Legislative Assembly of Alberta

The 28th Legislature
First Session

Standing Committee
on
Public Accounts

Health
Alberta Health Services

Wednesday, December 4, 2013
8:33 a.m.

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Standing Committee on Public Accounts

Anderson, Rob, Airdrie (W), Chair
Dorward, David C., Edmonton-Gold Bar (PC), Deputy Chair

Amery, Moe, Calgary-East (PC)
Anglin, Joe, Rimbey-Rocky Mountain House-Sundre (W)
Bilous, Deron, Edmonton-Beverly-Clareview (ND)
Donovan, Ian, Little Bow (W)
Fenske, Jacquie, Fort Saskatchewan-Vegreville (PC)
Hale, Jason W., Strathmore-Brooks (W)
Hehr, Kent, Calgary-Buffalo (AL)
Jeneroux, Matt, Edmonton-South West (PC)
Khan, Stephen, St. Albert (PC)
Luan, Jason, Calgary-Hawkwood (PC)
Pastoor, Bridget Brennan, Lethbridge-East (PC)
Quadri, Sohail, Edmonton-Mill Woods (PC)
Quest, Dave, Strathcona-Sherwood Park (PC)
Rogers, George, Leduc-Beaumont (PC)*
Sarich, Janice, Edmonton-Decore (PC)
Stier, Pat, Livingstone-Macleod (W)
Webber, Len, Calgary-Foothills (PC)

* substitution for Dave Quest

Also in Attendance

Forsyth, Heather, Calgary-Fish Creek (W)
Sherman, Dr. Raj, Edmonton-Meadowlark (AL)
Towle, Kerry, Innisfail-Sylvan Lake (W)

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Doug Wylie	Assistant Auditor General
Sergei Pekh	Principal

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Standing Committee on Public Accounts

Participants

Ministry of Health
- Janet Davidson, Deputy Minister
- Glenn Monteith, Chief Delivery Officer
- Susan Williams, Chief Strategy Officer

Alberta Health Services
- Francois Belanger, Zone Medical Director and Senior Vice-president
- John Cowell, Official Administrator
- Robert Hawes, Lead, Financial Reporting
- Mark Joffe, Senior Medical Director, Infection Prevention and Control
- David O'Brien, Lead, Primary and Community Care, Addictions and Mental Health
- Deborah Rhodes, Lead, Finance
- Rick Trimp, Interim Chief Executive Officer for Population Health and Province-wide Services

8:33 a.m. Wednesday, December 4, 2013

[Mr. Anderson in the chair]

The Chair: All right. Good morning, everyone. I'd like to call this meeting of the Public Accounts Committee to order. I'm Rob Anderson, the committee chair and MLA for Airdrie. I'd like to welcome everyone in attendance today, all our guests as well as regular members and those via teleconference. I don't think we have anyone by teleconference today, but if we do, hello.

Let's go around the table first to introduce ourselves, starting with the deputy chair on my right. Please indicate if you're sitting on the committee in substitution for another member if that be the case.

Mr. Dorward: My name is David Dorward. I'm the MLA for Edmonton-Gold Bar.

Dr. Massolin: Good morning. Philip Massolin, manager of research services.

Mr. Webber: Good morning. Len Webber, MLA, Calgary-Foothills.

Mr. Jeneroux: Good morning, everyone. I'm Matt Jeneroux, MLA, Edmonton-South West.

Ms Pastoor: Bridget Pastoor, MLA, Lethbridge-East.

Mr. Luan: Good morning, everyone. Jason Luan, Calgary-Hawkwood.

Mr. Stier: Pat Stier, MLA, Livingstone-Macleod.

Mr. Hehr: Kent Hehr, MLA, Calgary-Buffalo.

Ms Davidson: Janet Davidson, Deputy Minister of Alberta Health.

Mr. Monteith: Glenn Monteith, chief delivery officer, Alberta Health.

Mr. Trimp: Good morning. I'm Rick Trimp. I'm the interim CEO at Alberta Health Services.

Dr. Cowell: John Cowell, official administrator, Alberta Health Services.

Mr. Pekh: Sergei Pekh, principal, Auditor General's office.

Mr. Wylie: Doug Wylie, Assistant Auditor General.

Mr. Saher: Merwan Saher, Auditor General.

Mr. Anglin: Joe Anglin, MLA, Rimbey-Rocky Mountain House-Sundre.

Mr. Hale: Jason Hale, MLA, Strathmore-Brooks.

Ms Fenske: Hello. Jacquie Fenske, MLA, Fort Saskatchewan-Vegreville.

Mrs. Sarich: Good morning and welcome. Janice Sarich, MLA, Edmonton-Decore.

Mrs. Towle: Good morning. Kerry Towle, MLA for Innisfail-Sylvan Lake and the Wildrose Seniors critic.

Mrs. Forsyth: Hi there. I'm Heather Forsyth, MLA for Calgary-Fish Creek and the Health critic for the Wildrose.

Mr. Tyrell: I'm Chris Tyrell, committee clerk.

The Chair: Also, we'd like to welcome Mr. Khan from St. Albert. Go ahead. You say it again.

Mr. Khan: It sounded so nice when you said it. Good morning. Steve Khan, MLA, St. Albert.

