as opposed to sitting as, I guess, a policy-making board? The proactive boards and the role of the boards I would think would be an appropriate undertaking to ask the questions across all of Alberta. Are the boards taking a leadership position in the direction of both the assurance of quality as well as reporting?

***11:50***

**Mr. Chase:** Thank you. I very much appreciate your forthrightness in answering these questions.

**The Chair:** Mr. Strang, followed by Mr. Miller.

**Mr. Strang:** Thanks, Mr. Chairman. Mr. Saunders, I really appreciated your presentation at the start, especially on page 4. I'll sort of relate to that and back up on the aspect that Mr. Johnston asked about. What I look at is long-term care and where your associate partners had 52 per cent of your beds and the 48 per cent that you manage. I'm just wondering: with the aspect of the changing demographics in our province as a whole, why aren't we looking at aging in place? Then we don't, you know, move the people as much, and we look after their needs as they progress in the area in which they are. I think that that happens too often in our system now. I'm just wondering, with your new look at that, if you're looking at something in that light.

I guess that my second, supplemental question is on the home care. You know, we're always looking at trying to develop that, trying to keep the seniors in their homes as long as they can. On the wellness side how are we operating in your rural area? If you could give me an insight on that, please.

**Mr. Saunders:** The whole strategy around the long-term care we've talked about a fair amount. I think there are still opportunities that haven't been captured yet. I think the whole strategy of how we cope as we go into the large expectations around the growing number of seniors is going to be critical. Your concept of aging in

place is a very valid concept and could probably go a long way in addressing some of the priorities and expectations of people like myself as I enter into that age group. We will take that into our consideration in looking overall at the long-term care strategy back in East Central. I think East Central has adopted the philosophy of looking more at the alternative levels that Brian and others have addressed. We think that's a very positive step forward. It's one alternative. It doesn't address the challenges that we're going to face over the next 10 to 15 years.

Home care is huge. I mean, the expanse and the growth of home care, as you'll see in our accounts, has been synonymous probably with the rest of the regions as well as we move resources into the community, trying to keep people out of facilities and find a better way to care for them.

I think the wellness factor is very positive. I think the new emphasis on public health and on the quality and the standards and, I think, a shift in some of the emphasis away from the high tertiary level centres into the practicalities of providing service to the citizens of Alberta is critical to the long-term strategy.

**Mr. Strang:** Thank you very much.

**The Chair:** Thank you.

Now, Mr. Saunders, we have very limited time, and we still have five members wishing to direct questions to you and your delegation. It has been the practice in the past that these questions be read into the record, and if you and your organization could respond through the clerk to all members of the committee, we would be very grateful. So we will start this list as Mr. Prins has it here. Mr. Miller, if you could read your questions into the record, please.

**Mr. R. Miller:** Thank you, Mr. Chairman. I note on page 9 of your '05-06 annual report under the heading Major Consultations that the board met with local MLAs "to outline its strategic directions, discuss budgeting priorities and receive input on local, regional and provincial health care priorities." My question is whether or not at that time the concerns of sterilizations and infections were raised during that meeting with local MLAs.

Further on under Major Consultations – and I'll quote directly from your report – it says:

> The Board also recognized the need to actively involve Associate Partners early on in the development of a Service Plan for the region, and to continue to consult with these organizations at appropriate stages as the Plan is finalized.

So my supplemental question would be whether or not there were representatives from your associate partners at that meeting with the local MLAs and whether or not they were allowed to provide input into the region's strategic decisions.

Thank you, Mr. Chairman.

**The Chair:** Thank you.

**Mr. Dunford:** On pages 67 and 68 of the 2005-06 annual report there are lists of wait times, and in the case of tele-ultrasound and ultrasound there are some strategies for 2006-07. I wonder if you would provide, then, what improvements you're able to make on wait times.

Thank you.

**The Chair:** Thank you.

Mr. Bonko.

**Mr. Bonko:** Thanks, Mr. Chairman. On page 11 of the annual report under strategic directions, improving housing options for the elderly and disabled, it's fairly vague there. I'm just wondering in this strategy how much emphasis is placed on affordability. As we all know, that's a big issue right now with rising costs.

The other one is: has the region identified a best practice when it comes to caring for long-term care residents?

**The Chair:** Thank you.

Mr. Webber, and to conclude, Mr. Chase.

**Mr. Webber:** Okay. Mr. Saunders, a quick question. You briefly alluded to innovation that you're doing at East Central health regarding implementing the Eden Alternative. What I'd like to know is: where are you in the transformation of these long term care sites from institutions with regimented rules and schedules to places that residents can call home?

**The Chair:** Thank you.

Mr. Chase.

**Mr. Chase:** Thank you. On page 4 former board chair Ed Andersen states that "slightly more than half of our hospital and nursing home beds are operated by our private and faith-based partners." My first question: did the board members' management ever notify the minister or Premier about the confusion in authority between the region and the faith-based organizations?

Secondly, is the region now satisfied with the action taken by the minister to clarify the lines of accountability and areas of responsibility between the region and private providers, especially the faith-based providers?

**The Chair:** Thank you very much.

That concludes this portion of today's Public Accounts Committee meeting. I on behalf of all the members would like to thank the delegation, Mr. Saunders and his colleagues from East Central health region, for your time this morning. Again, thank you for the information that you provided to the clerk and to the researchers in advance. We appreciate that, and we wish you the very best in administering your budget and providing public health care to the citizens of East Central. Thank you.

**Mr. Saunders:** Thank you very much.

**The Chair:** May I have a motion to adjourn, please, until 1 o'clock?

**Mrs. Forsyth:** I'll do that.

**The Chair:** Heather Forsyth has made a motion that we adjourn until 1 o'clock. All those in favour? Thank you very much. We will reconvene at 1 o'clock sharp in this room.

[The committee adjourned from 11:58 a.m. to 1 p.m.]

**The Chair:** Good afternoon. I would like to call this portion of our meeting of the Standing Committee on Public Accounts to order, please. I would like to welcome on behalf of all members of the committee the officials from the Northern Lights health region. We look forward to discussing your 2005-06, 2006-07 annual reports, and we do appreciate the efforts you have made to provide that information to us all through the clerk.

I would like to advise you that you do not have to touch the microphones. Our *Hansard* staff will turn them on and off for you.

Now, perhaps we can start with the vice-chair and quickly go around the table and introduce ourselves for the record.

**Mr. Prins:** Thank you. Good afternoon. My name is Ray Prins. I'm the MLA for Lacombe-Ponoka.

**Dr. Massolin:** Hi. I'm Philip Massolin. I'm committee research co-ordinator for the Legislative Assembly Office.

**Mr. Eggen:** Good afternoon. My name is David Eggen, and I'm the MLA for Edmonton-Calder.

**Mr. Rodney:** Hello. From Calgary-Lougheed, Dave Rodney.

**Mr. Herard:** Good afternoon. Denis Herard, Calgary-Egmont. Welcome.

**Mr. Johnston:** Welcome. Good afternoon. Art Johnston, Calgary-Hays.

**Mr. Chase:** Harry Chase, Calgary-Varsity and shadow minister for Infrastructure and Transportation.

**Mr. R. Miller:** Good afternoon. Thank you for being here. Rick Miller, MLA, Edmonton-Rutherford.

**Mr. Bonko:** Hi there. Bill Bonko, MLA, Edmonton-Decore.

**Ms Danby:** I'm Gill Danby. I'm the vice-president corporate and chief financial officer with Northern Lights health region.

**Mr. Fetterly:** Good afternoon. Jon Fetterly. I'm the assistant vice-president of corporate services.

**Mr. Blais:** Bernie Blais. I'm the CEO for the Northern Lights health region.

**Mr. Fitzner:** Jeff Fitzner, board chair, Northern Lights health region.

**Ms Lawrence:** Valetta Lawrence, senior vice-president and chief operating officer for health services.

**Ms Applin:** Good afternoon. Madge Applin, vice-president of health services with responsibility for the west side of the Northern Lights health region.

**Ms Wong:** Good afternoon. Teresa Wong from the office of the Auditor General.

**Mr. Dunn:** Fred Dunn, Auditor General.

**Ms White:** Ronda White, Auditor General's office.

**Mr. Dunford:** Hi, folks. Clint Dunford, Lethbridge-West.

**Mr. Cenaiko:** Hi there. Harvey Cenaiko, Calgary-Buffalo.

**Mr. Cardinal:** Mike Cardinal, Athabasca-Redwater and your neighbour to the south.

**Mr. Webber:** Hi. Len Webber, Calgary-Foothills.

**Mrs. Forsyth:** Hi. I'm Heather Forsyth, Calgary-Fish Creek. Welcome.

**The Chair:** Corinne Dacyshyn is our committee clerk. She's doing committee business at the moment, but we wouldn't be able to function without her. And my name is Hugh MacDonald, Edmonton-Gold Bar.

Now, I understand that you have a brief opening statement, and following that statement, we will invite Mr. Dunn's comments. Please proceed, Mr. Blais.

**Mr. Blais:** Thank you very much, Mr. Chair. Good afternoon, everyone. We appreciate the opportunity to discuss the Northern Lights health region accounts with the committee members today.

The past couple of years, as you can appreciate, have been a period of incredible growth in our region but an opportunity for the Northern Lights health region as well. It has been a time of trying to balance needs with resources. The government has a priority of managing growth. It is a priority for them, and we share our experience in 2005-06. I think, if you'll notice, that we have shown that we can be incredibly creative, innovative in the hard work to deliver quality health services and wellness in our region in this period of high growth.

I would also like to take this opportunity to give an overview of the health region's 2005-06 budget, highlight some of the year's accomplishments, and outline some of the actions and recommendations from the Auditor General as well.

The Northern Lights health region focused on three core business areas in 2005-06. The first one was to encourage and promote healthy living, the second was to ensure delivery of quality health services, and, of course, the third was to ensure a sustainable and innovative health delivery system within the region. The total budget for that particular year increased by $4.611 million, or in percentage terms 5.6 per cent, over the previous year. The majority of this increase was thanks to the contribution of Alberta Health and Wellness and represented $4.517 million of that, the balance of it through other revenues.

To address the financial and service delivery efficiencies, we have reviewed our programs and services across our region. Opportunities for improvements were identified, and initiatives began in 2006 and, of course, continue to this day. The health region was proactive in identifying and implementing creative solutions to workforce challenges faced in 2005-06. For example, we implemented a temporary living allowance of $300 per month, that was allocated for each full-time equivalent in our region to help address the higher cost of living in the north in our particular region.

Collaboration of partnerships has been a major theme, I guess, of our particular region. For example, partnerships with Keyano College, Grande Prairie Regional College, NAIT, and others began to address human resource shortages through preceptorship and employment opportunities for new graduates. Bursary programs were also offered in partnership with the Northern Alberta Development Council, the regional municipality of Wood Buffalo, and the Fort Vermilion school district.

