Legislative Assembly of Alberta

The 27th Legislature
Fifth Session

Standing Committee
on
Public Accounts

Health Quality Council of Alberta

Wednesday, February 15, 2012
8:30 a.m.

Transcript No. 27-5-2

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John Cowell	Chief Executive Officer
Frans Heynen	Acting Controller
Charlene McBrien-Morrison	Executive Director
Patricia Pelton	Council Member

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Transcript produced by *Alberta Hansard*

8:30 a.m. Wednesday, February 15, 2012

[Mr. MacDonald in the chair]

The Chair: Good morning, everyone. My name is Hugh MacDonald, and I would like to welcome everyone to the Standing Committee on Public Accounts this morning.

Please note that this meeting is recorded by *Hansard,* and the audio is streamed live on the Internet.

We will now, as we usually do, quickly introduce ourselves.

Mr. Goudreau: Good morning. Hector Goudreau, MLA, Dunvegan-Central Peace.

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

Mr. Fawcett: Kyle Fawcett, MLA, Calgary-North Hill.

Mr. Vandermeer: Tony Vandermeer, Edmonton-Beverly-Clareview.

Mr. Kang: Good morning, everyone. Darshan Kang, MLA, Calgary-McCall.

Mr. Chase: Good morning. Harry Chase, the former teacher of two of Frans' children.

Ms Pelton: Patricia Pelton, council member, Health Quality Council of Alberta.

Dr. Tyrrell: Lorne Tyrrell, chair of the Health Quality Council of Alberta.

Dr. Cowell: John Cowell, CEO, Health Quality Council of Alberta.

Ms McBrien-Morrison: Charlene McBrien-Morrison, executive director, Health Quality Council of Alberta.

Mr. Heynen: Frans Heynen, acting controller, Health Quality Council.

Mr. Wylie: Doug Wylie with the office of the Auditor General.

Mr. Ryan: Ed Ryan, Assistant Auditor General.

Ms Dawson: Mary-Jane Dawson with the office of the Auditor General.

Mr. Sandhu: Good morning, everyone. Peter Sandhu, MLA, Edmonton-Manning.

Mr. Allred: Ken Allred, St. Albert.

Ms Woo-Paw: Good morning. Teresa Woo-Paw, Calgary-Mackay.

Mrs. Forsyth: I am Heather Forsyth, Calgary-Fish Creek.

Ms Bianchi: Giovana Bianchi, committee clerk, Legislative Assembly Office.

The Chair: Thank you.

May I have approval, please, of the agenda that was circulated? Moved by Mr. Sandhu that the agenda for the February 15, 2012, meeting be approved. All in favour? Thank you very much.

Now if I could please have approval of the minutes from the February 8, 2012, meeting as circulated. Moved by Mr. Chase that the minutes of the February 8, 2012, Standing Committee on Public Accounts be approved as distributed. All in favour? Thank you very much.

This comes to our next item on the agenda, which is our meeting today with the Health Quality Council of Alberta. We will be dealing with the following reports: the annual report of the Health Quality Council of Alberta 2010; the annual report of Alberta Health and Wellness 2010-11; reports of the Auditor General from 2011, both the April and November editions; and the annual report of the government of Alberta 2010-11, the consolidated financial statements and, of course, the Measuring Up document.

I would like to remind everyone of the briefing material that was prepared for us by LAO research staff, and I would like to thank them again for that.

Now, Dr. Tyrrell, if you would like to make a brief 10-minute opening statement on behalf of the Health Quality Council of Alberta, please proceed, sir.

Dr. Tyrrell: Thank you very much. I'm pleased to be here. We thank you for the invitation to come and meet with your committee. I want to begin by just saying that I have been with the Health Quality Council since 2006 when it was first established under the regional health act, and we were originally one of the regions under that act. We have seen a change in our Health Quality Council and the new act that was enacted on February 1, and we're pleased to see that change.

I would say that it has been a very interesting and enjoyable position I've had as chair of the Health Quality Council, to see the evolution of the Health Quality Council over the years since it was first established. We have really worked hard to see the growth of our organization in our mandates in measuring, monitoring, and focusing on safety and quality of the health care system in the province.

We have carried out a number of investigations at the request of either the regional health authorities or the government and through sections 13 and 14 of our act, and I think that we have established a credibility over that period of time that has been very important. As you point out, in this report we have a small budget relative to the health budget of the province of Alberta, and I think that we in many ways have punched above our weight in the importance of the Health Quality Council to the health system in the province. I think that we've just seen a continual growth in the activities and in the impact of the work we do.

I have asked that my vice-chair speak briefly to the Health Quality Council as well and to her experience on it, and our CEO, John Cowell, will take a few minutes, too.

Ms Pelton: Thanks very much, Dr. Tyrrell.

I'm also very pleased to be here. I'm Patricia Pelton. I have been involved with the Health Quality Council on the board for three years and in my previous role as CEO of Northern Lights health region was part of the founding support for the Health Quality Council, recognizing the need for such a body. There has been some great work accomplished and, as Lorne said, really, so many accomplishments given such a relatively small budget. I've been very pleased to be a part of it. Is there more we can do? I'm sure there is more that we can do, and we're really looking forward to this change with the new act that's coming into effect.

One of the pieces that I'm quite involved with is the establishment under the patient safety framework of the Patient/Family Safety Advisory Panel. This is where we hope and feel that we will get excellent contribution from the citizens of Alberta regarding our complete health system and feedback in areas of where to concentrate and focus in looking to delve further and, hopefully, see some improvement from a citizen's perspective. The panel has really got its legs under it now. We've gone through

a formal process of appointment on a staggered three-year term and are really excited about getting it going. Later on if there are any questions, I'd be pleased to answer any.

Thank you. I'll turn it over to John.

Dr. Cowell: Thank you, Patricia and Lorne.

I started out back in '02, coming out of semi-retirement to work with Bonnie Laing. She was, really, the originating chair, as some of you may remember. We were originally a ministerial committee called, very awkwardly, the Health Services Utilization and Outcomes Commission. We needed to shorten that name. It was kind of a big mouthful. Really, it was just Bonnie and me in a room trying to figure out what would the future look like. We had a wonderful original sort of advisory council that guided us to knowing that we needed to do things like the health services satisfaction survey and speak to Albertans through the Alberta report, a report to Albertans.

It was in that era that we realized that the point of view that we needed to take was that of the citizens. There was lots of representation for the professions. There was representation for the system from government. But who could sort of have a look at what the citizens were feeling and experiencing and translate that into meaningful information that could be used for policy-makers? In our annual report you will see this virtuous wheel. I have left some extra copies for you that you can have, if you wish, just to see the kind of model that we follow as we try to interface with the citizenry.

It's, of course, a dream come true for us that we went from a ministerial committee through, as Lorne was pointing out, a provincial health board under the Regional Health Authorities Act to now with our own legislative home. That has been a 10-year journey, and we're feeling quite pleased about that.

The only other aspect of our work that I would point out is that in '06 we were given additional responsibilities to conduct health system reviews. You know, we've published a number of these. We're up to about 14 now. The last major one that we published was the systematic review on H1N1, the provincial response, and the medevac situation here in Edmonton. So you can see that it's quite eclectic the kind of things that we tackle. Then, of course, we're on the verge of releasing the report on emergency services, cancer care, and physician advocacy.