The Chair: All right. That's right. You did say it better.

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First off, real quickly, let's approve the agenda. It's been circulated. Do we have a mover that the agenda for the December 4, 2013, Standing Committee on Public Accounts meeting be approved as distributed? Mr. Anglin. Those in favour? Any opposed? Carried.

Also, we have two sets of minutes to review this week. They've also been distributed. Could we have a mover that the minutes for the November 20, 2013, Standing Committee on Public Accounts meeting be approved as distributed? Mrs. Sarich. Those in favour? Any opposed? Carried.

An updated version of the minutes from last week's meeting has been distributed to everyone this morning as well. There was a minor error in the version posted to the internal site, which has since been corrected. Do we have a mover that the minutes for the November 27, 2013, Standing Committee on Public Accounts meeting be approved as distributed? Mr. Anglin. Those in favour? Any opposed? Carried.

All right. The reports being reviewed today are the Alberta Health annual report for 2012-2013, which, of course, will be a focus – however, any previous annual report is within the purview of this committee – as well as the Alberta Health Services annual report 2012-2013; reports of the Auditor General of Alberta from February, July, and October of 2013; as well as the 2012-13 annual report of the government of Alberta, consolidated financial statements, and the Measuring Up progress report. Members should all have copies of the briefing documents that were prepared by committee research services and the Auditor General as well.

Joining us today are representatives – they've introduced themselves – from both Alberta Health as well as Alberta Health Services. I would ask that each of you make an opening statement. Perhaps take about seven or eight minutes each maximum if you could so that in 15 minutes we can be wrapped up. Let's start with our friends from Alberta Health, and then we'll move to Alberta Health Services.

Go ahead, Ms Davidson.

Ms Davidson: Thank you very much, Mr. Chairman. I'm very happy to be here this morning to address the committee on behalf of Minister Horne. With me I have Glenn Monteith, who is the chief delivery officer for the ministry, and also Susan Williams, who's our chief strategy officer. As many of you know, I just joined the department in September, so the period which you'll be

discussing today is not a time that I was in the ministry. In order to make sure that we're able to respond to any and all questions that you have, I've asked them to attend with me as well as members of my senior team. Also, Dr. John Cowell, who's the official administrator for Alberta Health Services, is with us, and we'll be providing a joint presentation for opening comments today.

There were many accomplishments for Alberta Health in the 2012-13 fiscal year. In the interest of time I'll just highlight a few of them. We opened three pilot family care clinics to improve access to primary health care. We improved bathing standards for continuing care residents. We implemented a fresh food program for seniors in Alberta Health Services' long-term care facilities. There was significant investment in health infrastructure through the opening of the Kaye Edmonton Clinic in Edmonton, the South Health Campus in Calgary, and the announcement of an innovative new cancer centre in Calgary.

We've approved plans for redevelopment projects at Medicine Hat and Chinook regional hospitals. We've announced construction plans for the Grande Prairie hospital, the High Prairie health complex, and the Edson health care centre. We're expanding the immunization program to better protect against chicken pox, announcing a new tobacco reduction strategy to further protect young Albertans from tobacco and to take action to prevent tobacco use, and providing funding to enhance existing addiction and mental health services for homeless Albertans in Calgary, Edmonton, and Lethbridge.

8:40

There were 12 performance measures in our 2012-13 annual report. Performance measures were met or exceeded in several key areas: smoking among Alberta youth, access to primary care through primary care networks, reduced wait-lists for people waiting for access to continuing care in the community, physician utilization of electronic medical records, and increasing the percentage of generic prescription drugs dispensed by community pharmacists. Of the remaining targets that were not met, progress was achieved in reducing wait times for cataract surgery, reducing wait times for knee replacement surgery, reducing wait times for hip replacement surgery, increasing influenza immunization rates for children, and reducing the number of people waiting in an acute-care hospital for continuing care.

Regarding the Auditor General's report, as of today there are a total of 15 recommendations for our department. The department has concluded work on six of the recommendations, and we're awaiting follow-up audits by the office of the Auditor General. The new recommendation to Alberta Health for oversight and accountability for infection prevention and control is welcome to help ensure that we're doing everything possible to protect the health of Albertans. The Auditor General found no instances of immediate or significant risk to patients. We accept and will act upon the recommendations, including refreshing the infection prevention and control strategy, to reflect both the Auditor General's advice and the input we've already received from other key stakeholders.

Regarding the recent repeat recommendations on food safety, the Auditor General's recommendations relate to administrative processes and reporting, and Alberta Health is already working with Agriculture and Rural Development and Alberta Health Services to address the issues identified in the outstanding recommendations.

Work is actively proceeding on implementation of the remaining outstanding recommendations related to primary care networks, seniors' care, and mental health.

Regarding our financial picture for 2012-13 we received a clean bill of health from the Auditor General.

I'll now turn things over to Dr. John Cowell for remarks on behalf of Alberta Health Services, and I look forward to your questions.

Thank you very much.

Dr. Cowell: Thank you, Janet, and thank you, Mr. Chairman. My associates and I are very pleased to be here with the committee today, and we look forward to what will no doubt be a spirited discussion.