Sustainable and innovative health care delivery was on the agenda as primary care networks were under development on both the east and west sides of our region to expand community-based services and to greatly assist in reducing the strain on our acute-care centres.

With a focus on promoting healthy living, the Northern Lights health region went smoke free in 2005-06 and was proud to be the only health region in the province to receive the best safety performer award through Work Safe Alberta 2004.

Although the health region ended 2005-06 with a deficit of $6.53 million, it was a significant improvement from the budgeted deficit of $10.5 million. An aggressive deficit elimination plan was

developed late in 2006, and recently announced new funding from the government also included funding to eliminate the accumulated deficit in the region over the next three years.

As a rural health region we are able to strengthen the quality and efficiency of our program and service delivery through collaboration with key partners. I want to mention a few because this is an important part of what we've been working on, from capital projects to front-line patient service support. Our partnership with Capital health, for example, has helped enhance and expedite the work that we do at Northern Lights. Since '05-06 we have worked closely with Capital health to improve patient care through the following initiatives. I'll only mention a few. I think there are about 26 of them. For example, we currently have established a physician and senior staff orientation so that when we have new people coming into the region, we establish the relationship there, and we get them to understand how to access those services and how the system works. We also did a review of Capital health acute-care and hospitalist programs. When we implemented our program, we certainly sought their input and support and knowledge in terms of how to approach this issue.

The clinical telehealth opportunity is an area that is growing every day; again, we have a number of initiatives there. The diabetic nephropathy clinic. Group purchasing opportunities: our staff have been meeting to look at how we can work together in this particular area. Aboriginal health planning, emergency preparedness collaboration, obstetrical nurse training, staff secondment in key leadership positions. Recently we had no vice-president of finance. We basically seconded one of their staff, as an example of how to provide that service for a six-month period.

Also, we do have cross-appointment on each other's executive committees. Therefore, I sit as the CEO on their committee, and they have one of their senior executive members sitting on our executive committee. What that provides is an opportunity for us to understand where they're going and where we're going and how we might work together on strategic opportunities that come up or how we might work together to improve service delivery in our region. It's a first in my career where we've seen these cross-appointments across any type of organization. I think this is a good example of work that's been done.

Looking back on 2005-06, it was a year of big challenges, small successes, and big impacts. Having joined the region late in that fiscal year, I guess February 1, 2006, along with the new board chair, who's been here, I believe, two years now, I feel we have made solid steps towards strengthening our main resource – and that resource is people – in order to strengthen health and wellness services across our region.

Thank you, Mr. Chair, for the committee's time. We certainly look forward to answering all your questions.

**The Chair:** Thank you very much.

**Mr. Dunn:** Very briefly, similar to this morning. The work that we did in the last couple of years – that's fiscal '06 and fiscal '07 – has focused on the financial statements of the authority. The financial statements for both the years ended March 31, '06, and March 31, '07, have been unqualified auditors' reports. The members are aware of the recommendations from the Auditor General that deal with food safety, RHA global funding, and seniors' care, that we've talked about earlier. Certainly, my staff and myself will answer any questions directed to us, Mr. Chairman.

**The Chair:** Thank you very much. We'll proceed to questions from the members. We will start with Mr. Eggen, followed by Dave Rodney, please.

***1:10***

**Mr. Eggen:** Well, thank you. Once again I would like to welcome each of you to what is a new process here at the Legislature. We certainly couldn't be doing it without your assistance, so thanks very much.

My first question would be to do with the emergency capacity of Northern Lights in general in terms of hospital beds and the emergency capacity to deal with the unfortunate catastrophic event. I know that when I was up in Fort McMurray last year with the EUB hearings, it seemed as though it was a critical situation, that if there was any extra sort of unforeseen disaster, it would be difficult to deal with. I'm just wondering how you've budgeted this last year to accommodate for that and if you've been successful in mitigating that potential problem.

**Mr. Blais:** Thank you for that question. I'll answer part of it, and then I'll hand it over to our senior VP for more specifics.

It certainly has been a challenge for us in Northern Lights. Last year we saw 66,000 patients in our emergency department. The basic reason for that is that there are very few primary care services available in the community, so it looks like one-stop shopping. But we have implemented or developed a plan to expand our emergency department and ambulatory care to accommodate that particular growth, and we're hopeful that that will be implemented over the next year or so. In the interim we've also developed a plan to expand our emergency department on an interim basis to cope with that growth pressure at that current time. Our volume for this year, I think, is expected to be about 74,000 patients. As well, I'll just ask Valetta Lawrence also to provide you maybe with a more in-depth explanation.

**Ms Lawrence:** Along with what Bernie said, we are also continuing to recruit family physicians to Northern Lights health region, which is one of the concerns that came up. We have a working group right now that's looking at some of the ways to streamline the emergency visits that we're seeing. Hopefully, we can improve our primary care, and we can take some of those visits out of our emergency department.

Thank you, Mr. Chair.

**Mr. Blais:** If I could just add one more piece to that. We also implemented a hospitalist program, or fly-in docs, to help remove the pressure from the local physicians within our region as well. That has worked very well for us so far.

Thank you.

**Mr. Eggen:** Okay. Further to that, then, do you have an idea of how much you depend on, let's say, the services of Capital health to make up the difference in what you're able to deal with in your emergency program? Do you have any idea of how much you're using that?

**Mr. Blais:** Thank you for that question. There are a number of things that we do with Capital health, again, to deal with those pressure points, but I'll ask Valetta Lawrence to provide you with an explanation in terms of what those are.

**Ms Lawrence:** In the '05-06 fiscal year 25 per cent of the people that we saw in our emergency department were from outside of our particular region, so we are actually importing a lot of emergency

visits instead of exporting. We do certainly rely on Capital health to provide any tertiary services, and we use both the critical care line and urgent care line on a regular basis.

Thank you, Mr. Chair.

**The Chair:** Mr. Rodney, followed by Mr. Bonko, please.

**Mr. Rodney:** Thank you, Chair. Obviously the geography of the region poses serious challenges for acute care and other aspects. Coming from where I come from, the southwest part of Calgary, I would understand that infrastructure challenges are the most significant barriers to timely access. Maybe I'm wrong. Maybe you can correct me. But I'm really wondering: what does your health region do to mitigate some of the obstacles of distance to treatment?

**Mr. Blais:** Thank you for that question. There are a number of things that we have done to help mitigate some of that. On the west side of our region we are very fortunate that we have two hospitals, five or six community health centres, a stand-alone community care, so I think there we are very fortunate to have a fair amount of capacity, if you want, in terms of that. To mitigate, I think, is really the human resources issue; it's the one that we're trying to mitigate currently. Last year, I know, when I started and when I looked at the human resources issues, our vacancy rate was sitting at about 25 per cent as the number of positions on a daily basis that would be vacant. Our turnover rates per year were 42 per cent. Today I can tell you that we have been sitting below 6 per cent in the last four months, so we've come down. We've had a high degree of success to help mitigate. Geography is one thing, but even if you have a lot of infrastructure, you still have to have the people, the resources to deliver that. Our turnover rates are down at 27 per cent today and going down, and part of that has been as a result of the northern allowance that we receive to help recognize some of the pressure points that we have.

On the east side, as you know, we have received approval from the government to look at putting in place three community health centres. That will certainly help mitigate the infrastructure issues that we face currently and alleviate the pressure point in our emergency department that currently exists.

The other thing is the recruitment of physicians as well. It is going to be a key element in minimizing that impact.

We have also moved some of our services out of our health facilities. Our family health unit, or public health unit, has been moved out recently, hence making room for the expansion of the emergency and ambulatory care, as an example of some of the things that we can do to make better use of the acute care space for that purpose. We're looking at a second move now to allow further expansion of some of our other services as well.

We have put in place this kind of interim measure, and hopefully the community health centres that will eventually be built will certainly be one of the big points that will help mitigate the infrastructure issue as well.

Thank you.

**Mr. Rodney:** Thanks for the thorough answer. We're allowed one follow-up, and this would be mine. Perhaps you yourself, sir, or people with you could answer this. I think everyone around this table and at many tables around here knows that things are a little more complicated than they seem sometimes. I'll use an example from education. In urban areas we might think it's cheaper to provide educational services in the rural areas, but there are a number of other issues that maybe urbanites may not be aware of. Again, asking you from a different part of the province, people might presume: well, maybe it should cost a little less because you don't have to pay for this and that in the city. We know that there are different issues.

You've mentioned a number of ways that you try to tighten things up when it comes to infrastructure and human resources. Is there anything else you could add where I could explain to my constituents: actually we get a big bang for the buck because up there, when it comes to services or resources or pharmaceuticals, they are saving money in these new and different ways by talking to other regions in Alberta or other places. What can I say in terms of, you know, bang for the buck for the taxpayer for services, resources, or pharmaceuticals, that we are getting the maximum benefit for the dollar?

**Mr. Blais:** Well, I'll point out a few, I think, that are probably the most obvious and important. With the telehealth technology – and I'm the chair of the provincial committee, so I can tell you – I think that we're getting a good bang for the buck there, and we haven't even tapped the potential yet, I think. This is the relationship that we have with Capital health. It is one of the areas that we're focusing on, making better use of. It's probably one of the best things that's come out for northern or rural communities in the recent past, and I think it has tremendous potential for education and training as well. I have to tell you that I don't know how many meetings I attend now from the north using telehealth, so reducing the cost of travel. That is probably one of the best examples I can use.

Also, the implementation of technology, the electronic medical record direction, is really a good one. Again, when you look at the amount of times that we have to repeat things in our system, when we're looking at patient safety in terms of drug management, all of these things, I think that the electronic strategy that we have put in place – and the rural regions are all one partner in this initiative. I think that coming from other places in Canada recently, it's one of the best initiatives I've seen in years. How do you get seven regions to work together? This is pretty unique. So I think the opportunities for the best bang for the buck are, for example, in technology. How do we leverage technology more effectively?

The second thing is partnerships. Again, regions historically may have always worked in isolation of each other. That is not the case today. We are working in very good collaboration with our partners in Capital health. We're working with the private sector as well. They will be, hopefully, on their new sites building medical centres or more robust services on-site to avoid having people travel to our particular location. I think that that innovation is in place at least within our region. I can't speak for others, though.

Thank you.

***1:20***

**Mr. Rodney:** Thank you very much. I appreciate it.

**The Chair:** Thank you very much.

Mr. Bonko, followed by Mr. Webber, please.