8:40

We think our way through, I would say, virtually all of our problems through the Alberta matrix for health. Again, I've left you some extra copies. This model for thinking around quality is something that we've been relentlessly introducing into the province since 2004. You'll likely have some questions on that because your good research folk discovered this and put it into your briefing papers, which I'm delighted to see. This framework for thinking is really becoming enculturated throughout Alberta, and I'm happy to say that it's being picked up widely across the country, and we're now getting some international recognition for it.

That's all I'll say at this point. Thank you.

The Chair: Thank you very much.

Mr. Ryan or Mr. Wylie from the office of the Auditor General, have you got anything?

Mr. Wylie: I'll be very brief, Mr. Chair. As auditor of the Health Quality Council of Alberta we are pleased to note that we issued an unqualified auditor's opinion on the 2011 financial statements of the council, and that's indicated on page 54 of our 2011 annual report.

On page 109 of the same report we discuss our reason for deciding not to perform an audit on Alberta's pandemic response. We indicate that we made this decision because we reviewed the council's report of their work and the documentation and supporting findings and concluded that an audit by our office would likely not lead to additional recommendations.

We also discuss the lessons in the council's report that could be applied to other emergencies that government departments prepare for. Mr. Ryan is here today, and he'd be pleased to answer any questions with respect to that.

We also note that we have no new recommendations to the council, and there are no outstanding recommendations to the council. Thank you.

The Chair: Thank you very much, Mr. Wylie.

We'll now proceed to questions from members. I would encourage members that if you do have questions, let the chair know. We'll start with Mr. Chase, followed by Mr. Fawcett, please.

Mr. Chase: Thank you, Mr. Chair. In the name of improved transparency and accountability I had hoped that the Health Quality Council of Alberta's review would have served as the basis for a judge-led public inquiry into health prior to the election, as promised in the Premier's leadership campaign. That isn't going to happen.

Under salaries and benefits, according to page 205 of the Health and Wellness 2010-11 annual report, Chief Executive Officer Dr. John Cowell received $450,000 in base salary in 2011. Please qualify a salary that amounts to more than 10 per cent of the Health Quality Council of Alberta's total expenses last year.

Dr. Tyrrell: Thank you. I can speak to that, and I'll let John speak to it as well. Dr. Cowell's salary is reviewed on an annual basis by me. I would point out that his salary includes all benefits. It is not simply a salary; that figure you see includes all of his benefits. He pays his own health care. He pays his own pension out of that salary. There is no supplementary pension. As we've seen with some CEOs as well, it is purely done on that basis. When we did a comparison of salaries of Dr. Cowell and his qualifications, he is mid-range or in a lower range than most of our CEOs within regional health authorities.

He is also well within the lower range of the alternate funding plan. The alternate funding plan pays physicians who have fellowship qualifications. If you look at the alternate funding plan payments, which all of those people enjoy in addition to their salaries, the benefits, Dr. Cowell had been paid through his professional corporation, and he covers all of those costs. So although that salary may appear large to somebody looking at it casually, when you examine it in depth, it is not outside the range of the qualifications and the expectations of this position and the fact that he covers all of his other ancillary expenses.

Mr. Chase: Thank you. I suppose if you compared it to Jack Davis's millions of dollars of severance and then a $21,000 pension for the rest of his life, it may seem like a small amount, but I think for most individuals on the street it seems rather large.

Page 205 of that same report also indicates Dr. Cowell was paid $35,000 in other cash benefits. Was this overtime pay, bonuses, honoraria? How does that extra money get accounted?

Dr. Tyrrell: We have a small variable pay component that has never been above 10 per cent for any employees within the Health Quality Council, so what we have in fact arranged this year was from 2 per cent to 7 per cent in our variable pay bonuses.

Mr. Chase: Where do I apply?

The Chair: Thank you.

Mr. Fawcett, please, followed by Mr. Kang.

Mr. Fawcett: Thank you very much, Mr. Chair. I want to stay on the same topic regarding salaries. I believe that on page 205 of the Health and Wellness 2010-11 annual report there are details of salaries and benefits as referred to by the member from Calgary-Varsity. The Health Quality Council also lists remuneration for board members. Can you explain this, the remuneration schedule for board members? I see that there is some discrepancy between how much different board members make.

Dr. Tyrrell: Yes, I can explain that. There is a little more honorarium for each meeting attended by the chair of the board, so I have had the largest remuneration. It has ranged in the order of $20,000 per year. Given the responsibility of this board and the activities that we carry out, I think that has been a very reasonable, relatively low remuneration compared to many boards that we look at.

The attendance at meetings and attendance of subcommittees: I also am on the executive committee, I'm on the research and surveys committee, and I have also served on the audit committee recently. Given the meetings that I attend and the work as the chair of this board, I have not charged for many of the things that I do gratis in preparation for meetings, et cetera. It has all been done gratis. I think that when you look at this board and the responsibility of this board, my remuneration, which is the highest at around $20,000, has been very reasonable.

I would just point out that for the other people if you look at the number of meetings they attend or committees they sit on, that accounts for some of the variability. I would let Patricia speak to hers. I think you're in the next most . . .

Ms Pelton: Sure. Thanks for the question. Both Doug Tupper and I actually ended up at the same place in terms of compensation. I'll speak for myself. I'm the chair of the patient safety committee. I also sit on the patient safety network as the board representative for the Health Quality Council, and I sit on audit and finance, and I joined Dr. Tyrrell on the executive committee. Yeah, I would agree. I think it's a bargain-basement price given the amount of hours that we put into it from an executive perspective.

Thanks.

Mr. Fawcett: Thank you. I appreciate the answer.

My supplemental, Mr. Chair. On the same page it indicates that $30,000 was spent on severance costs in 2010-11. Why were these costs paid out?

Dr. Cowell: I can answer that. We have had a very successful recruiting and retaining history with fine individuals, but we did have one individual who did not work out. We did not want to dismiss for cause, so we sought and received good legal and human resources advice as to the correct approach to sever that individual. That was the severance that was paid to them.

The Chair: Thank you very much.

We would also like to welcome the hon. Member for Edmonton-McClung, Mr. Xiao, to the meeting this morning. Good morning, sir.

Mr. Kang, please, followed by Ms Woo-Paw.

8:50

Mr. Kang: Thank you, Mr. Chair. This is regarding the review of the quality of care and safety of patients requiring access to emergency department care and cancer surgery and the role and process of physician advocacy. As page 2 of its 2010 annual review indicates, the Health Quality Council's province-wide review of emergency department care, cancer surgery, and physician intimidation were the most significant of new challenges taken on by the council in 2010-11. Initiating its own terms of reference is said to have reinforced the Health Quality Council's "independence and commitment to transparency throughout the review process." My question is: how independent and transparent can this review have been given that the quality assurance committee that conducted it was appointed by Health Quality Council of Alberta members, members themselves appointed by the very ministry under review?

Dr. Cowell: This review was initiated by the hon. Gene Zwozdesky through a letter to the chair, who will undoubtedly speak to it. In that letter something was new that we had not experienced before. This letter asked us to conduct this review under section 13 of our regulation, which briefly states that the minister can direct the Health Quality Council to conduct a review or a study of an issue.