Mr. Chairman, we are here to focus on 2012-2013, the fourth year of operation for Alberta Health Services. Over that time Alberta Health Services has built a history marked by resilience and determination. Thanks to the commitment and compassion of the hundred thousand men and women who serve in our health system, over the past 12 months we have continued to lay the groundwork for growth and transformation, intensifying our efforts in building the progressive, responsive, patient-focused, and sustainable health system we want and need. Each day the staff, physicians, and volunteers of Alberta Health Services rise to the challenge and provide excellent care for Albertans in a rapidly changing and always demanding environment. We're focused on what matters to Albertans and why Alberta Health Services actually exists, to meet the needs and expectations of Albertans by providing timely, high-quality health care.

We use the Alberta quality matrix for health as our template and guide, and I know you are all familiar with this matrix from your knowledge of the work of the Health Quality Council of Alberta. I believe we are now seeing the benefits of the efforts that have been made and established in this provincial organization. As Janet has mentioned, wait times in emergency departments are stable even in the face of a 4 per cent growth in the number of people visiting emergency departments from 2011-12 to 2012-13. As you know, some 50,000 new Albertans came to our province in the last year, and many thousands more have arrived since the creation of Alberta Health Services. All those Albertans expect to receive high-quality and timely health care.

We thank the government of Alberta for its leadership and support for both planning and funding the health care services for Albertans. The stable funding you have provided has allowed us to focus on building a strong foundation. We are now in a position to maintain and build our focus on our key priorities, quality care and patient safety. In many high-priority areas we are seeing continued improvements and greater access to important services for Albertans. I'd like to provide a few examples of this.

There have been almost 700 additional cataract surgeries performed, and more than 1,800 hip and knee procedures were done in the past year.

Alberta Health Services has added nearly 900 new continuing care and palliative beds in facilities across the province in '12-13, and since 2010 Alberta Health Services has opened over 3,000 new beds.

New hospitals and community health care centres are being built, and existing ones are being redeveloped to ensure Albertans receive the care they need in facilities that meet the highest standards. Nearly $5 billion was invested in 41 active major construction sites, and over 1,000 other capital projects of all sizes by Alberta Health Services and its provincial partners were done '12-13.

In '12-13 Alberta Health Services invested over $100 million in health care equipment and new technology. This included upgrading, replacing, and purchasing over $30 million in diagnostic imaging equipment and over $76 million in other

equipment such as that that was needed at the South Health Campus in Calgary and the Kaye Edmonton Clinic, both of which opened in the past year.

For the coming year Alberta Health Services is investing $45 million in health care equipment and new technology, which includes almost $13 million in diagnostic imaging equipment, $6 million in cancer care equipment, and $26 million for other equipment needs.

While we are investing in what is most important to Albertans, Alberta Health Services is committed to achieving these savings by streamlining and improving efficiency, including reducing admin costs and overhead costs. In fact, Alberta Health Services' administrative costs are among the lowest in Canada at 3.6 per cent of total expenses.

Providing high-quality, sustainable health care is a challenge. It is a challenge that everyone in Alberta Health Services takes right on the head, with health and wellness care of our patients as their highest priority. We take this head-on. Our reason for being is to take care of people. Year over year we continue to improve the health care we deliver to the almost 4 million people, this growing population who rely on Alberta Health Services.

Over the years since Alberta Health Services was formed, everyone at Alberta Health Services has worked very hard to meet the many challenges that were known at the time of its creation and those that have emerged that were not anticipated. The approach has been to be responsive and responsible, adapting to meet the evolving health care needs of our population.

As many of you know, in my former role as the CEO of the Health Quality Council I was able to monitor and report on the health system both prior to the formation of Alberta Health Services and since its formation. I'd like to state personally that it is a great honour to be named as the official administrator and to work with the AHS team now on the health service delivery side. I'm very optimistic that you will be increasingly proud of this great organization.

Mr. Rick Trimp, who's sitting to my left, who's the acting co-president and CEO, will be the co-ordinator of questions that you will aim our way. We will ask other members of our team, which is behind us, to step forward and respond as appropriate to the content questions. Of course, I will answer any questions that are directed towards governance in my role as the official administrator.

Thank you.

The Chair: Thank you, Dr. Cowell. We appreciate that very much.

We'll now invite very briefly Mr. Saher, our Auditor General, to make an opening statement.

Mr. Saher: Thank you, Mr. Chairman. We issued an unqualified, or clean, audit opinion on the 2013 Ministry of Health consolidated financial statements, the 2013 Department of Health financial statements, and the 2013 Alberta Health Services consolidated financial statements.

In our February 2013 report, on page 24, we recommended that Alberta Health Services tighten its controls over expense claims, purchasing card transactions, and other travel expenses.

Starting on page 17 of our October 2013 report, we reported the recommendations we made in our audit of infection prevention and control at Alberta hospitals. We made one recommendation to the Department of Health and three to Alberta Health Services.

On page 59 of that report we repeat for the second time a recommendation to the departments of Health and Agriculture to improve the reporting on food safety in Alberta.

The list of outstanding recommendations for Health and AHS begins on page 123 of our October 2013 public report.

Mr. Chairman, thank you.

8:50

The Chair: Thank you very much.