**Mr. Bonko:** Thank you, Mr. Chairman. My questions are around recruitment and retention. It's an obvious concern not only in your area but throughout the province. Page 8 of your annual report states that "the local cost of housing remained the primary obstacle for individuals contemplating employment . . . in Fort McMurray." Also in that report it says that there is allocated $3.51 million, or just about $300 per full-time equivalent, per employee, to offset the cost of housing up there. So the point is: considering all the financial costs of these incentives, is the region in a position to fill all the positions required to operate new, updated, expanded facilities?

**Mr. Blais:** I'll make an attempt at that. That's a lot of questions at once.

As far as the allowance that was allocated by the region, as I expressed earlier, the government has since provided $1,040 for the east side for all employees – so that is now a funded initiative – and $525 for the west side. I think that what I can say without question is that it has definitely helped us to retain.

The question is never about recruitment. The question is about retention, right? So the best person you can recruit is by keeping the ones we have now. When you look at our current vacancy rate of 5.8 as of this week – it's been running at 6, 5.7 – certainly, I think it's self-explanatory that we believe that currently we have enough staff to provide all the services that we currently do.

On the physician side what I'd like to do is maybe ask Valetta Lawrence, who is responsible for that portfolio, to explain to you what our current situation is, where we're at today, and hopefully some of the things that we're putting in place.

**Ms Lawrence:** Thank you. Currently, as of today, we have 15.5 full-time equivalent general practitioners working in Fort McMurray. That certainly is much lower than we require. We would like to have probably 30 family physicians in Fort McMurray. On the west side of our region we currently have four physicians working out of High Level and four out of Fort Vermilion, and we are looking for four more on the west. We do have 18 specialists working in Fort McMurray and seven emergency room physicians. We are certainly very actively recruiting physicians, and that is ongoing. We anticipate that by the end of the year we will probably have another four to six physicians recruited. We do certainly have a very competitive recruitment package, and we have been seeing some success.

Thank you, Mr. Chair.

**Mr. Bonko:** Then my supplemental, Mr. Chairman: for how long can we continue to, I guess, supplement this program at its current cost?

**Mr. Blais:** I don't believe I could provide a reasonable answer to that. Given that the current cost of housing since I've arrived in Fort McMurray has gone up in a year and a half by $200,000, I would hope that that will continue for as long as there is this affordability issue. As an example, I've been working for eight months to recruit a medical officer of health. This is a hard-to-recruit position. Even at the salary that we would fund that individual, as of yesterday after months of effort that person has turned us down because of the cost of housing. It's not just the front line or employees that we suffer from, but it's also even the people that we're looking to recruit into those types of positions.

So I don't have a good answer to that other than that we would hope as a region that that will continue. It has helped us a lot in recent times, and again, if that was to be removed, I wouldn't want to go back to where we were, let's say, a year and a half ago, when I arrived in that region. I guess that that would be the only answer I have.

I would just like to add as well some of the other initiatives that have not taken full force yet. We are implementing a return-in-service program, and I actually signed up my first doc about two months ago, and in two years' time that person will come back to Fort McMurray and provide four years of service. Our goal is to have 19 more of those, hopefully from our region. This individual is from our region.

We're also just about ready to announce a partnership with the University of Alberta. We don't train people in our region, and, you know, all the research in the world demonstrates that unless you do that, you're not going to do very well. So, again, we hopefully will be announcing that very shortly.

Also, the hospitalist program, which I mentioned earlier, the fly-in doctors. That is a temporary measure, but now we're working on the next phase of that, which will make it permanent. We want permanent doctors in our building in the event that patients don't have a family doctor that can take care of them. All of these things are happening as we speak.

So, again, it's good news, some of it already in place and some of it just about ready to be launched.

Thank you, Mr. Chair.

**The Chair:** Thank you.

Mr. Webber, please, followed by Mr. Chase.

**Mr. Webber:** Thank you, Mr. Chair. The Auditor General, Mr. Dunn, has some fairly strong words in his annual report here, on page 4, with respect to food safety. He indicated that 8 out of 9 regional health authorities haven't met inspection targets, that follow-up and enforcement are lacking, so places with poor safety practices continue operating. My question is with regard to the Auditor General's recommendation that the RHAs should improve their food establishment inspection programs. What actions have you taken at the Northern Lights regional health authority following the release of this report?

**Mr. Blais:** Thank you for that question. I will ask Valetta Lawrence to provide a response to your question.

**Ms Lawrence:** Thank you, Mr. Chair. Northern Lights health region has been implementing the recommendations on food safety from the Auditor General's 2005 report. Certainly, we have increased our staffing resources by two full-time equivalents in order to be able to manage that. We have developed an inspection schedule, and we are ensuring that we are monitoring and measuring performance and outcomes. RHAs are required to post all food facility inspection reports on the website by July of '08, and we anticipate that we will meet that.

Thank you, Mr. Chair.

**Mr. Webber:** A quick supplemental with regard to the food inspectors. You indicated that you hired two additional. What in total have you got for food inspectors in your area approximately?

**Ms Lawrence:** I really can't answer that question with total assurance. Jon might be able to.

**The Chair:** If you would like, you can certainly provide a written answer through the clerk to all hon. members, please.

**Ms Lawrence:** We can do that.

**The Chair:** Okay. We appreciate that.

**Mr. Blais:** Jon Fetterly could provide an estimate if you wish and then follow up with a written response that's more accurate.

**The Chair:** Sure. Please proceed.

**Mr. Fetterly:** Thank you, Mr. Chair. I believe that just as an estimate of the number of food inspectors – and this is both the east side and the west side of our region – we would have, I believe, in the range of nine health inspectors.

**Mr. Webber:** Thank you, Mr. Chair.

**The Chair:** Thank you.
Just a point of clarification, please. Would these inspectors inspect work camps as well as commercial restaurants?

**Mr. Blais:** Yes.

**The Chair:** Thank you.
Mr. Chase, followed by Heather Forsyth, please.

**Mr. Chase:** Thank you. As the shadow minister for Infrastructure and Transportation I am very aware of the ongoing budget shortfalls your region is experiencing. In 2005 a delegation led by Mayor Melissa Blake called for a regional injection of $1.2 billion. By 2006 the need figure had risen to $2 billion. Grande Prairie is facing similar operational infrastructure budget shortfalls. On page 11 of the 2005-06 annual report it states that the Northern Lights regional health centre

> has opened 7 additional acute care beds in the 2005/06 fiscal year to assist with the demand for services, bringing our total bed count to 102. Even with the addition of the 7 beds, NLRHC is still below the benchmark of 1.9 acute care beds per 1000 population. Based on this ratio, we would require 136 beds. Plans are under way to open an additional 6 beds on surgery in 2006/07.

My question. I'd maybe lose the word "when" in front of it and just ask: will the region meet the benchmark of 1.9 acute care beds per thousand? I'm aware that that's an average and not a desired place to be.

*1:30*

**Mr. Blais:** Thank you for that question. The answer to the 1.9 is no. I don't believe that that will happen. But I do believe that there is the opportunity to look at other service delivery models. Again, we are very much focused right now on building capacity in the community where people live. That's one of our strategies; hence, the three community health and wellness centres.

The other aspect of that is that by getting the private sector to look at building more robust medical centres on-site, there's an opportunity to avoid people having to travel to our facility and also to discharge people if we know that those services are available for them. We're currently looking at a fairly big expansion of our ambulatory care system, and also over the next three years we will be expanding our home care service delivery system so that patients can be maintained in the home. We're looking also at crisis intervention, again, having a crisis nurse in emerg so that we can avoid those admissions.

We're very confident, I guess, in a sense, that we could look at maybe a different model, that we would be more amenable to the type of community that we are in terms of the way the community is growing currently. There is no question that in the next three years, four years at the outside, we will need additional capacity, definitely. So we're looking at how we can improve our current efficiency, looking at building capacity in the community, and looking at internally what things could be done on an outpatient basis, whether it's day surgery or other types of procedures. All those measures are being looked at and initiatives put in place.

Thank you.

**Mr. Chase:** Thank you. A very uncolourful or kind of derogatory term for seniors in hospitals is bed blockers, but there is a reality. My question is: what percentage of acute-care beds are used by patients waiting for a bed in a continuing care facility?

**Mr. Blais:** I'll just ask Valetta Lawrence to answer that question. Valetta.

**Ms Lawrence:** Thank you. We have a 43-bed medical unit. On an ongoing basis we have approximately 10 of those beds that have a patient that's waiting for placement in continuing care.

Thank you, Mr. Chair.

**Mr. Chase:** Thank you.

**The Chair:** Heather Forsyth, please, followed by Mr. Miller.

**Mrs. Forsyth:** Thank you, Mr. Chair. Welcome. I want to talk to you about global funding. In a large measure it's a population-based funding allocation model. We have requested that analysis be undertaken comparing the cost of the medical services provided by each RHA with funding received through the global funding formula. Well, we've had some success with Capital and Calgary but none, really, with the rural regions, who don't engage in costing, and I'd like to ask you why.

**Mr. Blais:** Sorry. I don't understand your question. I wonder if you could repeat that. I could try and give you a decent answer on that one.

**Mrs. Forsyth:** Well, I think global funding has been with the regional health authorities since 1997, and it's based on a population-based funding model. So one of the ways to receive more funding is to get some more information on the medical services provided by the regional health authorities. Capital and Calgary regional health authorities have been fairly good at responding on that, yet none of the rural regions have engaged in such costing, which I think is a situation somewhat sad. Yet it can be a huge impact to your communities, you know, for your residents to get accountability and outcomes and also achieve some more funding for you. I mean, you talk in your annual report about the shadow population, which is a huge problem, so I'm wondering why you're not engaging in this costing.

**Mr. Blais:** Thank you. I will call on our board chair to answer part of that question and then our vice-president of finance subsequently.

**Mr. Fitzner:** One of the things that the rural health regions were encouraged and absolutely engaged in was the initiative for a joint electronic information system. Phase 1 was all on the patient care modules, and then phase 2 was to provide that costing ability so that we would all have the ability to do the type of costing that you asked for. The funding has not been consistent there.

Our expectation is that we are going to forge ahead. We were the first one to sign up for it. Again, when you have the largest geographical area and smallest population, then technology has to be the one that evens the playing field. We certainly signed up for that. All seven health regions have participated. The later modules for that exact initiative are to provide those types of computerized costing systems with the data that are already going in to be able to use that data to provide the costing data.

So that's kind of all part of the medium- and long-term plan. The RSHIP initiative is what I'm specifically referring to, and that incorporates that costing capability.

**Mr. Blais:** Maybe Gill can provide more specifics.

**Ms Danby:** Yeah. I can just add to that. I support what Jeff has said in that we would agree with the committee that, you know, we would want to better understand our actual costs of procedures, et cetera, so that we can make good decisions to support decision-making, but we do need to develop the IT systems to support that type of very complex activity. We're currently developing an IT strategy that will link into the RSHIP, and that will be incorporated within that strategy to move us forward.
Thank you.