In the past when we got such a directive, we worked out those terms of reference for those reviews either with the minister's office or with the department. In this case we were not required to do that. We were actually given the independence to set up our own terms of reference for this review. This was precedent setting for us, that we unilaterally set up our own terms of reference. We did so, and we elected to conduct this review under section 9 of the Alberta Evidence Act, which is very clear. It gives evidentiary protection to those who participate in a quality assurance review. It is a very precious piece of legislation. In our minds we think of it as almost the highest form of whistle-blower protection you could possibly want to have. So that means that all the information, the conversations and the testimony, that we received is protected under this particular legislation.

In order to do this absolutely correctly – we are one of two institutions in the province that can actually do this, the other being Alberta Health Services – we very carefully constructed our whole process under the quality assurance provisions of the Evidence Act. It meant that we set up independent quality assurance committees and made sure that all of these committees were talking to each other. There's absolutely no trail back through that to, for example, any government official. So there are all kinds of degrees of separation as we set up and proceeded with this review.

Dr. Tyrrell: I would just point out that this is the first review where I felt it was necessary that we set up an advisory committee. Part of the reason was that I was the dean of medicine at the University of Alberta from 1994 to 2004. As the dean I was asked to come back and testify under the QA, so I have eliminated myself from the QA process in this particular example.

We have an advisory committee that was set up, and that includes Dr. Lakhani, the former chair of the board of the police here in Edmonton and a well-respected physician in the city; former Chief Justice Allan Wachowich; former Deputy Prime Minister Anne McLellan; former head of the B.C. Cancer Agency Simon Sutcliffe; and a businessman from southern Alberta very interested in health care, Art Price.

This advisory committee was set up to make sure that it is clearly independent and that these people give advice on this investigation. That's why it was set up, and I think that the response has been that it is a very good committee and quickly recognized the quality of that committee as an independent committee to give advice on this very sensitive and complex investigation.

Mr. Kang: My second question, sir: is the review open and transparent, and will we expect the report before the next election?

Dr. Tyrrell: You can expect a report before the next election. I don't know when the next election will be, but we have never changed our schedule on when the report would be made available, and I believe that report will be available next week.

Dr. Cowell: Yes. We've sent a strong signal that we're going to be releasing the report next week, the week of the 20th. The precise day will be announced this Friday as to which day next week we're going to be releasing it. It really is a matter of the workload. We want to be absolutely sure that we've got the finest report that we can produce. It has just been, without question, the biggest, most complex challenge a very small group of people have had to undertake. As Dr. Tyrrell pointed out, we've had a number of external advisers. It's just a matter of getting this job done correctly.

We now believe with complete surety that we can release it next week, and on Friday we're going to be announcing that date.

Mr. Kang: Given the track record of this government – they get the report, and then they tend to sit on it for months and years – you know, I just want to make sure that we get the report ASAP. Thank you.

Dr. Cowell: I would like to respond to that. There's absolutely no question that the report will be delivered to the minister of health and the public virtually simultaneously. We believe strongly in our independence on that, and I can assure you that we have not had any pressure to do otherwise.

Mr. Kang: Thank you.

The Chair: Thank you.

We're moving on now to Ms Woo-Paw, followed by Heather Forsyth.

Ms Woo-Paw: Thank you, Mr. Chair. Well, first of all, I'm very pleased that our province has this entity in place. In the introductory comments as well as in the report I think we can see that this entity has a relatively modest budget but is performing, I'm sure, very important work. I'd like to hear from you: in comparison to other jurisdictions how do we compare in terms of the nature of the work and the level of support for such an entity?

Dr. Cowell: We're the second-oldest quality council in the country. Saskatchewan beat us by maybe half a year. We're the most recent in terms of getting formal legislation. Different councils have had legislation earlier in their paths, and some still don't have it. We're one of the seniors, if you will, in this. We have unique reviewing powers, unlike others, although they are rapidly emulating some of the work we're doing. We're very pleased to see that. But we're pioneering that whole process of how to do reviews that don't take on some of the intensity of public inquiries although, as you know, in our new act we do have that new power, and it'll be extremely interesting to us to learn how to execute that wisely.

In terms of funding I'm just going to hand it off to Charlene because she has actually done the research on comparative funding.

Ms McBrien-Morrison: Thank you, John. As part of our own council's and now board's duties to see how we do compare to other organizations, we did present this to our board just within the past six months. The B.C. Patient Safety & Quality Council does similar quality and safety improvement initiatives. Educational initiatives have just begun, as John said, on the investigation side. They will fund research as well. Their '11-12 budget was approximately $6 million.

The Health Quality Council in Saskatchewan: again, very similar to us. They do have the authority to do investigations at the request of the minister; however, to our knowledge they have not done one to date. Their budget is a $4.7 million operating budget, but then they get, if you like, restricted grants that total $7.3 million in the '10-11 budget.

The Manitoba Centre for Health Policy, which does similar measuring, monitoring, and reporting functions as us: their annual budget is $4.4 million.

Health Quality Ontario, which was recently formed and amalgamated various institutions under one umbrella: their budget for '11-12 was $43 million.

ICES in Ontario, I-C-E-S, which again has similar measuring, monitoring, and reporting functions: their budget was $10.4 million.

So that gives you a sense of how we compare across the country.

9:00

The Chair: Anything else at this time?

Ms Woo-Paw: Not right now, but put my name on the list again.

The Chair: Okay. Yes.

Mrs. Heather Forsyth, please.

Mrs. Forsyth: Thank you, and thank you, Dr. Tyrrell and Dr. Cowell and the rest of the board members, for coming. I guess where I'm struggling with this is the independence of the committee. I don't think anybody can criticize the work you've done. I had the opportunity of meeting with Dr. Cowell in December, when I had some issues in regard to the answers that Minister Horne gave in regard to the intimidation and bullying of health care professionals, and Dr. Cowell was kind enough, after I sent him a letter, to allow me to come before the committee.

I guess where I'm going with this – it talks about your job and its independence and what can be done. Your reports, while you do release fairly good reports – H1N1 is one; medevac is another – and you can make recommendations, the bigger question is that there is nothing that forces the government to implement the recommendations. So here we are on the eve of getting another report that everybody has been waiting for – and people are talking about having it before the election – but there are no rules or regulations or anything in the act that force the government to implement it.

I guess that when you have an independent body and you release a report – I mean, the medevac – I understand that. I think it was Minister Zwozdesky when we called you this week to find out about a letter that he had sent you. It really challenges the independence of the committee. I wonder if, you know, you have any comments on that. That's my first question.

Dr. Tyrrell: Well, I think it's an issue that we have struggled with from the point of view of public perception as well. We want to be seen – this is why we have insisted that our reports always be released to the public. We feel that we must report to the public as well. You know, the minister gets the reports but only at the same time as the public and not in any sort of major advance of the public. We've always insisted that the 14 reports would be made public because it is important that our reports are seen as trying to improve the quality and safety of the health care system.

We feel that we have a major responsibility to the public of Alberta, and that's why we want these reports, so that they can see what we're recommending. We have at times asked, you know, how these reports will be followed up on and how the recommendations will be followed up on. We've done some of that in conjunction with the auditor. This is the other area where you can see this. But let me assure you that if anything would compromise the independence of this organization, I no longer want to be here. I feel that we have to be seen and behave as: what is the best for the public? What is the best for the health care system?