I just want to remind everybody that this committee is not question period. We have different rules in question period than we do in this committee. That means: please stick to the annual reports, the reports of the Auditor General, things that have happened in the past. Now, sometimes those do, of course, touch on policy, and that's okay, but we can't be talking about future policy ideas and things like that moving forward. There is a line, and I'm going to try to keep that line today. Please, when you're asking a question, I'd like you to refer to something in an annual report or in the Auditor General's report or something. When you're prefacing your question, if you could please do that, that would be fantastic.

What will happen is that there will be roughly 30 minutes or so for the Progressive Conservative caucus. We'll start with 15 minutes, and then they'll end with 15 minutes as well. Then we have 15 minutes for the Wildrose caucus, and seven and half minutes for both the Liberal and ND caucuses.

With that, we'll start with the PC caucus.

Mr. Dorward: Thank you, Mr. Chair. I for one am very proud of Alberta Health Services. You know, the overall health in Alberta as you talk to Albertans is really good. I mean, we're a model for other nations and provinces. We're just not perfect; otherwise, the AG report would have nothing in it. I don't know if we'll ever see that. However, when you talk to individuals who have had the need to go through the health care system, generally speaking it's been a very good experience.

My mother, Chris Dorward, wrote a history of the school of nursing at the Royal Alex, and I physically moved boxes over from the old cancer clinic to the Cross as she went over and ran the front end of the Cross Cancer Institute. That was my mother. My sister Linda Keehn – I get mad at people when they say relatives and then don't put them in *Hansard*. I can point in *Hansard* to my sister Linda Keehn's name now. She was the director of nursing at the Royal Alex and retired as an administrative nurse to go and do bedside nursing. You know, health care has been in my family, and for a long time I've been around it.

My question is going to reference the annual report of the Ministry of Health '12-13, page 21 and also page 23. One need not necessarily dive right into that, but on page 21 it references family care clinics to support the evolution of primary health care. The next, page 23, talks about access to primary care through primary care networks. If I were to walk down the streets – and I have done this – and talk to seniors, particularly in the area of Gold Bar, and I said to them, "What's the difference between a family care clinic and a primary care network?" (a) they may not know what either is or (b) they may be confused as to the difference between the two.

By the way, on this committee we cut people off. We do that because we don't have much time for answers, but we do have the opportunity to have both of you respond to us in writing after should we not have a fulsome enough answer. So if we feel like we want to move on to the next question for time considerations, then, certainly, we always are happy to have answers come to us through the clerk.

Could somebody over there please update us on family care clinics and maybe talk about whether or not there is an advantage

to telling Albertans – I don't know if that's TV ads but in some way – how they can access these things? We could have a sign down every single highway in Alberta. That would be just fine as well. It's working now.

Mr. Monteith: Okay. I'll ask Susan Williams, the chief strategy officer for Alberta Health, to respond.

Ms Williams: Yes. I'll start with the first part of the question on what's the difference between primary care networks and family care clinics. Primary care networks have been around for about 10 years. There are 41 in the province. They are largely a network of family physician clinics who have chosen to work together as part of their practice. As part of that practice of a network of family physician clinics they receive additional monies, $62 per patient that they are involved with, and from that money they get to hire other additional allied personnel to provide multidisciplinary care to them.

The 41 primary care networks cover a large part of the province, but they are a network of family physician clinics. Yes, we recognize that there may not be recognition when people go in to see their family physician as to whether that particular family physician is part of a network, in what the signage is and what the information is that is provided to the individual and the patient. That has been talked about with the primary care networks, about both increasing the level of understanding about the services that are available through the primary care networks and that they are actually part of the network.

The family care clinics. As was mentioned, there are three open, and we are working with 24 communities right now on the establishment of family care clinics in those communities. They are meant to be more of a one-stop shop, so they will be more of a footprint in a community that will bring together both physicians and other allied health professionals in one location within a community. It's meant to have multidisciplinary care, so it could have both nurses and nurse practitioners. It could have dietitians. It could have psychologists come in. It could have a pharmacist and others on-site or that it could have associated with it.

Some of the key parts of a family care clinic are access to extended hours of care, linkage to social supports and other social services that individuals from that client population might need in their community, access to prevention and wellness, support and access to mental health and addictions support if that's required in the community. The basis of the family care clinic is looking at what are the needs of the people in the community for health care and health care services and then designing the services around the needs of the people.

Mr. Dorward: Okay. That's great. Thank you.

We're going to go on to MLA Webber, and then MLA Amery, and then MLA Sarich.

Mr. Webber: Thank you, Deputy Chair. I want to refer to page 66 of the consolidated financial statements, please. I'm just looking at the accumulated operating surplus, at the bottom of that page, of $1,078,114,000 worth of accumulated operating surplus at year-end. I'm just quite surprised that it is so high and why Alberta Health Services really has to have that much, a billion dollars, to spend. Maybe you can just comment on that.

I want to then move further on, to page 103, which is the notes to the accumulated operating surplus, note 19(a), the reserves. I'm just looking down at the numbers, of course. You've got the South Health Campus, March 31. You've got the restriction of net assets there. Is it $16 million? Then you've got the cancer research reserve of $17 million. Then you've got parkade infrastructure reserve of what I think is quite high, $33 million in restriction of net assets there.

