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The 27th Legislature
Fifth Session

Standing Committee
on
Public Accounts

Alberta Health Services

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MacDonald, Hugh, Edmonton-Gold Bar (AL), Chair
Goudreau, Hector G., Dunvegan-Central Peace (PC), Deputy Chair

Allred, Ken, St. Albert (PC)
Benito, Carl, Edmonton-Mill Woods (PC)
Calahasen, Pearl, Lesser Slave Lake (PC)
Chase, Harry B., Calgary-Varsity (AL)
Elniski, Doug, Edmonton-Calder (PC)
Fawcett, Kyle, Calgary-North Hill (PC)*
Forsyth, Heather, Calgary-Fish Creek (W)
Groeneveld, George, Highwood (PC)
Kang, Darshan S., Calgary-McCall (AL)
Mason, Brian, Edmonton-Highlands-Norwood (ND)
Rodney, Dave, Calgary-Lougheed (PC)
Sandhu, Peter, Edmonton-Manning (PC)
Vandermeer, Tony, Edmonton-Beverly-Clareview (PC)
Woo-Paw, Teresa, Calgary-Mackay (PC)
Xiao, David H., Edmonton-McClung (PC)

* substitution for Hector Goudreau

Alberta Health Services Participants

Chris Eagle	President and Chief Executive Officer
Chris Mazurkewich	Executive Vice-president and Chief Operating Officer
David Megran	Executive Vice-president and Chief Medical Officer
David O'Brien	Vice-president, Seniors' Health
Deborah Rhodes	Acting Executive Vice-president and Chief Financial Officer
Catherine Roozen	Interim Board Chair
Don Sieben	Interim Board Vice-chair and Chair, Audit and Finance Committee

Office of the Auditor General Participants

Merwan Saher	Auditor General
Mary-Jane Dawson	Principal

Support Staff

W.J. David McNeil	Clerk
Shannon Dean	Senior Parliamentary Counsel/ Director of House Services
Robert H. Reynolds, QC	Law Clerk/Director of Interparliamentary Relations
Giovana Bianchi	Committee Clerk
Corinne Dacyshyn	Committee Clerk
Jody Rempel	Committee Clerk
Karen Sawchuk	Committee Clerk
Rhonda Sorensen	Manager of Corporate Communications and Broadcast Services
Tracey Sales	Communications Consultant
Philip Massolin	Committee Research Co-ordinator
Stephanie LeBlanc	Legal Research Officer
Rachel Stein	Research Officer
Liz Sim	Managing Editor of *Alberta Hansard*

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8:30 a.m. Wednesday, March 21, 2012

[Mr. MacDonald in the chair]

The Chair: Good morning, everyone. I would like to call this Standing Committee on Public Accounts to order, please.

My name is Hugh MacDonald. We'll quickly go around the table as usual and introduce ourselves, starting with the gentleman on my right.

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

Mr. Vandermeer: Good morning. Tony Vandermeer, MLA for Edmonton-Beverly-Clareview.

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

Mr. Chase: Good morning. Harry Chase, Calgary-Varsity. I have seven sets of questions that I'm hoping to at least get on the record.

Dr. Megran: Dave Megran. I'm executive vice-president and chief medical officer for AHS.

Dr. Eagle: Chris Eagle. I'm the CEO and president of Alberta Health Services.

Mr. Sieben: Don Sieben, vice-chair and chair of the Audit and Finance Committee, Alberta Health Services.

Ms Roozen: Cathy Roozen, chair of Alberta Health Services Board.

Mr. Mazurkewich: Chris Mazurkewich, chief operating officer, Alberta Health Services.

Ms Rhodes: Deborah Rhodes, acting chief financial officer, Alberta Health Services.

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

Mr. Saher: Merwan Saher, Auditor General.

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

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

Mr. Allred: Ken Allred, St. Albert.

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

Ms Bianchi: Hi. I'm Giovana Bianchi, committee clerk, Legislative Assembly Office.

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

The Chair: Thank you very much.

Could I have approval of the agenda, please, that was circulated? Ms Woo-Paw. Moved by Ms Woo-Paw that the agenda for the March 21, 2012, meeting be approved as distributed. All in favour? None opposed. Thank you very much.

May I also have approval of the minutes for the March 14, 2012, meeting? Mr. Chase. Moved by Mr. Harry B. Chase that the minutes for the March 14, 2012, Standing Committee on Public Accounts meeting be approved as distributed. All in favour? Thank you very much.

Of course, this comes to our meeting today with the officials from Alberta Health Services. I would like to thank on behalf of all committee members the delegation today from Alberta Health Services for your co-operation in preparing for this meeting. It certainly is appreciated. Thank you.

We are dealing with the 2010-11 annual report of Alberta Health Services this morning, the 2010-11 annual report of Alberta Health and Wellness, the November 2011 and March 2012 reports of the Auditor General of Alberta, and the 2010-11 annual report of the government of Alberta. That includes, of course, the consolidated financial statements of the government of Alberta, the annual report, and the Measuring Up document. Again, I would like to thank the LAO research staff for their efforts in getting this prepared for this meeting.

Now I would like to invite Ms Catherine Roozen, interim chair, Alberta Health Services Board, to make a brief 10-minute-or-less opening statement on behalf of Alberta Health Services. Please proceed, Ms Roozen.

Ms Roozen: Thank you, Mr. Chairman. I am pleased to be here with the committee today, and I look forward to our discussion.

Mr. Chairman, 2010-11 was a year of transformation for Alberta Health Services. We were focused on the transition from consolidating and organizing our services to more effectively and efficiently delivering health services to Albertans. This was year 2 of operations for Alberta Health Services, and through the efforts of our staff, physicians, and volunteers, who continue to uphold the highest standards of care, we began to build on the groundwork for change laid in the first year.

We continued to build on the solid foundation of savings laid in year 1 of operations, with $660 million in annualized savings realized or future costs avoided, through the implementation of a number of initiatives, including reorganization of management, administration, and procurement functions into one provincial system. The benefits of these savings continue to be returned to the front lines of care.

We reduced the rate of our administrative expenditures from in excess of 3.5 per cent of total expenditures in fiscal 2009 to under 3 per cent in the 2010 fiscal year. We have also begun to reduce the rate of growth of our expenditures from historical levels by operating within our 6 per cent base funding increase, excluding new facilities coming online. This continued to build on our commitment to sustainability in Alberta's health system and to ensure more dollars going forward towards patient care.

The 2010 fiscal year was the first year of the five-year health action plan and the government of Alberta's five-year funding commitment to AHS, which saw a 6 per cent increase in health funding. Taking a five-year view on health funding and performance improvement and backing it with a five-year funding commitment had never been done before in Canada when it was announced in early 2010. We thank the government of Alberta for its leadership and innovative thinking. In return, AHS remains committed to delivering on the targets outlined in this plan. This five-year stable funding agreement relieved us of annual budget uncertainty and allowed us to focus on what was really important, improving health care and increasing access.

We put the funding increase to work immediately. Our overall capacity increased by 1,490 beds in the 2010 fiscal year. Our target was to open 360 new acute-care and addictions and mental health beds to improve access for Albertans, including medical assessment beds, medical observation beds, transition beds, and palliative care beds. We opened 335 new beds by the end of the

2010-11 fiscal year and opened an additional 25 beds in the early part of the 2011-12 fiscal year to meet our overall target of 360 beds.

We supported Albertans with addictions and mental health issues by opening new addiction treatment beds and geriatric mental health beds in Edmonton. To help reduce demand for hospital beds, ease congestion in the emergency departments, and add capacity to the overall health care system, we opened 1,155 continuing care beds in communities across Alberta, the vast majority of which were supportive living beds.

The number of patients waiting in acute care for continuing care living options was reduced from 707 in the 2009 fiscal year to 471 in the 2010 fiscal year, which reflects a 33 per cent improvement. Our overall goal is to provide more options for continuing care by supporting Alberta seniors and adults with disabilities to remain in their own homes and maintain their independence for as long as it is safe to do so.

It also means we are focusing on expanding home care, increasing support to caregivers, and removing barriers by using technology. The number of home-care clients increased by 5 per cent to 112,000 people in fiscal year 2010 from 107,000 the prior year.

Stable funding allowed us to reduce wait times for a range of surgical procedures and radiation therapy. In the 2010 fiscal year an additional 9,790 surgeries were performed, surpassing the target of 3,000 additional surgeries outlined in the five-year health action plan by almost 6,800 surgeries. This included 4,300 surgeries for conditions ranging from cancer and cardiac to orthopaedic and vascular, 5,000 cataract surgeries, and 290 additional hip and knee replacements.

We saw wait times for coronary artery bypass graft surgery reduced to 24 weeks in the 2010 fiscal year from 31 in the prior year. Cancer patients waited 3.6 weeks for radiation treatment in the 2010 year, down from 5.4 weeks in the previous year. We are already seeing major improvements in wait times this year.