I've dedicated my whole life to the health care system here in Alberta. In fact, 52 years at the University of Alberta now is half of the university's lifespan. I've been there working on educating students and trying to find ways to improve the health care system. Quite frankly, in many ways I'm very proud of what the health care system in Alberta has done. We are designed to look at what the problems are, but there are many, many things about the Canadian health care system and the Alberta health care system, in particular, that are extremely good.

Mrs. Forsyth: Thank you, Dr. Tyrrell. I don't think anybody is arguing about that.

I think that where the argument lies is in the independence of the Health Quality Council. You are mandated to improve health service quality and patient safety on a province-wide basis and to provide Albertans with an independent assessment. That is your mandate. What isn't mandated anywhere is the government's reaction to the recommendations that you are bringing forward. That goes to the medevac report that you released, and you had many recommendations in that medevac report. We were trying to find out, as the health critic and member of the Wildrose, what recommendations have been implemented, and we got stuck.

I don't think the criticism lies in the job you're doing. The criticism lies with the government not following through on the recommendations, and that goes to the Member for Calgary-Varsity in regard to the fact of a full judicial inquiry. At least, if you have a judge-led inquiry – I see members shaking their heads, so they have more of an opportunity to follow up on these questions – that forces the government to act on the recommendations.

Dr. Tyrrell: I think that it's a good question on how the follow-up on the recommendations is enacted. We have toyed with the idea that we go back and look at what has actually happened with our recommendations at a later point.

The Chair: We'll move on now, please, to Mr. Allred, followed by Mr. Chase.

Mr. Allred: Thank you, Mr. Chair. Thank you, Patricia and gentlemen, for your overview. I found that quite interesting. I agree that you've got a very modest budget, but certainly the work you do is some of the most important work that is being done in Alberta, particularly with some of the turmoil and controversy that we have with regard to our health care system. You've alluded to the fact that the Canadian system and the Alberta system certainly aren't perfect and that they need a lot of improvement.

I believe it was Peter Drucker who said that you can't manage what you can't measure. There's quite a good rundown on – what's it called? – the Alberta quality matrix for health in the research report, which I believe you have. I understand it's sometimes very difficult to get accurate information when you're doing surveys of the public or patients, and the concern is noted on the bottom of page 7. "Please note that the [Health Quality Council] publications appear not to indicate how 'easy' is defined." I wonder if you would just give us a little bit of an overview on the Alberta quality matrix for health: what the purpose of it is, how you obtain the information, and how you ensure that it's reasonably objective.

Dr. Tyrrell: Go ahead, John.

Dr. Cowell: The Alberta quality matrix for health was really created back in '04. When we began this quest on quality improvement in the health system, I personally returned from a semiretired position to be a contractor. I actually to this day remain a contractor. I'm not actually a, quote, employee of the quality council, and that's why I have an all-contained sort of fee, if you will. I came out of the General Electric system, the NOVA corporation, and I used to be at one point the CEO of workers' comp in the '90s, when we turned around a very disastrous organization into a high-performing organization. You know, the way that was achieved was understanding what quality meant and being able to set performance targets against that and then measure yourself against it.

In '04, when we began this conversation, it was astonishing to some of us how little the notion of quality was actually understood in a measurable way by people who were in the health system. They all kind of assumed that the other guy knew what they were talking about, but actually they didn't. There had been no consensus as to what the dimensions of quality were that actually would drive improvement.

One of the wonderful achievements early on when we also created the health quality network, which I think you've referenced, too, was to get people together in a very highly concentrated time frame and say: in Alberta, when we're talking to each other, what do we mean quality to be? That's how the six dimensions of acceptability, accessibility, appropriateness, effectiveness, efficiency, and safety were determined. Now, we didn't invent these – they were out there in the world – but what we did was that we chose them, and then we chose to define them in Alberta language. These definitions that are at the top are Alberta consensus language. At the bottom of this we also, if you'll notice, listed all the people that actually signed off and committed to it: the nine health regions, the Cancer Board at the time, the college, and so on. These organizations, in effect, committed themselves to these concepts.

9:10

We also believed that there was too much focus on the acute-care system. People were forgetting that there's a long-term care system, there's end-of-life in our health system, and there's prevention. That's why we had the vertical line of the areas of need, to make sure anyone in the quality improvement world realized that these six dimensions affected all aspects of the areas within the health system. It created a spreading effect, and in a way it created a placemat for people to think and to discuss.

Now, it was out of this matrix that we realized that we had to understand from the people's perspective what their experience and level of satisfaction with those domains of quality were. With our health services satisfaction and experience survey, which is a running movie, by the way, we're the only province that actually can tell you over time what the citizens are actually experiencing every couple of years in relationship to the services that they're receiving. In that survey we actually ask questions that get at the issue of: how acceptable was your health experience with the system? How accessible was it in terms of wait times and waiting and frustration around that? Was your care appropriate? Did it actually make sense to you that you got the kind of care you needed in relationship to the condition you had?

We've got to, to some degree, get at the effectiveness dimension, but it's hard to get at that because that's actually a scientific idea. Also, it's a little hard for us to get our deficiency, but we do get that. We have shown numerous times in our results how badly the system co-ordinates care and how undermined that is by the lack of an effective electronic health record system, for example. Finally, we get at the experience of safety. All of those dimensions are, to a large degree, learned from the patient experience. We then – and that's going a little bit beyond your question – cobble that together with data analysis, but I'll leave that part.

When you asked a very specific question about easy, that's a survey question. It was really trying to get at the question of when you're trying to get care, how hard or how easy was it for you to actually get that care in any particular environment, be it in a pharmacy or going to your family doctor or getting your surgery or getting your admission to a hospital.

Ms McBrien-Morrison: If I can add to that, John . . .

The Chair: We're going to move on, please.

Mr. Allred, do you have a second question?

Mr. Allred: Well, I do have a second question. I appreciate that some of those questions are very subjective when you're asking patients. I appreciate that. I appreciate all of your various publications, Measuring & Monitoring for Success, and I agree with the monthly newsletter. I've got the December one, and I just take issue with one thing here when we're talking about measuring things. You're talking about the highlights of the long-term care family experience survey, and you say that in 2010-11 the average overall care rating was 8.2 out of 10, a significant increase from 8.1. I must say that I don't find .1 very significant.

Dr. Cowell: Oh, man. You are really hitting on a hot button, and a good one, too. It's just an awful scale when you're trying to describe improvement. We've had almost, you know, fights within our organization to find out if there's a better way of expressing this. I'll just defer part of this answer to my colleague.

Ms McBrien-Morrison: Sure. I'm happy to. I agree. John is absolutely correct in our internal discussions around how to express this. It really is down to statistical significance. That's what it is. Because we had such an incredible response rate to that survey – over 7,000 families responded, a 70 per cent response rate – statistically a .1 move is significant. To the public – I would agree – it sounds a little strange, but statistically it really is a significant improvement.

Mr. Allred: Thank you very much for your comprehensive answers.

The Chair: Thank you.

Mr. Chase, please, followed by Mr. Sandhu.