**The Chair:** Thank you.
Go ahead.

**Mrs. Forsyth:** Well, I'm not sure if we're talking on the same line. Maybe a clarification from the Auditor General if I may, Mr. Chair?

**Mr. Dunn:** I think I can help out here. You started out with global funding being population based.

**Mrs. Forsyth:** Right.

**Mr. Dunn:** That's the approach that the province has had to default to, primarily because it doesn't have comparable costing information by location. I think what the member was looking at is: is there a way of addressing the funding needs without having adequate cost information? Is there an alternative, in your opinion? Then I'll ask a second question if I may. Can you actually address the funding needs without adequate costing information?

**Mr. Blais:** Well, I'll give you my expertise. You know, I've been in this system 38 years. We've also had expert reports developed on this particular issue, so we've presented them to a number of individuals. Typically population health-based funding is a good funding formula. It works well generally. Where it doesn't work well is in high-growth areas because the assumptions on population growths are underestimated or the forecast is off.

There is another issue as well where population health funding does not necessarily work as well, and I understand that Alberta Health and Wellness is looking at that currently. In our case it's assumed that our population is healthy because average age, for example, in Fort McMurray is 31. But when you look at the actual health of the population – and it wouldn't be the trend nationally necessarily, so again if you're paid by age grouping – you will find that our population is not healthy: drugs, alcohol, depression, stress, mental illness, all of those things, and also in the teen population. I know that in England they have a modifier that helps correct that, that looks at that and makes adjustment. I think that overall I would say that I firmly believe – again, it's my position – that population health funding tends to work reasonably well with some exception.

The second piece of that is that it's important for us to have comparable information when we're looking at costing of a surgical procedure, whether it's a hip or knee or any type of procedure, unless we have the IT systems to help us produce that. I think it would take us to another level of opportunity for improvements. No question about that. We would be able to look at our performance in comparison to a similar-size facility, and that would provide an additional level of improvement, I think, to any type of funding formula.
Thank you.

**Mr. Dunn:** If I can just supplement to be absolutely clear. When we looked at the population-based funding model and then did our report on it, we were very clear that this is an allocation method. It takes the pie and allocates it. But if you really want to find out what is the cost of health care, you're going to have to get to the costs. That's why we addressed the issue.

I believe what the member was asking was: this is merely an allocation system, and thus even though you've got input of people and the grey shadow and all that, you can gain a little bit by taking from others. Your population is up, and therefore you'll get a little bit more, but the pie doesn't get larger. Therefore, back to the RSHIP initiative, et cetera: when will that be available in such a manner that we will have comparables as to the actual costs of procedures by patient, by prescription, et cetera? When would that be available in order to try to determine what is the cost of health care?

***1:40***

**Mr. Blais:** Maybe I'll ask Gill to hopefully give a stab at that.

**Ms Danby:** Okay. I can't answer that question fully, and I think we'll need to get you a response to that in relation to Northern Lights health region. Clearly, there is an ongoing program of development. It's a very complex and difficult program when you're looking at implementing something of a common standard across a number of regions. The precise date, to tell around exactly when that will be available, I think we'll need to get to you in writing.
Thank you.

**The Chair:** Thank you.
Okay. We'll proceed to Mr. Miller, followed by Mr. Cenaiko.

**Mr. R. Miller:** Thank you very much, Mr. Chairman. Further on the discussion of population and the growth of population page 11 of your '05-06 annual report says that

> with existing human and financial resources, NLHR has difficulty maintaining current service levels and responding to the needs and expectations of a rapidly growing population. For two years, the Health Quality Council of Alberta survey has shown that NLHR is significantly below the . . . standard of access to health services.

Aside from the program of the fly-in docs, what is the region doing to balance care throughout the week so that patients would receive the same care, say, on a Sunday that they would on a Tuesday?

**Mr. Blais:** Okay. Thank you for that question. The main thing is to keep in mind that the hospitalist program is seven days a week, 24 hours a day; it's not just during the week days. That program is a permanent program at this point in time.

Again, I talked about the human resource challenge and how we have made significant improvement in that area. So when I talk about how we improve care, it's all about having the people capacity in place to achieve that, and I think we had certainly demonstrated since '05-06 that we have significantly done that.

The bottom line as well in terms of future growth, because we expect our population to grow by another 50,000 over the next four years. This is why we're looking at the construction, I guess, of three community health and wellness centres that will basically service 20,000 to 25,000 people. So about 80 per cent of the services in those communities will be provided by those health and wellness centres.

Now, I don't know if anybody else would like to add anything to that, but there are so many things that we're doing to ensure that that service delivery is there. We're just posting right now for four nurses in emerg as an example. We're expanding the emergency department, expanding the ambulatory care department. We've also put in place two primary care networks: again, a very important aspect of our strategy for the future. One has been in operation since

August 2006, and the other one, I think, is just about ready to go live now.

Maybe I'll ask Madge to talk to that particular issue because it's an important part of how we're working to help do exactly what your question has asked of us.

**Ms Applin:** Thank you, Mr. Chair. Certainly, in terms of finding new and creative ways to not only deal with the illness needs of our communities but also, again, to focus on how we can work with our families and communities to enhance wellness, to stay well, maintain wellness, the primary care networks are an incredible strategy in that direction.

In our primary care network on the west side of the region, in High Level and surrounding communities, the network provides services to high-risk, pre- and postnatal clients, to children and youth with complex care needs like, for example, fetal alcohol spectrum disorder, and finally in the area of chronic disease management with a particular focus on diabetes and heart disease. That program is up and running with full involvement of all physicians in all communities on the west side of the region. Likewise on the east side of the region, where the primary care network has been going for two years with incredible success.

I think that in terms of our goal and our objective to find a new way of working together as health professionals in a truly team-based interdisciplinary approach to care, where all health providers are providing services in a way that makes services the best they can be for communities and individuals, the primary care networks are meeting that objective. On the east side of the region, in Wood Buffalo, the primary care network focuses on diabetes, heart disease, geriatric care, and palliative care, again with all family physicians involved and participating in the primary care networks.

Thank you, Mr. Chair.

**Mr. Blais**: Mr. Chairman, our board chair wanted to add a few comments on that. Is that possible?

**The Chair:** Please proceed.

**Mr. Fitzner:** I was just going to say that when we talk at this level, sometimes it's lost in the generalities, so I want to give you an example of what a primary care network does as far as creating a new model for delivery. It provides relief on our ER/ambulatory care, and it makes better use of physicians.

One was not too long after the primary care in Wood Buffalo municipality was started. It was advertised in the newspaper for patients to come for women's health tests. What that allowed was to come in, and those tests could be administered by a nurse practitioner. If the test results fell outside of the defined parameters, then those would be referred back to the physician for follow-up.

Well, in a very short period of time 3,000 tests were done, so there are 3,000 visits to a physician that did not happen. The only physician intervention that occurred was for that portion of the test, less than 6 or 7 per cent, that fell outside the defined parameters and that the physician then treated in a scope of practice as a physician needs to treat. Instead of seeing 3,000 patients in his office or having patients show up at the hospital when they have abdominal pains or something to that effect, now you have to have the intervention. So that's the type of intervention. That's the type of model delivery that a PCN introduces into this community, likewise soon to the west side.

**Mr. R. Miller:** Thank you very much. I, too, am a big fan of the PCNs, and I'm glad to hear that they're working as well in your health region as they are in south Edmonton.

What would be at the top of your wish list from the ministry to address the unique health care needs of your region?

**Mr. Fitzner:** As the board chair I'm involved at the strategic planning level, if that's appropriate for me to respond. A couple of things. Number one is that our wish list was granted. In February of '07 the minister announced with the Premier – and came to Fort McMurray to announce – some funding both for capital and for operating. Believe me, that was a wish list. We had travelled to Edmonton to meet with the then minister of health in November to request not only operating and capital funding but also a transition team to supplement the management infrastructure to be able to then deliver and to get the programs initiated. That happened as well. In conjunction with the funding announcement a transition team was also announced.

That transition team has been instrumental in providing leadership in getting eight working groups together to facilitate the speedy outcome of ambulatory care review, emergency department review. That was our wish list. That funding was announced, and it included three medical clinics. We're also looking at a helipad and a parkade because in Fort McMurray access to health care quite often is equivalent to access to the parking lot. You can't get in. We have a very high percentage of missed appointments because people drive around the parking lot for 20 minutes, give up, and go home. So there are physicians who have appointments, who are there to see patients, and the patients don't make it to the appointment because they can can't get into the hospital. These are all functional realities of delivering health services here. That was our wish list.

We're now going about: how quickly can we do the appropriate planning and due diligence and then deliver these? Time is of the essence because the cost of construction in the north, like the rest of the province, is beginning to feel on an increasing basis, doesn't stay static. The faster we can deliver these, the more we can deliver money to the primary project, so the transition team is critical in being able to supplement management so that we can get the planning process done on an expedient basis.

*1:50*

**Mr. Blais:** I'd just like to add to that. I think getting an 81 per cent increase in your budget base is a wish list. That was granted to us. We did get three community health and wellness centres. These are not medical clinics. These would be a combination of primary care networks and medical clinics and wellness. So those two alone certainly provided us an impetus to do what we're currently doing today.

The other thing was that the $1,040 in the northern allowance that we receive from the government as well as $525 for the west side has helped us tremendously. If anything else, it has given our employees a sense of hope that, you know, somebody is really – and they've been very, very enthusiastic. I can't tell you how many e-mails I've received from our staff.

The recent tripartite agreement as well with the physicians. There is recognition in areas of high growth like ours and where there is an underservice in terms of the number of physicians. We are quite hopeful that that funding that will come for our physicians in our northern region will help alleviate and achieve a similar impact as we have seen on the staff side.

So if I had a wish list, those would have been the three or four that I would have had at the top of the list, and they're all here today.

Thank you.

**The Chair:** Thank you. I would like to remind all present that the Public Accounts Committee research indicates that per capita

funding has doubled over the last five years on a global formula basis in your region. That's a significant amount of money.

Mr. Cenaiko, followed by David Eggen.

**Mr. Cenaiko:** Thank you very much. And thank you for being here this afternoon. Addictions to gambling, drugs, tobacco, alcohol are very serious problems throughout Alberta. As chair of AADAC we had the opportunity to have board meetings in Fort McMurray in June and an opportunity to visit not only the oil sands but as well some of the social agencies that we contract out with in Fort McMurray. So it was a real learning opportunity for us.

I appreciate the last answer that you provided, but what are some of the measures being taken by the health region to confront some of these challenges related to the tremendous amount of drug abuse and the tremendous amount of alcohol abuse in the community?