You know, I've talked to many, many people not only in my constituency but at places like the Tom Baker cancer centre, at which I've spent a lot of time, paying $10 a day to park, and I've seen people going in there to get treated who can barely afford to even take the bus let alone park. Why do you charge for parking when you've got such a high accumulated operating surplus and you've got a reserve here in your parkade of that high amount? Maybe just comment on both of those if you don't mind.

Mr. Trimp: Thank you for your questions. For the details that you've asked, I'm going to ask one of our experts, Mr. Robert Hawes, to comment on those.

Thank you.

9:00

Mr. Hawes: Thanks. With respect to the first question about the accumulated operating surplus during '12-13 Alberta Health Services converted to public-sector accounting standards. Through that change, we actually introduced a new presentation of our financial statements on our balance sheet and our statement of operations as well as terminology. So with respect to the accumulated operating surplus if you go to note 19 – you referenced page 102. If you look, there's a note that shows that net assets invested in capital assets represents almost all of that billion dollars. That represents funds that AHS has already invested in capital assets, so it's funds that are not available to spend. It's internally funded as opposed to externally funded capital assets.

Mr. Webber: I see. All right. I apologize for that. I didn't realize.

Mr. Hawes: No. That's okay.

With respect to the balance there is $78 million of reserves, as you've pointed out, which is at the board's discretion for how to spend. There's also $82 million of unrestricted net assets, that has no ties to it at this point in time. But $82 million in our world is less than three days of operating expenditures, so it's a reasonable buffer.

With respect to parking, parking operations at all of our hospitals and facilities are required, and they are not funded by health care dollars. They are considered ancillary operations, and we need to generate revenue to support them on an ongoing basis as well as to cover off some of the major expenses. If we have a parkade, every number of years the floor needs to be resurfaced, for example. That's several million dollars. In any particular year we're not allowed to generate a deficit in operations, so what we do is that we charge revenues to cover the costs of maintenance and to cover those large, irregular expenditures on an ongoing basis.

Mr. Webber: All right. Thank you very much. I appreciate it.

Thank you, Chair.

Mr. Dorward: MLA Moe Amery.

Mr. Amery: Thank you, sir. Good morning, ladies and gentlemen. I apologize; I arrived a few minutes late. I don't know if my issue was covered. I represent a riding that is truly diverse and international. When I visit a school in my riding and I ask the teachers and the principals as to how many languages they have in that school, they tell me: we have 84 different languages. So I don't have to visit the world to know that we have truly the best health care system in the whole world. When I talk to these people, they tell me.

However, there is one issue that has been bothering me for many, many, many years, which is waiting times in the emergency rooms. Whether we are spending $3 billion on health care or $17 billion on health care, we are still having the same problems, the same complaints. Many people tell me that they take their sick child to an emergency room, and when they have to wait four, five, six hours, they leave without even seeing a doctor. I wonder if you can address that.

Mr. Trimp: Thank you for your question. We have asked Dr. Francois Belanger to come and to speak specifically about your question, so I'm going to turn it over to Dr. Belanger.

Dr. Belanger: I'm the medical director for central and southern Alberta, medical director for the Calgary zone, and I'm an emergency physician as well. We've been working on this problem for 20 years. ED wait times is a complex issue. It's an issue that's best described and addressed through sort of the flow of patients through emergency departments: looking at input, the patients that come in; throughput, how patients are handled through the emergency department; and output, how patients are actually admitted and discharged.

I think, actually, since 2010 we have been implementing the surge capacity protocol in the emergency department, which has a direct effect on improving the number of boarded patients, or patients waiting for admissions within emergency departments. This has freed emergency bed spaces for those patients that are in need in the waiting room and has had an immediate impact on patient safety and quality. I think that's really important, and our improvements have been consistent since 2010.

When you look at what we've done over the past year in emergency wait times, four hour wait times have stabilized. Remember that we've seen a substantial increase in the number of ED visits, which means that if we've actually stabilized and actually improved a little bit, we've actually improved productivity. So there actually has been an improvement. I would like to point out that nationally Alberta is leading in the rate of improvement in terms of emergency measures. In fact, in terms of emergency indicators we're leading in certain areas.

One of the biggest improvements that we've done is with regard to the culture piece, the piece with regard to an appreciation that the ED wait times are not an ED problem; they are a system problem. In fact, you address ED wait times by addressing initiatives on a system-wide basis, and that includes a recognition that there's a shared accountability, a shared responsibility in addressing those issues. So while we've actually not been quite able to measure this, we've made significant improvement in that area.

As I say to people: we have the pedal to the metal with regard to our initiatives in ED wait times, and we're not letting off. It is a long journey. We're progressing. We're moving forward. We're refining all of our capacity protocols, for example. We're continuing to address our capacity issues, including the number of beds and in-patient capacity such as South Health Campus, including the number of continuing care spaces in a community, including investments in home care, et cetera. We're continuing with investments in input, throughput, and output.

The Chair: Thank you very much.

We will come back to the government caucus at the end.

Now I'll turn it over to Heather Forsyth, the Wildrose critic for Health, and Kerry Towle, the Wildrose critic for Seniors. They'll be going back and forth, I believe, rotating, starting with Heather.