We opened new points of access to the health system in the 2010-11 year. The province's third radiation therapy centre was opened in Lethbridge last year, which further improves access to care for cancer patients in southern Alberta. We began the important work of establishing a cancer patient navigation system to improve the co-ordination of care, speed up patient access to resources and services, and help patients find answers to their health care questions.

Many initiatives in the 2010 fiscal year were implemented to improve patient flow, including new province-wide overcapacity protocols, which were launched in December of 2010. The protocols were aimed at reducing peak pressures in emergency departments and other parts of the health system during periods of high patient volume. Pressure on emergency department wait times became acute in September of 2010. These protocols build on current practices by setting new thresholds that when reached will trigger immediate action to reduce emergency department wait times. The initiatives involve all areas of the health system working together to ensure patients receive timely access to care.

Length of stay for patients discharged from emergency departments and urgent-care centres at our top 16 sites improved 1 per cent; 64 per cent of patients were discharged within four hours, up from 63 per cent the previous year. The target is 70 per cent. Length of stay for patients admitted to hospital from emergency departments at all sites around the province improved 4 per cent; 53 per cent of patients were admitted within eight hours in the 2010-11 fiscal year, up from 49 per cent the prior year. The target is 55 per cent.

8:40

Our protocols, the capacity expansion, and the people working directly to move more patients quickly are working. It is never as fast as we would like, but we have set very aggressive targets in wait times, and we are making measurable progress. Every improvement makes a difference to our patients, and we continue to push forward. Let me mention a few of the ways we've addressed wait times.

AHS facilities have set aside areas within emergency departments where reclining chairs replace stretchers for less acute patients to increase treatment spaces and improve access and flow. In early 2010 we introduced the ED to home project, which connects seniors who visit emergency departments throughout the province with home care and community resources. As a result of this program we observed at some pilot sites such as the Red Deer hospital a 50 per cent reduction in admissions in our target population. The ED to home program continues to expand throughout the province.

To further improve patient flow, new computer software called Medworxx was implemented at the Rockyview general hospital in December of 2010. This system will help with patient discharge communication and will identify patients who are ready for discharge, making hospital discharges more efficient and timely. The software is now being implemented at other Alberta hospitals.

The five-year health action plan outlines the need for having the right facilities in the right place to meet community health needs now and into the future. These community initiatives also help to reduce pressures in the emergency departments, and I would like to highlight a few of these here today. In September of 2010 the East Calgary health centre, a new community-based care centre, opened with more than 30 clinics and programs. Services here include primary care, public health, chronic disease management, oral health, living well, addictions and mental health services, speech-language services, and asthma and chronic obstructive pulmonary disease services.

In February of 2011 Cochrane urgent care opened to provide same-day treatment for unexpected but non life-threatening health concerns such as broken bones, sprains, lacerations, asthma, dehydration, pain, and infection. It is supported by a full-service laboratory and X-ray department, which can also be accessed by patients with referrals from a physician, midwife, nurse practitioner, or chiropractor. The urgent-care clinic is expected to handle about 15,000 visits in its first year, increasing to 30,000 visits by its third year.

Last year Health Link played an expanded dual role in the public education campaign launched by AHS. This campaign promoted the province-wide telephone health information and advice service as one of a wide range of available health services which also includes family doctors, walk-in clinics, and urgent-care centres. During the campaign and on an ongoing basis Health Link Alberta also educates callers about these options. This campaign involved radio spots and signage at hospitals and other health care facilities as part of the overall strategy to reduce pressures in the emergency departments by ensuring Albertans receive the right care in the right place.

Patient enrolment in our primary care networks, or PCNs, also increased in the 2010-11 fiscal year. As of April 1, 2011, there were a total of 40 PCNs and 2.6 million enrollees. This is an increase of seven additional PCNs and 400,000 new enrollees from the prior year. With the creation of Alberta Health Services and the continued evolution of one health system Albertans will benefit from models of care based on the best scientific evidence available, better use of technology, increased patient safety, an

engaged and highly performing workforce, and less duplication resulting in cost savings.

The electronic health record is also an important tool for physicians, pharmacists, and other health service providers. It improves patient care by providing up-to-date information immediately at the point of care. Making basic patient information available to health service providers will support better care decisions and improve patient safety.

More health care providers across the province continue accessing the electronic health record system. There were approximately 10,300 new users joining the EHR in the 2010-11 fiscal year, bringing the total current to over 43,600. This represents an increase of 30 per cent from the prior year. As of June 24, 2011, diagnostic images can be accessed by health care providers across the province through the electronic health record. We are also taking measures to implement new privacy and security technology by the end of this year to further streamline care providers' access to the system.

In addition, Alberta's health research and innovation . . .

The Chair: Excuse me, Ms Roozen. That's well past 10 minutes. It was clear in the correspondence before this meeting was initiated that we would have 10 minutes for an opening statement.

There are many members with questions indicated already, so I'm afraid we're going to have to move on and get some comments, if he has any, from the Auditor General, and we're going to have to get directly to questions from members.

Thank you.

Ms Roozen: Thank you, Mr. Chairman.

Mr. Saher: Mr. Chairman, no more than two minutes.

My comments relate to our November 2011 report. We refer the committee to page 27, which has a progress report on our prior year mental health recommendations. We concluded that the department and AHS management have plans to implement our recommendations and mechanisms to monitor progress.

Page 33 of the November 2011 report has the results of our follow-up audit of seniors' care in long-term facilities. We found that AHS has made satisfactory progress in implementing our recommendations.

On pages 110 to 117 we report that Alberta Health Services has implemented our recommendation to improve its year-end financial reporting processes. It has begun establishing a system to measure and report on the effectiveness of its internal control over financial reporting and has made satisfactory progress on a number of outstanding recommendations, including developing IT control policies and processes and improving its controls over contracting. We issued an unqualified auditor's opinion on the 2011 Alberta Health Services consolidated financial statements.

There were no new recommendations made to Alberta Health Services in our April 2011 or November 2011 reports. Our list of prior year outstanding recommendations for AHS begins on page 156 of the November report. Many of these recommendations were made to the authorities that were in existence prior to the creation of Alberta Health Services. Our outstanding recommendations in the main relate to our former food safety audit, mental health audit, seniors' care audit, financial management systems for capital projects audit, and recommendations made to improve internal controls and performance measures.

Mr. Chairman, thank you.

The Chair: Thank you very much.

The chair would like to welcome Mr. Mason and Mr. Xiao this morning. Good morning, gentlemen.

We will now proceed quickly to questions. Mr. Chase, followed by Ms Woo-Paw, please.

Mr. Chase: Thank you. There have been more than 1,000 confirmed cases of elderly and disabled Albertans being abused in provincially funded facilities over the past seven years, and thousands more have filed complaints since Auditor General Fred Dunn released his scathing 2005 report on the inadequacy of long-term care in this province. My first question: please explain why, given the average of 500 abuse complaints a year from facilities housing more than 40,000 seniors and disabled adult residents, less than 2 per cent are referred to police.

Dr. Eagle: We have a number of audit mechanisms of care delivered in the care facilities that we contract to. We've worked diligently to increase the number of visits made to those facilities, a visit every two years. There is the Protection for Persons in Care Act, as you're well aware, that deals with the complaints as they come forward. We believe that those complaints are dealt with appropriately. If there are issues related to, you know, criminal activities, we fully co-operate with the police. I think that's a very minor number of the types of complaints that we get, obviously, but we take this very seriously. I mean, the care of people who are at risk and unable to protect themselves is absolutely important to Alberta Health Services and absolutely important to my team in delivering the best care we can to Albertans.

8:50

Mr. Chase: And, obviously, 2 over 500 is a major concern.

What are the chances of a senior or disabled person's complaints being taken seriously if they don't have a family member advocating on their behalf?

Dr. Eagle: We certainly believe that the environment that we have to create is one of safety. During the last year or two that's become very, very clear, that we need to make the health delivery system safe for our staff, safe for the clients and the families. The standards that are in place, you know, require the facilities to live up to expectations. There are opportunities for spot audits. There are opportunities for staff to identify where patients are not getting the care that they should be receiving through the Protection for Persons in Care Act.

I'm not saying that we are perfect in this domain. I think that we have a lot to improve upon. But I think that we pay very much attention to avoiding the kinds of cases that you're alluding to, which obviously are very, very disturbing for everyone in the health care system.

Mr. Chase: Thank you. Three deaths last year and 19 serious incidents.

The Chair: We're moving on now to Ms Woo-Paw, please, followed by Mr. Kang.

Ms Woo-Paw: Thank you, Mr. Chair. My first question is around children's mental health services. I remember attending a major announcement between the ministers of Education and children's services and health on the creation of some kind of protocol amongst the three ministries about two years ago, perhaps, in a school.