**Mr. Blais:** Thank you very much for that question. I'll ask Valetta Lawrence to respond to that.

**Ms Lawrence:** Thank you, Mr. Chair. The Northern Lights health region has been working in partnership with AADAC for several years. The provincial mental health plan, as you know, was approved a few years ago. The Northern Lights health region developed a regional mental health plan, and we then got three innovation projects approved. One of those was an addictions counsellor that we hired to help start training staff in concurrent disorders, and part of that was cross-training with the AADAC people in Fort McMurray so that we could try and expand the kind of services that we were providing, not try to do it ourselves but to do it in partnership. We have tried to really expand on that and work with others within the region to do that.

Thank you, Mr. Chair.

**Mr. Cenaiko:** I have no follow-up.

**The Chair:** David Eggen, please, followed by Mr. Herard.

**Mr. Eggen:** Thanks, Mr. Chair. As you know, this committee is designed to provide the sort of insight to ensure that the most efficient use of public funds is applied to all areas of responsibility for the government. In following what the chair mentioned, and something that I was thinking about as well: you experienced an 80 per cent increase in your funding from February 2007, which was definitely necessary, and a 50 per cent increase in the last five years in per capita funding. What else can we do structurally up in your health region besides throwing money at the situation? You know, these are huge increases. What in your estimation could we also do for Northern Lights to support efficient use of public health spending in your region?

**Mr. Blais:** Mr. Chair, I'd like to call on our board chair, maybe, to provide part of that answer.

**Mr. Fitzner:** Again, on the planning side a couple of things. First of all, as far as per capita funding, one of the things that we need to understand: over the past 10 years Wood Buffalo municipality has increased by approximately 9 per cent per year. The next closest community would be Grande Prairie, at about 2.5 per cent. On a more recent basis housing starts in Edmonton and Calgary this year over last year actually slightly decreased. Housing starts in Grande Prairie are about 2.5 per cent. Housing starts in Fort McMurray this year over last year: about a 74 per cent increase.

I don't want this panel to begin to think that there is exactly a blueprint here for the kind of growth that we're seeing. There isn't a standard planning format. It's not that someone was derelict. Every single growth forecast in Fort McMurray has fallen woefully inadequate. In 2001 we were forecasting that by 2010 Wood Buffalo municipality would be at 80,000. They're at 80,000 in 2006. These are the best forecasting models that we have. So how do you respond when every forecast is short and you grow faster than the forecast? While we have a 50 per cent increase in per capita funding, at that same time the population increased by 70 per cent. So is that a shortfall in funding? Those are the things that we need to keep in mind.

Going forward, is this sustainable? It is not. It is not sustainable. So how do we address that? While we have some very acute challenges in Wood Buffalo and in the Northern Lights health region, we also have some unique solutions. We have some unique opportunities. I'll just give you one example. The province owns all the land around Wood Buffalo municipality. That's very unique to other regions of this province. The land is tendered to developers. Developers then put in the infrastructure and sell lots to build houses. We then receive funding from the province to buy that land from the developer to build a medical clinic or some type of health facility on that land. When you sell the land at $50,000 an acre and you buy it back at $3 million an acre, there is a funding dislocation there. You've made $15 million by selling 300 acres, but you paid $12 million to now build a medical clinic on that 300 acres. So the net difference that this government yields is $3 million.

From a development perspective when we release land 300 acres or 800 acres at a time for development, we're going to have to put schools in there. We're going to have put a fire department in there. We're going to have to put in some kind of health facility because the model where we need to deliver health is at the community base, not at the big hospital centre. That's not facility-based health that's sustainable. It's the community-based health delivery. So if we're going to release land in 300 acres – and that's unusual. That doesn't exist anywhere else in the province, but it does exist in Wood Buffalo municipality.

What I'm suggesting is that we take into account when we release these lands areas for schools. Let's take into account and give the health regions stewardship of, you know, eight to 10 hectares of that 300 acres. The forgone income to the province is maybe $50,000 an acre at that level. But I'll tell you that our board has the expertise and the background and the technical skill to be able to with eight to 10 hectares self-fund. We can self-fund that medical clinic. We won't be asking for capital funding. We then will have land to be able to provide affordable housing for the very health practitioners that we need to service the community.

It creates options. Because we have access to land, we can partner with the community and say: well, let's put a medical clinic attached to a school. Then we've got health and wellness in one piece. Look what it does for growing our own solutions, for getting youth to consider health careers instead of trades careers, which is a big issue in our community. It gives them some options because it's visible, because they see it. It's not messaging that we have to stand at a pulpit; it's messaging they see every day when they go to their school. So these are some of the things that we have the ability to control as far as sustainability going forward.

**Mr. Eggen:** Thank you. That's an excellent observation. Would it be reasonable to say, perhaps, that moderating the pace of development in the region would also have a positive effect in delivering quality and cost-efficient health care in Northern Lights?

***2:00***

**Mr. Fitzner:** Well, I've had some experience in collective bargain-

ing, sir, and I managed to steer away from the group that was being very vocal at lunch time, but what I know is that when there's a deadline, then all of a sudden the level of intensity increases. When the level of activity is decreased, then sometimes so does the commitment because other things become a priority. I don't know if that rationale would be consistently applied. If we paced industry, would we still move with this level of urgency? That hasn't been the blueprint, but the reality is that, yes, it's playoff hockey in Fort McMurray. It's playoff hockey, and we don't have the luxury of an exhibition season. We don't have the luxury of an off-season. It's playoff hockey.

I want to say that the people that are sitting from the Northern Lights health region didn't bring on the circumstance that exists. In 2005-2006 there was only one person at this table that was in the position they're in today. These people have reacted and, I've got to say, are unqualified experts at being able to deliver in the kind of environment that is called upon. There isn't a planning blueprint, and the growth and the type of economic development just doesn't exist anywhere else in the world as it has over the last few years and that we can see in the foreseeable future right now.

**Mr. Eggen:** Thank you.

**The Chair:** Thank you.
Mr. Dunn, a supplement, please.

**Mr. Dunn:** I just want to let the committee members know. You're familiar that we did a review of the land sales from Alberta Social Housing Corporation in Fort McMurray. We will be following that up this fall, and then certainly we will take under consideration Mr. Fitzner's representation that land had not been set aside or had been I'll use the term "flipped" between developers. It was our understanding that lands had been set aside for public facilities, and that was one of the concerns as to who would be occupying those lands. We'll undertake to report to this committee following our fall work on the Fort McMurray land sales that indeed properties had been considered for education, health, and other needs because it was our understanding that those considerations were taken into account. We'll certainly follow that up.

**The Chair:** Thank you very much.
Before we get to Mr. Herard, followed by Mr. Bonko, Mr. Blais, in your draft annual report for 2006-07 on page 8 the total Northern Lights health region population is estimated at 101,000. Could you please tell us for our information: does that include people who are living in industrial or construction camps?

**Mr. Blais:** Mr. Chairman, yes, it does. The estimated population percentage is listed at 9,178. That would be the shadow population. So of that 79,000 at the top of that page, 9,000 would be the shadow population, or living in camps and basement suites and other places.

**The Chair:** Okay. Thank you. I appreciate that.

**Mr. Blais:** Just to let you know, that population currently stands at 23,000, the camp population alone. There will be a census released at the end of this month. Our guess is that it will be 23,000 plus, so that's up from last year.

**The Chair:** Okay. Thanks.
Mr. Herard, please.

**Mr. Herard:** Thank you very much, Mr. Chairman, and thank you very much for your very open discussion on all of these points. I tried to get some information from your website. I'd like, you know, to try and understand what the cost escalators and the cost drivers are, and I couldn't get anything other than this current report. In other words, there was nothing on the website from the past. That's just a comment. I was able to get four years of information from another health region. I haven't tried them all, but it would be great to have access to more than one annual report on the website.

I would like to try and understand. I think that as you speak, we're learning a great deal more about what goes on in Fort McMurray and the tremendous challenges that you have there. What are your major cost escalators and drivers? I mean, I would think that if you're having trouble staffing, you would be paying one heck of a lot of overtime. Is that a major factor in your costs?

**Mr. Blais:** I'll ask Jon Fetterly to respond to that question, and I will respond in part 2 as well with another component of that.

**Mr. Fetterly:** Thank you. Overtime certainly is a significant component of our compensation costs. I'll use the west side of the region, which currently has a significant shortfall in their registered nurse positions. I believe I'm correct in saying that there are about 14 positions that are vacant at the present time, which is a significant portion of the total registered nurse component. Services still need to be provided. Patients are still coming to the door of the hospital. How do we do that? Oftentimes there's a necessity for overtime. I guess we're certainly saving costs when the position is vacant, but we're actually incurring greater costs when overtime is incurred than we would be otherwise. So certainly overtime is a significant cost driver.
Thank you.

**Mr. Blais:** I will just add to that. If you look at the report, you'll note that one of the areas where we have incurred a fairly high cost is on the recruitment side. When we have to move people to Northern Lights health region, we have to pay their expenses, and if the turnover is very high – I mentioned earlier a 42 per cent turnover rate every 12 months – then, of course, you have high cost of recruitment. So to try and alleviate that, we have done extensive work on retention, again, and we're seeing a significant improvement in that area currently. But in 2005-06 that was definitely one of the cost drivers: recruitment, the high cost of recruitment.

**Mr. Herard:** Okay. One of the areas that I like to look at only because most of the time the kind of comments we get from electors is, "Oh, they've got so many chiefs; there are no Indians," all this kind of stuff – I tend to look at those things. One of the things that I noticed – by the way, overall these numbers show about a 22 per cent increase year over year, and that's without talking about that other dream list that you talked about – is that there was a 43 per cent increase in costs for the chief executive officer and the people that report to him. One line in there had an 80 per cent increase, which was the other management positions reporting directly to those above. So here you've got managers reporting to managers, and there's an 80 per cent increase there. Is that the result of having a bunch of vacant positions, or just how did that happen?

**Mr. Blais:** Well, in '05-06 our chief executive officer for the region left, so of course that would be recruitment costs in that particular line item. I will ask Jon Fetterly to provide a much more detailed response to that.

**Mr. Fetterly:** Thank you. I just want to clarify: are we discussing schedule 2 of the annual report in the financial statements?

**Mr. Herard:** Yes. Yes, that's it.

**Mr. Fetterly:** Okay. Taking a look at this, we certainly did increase our management component year over year. Comparatively to the 2005 fiscal year there was an increase of six FTEs, and obviously compensation increased as a result of that. I'm certain, of course, that there were compensation increases also associated with just general inflationary or general increases in compensation for that same management group as well.

**The Chair:** Thank you.
Mr. Bonko, followed by Mr. Cardinal.

**Mr. Bonko:** Thanks, Mr. Chairman. Given the problems with staffing levels and capacity, how prepared is the region for a large accident or epidemic?