Mrs. Forsyth: I'm going to ask the first few questions, and then Kerry.

The Chair: Okay. Heather, go ahead for the first few.

Mrs. Forsyth: Thank you for coming. I'd like to go back to something that Ms Davidson said in regard to the waiting times and the improvements on cataracts and knees. I wonder where the September quarterly report is and why it hasn't been released. I understand from the minister that you're looking at doing something different, and I can appreciate that because December is now due. But where's the September report?

Dr. Cowell: I can take that if you want. The report actually is now ready and is going to be in the hands of the minister, literally, before the end of this week. What we've been doing in the last couple of months, especially since I've been on board, is reformatting the report so that it actually lines up with the dimensions of quality that are well understood through the Alberta quality matrix. The reason we did that is because we believe that for this report to be really relevant and understandable to both the public and to others, we needed to show the results and the targets that we were striving for in relationship to accessibility, acceptability, safety, efficiency, effectiveness. So it's taken a while for us to reformat it. As I said, it's going to be in the hands of the minister shortly, and I believe he's going to release it immediately thereafter.

Mrs. Forsyth: Thank you, Dr. Cowell. I can understand doing that for the December report, but the September quarterly report, quite frankly, should be out in September, and then you could have done all your reformatting for December.

Currently Alberta Health Services has 80 vice-presidents. Page 108, schedule 2, of the 2012-13 AHS annual report shows 11 executive FTEs, line item 2, and 38 FTEs for management reporting to CEO reports, line item 3. There are only 49 FTEs. Where can the others, now former VPs, be identified in the 2012-13 AHS annual report? Are any included in the other management line item? With the reduction of VPs from 80 to 10, where will the other 70 be designated, and has there been any overall reduction in compensation for the 70 former VPs? Can you provide through the chair a full breakdown of the 3,270 FTEs designated as other management in line item 4?

9:10

Mr. Trimp: Thank you for those questions. I would like to get back to you in writing on that. I think that, you know, this requires a significant amount of discussion and detail that you're asking for, so I would like to ask the chair if we could come back in writing.

The Chair: Of course, Mr. Trimp.

Mr. Trimp: Thank you.

Mrs. Forsyth: Thank you.

On the same page we see in line item 1 that total compensation for your former board came to $593,000. Now we pay a single administrator $580,000. The new Deputy Minister of Health also receives $580,000. The two current co-CEOs receive between $450,000 and $747,000 combined, and the outgoing CEO has a base salary of $580,000. Are these numbers correct, and if so, how do you rationalize that?

Mr. Trimp: You know, I think this is a discussion about fiscal year '12-13, and the questions that are being asked – Mr. Chair, if

I can ask you. This is the current year that is being asked about, so I just want a clarification.

The Chair: Member, are these from this year, or is this from last year's report?

Mrs. Forsyth: I'm going back to the same page that I referred to, page 108.

The Chair: Page 108 of . . .

Mrs. Forsyth: The AHS annual report.

The Chair: Okay.

Mrs. Forsyth: It shows the compensation for the former board. That came to $593,000, where you had a board of, I think, 12, four doctors included. Now I am asking you about the single administrator and the changes that have recently come to AHS.

The Chair: Okay. Well, we have to ask questions about the last report. Now, you can ask what the breakdown is for that number in the last report.

Mrs. Forsyth: All right. If you could do that, please. That goes back to what I asked you in question 1, on the breakdown for total compensation of the other management, et cetera.

The Chair: Okay.

Mrs. Forsyth: On page 110 the total dollar figure for the pay-at-risk component for the board and CEO direct reports totals $637,000. The Minister of Health has stated that he would hope that the performance bonuses would be returned. Were there any returned? What was the total amount actually paid out in the form of pay-at-risk for board and CEO direct reports? And what was the total paid in pay-at-risk through the entire organization?

Mr. Trimp: I'll be turning this question over to Deb Rhodes, who is our interim chief financial officer.

Ms Rhodes: Hi, Heather. Just to make sure I get all of your points. In terms of the $637,000 there was actually one pay-at-risk payment that was returned. That was the first part of your question.

The next part?

Mrs. Forsyth: What was the total amount actually paid out in the form of pay-at-risk for board and CEO direct reports?

Ms Rhodes: Okay. There is no pay-at-risk for board members. The total, then, for the senior management and vice-president levels was about $3 million for '12-13.

Mrs. Forsyth: Page 114, footnote (w), states that Mr. Merali was not paid severance upon his departure from the organization but that he's now disputing this. What is the status of Mr. Merali's severance, and what is the total amount that's been spent on legal fees fighting this?

Ms Rhodes: To date there has been no payment to Mr. Merali, and as of this point I don't believe that there have been any external legal costs incurred as well.

Mrs. Forsyth: Thank you.

I'm going to refer to the 2004 provincial mental health plan and some of the recommendations and criticisms and comments that came from the AG. Dr. Cam Wild was contacted by the ministry to perform a gap analysis on mental health programming in Alberta, and his report is now sitting on the minister's desk. When will that be released?