Mr. Chase: Thank you. Following up on the comments of the hon. member Heather Forsyth, representing Calgary-Fish Creek, it must be extremely frustrating when experts make recommendations and then the government cherry-picks whether or not to follow through. Ken Allred brought up the long-term care in point 1. In 2005 then Auditor General Fred Dunn released a scathing report on long-term care. Several of those recommendations have not been implemented seven years later. I realize you can't compel the government to follow through on your hard work, but having spent that time, you would at least hope it was dealt with in an honourable and quick fashion.

My next set of questions has to do with revenue. According to page 198 of the Health and Wellness 2010-11 annual report the Health Quality Council of Alberta received $207,000 in "restricted funding" from the ministry. What was the purpose of this funding, or how was it allocated? Maybe just while you're looking it up, I'll give you this.

Ms McBrien-Morrison: Certainly. Thank you.

From time to time, yes, for very specific projects the ministry will provide us with restricted grants. This particular amount of money was a carry-over from a previous restricted grant that we were given to do the very first long-term care survey and emergency patient survey. As well, there was a grant to deal with medication safety – we are still working on that project today – in supportive living environments.

Mr. Chase: Okay. My follow-up question is: why did the Health Quality Council of Alberta not budget for this funding? Leading off of that, do you have trouble receiving the funding in a timely manner to carry out the research you wish to do?

Ms McBrien-Morrison: As in timely receipt of funding as our normal operating grant? No. That is deposited at the first of each quarter into our bank account, so that has never been an issue. These particular projects will come up during the middle of the year, after you've set your budget. You've decided which projects you're going to do, and it will come to light that there is something else that perhaps we should look at and/or the ministry may ask us to look at something specific because of our mandate and our expertise, medication safety being a great example of that. Therefore, then they will provide the additional funds to do that project.

Mr. Chase: Thank you.

Dr. Tyrrell: May I add one comment to that briefly?

The Chair: Yes, please.

Dr. Tyrrell: It's just that one of the things that I've been very passionate about is that safety and quality is a relatively new area of research within the health care system. We've wanted to have some restricted grants used to help encourage students, instead of always doing biomedical research or clinical research, to be involved in research related to the safety and quality of the health care system. We have sponsored a few students each year at NAIT, at all of the postgraduate educational centres in Alberta to encourage students to have an interest in this area.

Ms McBrien-Morrison: If I may make a small correction as well, Frans just brought to my attention that I spoke in general about restricted funds. That particular amount of money was for the H1N1 review.

Mr. Chase: Thank you.

The Chair: Thank you.

Mr. Sandhu, please, followed by Mr. Kang.

Mr. Sandhu: Thank you, Mr. Chair. I would like to thank Dr. Lorne Tyrrell and Dr. John Cowell and your organization. Albertans have a lot of faith in your organization. You're doing a wonderful job. You've spent all your life in health, and I want to thank you for that.

On page 11 of the Health Quality Council 2010-2011 annual report there is an explanation of a review of patients requiring

medevac services to and from the Edmonton International Airport. What was the main finding of the review?

Dr. Tyrrell: That was page 11?

Mr. Sandhu: Yes.

Dr. Cowell: Are you talking about the medevac?

Mr. Sandhu: Yes, medevac.

9:20

Dr. Cowell: The number one finding was that if the airport is closed prior to an adequate alternate evacuation plan for high-risk patients, especially coming in from the northern regions of the province, then their lives will be at risk. There is an absolute requirement that before the airport medevac facilities are fully closed that a fully functional alternate plan be available, be it at the Edmonton International or, as we recommended, several other possibly available airports like Namao. We put that in our report as well. The precipitous closing without an alternate plan would be quite dangerous and would put lives at risk. That would be our absolute number one.

Then we provided a number of recommendations around how you could mitigate the closing. We did not conclude whether the airport should stay open or closed. That wasn't where we got to. What we got to was: should it be closed, then you must have the alternate evacuation plan in place, up and running and safe.

Mr. Sandhu: For a review such as the medevac review how does the Health Quality Council of Alberta monitor the progress of the recommendations in the report? Are there dedicated staff and resources in place to perform these functions?

Dr. Cowell: You know, we've been discussing that. It is a frustration of the quality council that when we make recommendations and they are accepted, who, in fact, is going to be held obliged to take the action? Literally our only recourse is to the Auditor General. We rely upon the Auditor General to recognize accepted recommendations and then to conduct an audit to see whether or not those recommendations, in fact, have been acted on.

We ourselves have no powers to follow up on recommendations. I think we would have liked those powers, and we'll probably continue to seek them in the future to close the loop, but currently we don't have them. So, as Dr. Tyrrell pointed out, all we can do is do the good hard work, come up with recommendations and, when they're accepted, then hope for the best.

Mr. Sandhu: Thank you.

The Chair: Thank you.

Mr. Kang, would you mind changing your position on the list, please, with Mrs. Forsyth? She has to leave here at 9:30. Would that be okay?

Mr. Kang: That would be good. Thank you.

The Chair: Thank you very much for your patience.

Mr. Kang: She can ask all the questions she wants.

The Chair: Okay. We'll just change your spots on the list.

Mrs. Forsyth: Well, thank you, Chair, and thank you, Darshan. I appreciate it.

I guess I'm like you are, Dr. Cowell and Dr. Tyrrell, in the frustration you feel in regard to the hard work that you do in making recommendations. You know, you can go to the 17 recommendations in regard to the H1N1, acceptance of all 17 recommendations by the government. We can go to the medevac situation, where you had 18 recommendations made and, if I may say, accepted by the government. I think in one of those reports there was one that they weren't accepting of.

Again, I want to emphasize the report coming out the week of February 20, which I think is probably going to be one of the biggest reports with one of the biggest impacts in regard to cancer care, queue-jumping, the intimidation of health care professionals in our province, and there are no powers for you to make sure that these recommendations are implemented. So I think it's important on the record for Albertans to realize the good work that you're doing and the bad work that the government is doing by not implementing the recommendations after they've either asked you to do it independently . . . [interjections]

The Chair: Please get to your questions.

Mrs. Forsyth: Excuse me. I would like to ask you, because you mentioned the fact . . . [interjections] You know, you always know when you're getting to the government when they start yelling.

What powers would you recommend by legislation so that they would be followed up? You said you have no powers to follow up, so what would you recommend, then, on that?

Mr. Fawcett: Point of order, Mr. Chair. That is not a relevant question for Public Accounts.

The Chair: The chair is going to allow her to proceed.

Mrs. Forsyth, you know the rules. The research has been done.

Mrs. Forsyth: I apologize.

The Chair: That was a ramble, and you know better. The other members have been gracious in allowing you to go ahead on the list because you said you had to leave. Proceed.

Mrs. Forsyth: Thank you, Chair. I've got it, Chair. Thank you. My apologies.

Dr. Tyrrell: Well, as we have said, the work we do I think is important. The recommendations we make are important. We would like to see more ability to follow up on these recommendations, and we have discussed that.

The Chair: Have you got a supplementary, Mrs. Forsyth?

Mrs. Forsyth: When you speak about the ability to follow up – and I know you've been working with the Auditor General – are there any recommendations from that?

Dr. Tyrrell: We have worked with the Auditor. I think that, John, you may speak to this. It's more work that you have done with them directly and, I think, has been quite satisfactory, particularly on the H1N1, as an example, where the Auditor was planning to do their own review and they saw what we had done and the recommendations we made. We came to an agreement that another review was not necessary and that the Auditor would help follow up on those recommendations.