**Mr. Blais:** Well, I think that's an excellent question. It's an area that we are working on very hard right now. We're playing catch-up, I guess I would say. Recently I hired a senior level position to head up that particular portfolio as well. As I mentioned earlier, we're in the process of recruiting a full-time medical officer of health, which is very, very important to achieving that strategic goal as well. Also, we are working with Capital health – we have, again, those relationships that we've developed – and their public health officers there, their leadership position, to adopt or transplant a lot of the things that they have already developed. So we're not trying to replicate anything.

***2:10***

I would think that in the last year and a half since I've been here we've come a long way. We also will be building up, probably putting in a few other people in that particular portfolio to be able to maintain some degree of continuity. It's not just ramping up; you've got to maintain it.

We also recently undertook an exercise: we did an evacuation of one of our floors. We are working with the regional emergency preparedness committee very effectively. We have representatives at all of those committees currently. I think that overall I would say that we're not where we want to be, but we're certainly a long way from where we were, say, a year and a half ago.

**Mr. Bonko:** Okay. In supplement to that: are there any systems in place with any other regions to assist Northern Lights in case of a serious accident that's beyond its means and control, or are you also partnering up with some of the industry as well?

**Mr. Blais:** Well, I can say that there is and that we deal with serious accidents all the time, as you can appreciate, in a region like ours. I can ask Valetta to give you how those things are handled typically from an on-the-ground perspective.

**Ms Lawrence:** Thank you, Mr. Chair. In Fort McMurray there are several industry partners that have emergency personnel, and we have a mutual aid agreement with all of those. So we certainly work in partnership with all of those people in the event of an emergency.
Thank you, Mr. Chair.

**Mr. Bonko:** But there were two parts to that: one was with the partners up there, the other was with the other regions.

**Mr. Blais:** Right. As it relates to our referral centre, there are very sophisticated systems in place if we need to refer someone. What do we call that again?

**Ms Lawrence:** The critical care line.

**Mr. Blais:** The critical care line. We have immediate access to their specialists at the other end, and if there's a requirement for us to medevac or send someone by air ambulance there, it works extremely well. We get incredible service from Capital health in that regard, especially when you're dealing with trauma or things that have to be done expeditiously. That system has been in place for quite a long time, and I must say that it works very well.

**Mr. Bonko:** On a small scale.

**Mr. Blais:** Well, for those kinds of cases that you referenced earlier. Also, as you know, we have been working on the development of a district trauma centre as well. That will, again, add another dimension of service to that level as well. I think that was recently announced, but we started working on that about a year ago.

**Mr. Bonko:** Thank you.

**The Chair:** Mr. Cardinal, please, followed by Mr. Chase.

**Mr. Cardinal:** Thank you very much. And thank you for your good, informative presentation. Also, as a northern MLA I would like to take a moment to thank you and your organization for all the good service you're providing. Between Aspen and your area, which I cover, I get very few complaints in health care. Lots of advice. We make changes as we go. They work very well.

I do have, though, one comment or concern, and it's in relation to the existing boundary of the health region. I know as the MLA for Athabasca-Wabasca then, which covered my boundary up to the Territories, I wasn't really in favour of setting up those boundaries as big as they are because it covered about one-third of Alberta and goes east and west. The reason I didn't really support it was, number one, there was no road network east and west; number two, generally people migrate north and south. The northwest area of that health region really had not too much in common with the people on the east side. I just wonder, as your population grows – maybe this is an unfair question because it's probably more a political question – do you think that it would be wise to look at a review of that boundary again? With a new minister now from Fort Vermilion maybe this is a good time to have a peek at it and see. Can we provide a better service by streamlining the operations and allowing boundaries to move north and south rather than east and west?

**Mr. Blais:** Well, I can give you part of that answer, and I guess I'll look for the political part from the board chair. I was recently, up until I came here, the Deputy Minister of Health and Social Services for Nunavut. Every community is isolated there. There are no roads. Somehow I managed 25 communities across 2.2 million square kilometres, twice the size of Ontario, and we had them divided into three basic regions. I thought it worked very well. We had very few doctors but lots of nurses, who provided all the care. So I think that sometimes boundaries are really artificial because, again, people want good service, and however we do that, it is important.

I mean, I can't comment on whether this region should be divided, but I can tell you that we have been very committed to east and west and have been improving services there as well. I don't see roads as being a boundary. Since I've been up in Nunavut, that type of obstacle, in my view, is . . .

**Mr. Cardinal:** They didn't have roads over there either, though. It's all by air, right?

**Mr. Blais:** No roads. No. It has, however, one of the highest disease prevalences. The poorest place in the country, yet somehow they have done things there that we could learn from on how to deliver services using other health providers. There are exceptional things that have been done there. Boundaries are not really a factor. It's about service delivery in community and how that's done.

Maybe I'll ask my board chair to respond to part 2 of that.

**Mr. Fitzner:** I must say that the correspondence I receive is that the challenging part of being in a governance role is to meet the expectations of the population. At the end of the day every community would like their own hospital. That's a fact. At the end of the day if it's your child that is about to be born, you want a specialist and access to that specialist. If you have a geographical area that covers approximately 15 per cent of the province and has maybe half a per cent of the population, what's realistic to deliver health services? Is a boundary change going to change that? Is a boundary change going to change those expectations? In fact, sometimes when you change a boundary, you create greater expectations.

Changing boundaries has been a political decision, but what I know – I came onto the board after the last boundary change had occurred – of the process is this. I sat down with the former board chair, who had been around for 10 years and was through that process. Quite an unusual thing happened. Government invited the board chairs and CEOs to make a recommendation. They said: we're going to make some boundary changes, and we want to reduce the number of health regions; would you like to provide input? In fact, they said: we want your input. That's a very unusual opportunity. The northwest region had the opportunity to choose to go with Peace, and they chose to go with Northern Lights. That was their choice. Now, at the end of the day did that represent the wishes of every single person in the community? I suspect that they said: well, let's wait and see. That was probably the general attitude: let's wait and see what happens.

Did going from 17 to nine make a difference in health delivery? It absolutely changes how you govern. Were there economies to be gained in administration and governance? All I can say is this: if I'm board chair of Capital health, I call a board meeting and everybody drives to my meeting. In Northern Lights you're gone from your office for two to three days, and you're flying on a charter airline. We spend more than a quarter of a million dollars just for board members to attend board meetings. Should that be revisited? Again, that becomes a political decision in the context of a whole bunch of other things. If we change health boundaries, then do we change other boundaries for other public services that are provided, like education? Do we change education districts, and do we change fire districts and the whole shooting match?

From the perspective of a health provider we react, and we will follow government's direction. If government decides tomorrow that there should be four health regions, then we will do our best to deliver what's best for the residents in that health region. But as it sits now, it took two years. It took two years for a board to amalgamate payroll and admin and HR and to make those systems work and take two health regions and turn them into one. If I was king of the world, I'd like them to have a couple of years to rest and then look at what makes the most sense going forward.

What changes? Technology. Technology is the place that we can make the playing field equal. We can do eye exams by distance now. What's the big cost? The big cost is where someone has to leave their home and travel to a major metropolitan area to get specialist care. If they have to make three or four pretrips and then they have the procedure done and they have to make two or three follow-up trips – and a flight from High Level to Edmonton can be $1,100, $1,200, $1,500 – now you're looking at $10,000 to get that health service. So if we can deliver it distance, then I don't think the geographical boundary of the health region really comes into play.

***2:20***

That's why Northern Lights was the first one to sign on to the electronic health record. That's why Northern Lights was the first one to come into RSHIP. That's why Northern Lights has to deliver on the technology side. Why? Because we have the smallest population and the largest boundary, and that's always going to be the case for the people in the north. It's a small population, large geographical area. We have to utilize technology. There's an investment in technology, but generally it's one time.

**The Chair:** Are you satisfied, Mr. Cardinal?

**Mr. Cardinal:** Absolutely.

**The Chair:** Okay.

Mr. Chase, please, followed by Mr. Johnston.

**Mr. Chase:** Thank you very much. I'm getting the strong feeling that the best we can do in two hours is get a very slight snapshot of the challenges faced by the regions. My questions have to do with environmental health concerns. On page 16 of the 2005-06 annual report it shows that a key strategy for the region is to

> protect our community from environmental health risks through education, environmental monitoring, regulatory compliance and enforcement in partnership with our key stakeholders.

However, one of the key so-called stakeholders or supporters is the Ministry of Environment, which receives less than a per cent of general revenue to provide the support necessary. My first question: what studies have been conducted into the long-term impact of industrial development such as tailing ponds, increased emissions, draws on and pollution of the Athabasca River on the health of residents in the region?

**Mr. Blais:** Mr. Chairman, I'll ask our board chair to respond to part of that, and I guess we'll go from there.

**Mr. Fitzner:** A couple of things. The CEO and I with a number of members of senior management and our physician group attended three AEUB hearings last year, in 2006, for the expansion. A typical application for an expansion is about 8,800 pages. Of those 8,800 pages approximately 8,650 pages have to do with the environmental impact and 150 have to do with the socioeconomic impact. It's my forecast after three AEUB hearings that that 150-page part on the socioeconomic will be a larger piece, and it won't be an 8,800-page submission. It'll probably be closer to 10,000. But the bulk of those AEUB hearings are dedicated to: what are the long-term impacts? Are there studies being done?

There were quite newsworthy results seen of cancers in the Fort Chipewyan area that appeared to be an anomaly for the statistical numbers of population involved, so Health and Wellness went up and took a look at that study and began to gather and then report on the data that they found. There appeared to be a dislocation from kind of the initial reporting to when we go in, roll up our sleeves, get at the data, what the data is telling us. There seemed to be a dislocation that the data didn't seem to support the initial reporting. Those reports are ongoing.

I have to say that from First Nations groups to environmental groups there continues to be an increased profile of the need to not only look at the things that we've done traditionally as far as looking at the environmental impact but to broaden that scope. The health

region gets invited to participate in a number of these forums. There are far more forums than even we participate in. There is an industry group, RIWG, that is, obviously, hand in hand in that piece.

Do I think it's enough? I don't know when we'll have all the answers. I honestly don't. This is mining on an unprecedented scale. The environmental standards were just raised by the federal government this past year. What impact that's going to have long-term and the impact on fish habitat for tailings ponds 20 years down the road: there are certainly forecast models.

The Department of Environment works with our people. Air monitoring: in 2006 this health region in conjunction with the Department of Environment closed the flue gas unit down for Syncrude for a period of time because of odours. There continue to be odours emanating from a pond that more recently the residents of Fort MacKay have complained about. We're very involved in that. As for the future studies, this health region aren't the front-line people on that piece, but we certainly are involved in the ongoing monitoring on a day-to-day basis.