When I look at the performance measure on this service area, I believe on page 35 it indicates that you had set a target of 85 per cent of the children receiving assessments within 30 days, and the result is 5 to 10 per cent below your target. So would you please speak to that performance measure outcome?

Mr. Mazurkewich: We take that target quite seriously. We've done a number of improvements in the processes through Calgary, there's been some really good work done in Lethbridge, and this year Edmonton has done some great work on that measure. At the end of this year you'll see a significant improvement. So over a two-year period we've put a lot of energy into that. It's an important standard for us to meet.

Ms Woo-Paw: The reason I ask is that, actually, I ask this question every time I visit the over a dozen schools and feeder schools in my riding. My riding also includes the only mental health class for children in Calgary. The principals are very concerned about access for children with special needs, so I'm pleased to hear that progress is being made.

Why is it that we are placing less of a priority on treatment for adults for mental health services than children in Alberta?

Mr. Mazurkewich: I don't believe that statement is quite true. The addiction and mental health services strategic plan was just approved and released in the fall, and now Alberta Health Services is working with a variety of ministries to focus on that. You'll see action in the fiscal year '12-13 as part of the budget process rolls out.

Ms Woo-Paw: My last question. Don't I have two supplementals?

The Chair: No, you have one.

Mr. Kang, please, followed by Mr. Vandermeer.

Mr. Kang: Thank you, Mr. Chair. My questions are on surgical wait times. According to page 47 of the performance report, appended to this 2010-11 annual report, it exceeded its targeted wait times for hip replacement surgery by two months 90 per cent of the time. Why has the AHS set targets for wait times for this procedure that are two weeks longer than the provincial/territorial benchmark?

Dr. Eagle: The benchmarks were developed in conjunction with Alberta Health and Wellness. The way that the benchmarks were developed were they brought in clinicians, surgeons from around the province to say: what's the best practice? What's achievable? That number comes from, you know, working with the department but also from the input of the front-line clinicians. We take their input as being the main driver of this as to what is most appropriate.

We have a lot of work going on in the province around wait times. In the province of British Columbia they have developed standardized wait times for a variety of different surgical conditions. We are using those standards here in Alberta to make sure it's appropriate, but our physician and surgeon leaders are using those standards. So for each surgical procedure we will have a well-known and agreed upon benchmark target, and then it's up to AHS to figure out how to deliver those targets.

Mr. Kang: Thanks.

My supplemental is that in 2010 Alberta ranked sixth among the 10 provinces for hip replacement surgery wait times. Has the province's ranking with respect to such wait times improved since then or not?

Dr. Eagle: We're working on improvement. Since the time of the report we've opened the orthopaedic surgical centre at the Royal Alex. We have the bone and joint network, working on central intake models across the province. We've put additional financial resources into hip and knee access. We've done all of the fundamental things that we need to do to improve throughput, you know, so we're doing more hip and knee surgery.

We've also taken a look at what is on the waiting lists. Should those patients be on the waiting list? Have they had surgery done elsewhere? You know, do they still want to have the surgery? Are they still eligible for the surgery? We're also cleaning up the wait-list. Part of the idea of having an accurate wait time is that the people on the wait-list actually should be on that wait-list.

The Chair: Thank you.

Mr. Vandermeer, please, followed by Mrs. Forsyth.

Mr. Vandermeer: Thank you. First, I'd like to make a comment. My father recently, in the last couple of years, needed to be in the health care system and later on into palliative care at the Norwood centre. I have to say that he received exceptional health care. I know a lot of times you guys just hear the bad news. I think it's important that you hear the good news as well. So thank you for that excellent work.

In the 2010-2011 consolidated financial statements, on page 70, Alberta Health Services is showing a cash balance of $2 billion, a cash equivalent of $1.72 billion, and noncurrent cash and investments of $599 million. The question I have is: if Alberta Health Services has so much money in the bank, why does Alberta Health Services still need funding increases?

Mr. Sieben: Well, Mr. Vandermeer, financial statements are recorded on an accrual basis. What that means is that it's not a cash basis. It's not cash in, cash out. We have a number of accounts payable there that, if you look in the financial statements at the balance sheet, it'll show accounts payable and accrued liabilities, which means that we still haven't paid those payables. I don't have the numbers right in front of me – I could look them up – but that's the essence of it. Normally, what happens with most financial statements is that you might have the cash, but you haven't paid your bills yet. That's kind of the simple answer, and that's the way it works. As soon as the bill comes in the door, you don't pay. You might wait 30 days or 45 days, things like that. So that's the reason for it.

All we had as a surplus, if I remember correctly, was about $116 million at the end of the year, and that's only about close to four days of operational activity for Alberta Health Services.

Mr. Vandermeer: So actually a fairly tight . . .

Mr. Sieben: Yeah. Well, that's always the issue when you get into government-sponsored activities. Even as an auditor myself outside of Alberta Health Services you walk that fine line as to how much cash you have as a surplus. Or do you go into a deficit and then run the risk of not being able to meet your obligations as they become due? It is a fine line sometimes.

Mr. Vandermeer: Okay. I'm going to use my supplemental to ask a different question if possible. Last time we met I asked about Health Link and if it was financially viable to have nurses answering telephone calls and then sending them to emergency or health clinics, and you were looking into that.

Dr. Eagle: We look at the activity of Health Link as quite an important service for us. As you'll notice from the report, there are about three-quarters of a million calls made per year to Health Link. Not quite half but close to half of those calls are actually for reassurance of patients. Only about 16 per cent of those patients, if I remember correctly, between 15 and 20 per cent, actually go to the emergency department. The remainder, between this 15 and the other 45 per cent, will be referred to other types of health care providers in the community. It might be the local primary care network.

We believe that Health Link provides an important reassurance mechanism for the public. It's available 24/7. When we've looked at the kinds of people who use it the most, often it's mothers inquiring about the health of their children, and they need reassurance or advice on how to deal with a particular situation, which would be hard to get otherwise. So we actually think that Health Link is a very effective way of providing 24/7, 365 access so that Albertans, you know, can get simple advice or proper referral into the health care system.

Mr. Vandermeer: It sounds like it's working, then.

Dr. Eagle: I believe it is.

Mr. Vandermeer: Great. Thanks.

9:00

The Chair: Thank you.
Mrs. Forsyth, please, followed by Mr. Sandhu.

Mrs. Forsyth: Thank you. I'd like to talk about the comments that Catherine made in her opening remarks. You were throwing a lot of figures out when you were speaking, Catherine, so hopefully we'll get that recorded in *Hansard* so we can go back. If my figures aren't right, then maybe you can correct me because I was trying to jot the numbers down as you were speaking. You talked about the continuing care/supportive living beds that you were adding to the system of 1,150. I'd like to know what percentage of those are long-term care beds.

Dr. Eagle: Maybe I could start with that. I have the numbers for '10-11 right in front of me, so I can read those. Of the beds invested in '10-11, about 130 were long-term care, 660 were supported living for dementia patients. We had supported living 4, which is a high-level dependency supported living, where it's 326, and the lower level of supported living, supported living 3, was 39. I think that adds up to the right number. I may have transcribed a problem there. The majority of our investment is in supported living rather than long-term care. The reason for that is that when we do the assessments – and they're assessments that are designed internationally called interRAI; there is a standard way of assessing seniors patients – we find that about 15 to 20 per cent of patients actually by those criteria need home care. Many of the patients could, you know, receive supported living or advanced home care.

Mrs. Forsyth: How many long-term care beds do you currently have?

Mr. Mazurkewich: We have approximately 14,500, and we have approximately 7,000 supportive living beds.

Mrs. Forsyth: I want to ask, I guess, if I can follow up on the definition because we keep having different definitions thrown at us. Maybe you can explain to the committee the difference between a continuing care bed/supportive living bed.

Dr. Eagle: With the permission of the chair we have an expert on this sitting in the audience, Dave O'Brien, who is sitting to the right. Would it be permissible for him to answer the question?

The Chair: Please, sir. Just identify yourself for the record.

Mr. O'Brien: Thank you. Good morning. My name is David O'Brien. I'm vice-president for seniors' health at Alberta Health Services.

In answer to the MLA's question on supportive living, we have essentially two levels of designated supportive living where health care services are provided around the clock to clients. Supportive living level 3 is where a client will receive 24-hours-a-day health care aide assistance with daily living supports. There is 24-hour LPN supervision and care and treatment for clients in supportive living level 4 along with 24-hour health care aide. Then within long-term care there is the additional registered nurse supervision of the work and assessment of the client. The client in long-term care is typically unstable or unpredictable in their health needs and needs around-the-clock registered nurse.

The Chair: Thank you very much for that. Appreciate it.
Mr. Sandhu, please, followed by Mr. Mason.

Mr. Sandhu: Thank you very much, Mr. Chair. I want to make a little comment. My dad had surgery for gallbladder stones last year. He received excellent care in the Royal Alex. Not many people recognize the good work you guys do.