Dr. Cowell: The other important point I want to make is that we as an organization do not want to be auditors or be seen to be auditors. We are a monitoring agency. We want to be believed. We want our recommendations to be seen as very credible and, obviously, when they're accepted, are anxious to see those

recommendations acted upon. So we actually have gone to some lengths to work with Auditor General – and perhaps they would comment – as to what they could do in relationship to accepted recommendations. Recommendations that aren't accepted: well, that's fine; they're not in play.

The H1N1 was a bit of a precedent in the sense that concurrent to them wanting to do an audit of the response and us having a mandate to look at the response, it was a unique opportunity for us to go ahead and do the work. Then they had an opportunity to oversee that work and see whether or not it was adequate to substitute. That then becomes, really, their project as far as we're concerned to follow up on those recommendations as opposed to us. So it's a tricky point as to, you know: where do you go with the follow-up of recommendations?

I don't know if the Auditor General would be prepared to step in and make a comment. I think that would be helpful to us.

Mr. Ryan: Mr. Chair, I'd be pleased to. I'd just like to make a point of clarity. We're not, in effect, following up on recommendations of the Health Quality Council of Alberta. We recognize the work that is being done, and what we do is monitor and consider how the world may have changed post-HQCA report. So we're not following up on their recommendations specifically; we're looking to see when and if those recommendations are implemented, how they're implemented, and if a system has been developed to ensure that the recommendations are implemented successfully and the system is operating as it was designed. So a little bit of a nuance change. We're not following up, but what we were doing is creating a new audit to understand what happened after HQCA did their work. We did that with the H1N1.

The Chair: Thank you.

Mr. Wylie: Mr. Chair, if I could just supplement briefly just for clarity. Our understanding of the legislation under which we operate is that we do not have the mandate to follow up on recommendations of other organizations. As you understand, recommendations are made for various independent and, indeed, other officers of the Assembly. The Ombudsman makes recommendations to the Assembly. We can follow up on our recommendations, and we have the mandate to do that.

What we do, though, in scoping out our work, obviously, is that we look at the work of various organizations with respect to organizations that we're auditing and take those into consideration with respect to the work that we might undertake. So as Mr. Ryan has indicated with respect to the work we were going to do with the H1N1, clearly the work of the Health Quality Council was aligned with what we had the scope to do, so the recommendations arose. We're looking now to see how the committee that's struck to deal with those recommendations is going to be addressing the risks, quite frankly, that were identified. As Mr. Ryan indicated, the nature of any involvement, should there be any in the future, would be with respect to our mandate. We are confined with our work as the mandate given to the Auditor General's office. So just a point of clarification.

The other complicating factor, other than the legislative mandate, is that the organizations which I've just referred to are, indeed, our auditees. So we have to be very careful with respect to our association and the extent of partnering that we do with organizations that we audit for fear of someone indicating that, you know, we might be independent, then, with respect to the work that we do in those organizations or that we lose our objectivity with respect to the carry-out of our mandate.

So two important considerations, I think, with respect to our involvement of organizations in the recommendations, but clearly, as Mr. Ryan indicated, we're looking at the risks that were identified, and we will be following those up from the perspective of our mandate.

9:30

The Chair: Thank you, Mr. Wylie.

Now we're going to move on, please, to Mr. Vandermeer, followed by Mr. Kang. We thank you for your patience with us this morning, sir.

Mr. Vandermeer: I'd like to get your opinion on the ambulance services that we have here. It has been a problem ever since I was elected in 2001. We have lineups with ambulance, and we thought that when they became part of Alberta Health Services, it would somehow magically be rectified. Have you done any quality investigations on how we could improve that system and get patients in emergency quicker and ambulances back on the streets?

Dr. Cowell: We've looked at the ambulance service twice in our history, once in 2007 when we did a thorough review of the emergency services in the Calgary health region and the way the ambulance service interfaced with the emergency departments. We found there were serious problems with offloading with the ground ambulance – we're speaking to the ground ambulance, not air ambulance – and made a number of findings and recommendations about improving that interface while the ambulance service was still within the municipality. Some tremendous work was undertaken in that 2000-2007 era to improve that interface so that ambulances were not stacking into Foothills and so on.

The other time we looked at it was in regard to the medevac when we saw again that there were potential interface problems when you were transferring a patient between an airplane and the hospital location, and there were serious issues that we addressed in that. Beyond that we have not studied the ambulance system, although it is increasingly on our to-do list. Beyond that I couldn't give you any further analysis.

Mr. Vandermeer: Just a comment, then. I would hope that you'll move it up on your to-do list and see whether we can get some recommendations for that.

Thanks.

The Chair: Thank you very much.

Mr. Kang, please, followed by Mr. Xiao.

Mr. Kang: Thank you, Mr. Chair. My questions are regarding the business plan. On page 16 of the HQCA's 2010 annual review there's a reference to a 2010-11 business plan. Did the Health Quality Council develop a 2010-11 business plan?

Ms McBrien-Morrison: Sorry; which page?

Mr. Kang: Page 16. This is about the reference to a business plan. It says, "Sound fiscal management practices allowed the HQCA to work on the initiatives identified in the 2010-2011 Business Plan." Did you have a business plan?

Dr. Cowell: Oh, absolutely. Yes.

Mr. Kang: Why is it not posted on the council's website? If not, how does the council set goals, prioritize initiatives, and measure the performance?

Dr. Cowell: We absolutely do have a business plan. In fact, here it is. It's modelled after the provincial health plan over a three-year time horizon, and then there's a one-year business plan. The way this business plan comes about is that first we work it within the administration and then our board of directors, and then it is approved by the ministry and the minister of health. I don't think there's any particular reason why it isn't posted. It's all over the place in terms that it's within the ministry, and it's certainly an active document. We also report our performance on that business plan on a quarterly basis with the ministry and, of course, to our board of directors. So it's a public document. Why it's not on the website, I don't have a good answer. Sure; it could very well be. Excellent suggestion. Why don't we do it?

Mr. Kang: Thank you.

The Chair: Mr. Xiao, please, followed by Mr. Chase.

Mr. Xiao: Thank you, Mr. Chair. Good morning, everybody. You know, by listening to you, I think you answered some of my questions. I understand your mandate is to monitor and measure and make some recommendations, but you don't have the power to enforce, you know, to implement your recommendations.

That comes to my question. Communication becomes a very important piece. On page 204 of the Health and Wellness 2010-11 annual report there's no reference to the communication budget for you. My question is: how much did you spend on communication? Also, how do you work with other organizations in order to communicate and get your message out?

Dr. Cowell: Excellent question. First to the number. The actual amount on communications, all in, is just $178,000, which includes supplies, some staff time as well as communication materials.

One of our major publications is the Health Report to Albertans. That is the one paper device where we're actually communicating directly with Albertans. We've been attempting various ways of writing it and getting it into newspapers and distributing it and putting it in doctors' offices and so on. The topics that we've covered in each of those: one of them is called Playing It Safe, which was helping the citizens understand how to manage their own medications, how to keep track of their medications, how to tell their care providers what their medications were, which was another one.