Ms Williams: Yes, you are correct. As part of Creating Connections: Alberta's Addiction and Mental Health Strategy one of the first key actions was to actually look at an analysis about what types of services and that were being provided on addiction and mental health. Dr. Cam Wild, from the University of Alberta, was hired to do that study. He has completed that study, called the gap map, looking at the provision of addictions and mental health services in Alberta, and that report is currently with the minister. It has just recently been finalized, and the intention is to release it momentarily.

Mrs. Forsyth: When you say momentarily, momentarily in the government's mind can be quite long. May I ask: will it be released by the end of the year?

Ms Williams: Yes.

Mrs. Forsyth: Thank you.

I'd like to talk about your capital planning process if I can. Each year AHS submits a list of 10 priority projects to Alberta Health for approval. For each of the last three years how many of the 10 priority projects were approved by government? Can you provide a list of all these approved projects through the chair? I'm going to preface this with: we have the FOIP on all of your projects, including the most recent. I'd like to ask: maybe you can explain to me why as an organization you spend an incredible amount of time and organization on prioritizing your 10 projects, and many of them aren't followed by the government.

Mr. Trimp: Thank you for your question. We would like to get back to you in writing on this one as well. You're asking for a significant amount of detail, so we'd be pleased to provide that.

The Chair: If you could please do that. Thank you, Mr. Trimp.

Could you please provide an answer to: is it usual for the government to fund all 10 of your priority projects every year?

Mr. Trimp: We work very closely with Alberta Health and Alberta Infrastructure in developing our project needs through a capital lens. As you know, we have a significant amount of infrastructure within the province that needs to be maintained and also, based on the need, may need to be a new build. We identify our capital projects through a capital planning process with government, and Alberta Infrastructure has taken a major role in that process over the last year.

The Chair: Are there ever projects that are approved that aren't on the list and ones that are not approved that are on the list? Do you know what I mean? Of the 10 projects, do some not get approved while others that aren't in the top 10 do get approved?

Mr. Trimp: Once again, that comes down to that we make a recommendation, and if there are needs that are identified throughout the course of the year that require a project to become more of a priority, then we adjust accordingly.

Mrs. Forsyth: I just want to comment on that if I may. You've had the Foothills kitchen renovation on your priority capital list for as far back as we can go, which has been for the last three years, and it's still not funded. It's been cited for several health citations with asbestos and mould, and it still hasn't been fixed. It's been one of your top 10 priorities for the last four years, yet

we've seen other capital projects go ahead which have never been on your list. I would like to ask why.

Ms Rhodes: Again, I can give you a high-level answer, and if you require more detail, we can get back to you. The Foothills kitchen project is a very complex project. It actually requires about seven phases to get it done. As you know, the Foothills medical centre is one of the busiest sites in the province, and we need to ensure that that kitchen keeps running through the remodeling and the refurbishment. It is a very complex project that is in planning, but it has about seven phases and will take between three to five years before it is complete. I'd be pleased to answer and provide any further detail that you might require.

The Chair: Thank you.

Mrs. Towle.

Mrs. Towle: Thank you very much for the opportunity, and thank you for being here this morning. I want to start off with something that Ms Davidson said. You talked about improving standards, and this is pretty near and dear to my heart as well. What I'm interested in is: how do you know that you improved bathing standards? What I hear from the front-line workers is that they couldn't give one bath a week, and the standards by which bathing can be improved could include just a simple sponge bath or could include both baths per week being simple sponge baths.

When you say that you've improved bathing standards, when I look through the annual report, I can't see any additional resources going to staff to allow them to have more people, because that's what's required to do bathing. I'm not aware of any directive, actually in writing, from Alberta Health Services that actually says that this is the process by which we will make sure that every person who wants two baths gets a minimum of two baths.

Thirdly, quite frankly, the feet on the ground aren't able to give two baths a week. I'm really concerned. When you say that you've improved bathing standards, I'm not so sure that you actually have proof you've been able to do that. I'm wondering: what was the process for Alberta Health Services on how they implemented ensuring two baths a week happen, and then how are you measuring that outcome?

9:20

Ms Davidson: John, do you want to speak to that? Obviously, it's a very good question about: on the ground how do you actually measure that?

Mr. O'Brien: If I may, my name is David O'Brien. I'm lead for primary and community care with Alberta Health Services. To answer the three-part question, first of all, Alberta Health has revised the standards, the continuing care health service standards, which essentially govern what operators are asked to do as a minimum with respect to caring for clients.

On the second piece, your question around funding, you are correct. There's been no additional funding that's been provided by Alberta Health or Alberta Health Services in order to increase the resource requirement around the bathing. That's something that is still under consideration.

The third aspect is around: how do we assure ourselves that this continues to occur? There are regular audits and reviews that are undertaken within each continuing care health facility. It's through these audits that we are able to assure ourselves that the standards are being met. There have been additional ad hoc surveys around the bathing in particular. There's been a lot of discussion with operators as to their capability to provide two baths per week within the current funding, and it varies, so it is something that some operators are not having concerns with. There are many sites that were previously providing two or more baths already, so for them it's not an issue whatsoever.

The Chair: All right. Well, we'll have to end it there.

We'll move to the Liberal caucus, and that's going to be Mr. Hehr. Go ahead.

Mr. Hehr: Yeah. Just for three and a half minutes, and then I'll turn it over to Raj.