Secondly, if you look at page 13, annual report 2010-2011, public rating of access to emergency department services, currently actually you're at 59, and your target is 60. Where are we at compared to other provinces in Canada?

Dr. Megran: Thank you for that question. Many of the indicators we use are, indeed, very similar to what are used in other provinces and do allow for comparison. We have seen gains in those key indicators over the last few years. Maybe of particular note right now is that if you look at the two or three main indicators for emergency department functioning and flow through, we're about 7 to 16 per cent better than where Ontario is, and in the last few years Ontario has been touted as being quite innovative in the things that they've done. So that at least gives us a comparison to a major province that has undertaken a lot of initiatives with respect to emergency department wait times.

Mr. Sandhu: My supplemental question. The last few weeks I was running around, and a concern from a constituent is small babies. You know, when they go to emergency, they wait like seven, eight hours. They said that if it's a man or an adult person they can wait for that long, but small children cannot wait that long. Is there anything we could do to make it better?

Dr. Eagle: One of the things we have done is open the new emergency department at the University hospital, the Stollery children's hospital. That produces a significant amount of additional capacity in the Edmonton zone for the care of young children, including babies. The volumes that go through emergency departments are highly seasonal, and they're very much influenced by the viruses that are active in the community. So there are parts of the year where there's a lot of RSV, or respiratory syncytial virus, where there are a lot of visits. We aim to give good access all the time. Where we are challenged because of the viral issues like that, we bring on additional staff, and we try and make sure that we're triaging the people waiting for admission most appropriately so the sickest are seen first.

The Chair: Thank you.
Mr. Mason, please, followed by Ms Woo-Paw.

Mr. Mason: Thank you very much. I want to ask about emergency wait times, and I'd like to ask the question globally but also with specific reference to the Royal Alexandra hospital on the north side. Mr. Sandhu and I both represent constituencies on the north side of the city. The concern, of course, is that we're not

making progress that was promised, and on several occasions we've sort of recalibrated and reorganized and said that we're going to do something differently. I remember, sir, that when you were appointed, there was a major change in how we were going to attempt to improve these waiting times. I'd like to ask what the problem is and what can we do to fix it?

Dr. Eagle: It's a real significant issue in Alberta, particularly in the urban areas, and it's an issue across urban Canada, so it's one that we take extremely seriously. In late 2010, early 2011 the issue that drove the emergency docs in terms of becoming very public around their concerns was what was called EIPs, the emergency in-patients. What that was doing was blocking patients from being seen. People were sitting in the waiting rooms not being seen. That's, obviously, a significant safety risk.

The first thing we did was create these overcapacity protocols, right? So we got patients through the emergency departments into, you know, perhaps a hallway in the hospital, perhaps a waiting area in one of the hospital units, but people were being moved into the hospitals so patients in the waiting room could be seen. That's a fundamental step. It doesn't hit the wait time issue – you're right – but it's actually fundamental in terms of safety.

We've done a lot of things across the province in terms of trying to improve flow through the facilities. One, we've looked at bringing in technologies like lean into our facilities, so we lean out the processes, make it very, very efficient. Some of the emergency docs, particularly some at the Royal Alex, have led that process.

We've brought in experts from the U.S., who are very good experts from the Institute for Healthcare Improvement, who are themselves emergency docs, to help us design better processes across the bigger hospitals in the province. We're doing that right now.

We've brought in additional approaches called medical assessment units that allow emergency patients to be looked at in different areas.

We've looked at different staffing models. We make sure that we've got the right number of emergency docs to look after patients immediately, and we staff for the peaks, not for the 4 o'clock in the morning time when it's relatively quiet. What's it like at 10 o'clock and midnight?

We've done a lot of things. We've not lost any ground in wait times. We certainly haven't made the kind of progress that I would have liked. Part of the reason for that is that across the province we've seen a very significant increase in volume of emergency department visits. You know, over the winter, compared to other years, we've had a 10 to 15 per cent increase in volume. So while we've done a lot of things, keeping up with that increase in demand has been a real significant problem for us.

That's kind of my overview. Could I just see if Dr. Megran has anything to add?

9:10

Dr. Megran: I'll just quickly add that, in fact, over the past year in the 16 busiest emergency departments in Alberta it's actually an average of 17 per cent increase – 17 per cent increase – in the number of patients.

When you look at the four- and eight-hour indicators, we've made small gains, in the order of about 1 per cent versus the year before, but that is in the face of seeing 17 per cent more patients. Other indicators in emerg – such as how many people leave before they get seen because they're tired of waiting; the emergency in-patients, those people that have been seen but waiting for a bed in the hospital – have actually fallen during that time, but the four- and eight-hour ones have been more difficult to affect in part, we believe, because of the 17 per cent.

For the Royal Alex, itself, I will say that the staff being very, very engaged in leading change, more recently we're proceeding to introduce a clinical decision unit, which is designed to take care of more difficult to diagnose patients and to do that more quickly. As well, we have markedly increased what's called fast track, which is a separate stream designed to take care of those people with less serious complaints but who can get in and out quickly if you use your space properly. Our board chair mentioned the idea of using chairs for those people instead of stretchers and getting more people in and getting them through faster, thereby increasing flow.

Mr. Mason: Thank you.

Dr. Eagle, you didn't really touch on two factors that I'm quite interested in, and I hope that you'll be able to address them. First of all is the difficulty in clearing stabilized patients from the ER into acute-care beds because those beds are occupied by people who require either long-term care or mental health care beds. I'd like to know what's being done about that.

Secondly, Ms Roozen indicated in her opening comments that there is a move to increase the use of urgent care as a way of diverting people from the ER. I will note that the East Edmonton health centre has been sitting almost half empty for nearly two years, and an urgent-care centre is planned there. I'd like to know what plans you have for opening that urgent-care centre in order that we might relieve some of the patients. It's my recollection that over 30,000 cases a year at the Royal Alex ER were expected to be cleared, or forestalled, I guess, is the word because of the availability of that particular centre. If you could address those two points, I'd be most grateful.

Dr. Eagle: Thank you for that. I was just thinking when I was finished my answer that I hadn't really talked about things beyond the emergency department that influence flow, so your points are very germane.

What we've also been trying to do to keep patients flowing into hospital – we've talked about over capacity. Well, you know, sitting in a hallway or sitting in a waiting room in a hospital ward is not a good place to be, especially when you have a large number of patients who are waiting for placement in some form of continuing care. We call those the ALCs, or the alternate level of care patients. I think everybody is aware of the issues there.

Over the last while we've put a lot of effort into trying to increase seniors capacity, you know. The thousand beds a year, thousand spaces per year is very much driven by the need to decrease the number of ALCs in our hospital beds. On any given day 4 out of 5 admissions to continuing care come from the hospitals to try and keep that ALC number down. We've actually made some progress in the recent while about bringing down the ALC numbers, and I think the numbers sort of were about 200 less than we were earlier in the year. It's from a base that has been as high as 600 ALC patients. If you have that many alternate level of care patients, you have difficulty getting patients through the system. We have to improve our way of getting seniors back home or back into care centres, and that's a very significant part of what we're doing.

I think in some of the materials it talks about sort of a program where patients are seen in the emergency departments by home-care nurses, and some of those patients can go home from there. We're looking at programs where patients who are in the hospital and are waiting can perhaps, with appropriate home care, go home rather than going into a care centre. We're looking at everything

we can possibly do to try and use our hospital beds as efficiently as possible. So the ALCs are one piece.

The next piece is: how are we performing? If you look at the number of bed bays per hospital in Alberta, we use a lot of hospital bed bays. If we were the most efficient in the country, we'd use less, maybe about 10 per cent less. So we are looking to our teams about: how do we create a more efficient hospital environment? You know, there are a lot of things going on to improve throughput of the hospitals as well as the emergency departments.

On the urgent care . . .

The Chair: All right. Thank you very much. We have to move on.

Mr. Mason: I need to hear about the East Edmonton health centre, Mr. Chairman.

The Chair: No. Mr. Mason, there's a long list of members here, unfortunately, who are waiting patiently, and that question was very, very long.

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

Ms Woo-Paw: Thank you, Mr. Chair. Looking at page 76 of the AHS performance report, you have achieved an accumulated surplus of $116 million at the end of March 2011. I'd like to know where this surplus was directed.

Ms Rhodes: We've already answered that question.

Ms Woo-Paw: Okay. So why wasn't it directed to address priority areas like mental health services and address some of the food safety issues?

Ms Rhodes: As Don had mentioned earlier, the operating surplus represents about 1 per cent, the accumulated surplus, about 1 per cent or about three days of activity. As a general principle we use those operating surpluses or accumulated surpluses to assist with internally funded capital purchases, so the purchase of equipment or continued investment of IT systems that help enable patient care.

We also may do some internal restrictions for specific priority initiatives as well as sort of setting aside some funding in case in future years we have any operating deficit. So that's what that's used for. As Don said earlier, that's a very small percentage, less than 1 per cent of our funding.