Another one that we're very happy with is called It's Okay to Ask, and this was a whole piece done on helping our citizens know how to communicate with their care providers because there's often an intimidation in the relationship between a care provider, especially a doctor, and a patient, and they're afraid to sort of say what they need to say, or they don't know how. So we went to considerable lengths to create a publication piece that would do that and guide people. This was a tremendously successful set of publications, but they're costly, and they're difficult to put together. So we're careful about it. Also, it doesn't reach the people who are not literate. That's one of our devices.

Another one is that when we publish any of our surveys, we have a very technical report that's used by researchers and others, but we also have a very short version. Your colleague had a copy of what we call our public piece, which is often a three- or four-page summary of the key findings, and that's a widely distributed document.

All of those surveys, especially the health services satisfaction, the emergency services, and long-term care, always have a companion piece that's translated into sort of layman's language, if you will. We post everything on our website, with the exception, it turns out, of our business plan. We're pretty obsessive about putting things on that website.

We continue to work with the whole issue of literacy because we know that there is an astonishingly low literacy rate amongst our population generally. It could be that maybe only 50 per cent of people can actually read with comprehension, so we're looking for different techniques to communicate.

Mr. Xiao: That would answer the question.

Also, still related to the communication piece, do you have any external contractor, you know, to help you to do the communication? Why? How much do you spend on that?

9:40

Dr. Cowell: Within the organization we have a fairly lean staff, so we don't actually have a very robust communication group. We have a single individual who sort of co-ordinates it. We rely heavily on intermittent use of experts. Perhaps I'll just get Charlene to explain some of that.

Ms McBrien-Morrison: Sure. As John mentioned, we have one person there that's not even full-time. Then depending on the project and what kind of communication we may need to do, we would contract out design of products like your colleague had held up there, or it may be around designing our website. Those types of things are what we would contract out, from a communications perspective.

There are times when we'll hire external writers, when the workload gets too much for that one part-time person. Depending on how many projects we're doing at the same time, we'll bring in an external communication writer to help us with some of the writing of the products as well.

Dr. Tyrrell: If I could just briefly comment that there is a meeting coming up called the American Society for Quality in the health care systems. Because the quality matrix and the Health Quality Council of Alberta is seen as one of the examples of a good-quality network or a good-quality organization in health care, we've had a request from UKTV to do an information session based on the Health Quality Council of Alberta that will be shown internationally as an example, I think, of some of the things we've been able to achieve. As a result of agreeing to that, we're going to get the film back so that we can use it to help inform Albertans about the Health Quality Council.

The Chair: Thank you.

Ms McBrien-Morrison: If I can add to that, the actual contracted-out services were $35,000 in the budget year we're speaking to.

Mr. Xiao: Thank you.

The Chair: Thank you.

Mr. Chase, please, followed by Ms Woo-Paw.

Mr. Chase: Thank you. The topic for this set is patient safety framework for Albertans. On page 10 of the Health Quality Council of Alberta's 2010 annual review the establishment of the Patient/Family Safety Advisory Panel is said to be "one of six significant outcomes" of the patient safety framework for Albertans launched in September 2010. Has this panel been appointed yet? If so, what was the process? If not, why not? That's my first question.

Dr. Tyrrell: Patricia is the chair of this council and committee, and I'll let her speak.

Ms Pelton: Thanks very much. The liaison between the Patient/Family Safety Advisory Panel and the board, through Dr. Tyrrell, is through the patient safety committee, and I chair the patient safety committee. We did set up an interim panel, and essentially we drew from folks that had been involved on former advisory panels in the former health regions, and we took a year to storm, norm, and form and do some of our basics.

Then we felt we had to have a transparent process to bring candidates in. So we advertised across the province and got a number of applicants, went through a review process, and we now have terms of reference that are established and members that have been appointed on a staggered three-year term basis.

Just going back to my days as CEO of the health region, when we did the health council development as well as establishing health ethics committees, it takes some educational components to get folks that are on these types of panels really up to speed. We have focused on educating regarding the health system. Remember that the Health Quality Council has a mandate, as does this panel, for all services that are publicly funded, not just Alberta Health Services. So bringing people up to speed on that.

Right now the panel is I think feeling quite confident and ready to go on approaching different areas of concern. We've used as our basis the patient satisfaction survey, and certainly there are a number of stories that can be drawn out from that where we need to pay more attention. One, Mr. Chase, would be home care, so I think there's going to a focus – I don't want to speak too prematurely because the panel hasn't landed specifically on what that will be. Potentially, emergency department issues as well.

Mr. Chase: Thank you. As a person who appreciates poetry, I enjoyed your terminology of "storm, norm, and form."

My second question. Please describe the method or methods by which patient experiences and perspectives were gathered and how they'll be published or shared.

Ms Pelton: You know, we could answer that in many different ways. In the measuring and monitoring report we've actually tried to illustrate points by using stories. In terms of the panel, although it wasn't a requirement – it wasn't a prerequisite – we did suggest that people that had had experiences either good or bad in the health system be part of the criteria for their nomination. In fact, most of the people that have been chosen for that panel do have personal experiences that they have shared with our group, with the whole panel. In fact, in one case one of the stories will actually be used as the basis.

We at the HQCA find storytelling very helpful to illustrate points because it is humanizing. There was some research that was done in Sweden – and I won't go on too much longer, but I'm passionate about this – that used the name of a woman named Esther. Esther was a figment of imagination, but essentially it was everyone's mother, a 70-year-old Esther. We always tried to think about quality in terms of Esther. How would we want Esther treated? How would we want our mother treated? That will be the basis of how the panel goes forward.

Mr. Chase: Thank you.

The Chair: Thank you.

Ms Woo-Paw, please.

Ms Woo-Paw: Thank you, Mr. Chair. I was hoping you would skip the storming and get to performing.

I am pleased to see that the dimensions of quality include appropriateness and accessibility and acceptability and effectiveness and so on. What has the Health Quality Council done in response to our changing demographics and the level of diversity in terms of focusing on the aboriginal context and experience, increasing diversity in terms of race and culture, socioeconomics, age, et cetera, in terms of your survey designs, your execution, measurements, patient safety, education, and knowledge transfer? How have you incorporated and responded to the changing demographics and diversity?

Could I just ask my second question together?

The Chair: Sure.

Ms Woo-Paw: What have been some of your key achievements and challenges in terms of integrating the quality matrix for health into the attitudes and approaches of the health system, the citizens of Alberta, and stakeholders?

Dr. Cowell: In response to the changing demographics it wasn't actually long after the Auditor General's report in '05 that we already had a strong interest in aging population, long-term care, continuing care issues. It was at that point that we initiated our first massive survey of residents as well as family members in long-term care facilities, many of whom were the elderly. That was a seminal survey to really get our feet wet, if you will, as to what was going on, especially the seniors who were already in long-term care or continuing care or aging in place kinds of settings. Then we followed it up with the resident survey, which we just recently released, to see whether there was any change. That's an example of one huge initiative.

In regard to the aboriginal population we've had numerous interactions with aboriginal communities, most recently with the Siksika. We're in a very early stage of developing an MOU with the tribal council there. I've been in recent contact with Chief Kory Duck, and as soon as we get this current workload sort of back to normal, we're going to be pursuing that.