**Mr. Chase:** Thank you. My sense is that though we've lost several forests to environmental reports, there doesn't seem to be any evidence of applying the brakes, so to speak. On page 4 of the 2006-07 annual report, which we just received, it shows that the region has a higher rate of death from respiratory disease than the rest of Alberta. Is there evidence that contradicts the research suggesting that unrestricted industrial development is the primary cause of the higher respiratory death rate?

**Mr. Blais:** I guess I'll take a stab at that. If you look at some of the issues that we face in our particular region, tobacco both in teens and adults is of a very high proportion. I would suggest to you, based on discussions we had with our acting chief medical officer of health, again at a meeting we had – we're just completing a community health needs assessment – that that would be pretty well a good explanation to that particular problem. Again, tobacco, diabetes, heart disease: they're all interrelated. That's my sense of it because the average age of our population is only 31.

We mentioned earlier that we were the first out the door to pass a no smoking bylaw, in '04-05. Now the municipality, I think, has just implemented a bylaw across the region, across the Fort McMurray area. We have been very big advocates of this particular issue because we know, again, that this is a preventable issue, as much as we can determine. I think our community health needs assessment, once we have all the results in, will demonstrate that to be true.

**The Chair:** Thank you very much.

Mr. Johnston, please, followed by Rick Miller.

**Mr. Johnston:** Thank you, Chair. My question is regarding the deficit elimination plan. In March 31 of last year it was approximately $4.4 million. As you're probably well aware, you have to have a plan under the Regional Health Authorities Act. Can you tell me what your plan is?

**Mr. Blais:** I'll just ask Jon Fetterly to respond to that question, please.

**Mr. Fetterly:** Thank you. Can I ask for clarification on the question with respect to the date that was referenced?

**Mr. Johnston:** Yeah. It was March 31, 2006.

**Mr. Fetterly:** For the year ended March 31, 2006, the Northern Lights health region had an accumulated deficit of $4.43 million. As per Alberta Health and Wellness, Alberta regulations, and the Alberta Regional Health Authorities Act the region is required to present a deficit elimination plan. The region worked with Alberta Health and Wellness in the submission of a deficit elimination plan late in 2006. Since that time, the funding announcement of February 2007 has served to alleviate our accumulated deficit at this point.

Thank you.

**Mr. Johnston:** That's my only question.

**The Chair:** Is that it, Mr. Johnston?

**Mr. Johnston:** That's it, yes.

**The Chair:** Thank you.

Mr. Miller, followed by Mr. Dunford.

**Mr. R. Miller:** Thank you, Mr. Chairman. I'd like to talk about sex. I thought we could lighten things up a little bit after all of the money talk. My colleague Mr. Cenaiko had talked about drug use, and of course lifestyle is a big factor, particularly in the Wood Buffalo area, I think, in terms of health usage. I note on page 4 of your '05-06 report that the rate of sexually transmitted infections is dramatically higher in your region than it is on average province-wide. It looks like almost twice the province-wide average in chlamydia, about two and a half times for gonorrhea, and hep B more than twice. So my question would be: what measures has the region put into place to attempt to reduce the rate of STIs?

*2:30*

**Mr. Blais:** Thank you. That's a different type of question, so I appreciate that change. I'll look to Valetta Lawrence to respond to that question. I haven't been there long enough to give you a good answer.

**Ms Lawrence:** Thank you. Fort McMurray is fortunate that it has one of only a few STI clinics in the province, and we are certainly focusing on and will be over the next year increasing focus on promotion/prevention to try and assist with some of those issues such as STIs.

Thank you, Mr. Chair.

**Mr. Blais:** I just want to add to that that we also have a very important strategic partnership with the two school boards, and that initiative hopefully will also take shape. We've already started a number of activities, and that will evolve over the next two to three years. It's one of our major areas of public health focus.

Thank you.

**Mr. R. Miller:** Thank you. Then as a supplemental I'm wondering whether or not you have set targets for those rates and what those targets would be set at.

**Mr. Blais:** I'll just ask Valetta to give you a response to that.

**Ms Lawrence:** Thank you. Mr. Chair, I don't have that information in front of me today, but I could provide that at a later date.

**Mr. R. Miller:** Thank you.

**The Chair:** Thank you.

Mr. Dunford, followed by David Eggen, please.

**Mr. Dunford:** Yes. Thank you. This shadow population has come up a number of times. I'd like to drill into it just with one question. How does the funding actually work for a shadow person? How does it fit the formula? I don't even know what the formula is, by the way, but how does it fit in?

**Mr. Blais:** I'll ask our board chair to provide a response to that, and if we need to, we can ask our finance people as well.

**Mr. Fitzner:** We have a fairly public statement or set of statements on that at the EUB hearings. I've been through it a few times, so I understand it pretty well. From the aspect that the funding formula historically has been based on postal code, if you live in one region and work in another, your funding goes to where your postal code is, so typically anybody living in a camp would not be part of the global funding formula. However, if they show up at the health centre for any type of treatment, then there would be a charge back to that region. Theoretically, it should kind of righten the ship if you've got that.

The problem is that in most cases some of the challenges are that the family doctor that knows the history of this patient is in another region, so it's a high-risk patient that shows up every time. You've got absolutely no background. You've got to diagnose them in a cubicle in an ER room that's got 66,000 people going through it, which is a patient every seven minutes, and you've got to treat them with no background or history. So it's highly stressful for the physicians that are providing it.

The other piece is that you have to have the capacity. So when that person does get sick, you're not funded for them, but you need to have the capacity. We have 80,000 people in the region. We may only be funded for 52,000, but we have to have the capacity for 80,000. If there is a major emergency, we have to have the capacity and be able to respond to 80,000 regardless of where their funding occurs.

So from that aspect, not having the medical background, again, if they're from Alberta, the electronic health record is a huge initiative because then we can access that and look at the tool that you provide the doctor that's seeing this patient for the first time. Again, if a patient comes in unconscious, you don't know if they're diabetic. You don't know if they've got allergies to certain drugs. So you can imagine the high-risk nature that you're dealing with in serious health issues where the patient can't talk to you.

Can you imagine if 20 per cent of your population was shadow? That's the reality that exists in Northern Lights. In fact, we saw that 27 per cent of our patients last year were out of the region. Can you imagine if in a community of a million you had a shadow population of 200,000 living around the community, using your services but for which you aren't funded. That will continue to come to a community near you as this province's boom continues to extend throughout the province.

So those are some of the challenges presented by a shadow population.

**Mr. Dunford:** I can see where if the postal code started with a T, there would be a set of problems, but what happens if it starts with a V or a B?

**Mr. Fitzner:** That's an excellent question. I think the oil sands have generally felt that they have recruited from Alberta. The people that are going to Fort McMurray are either in Fort McMurray or have decided that they're not going to work in Fort McMurray, so the recruitment has extended to other provinces.

We have oil sands sites that have built their own airstrips. In fact, in one case, just one airstrip alone, if it were a commercial airline, would be the third-largest airline in Canada. So they're flying their workers in. A typical commute used to be the Edmonton, Calgary, Red Deer, Lethbridge corridor with Diversified buses travelling these highways. A typical commute now is that you work 10 days and you have four days off, and on Thursday at 6 o'clock you finish your shift, you get on a plane, and at 9 o'clock you're home in New Brunswick. They fly in 3,000 workers a week. So it's not only in Saskatchewan; a commute now is where companies are flying them from all over the country. We have workers now by the hundreds coming in from other countries as well.

Again, it becomes more complex. You have to have the capacity, but the global funding doesn't recognize the shadow population. From the province's perspective how many times do you fund a patient? If we're funding them in Calgary, do we also fund them if they're working in Fort McMurray? You can imagine the complexity that it has for a global formula. How many times do you fund that worker?

**Mr. Dunford:** Thank you.

**The Chair:** Thank you.

David Eggen, please, followed by Ivan Strang.

**Mr. Eggen:** Well, thanks, Mr. Chair. I realize that given that Northern Lights' average age of population is 31, still there are people in senior care facilities. My question, that I had already asked this morning and I'd like to ask you now, is in regard to making corrections in the deficiencies that were identified by the Auditor General's report last year. From page 191 there were a range of problems that were identified, and I just would like to ask what Northern Lights has been doing to answer those questions and measure how successful the steps that you've taken have been to improve seniors' care in Northern Lights.

**Mr. Blais:** Thank you for that question. Again, I appreciate it. At my age I'm really interested in that particular topic. So I will ask Madge Applin, our vice-president west, to provide that response. We've done a lot of measures, and I think that it's good news from our perspective.

**Ms Applin:** Thank you, Mr. Chair. I don't have page 191 to refer to, but let me just say that Northern Lights, both in Fort McMurray and on the west side of the region, certainly has been working with Alberta Health and Wellness to put the tools and processes and training in place to be fully compliant with the new continuing care standards for the province.

In addition, certainly the region has conducted internal audits of its two long-term care facilities and has implemented strategies to address any deficits identified in those internal audits. In addition to that, the region is working with its partners to ensure that clients who get services in supportive living facilities indeed have services that are compliant with the new standards.

**Mr. Blais:** I just wanted to add to that aspect as well that recently we've also with our partners at Capital health been very fortunate to retain on a part-time basis a geriatrician, who just last week was on the west side providing that level of service, which is something we have not had historically. So we're again continuing to work with our partners to bring expertise that simply wasn't there before.

Thank you, Mr. Chair.

**Mr. Eggen:** Excellent. Just further to that, I was curious if you

might comment on Northern Lights' participation in this province-wide trend to move from long-term care to daily assisted living types of beds and whether or not in the process of increasing daily assisted living places – we should call them that really – are you cutting long-term care beds at the same time?

*2:40*

**Mr. Blais:** Well, I'll ask Madge to answer that second piece of it. As we explained earlier, we have an overflow currently on our acute-care beds, so everything we do is in the hope of trying to reduce the overflow that currently exists. Of course, that becomes an important direction for us as well.

Madge, do you want to answer that second part of the question?

**Ms Applin:** Thank you, Mr. Chair. Certainly, the Northern Lights health region is moving forward with continuing care services and programs that reflect the new continuing care framework for the province. Part of that is to conduct regular assessments, using new assessment tools, of all residents who require continuing care services to determine the appropriate level: whether the care can be provided through home-care services in the home, whether clients require services in a lodge or a supportive-living facility. We have a centralized assessment process in place whereby the determination is made as to where a client should be appropriately placed, and the client then is placed appropriately. We are right now going through an assessment process of all of the residents in all of our continuing care facilities. We do anticipate that there will be some reallocation, some shifting of residents from existing accommodation to alternate accommodation, but that's a process that is in place and progressive.

**Mr. Blais:** I just want to mention the fact, as I referenced earlier, that the expansion of home-care services is really pivotal or essential to achieving that goal, and over the next three years that is one of our key objectives as well.

**Mr. Eggen:** Yeah. I certainly do recognize that. I just don't necessarily follow the logic that if you create more home care, you cut long-term care. The two don't have to match up, right?