Ms Woo-Paw: So how are you incorporating responding to some of the recommendations from the Auditor General's office around issues of food safety, mental health services, and IT in your overall operating plan? How do you intend to address some of those? Some of them have been in place for a long time.

Mr. Mazurkewich: Yeah. Part of it, as Deb just mentioned, is for the IT. We're using some of our monies for that. We've made investments of about $150 million to $200 million a year for the last few years in IT, so there's been significant investment in that.

The other part is that through the budget cycle we look at the minister directives and tier 1 targets and those kinds of things, and we put the money in. Now that we have the mental health and addictions strategic plan as part of this budget cycle going into '12-13, as I mentioned earlier, we're putting money in the budget to move some of those significant items forward.

For the OAG recommendations we meet with our board once a year, and we go through a progress audit, what we're doing, and we take the priority items from that that from our perspective will influence patient care and we try and make progress against those. I think that based on what the OAG's report said, we are making progress on those items, and I think that has been made pretty clear.

The Chair: Thank you.

Mr. Chase, please, followed by Mr. Xiao.

Mr. Chase: Thank you. Another set of questions on long-term care. Tatiana Marchak's family is but the latest to come forward with allegations of horrifying neglect and abuse occurring in our province's long-term care facilities, yet according to page 157 of the November 2011 Auditor General's report recommendations that systems for monitoring the compliance of such facilities with basic service standards be improved have gone ignored since 2005, October. For almost seven years now a recommendation that might have prevented tragedies such as those suffered by the Denyers, the Chudyks, and now the Marchaks has been ignored. Despite health Minister Fred Horne's claims that these are one-off anomalies, the number of abuse complaints continues to escalate. Why haven't Auditor General Fred Dunn's recommendations been implemented?

9:20

Dr. Eagle: The Auditor General's report from November indicates that we're making progress on many of the issues related to seniors' care. Frankly, as I said earlier, seniors' care is a major priority for us. If you look at the pillars in our business planning, you'll see that seniors' care, continuing care is a big priority. The provision of safe services is obviously of significant concern. Where we have opportunities to improve quality of review, quality of patient safety, look at what we can learn from the incidents that you mentioned, you know, we will do that, and we're doing that right now. We're looking at: how do we improve the quality of the assurance for the public about the services that we offer?

You know, I could ask Dave O'Brien to go into more detail, but I have to give you the commitment that we take this very seriously. It's not so much the Auditor General's recommendations; it's what this means for people and clients in our facilities or facilities that we contract with. That's the most important thing.

Mr. Chase: The results in continuing care facilities are even worse, with double the number of continuing care individuals ending up in emergency hospitals.

But I'm going to stay with long-term care. During the AG's 2005 facility visits it was found that on average 31 per cent of basic service standards were unmet. In the absence of adequate monitoring systems does AHS have any idea what the current rate of noncompliance is?

Dr. Eagle: We have a monitoring system. I can't give you a number off the top of my head. We can provide to you, probably in writing, I think, if that would be appropriate, you know, more detail on what our current inspection standards are, how often facilities are reviewed, and what the type of error or type of omission is in those care facilities. We can provide that in writing in detail if that would be satisfactory.

Mr. Chase: That would be appreciated. Thank you, Chris.

The Chair: Thank you very much.

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

Mr. Xiao: Thank you, Mr. Chair. Good morning. I'm going to ask a couple of tough questions. You know, I've been knocking on doors for years. I have people working in management, I have nurses, and I have many doctors living in my riding. The consis-

tent message I get is that we have too many chiefs, no Indians. My question is that in terms of the payroll cost – I'm a businessman – 85 per cent goes to pay salaries and pensions and benefits. No other business can survive like that.

Also, why do we need more than 70 vice-presidents? Can you imagine having 70 vice-presidents in one room to make a decision? We have so much middle management and front management. Those are my questions. I hope you can address them.

Dr. Eagle: I ask myself the same question frequently. I think it's a very good question of: do you have the right balance between the ability to lead an organization of 90,000 people on an $11 billion budget? What is the right answer there?

When AHS was formed, we had about 144 CEOs, VPs, and so on, and that was costing the system somewhere around about $28 million, $29 million to support those people. We currently have 84 people – what I was going to say was actually inappropriate. I was going to use some terminology that was probably a little too slanglike. We have 84 people in roles. I have made a commitment that we will have no more than 85 vice-presidents at this point in time. That's the commitment. We're currently spending about $18 million versus $28 million before.

What is the right size? If you were in Ontario, we would have the same issue with CEOs. You know, each hospital has its own CEO. Look at this system, and there is one CEO for the province. There used to be nine CEOs. Before that, there were probably 50 with all of the hospitals. So we have consolidated leadership. Do we have it right? Perhaps not. Is it maximally efficient? Perhaps not. But if you look at the kinds of roles that people have, instead of having a CEO in charge of the Foothills hospital, we have a vice-president. That's the decision we've made in terms of this organizational structure. To some extent it's a labelling thing. We have to call those leaders something.

So that's where we are. I appreciate the question. You know, I think that in order to demonstrate value for money to the public of Alberta, that is a great question. Cathy talked about the administrative costs. That's part of it.

Mr. Xiao: Thank you for the answer. I'm saying, sir, instead of comparing it to ourselves in the past – I don't think that's the right answer – looking around, you know, comparing ourselves to GE, Boeing. Many other international companies, the size of their business is probably 10 times bigger, but they have a much lower number of executives. So that's my point. We have a lower number of executives compared with what we had in the past, but it doesn't justify that that's the right number. This is the constant message I got at the doorstep.

My next question is: how much overtime pay did we incur for nurses? A lot of new grads cannot get jobs, but the existing nurses are being burned out. On average in Alberta most nurses are making over a hundred thousand dollars, including their overtime pay, but they're not necessarily that happy about it. You know, all I'm saying is: how can we improve the situation? We've got newly graduated, well-trained nurses waiting for jobs, but they cannot get them. My question is: what measures are you going to take to improve the situation? The nurses, the doctors, everybody all talk about how we are short of doctors and we are short nurses, but we've got nurses-in-waiting. That's my question. I'm sorry for the hard questions.

Dr. Eagle: No. They're good questions. One of the other areas the annual report talks about is the percentage of full-time staff that we have and, you know, how much of the graduating class we are hiring. We have a commitment to hire at least 70 per cent of the graduating RN class. There are other parts of the health industry beyond AHS in this province that need that class as well. So we are very committed to hiring nurses that have graduated in this province. We would like to hire them full-time. We are looking at what impediments there are to hiring people full-time. I mean, some of it is the mechanics of the rotations of how people get scheduled. Where we're finding those things, we're trying to break down those barriers. It's really important that we hire people to full-time jobs.

There's another side to this, too, and that's: what do the workers actually want? We have situations where we've hired full-time nurses, you know, say, a batch of six full-time nurses. They work for about a month or two as full-time, and then they apply to go part-time. That is a major problem for us, the incentives for individuals to work part-time, because they capture a lot of the benefits, but they have a lot more freedom of their time. That is a problem for us. So we have to design the right incentives into our agreements with UNA that encourage people to work full-time. There are many problems with having a large number of part-time workers, and I won't go into that, but our goal is to hire full-time, keep overtime costs down, and move away from this part-time worker culture that we have in the health system in Alberta Health Services.

The Chair: Thank you.

Mr. Kang, please, followed by Mr. Allred.

Mr. Kang: Thank you, Mr. Chair. According to page 69 of the AHS 2010 annual report spending for promotion, prevention, and protection services decreased in 2011 by 5 per cent, yet in the same year AHS failed to meet its targets for influenza immunization rates for both seniors and children. The influenza immunization rate among seniors was 16 per cent below target and that of children six to 23 months was 48 per cent below, pages 35 and 36 of the performance report. How does AHS intend to increase these rates in the absence of adequate funding?

Dr. Eagle: The issues of funding were related to how we hire staff. It takes time to hire staff, so there's a delay in hiring staff. There is no more important program in this province for young people and for seniors than immunization programs, so the identification of this issue is very serious for us. We have done everything we can to encourage people to come and have immunizations. I have done personal radio spots across this province to try and encourage people to come and get vaccinated. You know, if you have a way of indicating to the public that's better than what we're doing about how we get the public to show up for vaccination clinics or how we get the parents to have their children vaccinated, I am very, very interested to hear that. We are trying everything that we can to get people to receive their vaccinations because it is the most significant public health issue that we have.

Dave?

9:30

Dr. Megran: I'll just add quickly that this issue was highlighted during the H1N1 pandemic. Alberta really lagged behind in terms of the proportion of the population vaccinated, and we've seen these kind of trends with more routine vaccination. We've entered into discussions with Alberta Health and Wellness, who are obviously an important partner in vaccination and public health. I think we need to actually look at what it is that Albertans expect from vaccination and why we have significant portions who don't seem to want to come forward regardless of how much we advertise, how much we stress it, and how easy we make it to get

the vaccines. I think we really are at a point where we need to understand the factors in Albertans' minds about vaccination if we're going to make significant steps forward.