In regard to the changing sort of cultural demographics, especially with language challenges and so on, we've really realized that it's not just a literacy issue; it's also a comprehension/language issue. We've started, really, down the path of trying to figure out how we're going to more appropriately communicate what we know and also learn what we need to know in regard to the experience. To that end, when we did the long-term care survey, especially when we were actually in the Chinese community, we had Chinese interviewers to be sure that we were getting the stories the way they ought to be heard.

It's early times for us, I have to admit. It's just one of the many huge challenges we're facing, but we are totally sensitive to the questions that you're raising, and these are examples of how we've started to respond.

The Chair: Thank you.

Ms Woo-Paw: And the second part?

The Chair: No. You had two questions there. We have to move on in light of the time. We still have a number of members who have an interest in presenting their questions, so we're going to have to read them into the record.

Dr. Tyrrell, if your Health Quality Council could please provide written answers through the clerk to all members, we would be grateful.

We will now proceed if you would like to read your questions into the record, please, starting with Mr. Kang.

9:50

Mr. Kang: Thank you, Mr. Chair. My questions are regarding the emergency department patient experience survey on wait times. We still have long wait times in the emergency departments and ambulances getting held up. A week ago I had a personal experience when an ambulance was held up for over six, seven hours. According to page 8 of the Health Quality Council 2010 annual review the council has since 2009 collected patient experience and wait time measures in Alberta's 12 largest urban and regional emergency departments on an ongoing basis. Page 8 says that the results will be available starting in autumn 2011. Are these results available yet or not? That's question number one.

The second one is: please explain the delay in making available the data that is set to give us a more accurate and timely picture of what is happening in Alberta's emergency departments.

Thank you.

The Chair: Thank you.

Mr. Allred?

Mr. Allred: Yes. Just a couple of quick ones. Certainly, your organization is all about quality assurance. I don't know if there are any international standards such as the ISO, the international standards organization, on quality assurance, but if you could just tell us if you follow any international standards or if you have developed them on your own.

Secondly, more of a comment. You indicated that you hope to study the emergency/medical transfer ambulance service in the future. I would hope you would also look at the integrated services that are available in probably half a dozen communities in Alberta, including St. Albert.

The Chair: Thank you.

Mr. Chase.

Mr. Chase: Thank you. My set of questions has to do with the primary care initiative and networks. The Premier has proposed some type of new family clinic approach, which appears to be a reinvention of existing PCNs. According to page 9 of the Health Quality Council of Alberta's 2010 annual review the council continued last year to engage in partnerships with volunteer primary care networks, PCNs, and providers on a pilot quality measurement initiative. Would you please, in written form to the clerk, describe the quality measurement initiative? What does it entail, and when do you expect to release the results of this initiative, which I see is extremely effective?

The Chair: Thank you.

Mr. Goudreau: Just very quickly. Page 12 in your background research sort of identifies some of the mortality rates for patients with strokes. I'm quite concerned about the rural areas, where they're considerably higher than in the cities of Calgary and Edmonton, for instance. Are there other statistics, you know, in terms of health outcomes that would show that the health outcomes in rural Alberta, maybe in aboriginal communities, are quite different than what we would find in Calgary and Edmonton?

The Chair: Thank you.

Are there others? Mr. Kang, please, and be quick if you don't mind.

Mr. Kang: Very quick. My questions are regarding the patient safety framework. On page 12 of the HQC's 2010 annual review the implementation of a provincial adverse event report and learning system is named as one of the six significant outcomes of the patient safety framework for Albertans, launched in September 2010. My first question is: has this system been implemented, and if not, why not? The second one: if so, how is disclosure encouraged, and what legal immunity is afforded to those who disclose a potential liability?

Thank you.

The Chair: Thank you.

Mr. Xiao, followed by Mr. Chase.

Mr. Xiao: Yeah. My questions are related to your annual report 2010-11, regarding the 2009 H1N1, the province's response to the pandemic. I want you to provide some information about the outcome and also a recommendation about how in the future we should respond to a similar pandemic on a scale such as this and what kind of extra resources in terms of financial are required to implement that strategy.

Thank you.

The Chair: Thank you.

I'm afraid we're out of time, Mr. Chase, because we have other items on our agenda.

Dr. Tyrrell, on behalf of the committee I would like to thank you, Dr. Cowell, and your staff for your time this morning. It certainly was interesting. It's, I think, one of the smallest budgets we've ever examined before this committee in my time. It certainly was interesting, and there's no doubt of the importance of the Health Quality Council to patient safety and health care in this province. I would like to express my gratitude to you and your staff for your time with us this morning.

Thank you.

Dr. Tyrrell: I would just like to say on behalf of the Health Quality Council and the members that are here: thank you very much for this opportunity to meet with some of the MLAs and to have these questions and give answers. I've really been impressed at how well you read the reports, and I thank you very much for going through the details. I think there were some interesting suggestions, and we will answer the questions that you have raised.

Thank you very much.

The Chair: Thank you, and good luck with all your endeavours.

Mr. Chase: Remember what Darshan says. Trumpet your successes.

Dr. Tyrrell: We will try to do more of that.

The Chair: You're free to go while we conclude our other items on our agenda. Thank you.

Dr. Tyrrell: Thank you.

The Chair: Now, hon. members, other business, item 5, committee report on 2011 activities. As discussed at the last meeting, I would like to get your acceptance of the Standing Committee on Public Accounts report for 2011. This has been distributed, and I would like to table this in the House after, of course, there is a motion from the committee.

Mr. Chase: I move that the chair be granted permission by this committee to table the report on our behalf.

Mr. Goudreau: I see no objections, colleagues, to tabling this report.

The Chair: No, it's pretty innocent. Moved by Mr. Chase that the Standing Committee on Public Accounts approve the draft 2001 report of the Standing Committee on Public Accounts as distributed.

All in favour?

Mr. Allred: Just a comment. I notice that there's more in the report on the conference than there is on the rest of the activities.

The Chair: That's why I said that it was an innocent report.

Mr. Allred: Right. Well, it is innocent, then. Not much substance to it.

The Chair: Yes. Thank you for that. I appreciate that.

All those in favour of this innocent report? None opposed? Thank you very much. We'll get it organized, and we will table it at the appropriate time in the House.

Now, I would also like to bring to your attention another letter that I received in a follow-up from our November meeting with the AGLC. This is a letter dated February 13 from the chief executive officer of the Alberta Gaming and Liquor Commission. I received this yesterday. I would just like to let you know and invite any of the committee members. Mr. Ryan, the Assistant Auditor General of Alberta, has agreed to provide an explanation to me or answer questions regarding the change in 1999-2000. Apparently – and I'm reading this letter – it indicates that there was "no formal written recommendation . . . provided to the AGLC" to change the reporting mechanism from cash-in, cash-out to bets played. I'm going up this afternoon to the office of the Auditor General – they have been very gracious and accommodating – at 3:20, and if any other members want to come along, they are quite welcome. Okay. Thank you.

Now, the date of our next meeting is next Wednesday with Alberta Municipal Affairs. Breakfast will be served at that meeting.

If there are no other items, may I have a motion to adjourn?

Mr. Vandermeer: So moved.

The Chair: Thank you very much. Moved by Mr. Vandermeer that the meeting be adjourned.

[The committee adjourned at 10 a.m.]

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of the Legislative Assembly of Alberta