Thanks a lot.

**The Chair:** Mr. Strang, please, followed by Mr. Bonko.

**Mr. Strang:** Thanks, Mr. Chairman, and I must compliment your group there from Northern Lights. You've done an excellent job of answering questions.

I want to throw a twist at you to look at the aspect of what we should be doing. I really appreciate what you've all said. It gives us a lot better insight into a lot of it. You talked about shadow population, and as I look at your goal 1, it's promoting a healthier lifestyle. When you look at the lifestyle that those people have, I mean, all they do is work and sleep. The big thing is, you know, what kind of a lifestyle they have, but it affects the health care system, whether it's in your region or whatever region they come from. I'm just wondering how you profess to move forward so that you can give us ammunition so that we can help you on the side of the shadow population.

I guess my supplemental to that is: is your regional health authority working with the private sector to ensure that an effective workplace safety culture exists?

**Mr. Blais:** I'll ask our board chair to provide part of the answer, and I will answer part of it as well since I have been very much involved in the questions that you've asked as well. I think we can provide some pretty good direction in terms of what we're looking at right now.

Jeff.

**Mr. Fitzner:** Sure. First of all, I think it should be understood that the oil sands participants don't want to be in the camp business. They don't want to be in the housing business. What has precipitated that has been a kind of a pent-up shortage on the supply side of homes. As land is being released by the province, that will go a long way to solve that issue. As people can buy homes, then with a 74 per cent increase in new housing starts, that begins to address that. Companies won't provide camps if their employees can find homes. In fact, in a land release that occurred in 2006 – it's parcel D – 40 per cent of those lots will be purchased by one oil sands operator to provide housing for all of their workers that are going to be the permanent ones. So if there is access to housing, the camp issue begins to become less and less and less of an issue. Because there is a backlog, oil sands in order to achieve their outcomes had to provide temporary housing.

The other piece we should understand is that we've taken many tours through the new camp facilities that these oil sands operators are utilizing, and they get it, too. These camps have a lot of things to keep people occupied and to provide quality time when you're separated from your family. The reality is that there's a quality of life that just gets lost there, but for the period between when they finish a shift and when they go back to a shift, what can we do? From having computer labs and movie lounges and pool things and tournament ladders for those kinds of recreational activities, those kinds of things are the improvement in camps. The quality of camps themselves and the alternative kind of waking hour activities is increasing from that perspective.

The other piece is that the private sector has more than, I guess, been proactive in contacting the health region – and Bernie can speak to those kinds of issues – on what we can do for our workers. Everything from the treatment side: let's get them treated on-site so they don't have to lose the productivity of leaving the community or driving into Fort McMurray because these things are becoming progressively further out, the newer ones. So what we can do so that we can treat our own people on-site and not have them show up at your facility is another piece. As these oil sands sites move further out, then those issues become more and more critical.

**Mr. Blais:** I have to say that, again, in the year and a half I've been there, I have found working with the energy sector extremely easy, that we've been at them, asking them if they will sit down with us, and that's not been a problem.

In September 2006 we made a presentation to the rig board in Calgary, all 26 companies, identifying what our challenges were and what their challenges were to look at how we could work together to improve the health of the people working in their camps and at the same time how we can achieve a public health goal or strategy that would be significantly improved. I'm very pleased to say that based on that, we have what we call a subcommittee of that board – Valetta is the lead on that – and we have met quite frequently to look at those opportunities.

In talking I think two weeks ago to Petro-Canada, the health sector is not a safe environment, by the way, for workers. They probably have the highest rate of incident of any industry in the world. The energy sector has a very good record of accident prevention and safety, so one of the questions was: is there the ability to use your knowledge on how we might transplant that into our health system? In other words, they are better at that than we are. That's a fact. Just to give you an example of the opportunity on the public health

side as well, looking at how we can address influenza outbreaks and things like that, we're working on those initiatives currently.

Thank you.

**The Chair:** Thank you.

Mr. Bonko, followed by Heather Forsyth, please.

**Mr. Bonko:** Thanks, Mr. Chairman. On page 29 of your annual report 2005-06 the report states that "Northern Lights Regional Health Foundation through a formal capital campaign has undertaken to raise $3.5 million" for an MRI for the region. Did the region request funding for an MRI from the ministry and was denied?

**Mr. Blais:** Thank you for that question. The Premier, I believe, in 2005 announced $2 million in funding to help construct and provide training for all of our radiologists and technical staff. Subsequently, we undertook to raise $3.5 million for the balance of that. Last night we officially opened the MRI, but it actually opened July 3. So far we have see about 400 patients, I believe; 400 people have been through our MRI scan.

Now, the thing that you have to keep in mind is that fundraising was expected to be a two-year initiative, and it actually took us seven months to raise that funding. So it's actually open today. But $2 million of that came from the government.

***2:50***

**Mr. Bonko:** Okay. I'm just wondering if the ministry provided the region what was considered essential health equipment and what should be paid through fundraising. Did they kind of give you those lines?

**Mr. Blais:** Maybe I'll ask our board chair. I wasn't there at the time, but I was glad to inherit this problem. It was really one of those things that you want to be involved in. So, Jeff.

**Mr. Fitzner:** To be honest, there are health people that know the precise number. Typically before you put an MRI in, you have a certain population base. Wood Buffalo municipality doesn't meet that population base. So guess what? The industry said: "You know what? If our guys have to go to Edmonton to get an MRI and they have to wait seven or eight months, there is a productivity loss that's significant." So you know what? The province is giving you $2 million worth of seed funding. Would the province have paid all of it over time? Quite possibly. But the community said: "Let's put up the balance. Because you know what? It's in our favour if our workers don't have to be gone for three days. Let's start measuring the cost of productivity loss. Let's start measuring the cost to families if dad isn't earning an income and those types of things."

I've got to tell you, we had a corporate lead donor, and then we had another donor that said: we're not going to be the corporate lead donor, but can we donate a quarter of a million dollars to it anyway even if we're not going to, you know, have our name attached to it, or we're not going to be recognized like that? I mean, that's the kind of commitment. Then the executive vice-president of Suncor, who's now the president of Suncor, Steven Williams, said: "Look. If health is having a bad day, we're all having a bad day." He said: "When we go to recruit around the country and other places, the first thing they ask is, what are the health services? So tell us what you need, and we'll assist you with that." So they've assisted on seconding staff to the health region.

**Mr. Bonko:** We're getting away from the actual question. The question was: was it defined as to what was essential and what should have been filled through fundraising for the health component?

**Mr. Fitzner:** For the MRI we wouldn't typically have a population base to support the, you know, traditional funding of an MRI, so the community picked up the difference there.

**Mr. Bonko:** So you're saying that was clearly defined by the province as to what was and what was not going to be covered and should be funded.

**The Chair:** Mr. Bonko, that's your fourth attempt at that question. There are four other individuals, in light of the time that we have, that have indicated to the vice-chair that they would like to ask a question, so we're going to conclude that exchange if you don't mind. However, I did find it quite interesting.

Mr. Blais, in the time that we have left, it has been a practice of this committee that if the members still have questions as the time expires, they will read them into the record, and we expect you to provide an answer, again, to all members through the clerk. So we will start by reading our questions into the record, please, and we'll start with Heather Forsyth.

**Mrs. Forsyth:** Thanks again. I'm going to start off by again encouraging you on that global funding question I asked and starting work on the medical services because, truly, I think it will benefit you more in the long run when I've listened to the conversation where Jeff even spoke about the shadow population that they're trying to provide services for. As chair of the safer communities task force it's one of the things that we've heard, and we've had lots of reports come in front of us, including the northern development, that talked about the shadow population. Everything that I've read and everyone that I've talked to: no one has given solid recommendations on how to deal with the shadow population. You know, you talked about the postal codes. I guess my question is – it would be really beneficial to government and to yourselves – how do you fund the shadow population? Because postal codes isn't working.

My other question is: when you talk about the industry expansion and development and about the huge billions of dollars that are coming into your area and the corporations that are using this shadow population, what are they giving back to address this? I think there's a huge gap. That's more of a statement than anything.

**The Chair:** Thank you very much.

Mr. Chase, please.

**Mr. Chase:** Thank you very much. Dr. John O'Connor, despite harassment from both the federal and provincial governments, raised a chronic diseases regional anomaly alarm. On page 4 of the 2006-07 annual report it shows that mortality rates from heart disease and cancer are higher than the provincial average. Short of a smoking ban in public places and a traditional awareness program, what is the region doing to address chronic illnesses in your region?

Secondly, how is the region addressing the basic health and nutrition of rural residents, including First Nations and Métis, who have had to abandon traditional hunting/gathering due to high levels of pollution and development?

Thank you.

**The Chair:** Thank you very much.

**Mr. Dunford:** My interest is the impact that the SuperNet is having

in rural Alberta. I would like to know, during the period that we are here to analyze, '05-06 and '06-07, what impact the communities hooked to the SuperNet had on your ability to deliver health care services.

**The Chair:** Thank you.
Mr. Miller, followed by Mr. Bonko.

**Mr. R. Miller:** Thank you, Mr. Chairman. Regarding electronic health records page 9 of your '05-06 annual report shows the participation in the nonmetro common health information system, the picture archival communications system, and the provincial electronic health record project. My questions are: have any of these services been contracted out to foreign-owned companies? Then the supplementary: if so, could you provide us with the names and the amount paid to each company that was contracted for those services?

**The Chair:** Thank you.
Now Mr. Bonko.

**Mr. Bonko:** Thanks, Mr. Chairman. Just with mental health page 9 in your 2005-06 annual report states that funding was approved for a three-year project for Health and Wellness under the regional mental health plan. How successful was the rate of the outcome of the project? The other is: how are mental health programs tailored to the mental health issues of the transient population, or that shadow population?

**The Chair:** Thank you.
Are there any other members with questions? Seeing none, this concludes this portion of our meeting. I would like on behalf of the committee to thank the members from Northern Lights regional health authority for their time this afternoon and their patience. We appreciate it. And good luck with all your endeavours in administering your programs.
Now, item 7, Other Business. Is there any other business at this time that the committee would like to discuss?
I would like to note that the clerk has circulated information that was provided to us by the Auditor General, and that is in reference to our meeting tomorrow. Again, tomorrow morning we are meeting at 10 o'clock with the Capital health authority and then in the afternoon at 1 o'clock we will be meeting with the Calgary regional health authority.
May I please have a motion to adjourn? A motion to adjourn by Heather Forsyth. All those in favour?

**Hon. Members:** Agreed.

**The Chair:** None opposed. Thank you.
I would also at this time before we adjourn let everyone know that you can leave your material here if you would like. The room will be locked, I'm told by Corinne.
Thank you.

[The committee adjourned at 2:58 p.m.]