Mr. Kang: Okay. My supplemental is around cutting spending, too. Why would AHS cut spending in an area proven to diminish health care costs in the long run? How is cutting spending going to help make Albertans aware that they should have their immunization documents?

Dr. Eagle: I am not aware that we are cutting spending. We may not have spent everything in the budget, but I'm not aware that we're cutting spending. If we're not meeting our budget, it's because of staffing. We just can't find the staff.

You know, if you look at one of the other pillars in our annual report, it's related to health promotion and wellness. That is an increasingly important concern for us. With an aging population and a population that has increasingly more than one chronic disease, the ability to deliver appropriate population public health is absolutely critical.

The Chair: Thank you.

Mr. Allred, please, followed by Mrs. Forsyth.

Mr. Allred: Thank you, Chair. I guess to follow up, Dr. Eagle, on some of the questions you've just been asked, you just said that you're not cutting spending, but the next fiscal year is going to be the last year you have a 6 per cent increase guaranteed. Then you go down to 4 and a half per cent. I guess my question is sort of a follow-up to Mr. Kang's. How are you going to manage with that 1 and a half per cent decrease in funding; i.e., spending?

Dr. Eagle: I'll start and maybe look to my colleague to my right to fill out the other answers here. We have started planning already for the 4.5 per cent years. We have to. If you look at the dollars that we spend in health care in Alberta – and I'm talking as a citizen here – and the sort of health impact we get, we know that we're not as efficient as we can be. You look at, you know, how many nurses there are per bed. You look at what the costs of those nurses are per bed. You look at what our average length of stay is. We know that there is lots of improvement we can make in this health care system. We know that. So we're looking aggressively at how without negatively impacting care. I'm a physician. I'm not interested in negatively impacting care, but I am interested in making sure that Albertans get the best bang for the buck that we can get out of this.

We know from the work that Dr. Duckett did when he was here that there are a lot of questions you can have about the efficiency of this system. I think that my job, in addition to delivering care, is to look for those efficiencies. So we are looking at a very broad sweep of things. Some of them relate to the administrative overhead. Some of them look to: are our back office systems as appropriate as they should be? Some of them look to: how efficient are our acute-care operations? Are there things that we can do differently there? With our board we're looking across the board at those things.

I would say that a 4.5 per cent increase in revenue is not a decrease. I mean, most places in the country are looking at things that are far more negative than that.

Mr. Sieben: If I might just add to that, sir, that we've set up a sustainability committee made up of the chair, the vice-chair, and another important member of our Audit and Finance Committee together with Alberta Health Services administration. We already started about six months ago looking at going from 6 per cent down to 4 and a half per cent.

Dr. Eagle is correct. It's easy to cut, but that's not why we're in the business. People's lives are at stake, so we've got to wring out the efficiencies and become more effective in what we do. Now we've got a committee to do that, a subcommittee that will report to audit and finance and then through the board to make sure that no harm comes to patients in what we're trying to achieve in terms of going from 6 to 4 and a half per cent.

Mr. Allred: Well, thank you. I appreciate that you're addressing those efficiencies and that your primary concern is the health of Albertans. There's no question about that. Certainly, we do have budgetary concerns because the percentage of gross domestic product going to health care over the last number of years is just climbing steadily, and we can't continue to see that.

I guess my supplementary will be related to what you have done over the past three years, when you have gone from, actually, a dozen different agencies to now only one, in reducing some of the redundancies in staffing.

Mr. Mazurkewich: There's a whole variety of factors. One of the things I do want to point out is that the administrative costs as a percentage of the total budget are the lowest they've been in this province for 10 years. The records go back 10 years; we've got the lowest.

We've done a number of factors. As Dr. Eagle mentioned earlier, we've been streamlining the back office kinds of things. The procurements: we're consolidating procurements; we've been driving harder bargains with the vendors, and we've been hearing about it from them, right? So we're looking at those types of things. We're also looking at, as I mentioned earlier, heavy investment in IT for the efficiencies that IT brings. We've been doing major investments in that. A simple example of something that we're experimenting with right now, as some businesses are doing, back to what outside private businesses are doing: we're going to hotelling concepts. Rather than providing leases and having to spend money on leases, we're going to have this September about 250 people working from home. Other companies are doing that, and we're moving down there. That decreases our leasing costs significantly for 250 people.

As we go through those types of exercises, it's the same thing that we've been looking at on the clinical side. If I can use hips and knees because people are interested in those, we've decreased through clinical leadership the average length of stay. That saved us about $6 million or $7 million per year worth of hospital bed capacity. It allows us to put the same number of patients through the system but saves us about $6 million to $7 million worth of beds. We have a number of initiatives on the clinical front as well looking at how we can be more efficient yet still remain effective in terms of good patient care.

So there's a whole swath of items.

Mr. Allred: Can we get a written follow-up on your decrease in administrative costs over the last years that you've just mentioned?

Mr. Mazurkewich: Sure.

Mr. Allred: Thank you.

The Chair: Thank you.

Mrs. Forsyth, please, followed by Ms Woo-Paw.

Mrs. Forsyth: Thank you, Mr. Chair. I'm looking at the outstanding recommendations of the Auditor General and going back to

the criticisms since 2005 in regard to seniors. We've had over seven years a thousand confirmed injuries or deaths of our elderly and disabled. Last week I asked the Minister of Seniors in regard to the facts, and we were quite taken aback when he said that there have been 22 serious injuries or deaths over the last year in the facilities.

I guess my question to you is: how can you even say that the Protection of Persons in Care Act is working when we look at some of the appalling things that are happening with our seniors and our elderly and our disabled citizens, our most vulnerable? I just don't know what to say about that, to be honest with you. Continually as the Seniors critic I hear from all over the province from seniors and from their children on things that are happening. The latest I have: two of your VPs were stopping some things that were happening at the General hospital. I can't imagine that that's what you want as an organization, so how are you going to address that?

[Mr. Fawcett in the chair]

Dr. Eagle: There are a number of facets to your question there. I think that the Protection of Persons in Care Act was changed recently to have a much broader definition of abuse. With that broader definition I think we'll be getting more uptake, you know, more transparency around the issues that are occurring and earlier notification of where there are problems.

I think it might be worth having Mr. O'Brien just talk briefly about how we ensure quality because what you're talking about is how we ensure quality, as I understand the question.

Mrs. Forsyth: Well, Chris, I think it's more about how you ensure that patients are taken care of.

Dr. Eagle: Yeah.

9:40

Mr. O'Brien: It obviously is a huge concern for Alberta Health Services and for our contracted operators. What we are doing is in respect to our quality audits and inspections from the various agencies that undertake these inspections: the Ministry of Seniors, the Ministry of Health and Wellness as well as Alberta Health Services, the office of the public guardian as well as the Health Facilities Review Committee. So there are a number of different opportunities for us to be within our contracted facilities to ensure that the level of care is adequate. We can't be there around the clock, obviously. We contract with providers to do that.

We are working to really get the message out about the mechanisms and the methods for patients, for clients, for families, and for other caregivers to report any incidents or issues that exist within the facilities. It's a real way of trying to be as proactive as possible around identifying opportunities for improvement or issues that might exist within current facilities to avoid these unfortunate cases.

Mrs. Forsyth: I have a supplemental, but I know that there are others chomping at the bit to ask questions, especially Mr. Mason, so I'll give up my supplemental.

The Deputy Chair: Sure.

Ms Woo-Paw, followed by Mr. Mason.

Ms Woo-Paw: Thank you, Mr. Chair. One of the recommendations from the Auditor General's office calls for developing a protocol with the nonprofit sector to look at better co-ordination. My riding is one of the fastest growing areas in the city of Calgary, and it has no baby clinic. The previous health authority purchased a piece of land for $4.1 million back in 2006 for a health facility. I guess my question is: what kind of working relationship does AHS have with, say, the municipalities and the nonprofit sector to look at providing health services and facilities in fast-growing areas?

Dr. Eagle: I think we'd start by saying that each community is different. We've asked each zone to develop what we call zone implementation plans, which are annual plans that look at what the health needs are for each area within the zone. We have health status data and demographics right down to the postal codes, so we can have very detailed views of, you know, what services are needed. We're trying to make our services match the needs of the population. We're looking more and more at high-needs populations where services are not available, you know, making sure that those services are there.

Some of the work we've done in east Calgary is the first glimmer of that, where we're trying to bring, you know, into the community health centre there the kind of services needed in that community. As we progress with our matching of population needs to health services, you know, get that in balance, I think we'll see a lot better involvement.

In the East Calgary health centre, for example, we're looking at relationships with all of the different agents, whether they're municipalities, whether they are, you know, the other government social services agencies that we need to connect with. We're also looking, as we go into the next generation of these things, at how we could have a relationship with the private sector so that we could have sort of different services that people need, more wellness services that aren't covered by government, for example, on the same site as the family care environment that is needed to support people at risk.

Ms Woo-Paw: I have to forgo my planned question. I know that the reason that facility has been bumped off the capital plan two or three times is because we have one of the healthier populations. I agree. I support the decision to bump off this facility to build the east Calgary facility first because of greater need.

However, in an area of 62,000 people and with, you know, 8 per cent of our people living in poverty, just like everywhere else, an average higher than the city average of people who did not complete high school, an average higher than the city average of people who are single parents in my area, a seemingly middle-class area – they're still going to the baby clinic that I took my children to 30 years ago. There's nothing. There's no community association building. There's not one community-based service agency that's located within this riding of 62,000 people.

Then we also talked about wellness and promotion. I think there might be a need for Health Services and the city to actually look at a better co-ordinated plan for new areas in our province.

Dr. Eagle: We accept your comments, and I think that's a struggle across the entire province. I think it's a good example of: how do you make sure the investments actually match the needs of the people? You know, we need to make sure that we invest in the areas that do that.

The Deputy Chair: Mr. Mason, followed by Mr. Allred.

Mr. Mason: Thank you very much, Mr. Chairman. I'll be very brief, and I hope the answer can be as well. I remind the chair that there's another item of business under number 5, so I hope we have enough time to deal with that as well.

My question – and I would appreciate this in writing so we don't take the committee's time – is about patients requiring long-

term care or mental health or other more appropriate forms of care beds occupying acute-care beds. I would like to know the numbers of those, what types of patients, and some sort of general distribution: Calgary, Edmonton, south, north, whatever, however you keep your stats.

I don't need a verbal answer to that, but I would really like to know about the urgent-care centre at the East Edmonton health clinic and what your plans are for that.

Dr. Megran: You've identified a very important area. I think shortly we'll be hearing an official announcement, but as we go back to the Speech from the Throne, there was follow-up on the Premier's commitment to family care centres. There will be a number of pilot family care clinics initiated very soon. One will be in the East Edmonton health centre. The people developing that pilot site are out actively at the Royal Alex emerg looking for people who are unattached who have intermittent health problems that would be better cared for in another location.

We hope to have it open very soon. As that clinic evolves into the fall, one of the components will be to either offer through that clinic or link it to an urgent-care centre in east Edmonton. That's what we're trying to work through. In fact, Minister Horne has encouraged us and given that commitment that we need to go ahead and link that for that part of Edmonton.

Mr. Mason: Thank you very much.

The Deputy Chair: Well, you . . .

Mr. Mason: I'm happy to give it up, Mr. Chairman.

I just wanted to say that you didn't let the cat out of the bag because the minister had already said in question period that this was going ahead. I know you were nervous about that.

The Deputy Chair: Great.

We're going to take one more question. If you could please keep the questions and answers as short as possible here.

Mr. Allred: Okay. Ambulance service, particularly related to St. Albert. We had an integrated service. We had five ambulances, and now we're down to two and a half. The response times have increased. I know there's a question about these statistics, but 10 per cent of the time there are absolutely zero ambulances in St. Albert. That's a major concern, going from five all the time down to zero.

Mr. Mazurkewich: Yeah. We're cognizant of the St. Albert situation. We've studied it. We're actually feeling reasonably comfortable from the Alberta Health Services side, but we continue to monitor it. We've examined the usage of the ambulances – how often they're used, when they're used, what days, what times – and we've added capacity in Edmonton, which we think will help in St. Albert as well. We continue to monitor the situation. We will adjust, similar to what we did in Edmonton, if we believe the need arises.

There are some dispatch items in that community as well as we work our way through that.

We are monitoring that situation very closely, and we'll adjust if we need to. We have adjusted in other communities as the needs have arisen.

Mr. Allred: Okay. Thank you.

Just a follow-up. Family care clinics: could you identify the difference between family care clinics and primary care networks? A written answer would be fine.

9:50

The Deputy Chair: You know what? I'm going to rule that question out of order because it's not really a Public Accounts question.

We're going to go on. A few more members have questions that we don't have time to get answers for today. I'm going to let those members read their questions into the record, and if you could please provide the answers back to us in writing through the committee clerk as soon as possible, that would be great.

We'll start with Mr. Chase.

Mr. Chase: Thank you. I have four questions I'd like to read into the record, the first on continuing care wait times. According to the Health Quality Council of Alberta's recently released report the solution to the unacceptably lengthy wait times in the province's busiest emergency departments lies in dedicating resources towards improving acute-care in-patient occupancy rates. Yet as page 63 of the performance report appended to AHS's 2010-11 annual report indicates, individuals assessed and approved for continuing care placement waited an average of 47 days in acute and subacute hospital beds. One, has AHS now set a target for this indicator? If so, what is it?

Another 1,115 individuals, 140 more than AHS's target, waited at home for continuing care placement. Why has this number steadily increased since 2009-10?

Under mental health, amendments to the Mental Health Act in force since November 2010 allow for the issuance of community treatment orders, CTOs, yet according to page 157 of the AG's November 2011 report a number of recommendations that might enhance community-based mental health service delivery remain outstanding. Question one: why for almost four years has AHS not implemented the AG's recommendation and improved such things as wait time management and client follow-up? Two, how many CTOs might have been issued but for a lack of necessary of community supports?

Mental health, continued. In October 2008 the AG recommended enhancements to the following as a means to reduce gaps in mental health delivery.

- Mental health professionals at points of entry to the system
- Coordinated intake
- Specialized programs in medium-sized cities
- Transition management between hospital and community care.

Meanwhile, last summer Crown prosecutors were forced to abandon an application to have notorious sex criminal Eric Wanamaker declared a long-term offender due to delays in getting his psychiatric assessments performed. One, why according to page 157 of the AG's November 2011 report has AHS jeopardized patient well-being and public safety and ignored this recommendation for almost four years? Two, the current wait time in Calgary for a psychiatric assessment is as long as six months. What is the average wait time in rural areas of this province?

My final mental health set. The rate of mental illness in aboriginal people is significantly higher than that of the general population. It's been blamed on factors such as discrimination, oppression, and residential school trauma. Yet according to page 156 of the November 2011 AG report AHS continues to ignore calls to prioritize aboriginal mental health. One, why has AHS not acted on the AG's recommendation and prioritized aboriginal mental health issues in its strategic mental health plan? Two, since the 1970s Alberta's suicide rate has been consistently higher than the national average. Why has AHS not prioritized suicide prevention in its strategic mental health plan as the AG also recommended four years ago?

Thank you for this opportunity to have the questions on the record. I look forward to them being answered.

The Deputy Chair: Okay. Mr. Kang.

Mr. Kang: Thank you, Mr. Chair. My questions are about emergency wait times. According to page 53 of the performance report appended to its 2010-11 annual report, AHS failed to meet its own target of having 70 per cent of patients in the province's highest volume emergency departments discharged within four hours. Just recently we learned such targets will not be met this spring either. My first question, to quote from Dr. Paul Parks, who warned 18 months ago of a potential catastrophic collapse in the system, is: "What does accountability mean to this ministry?"

My supplemental is: since they are included in this performance measure, can AHS please tell us how many patients left without being seen? How many left against medical advice? How many died before or during an emergency room visit in 2010-11?

I've got a question on physicians and staff engagement. As the Health Quality Council of Alberta's recently released report confirmed, physicians in this province have long felt intimidated, placated, muzzled, censored, and ignored, yet AHS has set a performance measure target for physicians' overall engagement of just 43 per cent. My first question. According to page 71 of the performance report appended to the AHS 2010-11 annual report, only 26 per cent of the physicians associated with AHS responded positively to statements such as "I am proud to tell others I am associated with Alberta Health Services." How does AHS account for such appalling results?

The supplemental one is: why has AHS set such low performance measure targets for both physician and staff overall engagement?

This one is on the legal claims. Note 18(d) in the consolidated statements of financial position, page 98, AHS 2010-11 annual report, indicates that as of March 31, 2011, AHS is named as a defendant in 361 legal claims; 314 of these have specified amounts totalling $325,490, and the remaining 47 have no specified amounts. My first question: is AHS able to provide a breakdown by cause of action of these 361 claims? For example, how many are claiming negligence, and how many are claiming wrongful dismissal? The supplemental is: how many claims have been filed against AHS since March 31, 2011?

Thank you.

The Deputy Chair: Okay. Thank you, Mr. Kang.

Mr. Xiao.

Mr. Xiao: Thank you, Mr. Chair. The annual report on page 21, the lab tests. My question to you is: in the last year, between 2010 and 2011, we had 61,260,258 lab tests. Given that the population we have today – I just round it up – is about 3,780,000 people, that means every single Albertan had . . .

Mr. Mason: What's the question?

Mr. Chairman, are people supposed to just read their questions?

Mr. Xiao: This is the question.

The Deputy Chair: Please keep your questions short.

Mr. Xiao: Yeah. This is a question. I'm not reading notes. What's wrong with that?

That means every individual Albertan has done close to 16 lab tests.

The Deputy Chair: What's the question? Please read the question.

Mr. Xiao: My question is: what's the cost per lab test? I just assume there must be a lot of redundancy. What measures are you going to take to reduce that? Different doctors send you for the same tests again and again. That's my question.

The Deputy Chair: Okay. Thank you very much, Mr. Xiao.

I want to thank Dr. Eagle and Chair Roozen for coming today. We appreciate your answers. You guys don't have an easy job to do, delivering health care to Albertans, but we do appreciate your being here and taking our questions. Please feel free to go. We have other business to conduct, so the committee will be staying here.

We're going to be moving on to other business. I believe, Mr. Mason, you have something under other business.

Mr. Mason: I do. Mr. Chairman, I have two motions. The first one I'll make right now, that

> the Public Accounts Committee requests the Auditor General of Alberta to conduct a value-for-money audit of the entire drilling stimulus initiative to determine if it was an effective and efficient use of taxpayers' dollars to stimulate employment in the oil and gas sector.

Mr. Chairman, I have some documents that were obtained under freedom of information, internal documents discussing the progress of the drilling royalty credit program. It makes a number of points.

- [The] program has been onerous to the Crown and industry to administer.
- Industry has expressed concerns that they will be unable to receive payments for all credits established . . .
- As such industry has requested that government consider options that would allow industry to receive payment for more credits.
- Current estimates are that drilling credits exceed the royalties available by . . . 60%

Well, there are a number of things. People can have a look at the documents.

Mr. Chairman, this was a program that cost $2.9 billion, but during the period that it was in effect, there were still 10,000 jobs in the sector that were lost. The question is whether or not $3 billion got value for money.

Now, the Auditor General has reported that the drilling stimulus initiative program was functioning as designed, but to say that a badly designed program was functioning as designed is not particularly helpful. What I think we need here is a value-for-money audit to determine if, in fact, the $3 billion invested in this program was well spent and whether or not the program was, in fact, an effective program and whether it delivered the results that it was intended to.

10:00

The Deputy Chair: So you have a motion that you're moving?

Mr. Mason: Yes. I thought I made it.

The Deputy Chair: Okay. I think you did.

We have a motion on the floor. I think, Mr. Vandermeer, you have some comments.

Mr. Vandermeer: This is the motion that we're talking about here, number 1?

The Deputy Chair: Yes.

Mr. Vandermeer: I don't think it's the Public Accounts Committee's responsibility to be telling the Auditor General what he should be doing and what he shouldn't be doing. I think if they

feel that it's necessary to do an audit, it should be up to them. I don't think it's our mandate to send the Auditor General on wild goose chases just like we did with the health inquiry.

The Deputy Chair: Thank you, Mr. Vandermeer.
Mr. Allred, followed by Mr. Chase.

Mr. Allred: Thank you, Mr. Chair. We've just been handed a three-page document, and without having time to really look over this document and compare it to the motion, we don't have any time left to make a decision on it. I wouldn't be prepared to support it at this time.

The Deputy Chair: Okay. Thank you very much, Mr. Allred.
Mr. Chase.

Mr. Chase: Thank you. It was characterized as a wild goose chase. Auditor General Fred Dunn indicated that we were potentially failing to collect billions of dollars in our previously designed royalty program. If we are losing out on billions of dollars, I think Albertans would like to know if it's because of overly rich drilling credits or if it's due to failure to collect what our royalties are currently set at. We have never in this province collected all the royalties that we're due regardless of the royalty rates set. We're talking billions of dollars.

We're not ordering the Auditor General to take this on. We as the Public Accounts Committee are responsible for the well-being of the management of Alberta's economic resources. We're requesting that Albertans get their fair share. I think it's a reasonable request, and I'm looking forward to hearing the Auditor General's response with regard to this request.

The Deputy Chair: Mr. Saher, would you like to comment?

Mr. Saher: Yes. Thank you. In trying to be practical and move this issue forward, I think a minor change to the wording of the proposal might help. So if I could give you that suggestion.

> That the Public Accounts Committee ask the Auditor General of Alberta to consider conducting a value-for-money audit of the entire drilling stimulus initiative in accordance with the Auditor General Act to determine if it was an effective and efficient use of taxpayer dollars to stimulate employment in the oil and gas sector.

Mr. Mason: That's friendly to me, Mr. Chair.

The Deputy Chair: Okay. Well, I'm just not sure that Mr. Saher can make an amendment to a motion. It needs to be a member.

Mr. Mason: Well, I'm prepared to modify it.

The Deputy Chair: You'll modify your motion?

Mr. Mason: Yes. Absolutely.

The Deputy Chair: Okay.

Mr. Allred: Well, Mr. Chairman, just for clarification, what are the modifications? Is the word "request" changed to "ask" and after "Auditor General of Alberta" to "consider conducting"? Is that the only change?

Mr. Saher: Correct.

Mr. Allred: Well, Mr. Chairman, I don't think that really changes the intent of the motion at all. I still have concerns that we need to study this document before.

Mr. Saher: If I could answer, you see, I sit here as the Auditor General listening to all members of the committee. The sessions that we sit in at are incredibly useful in helping the audit office in prioritizing its work program. I think the member who brought this motion forward has an issue that he would like the office to consider doing audit work on, and I think that that's how the office of the Auditor General and the Public Accounts Committee should interact. Hence, my attempt to recraft the motion such that it's simply members of the committee doing what I think is perfectly within their responsibilities, to ask the office to consider doing a piece of work.

Mr. Kang: I think, Mr. Chair, we already know that 10,000 jobs were lost even though we had this drilling credit program in place. I don't think there's anything much really to study here. It's fairly reasonable to ask the AG to conduct the review of this, so I'm supporting that motion.

The Deputy Chair: Okay. Mr. Sandhu, then Mr. Allred, and we're going to have to wrap this up.

Mr. Sandhu: Just a question to Mr. Auditor General. Will you require any extra funding to do all this stuff?

Mr. Saher: No. I think one of the reasons for suggesting that the word "consider" be put there is, I mean, as an office we would have to take the request, the idea into consideration in relation to our work plans, our resources, skills available, and my mandate. But I commit to the member who put this idea on the floor that we will study it seriously as we do all sorts of other ideas that are brought to the office's attention throughout the year.

Mr. Mason: Then, Mr. Chairman, maybe my motion is redundant. I'll withdraw it under that undertaking from the Auditor General, which I appreciate very much.

The Deputy Chair: Well, certainly, I do think the Auditor General has the freedom within the purview of his office to undertake any investigation within the means of the Auditor General's office, and if the Auditor General chooses to do so, he's free to do so as an independent officer of the Legislature. If you're going to remove your motion, that would be fantastic, and we can move on. Is that what you're doing?

Mr. Mason: To the adjournment.

The Deputy Chair: The only other thing is that you did have another motion.

Mr. Mason: Yes.

The Deputy Chair: We do have some meetings scheduled after our break, and I believe we haven't scheduled any departments to come forward. We all know what the situation is, but in the case that we do end up being back here, I think the next meeting would be April 4. I do have word that the last time the Department of Energy was here was March 23, 2011. May I make the suggestion that we do schedule for the April 4 meeting, if there is one, the Department of Energy?

Mr. Mason: So moved.

Mr. Allred: Mr. Chairman, just a question on that to the Auditor General. Is that enough time to prepare the report that's required?

The Deputy Chair: Well, I don't necessarily know we need the Auditor General to prepare a report for it. I think it's just in our normal course of business that, you know, it's been a year since

we've had the Department of Energy. A member has brought up the desire to maybe have them here again, and we're looking for somebody on that date if it exists.

Mr. Mason: Do you want a motion?

The Deputy Chair: Sure.

Mr. Mason: Then I'll move that
on the April 4 meeting, if it occurs, we hear from the Ministry of Energy.

The Deputy Chair: That works for me.

Mr. Chase: Does the motion require a seconder?

The Deputy Chair: No.

Any other comments on that? Can we vote on that motion? All in favour? All opposed? It's passed. So we do have, if needed, a department that is identified to come before Public Accounts on April 4.

Now we're just going to move on to our last piece of business. I just want to mention for the record that we've received written follow-up responses from the Workers' Compensation Board and Alberta Municipal Affairs related to the February 8 and 22, 2012, meetings, and in accordance with our practices these responses have been posted on our public website and will be attached to the committee minutes as well. We still have not yet received any response from Seniors. That was, I believe, last week.

The date of our next meeting, if it's needed, is April 4.

Can I have a motion for adjournment?

Mr. Allred: So moved.

The Deputy Chair: Mr. Allred. All in favour? Passed.

[The committee adjourned at 10:09 a.m.]

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