The Chair: Okay.

Mr. Hehr: I listened intently to Ms Davidson's report, and she said that there are currently three pilot family care clinics up and running in the province. What are the stages over the course of the next little while to roll out the other 137 promised in the last election?

Ms Williams: As of June we announced a further 24 communities that we were interested in working with over the course of the summer and the fall. There have been community working groups and teams coming together in those communities to talk about what a family care clinic is and what it would involve and what the stages are and all the rest of it. As you can imagine, it takes a little bit of time to get the community involved to understand what's required and to get a decision and to find the workforce and all the rest of it to be able to stand up a new family care clinic. We are approaching this as a bit of a phased approach. There are three in operation right now, and we are working with 24 communities as the next wave, wave 2, as we are calling it.

Mr. Hehr: So 18 months into this mandate you've had conversations with 24 communities on possibly setting up family care clinics. Is that what I'm understanding from your report?

Ms Williams: We've had more than conversations. We are now getting firm commitments from upwards of half of them. I think we have about 11 that are actually getting committed to move on, and we're continuing to work with the rest. The information is out there publicly on our website as to what a family care clinic is and what's involved. We are also willing to work with other communities outside the 24 if they're interested in coming forward.

Mr. Hehr: It's my understanding that Alberta Health Services has 140 people directed to IPC, the infection prevention and control strategy. Is that correct?

Mr. Trimp: I don't have that exact number in front of me.

Mr. Hehr: Well, that was reported to me by the Auditor General. Yet we still see that there's only a 66 per cent compliance rate with actually following the protocols of what is considered reasonable and effective. Also, the Auditor General notes that responsibilities of partners under the IPC strategy and the hand hygiene strategy are not clear. "The department does not have adequate systems to monitor and report implementation progress." How is it that with 140 people at AHS directed to put into place the IPC strategy, we are failing so miserably on this file?

Mr. Trimp: Thank you for your question. There have been significant improvements on the infection prevention and control front. The comments made in the OAG's report articulate some guidance for us and some recommendations, that we've taken very seriously. Infection prevention and control is number one for all of

our staff, beyond the 140. We have to live in an environment where we're concerned about our patients.

The infection prevention and control program has been enhanced with standards and protocols. We are very much ensuring that people reach a target of a hundred per cent hand hygiene in our facilities. We are working towards that. We've made significant improvements, and that's where you see that the 66 has increased.

Mr. Hehr: Raj, go ahead.

Dr. Sherman: Thank you. First of all, I'd like to thank everybody in AHS, all the staff and management. You've got a tough job to do.

To the Auditor General: in your infection prevention report did you do the analysis on overcapacity protocols, their contribution to the infections that are spreading in the hospitals? Typically hospitals should be running at 85 per cent capacity. The OCPs are essentially emergency crisis protocols, that should only be used a couple of weeks a year maybe, but they've been implemented persistently 12 months of the year every year since 2007. I don't see the analysis of that contribution as well as the analysis of the contribution of everyone else who walks through a hospital and their handwashing.

Mr. Saher: I think the simple answer is no. Our report doesn't speak to the influence of overcapacity in the results with respect to infection prevention and control.

Dr. Sherman: Thank you.

Health spending today is 43 per cent higher than it was five years ago. The total expenditures went from $11.9 billion to $17 billion at a time when population only went up by 11.1 per cent. There was an annual injection of $1.3 billion into AHS in 2009 and a supposed cost savings of $700 million a year on an annual basis.

The main performance measure of a system, the canary in the coal mine, is the length of stay for admitted patients in the emergency room. The goal was 75 per cent for this year, which is a very low, meagre goal for the amount of money we're spending. We're only meeting that 20 to 45 per cent of the time in Edmonton, maybe 50 per cent in Calgary despite using the OCP beds.

In life-threatening cases the ambulances are only getting to their patients within eight minutes 50 per cent of the time. The delays in care are causing escalations. Can you please explain to me why with this massive injection of money the system is not performing as it should?

The Chair: Is this for AHS or Alberta Health?

Dr. Sherman: For AHS or Alberta Health, whoever wants to answer.

The Chair: Okay. Well, let's give it to AHS. Go ahead.

Mr. Trimp: I think we've heard from Dr. Belanger and others about the improvements that have happened in the system. We've seen significant improvements in our reduction of wait times. We've enhanced our surgical capability with the investments that we've made. We have a population boom ongoing here in Alberta. With the immigration of that population, we're looking at the characteristics of that population to understand what their specific health needs are because that creates a demand on our resources.

As we've talked about, in our capital budget we have a number of items where we have aging infrastructure. We need to make investments in order to ensure that we're providing quality of care to our patients and to the public that we serve. We've seen a remarkable number of enhancements to the system that have actually addressed some of the health status needs of our populations that we serve.

9:30

The Chair: All right. We'll move on to the ND caucus and Mr. Bilous.

Mr. Bilous: Thank you very much. I'll thank the ministry for being here today. There's been a great deal of confusion about whether Duncan Campbell or Minister Horne delayed or slowed or cancelled or reinstated the RFP process for the massive privatization of Edmonton's lab testing. Even the Provincial Lab, ProvLab, will be housed in a private corporation's new megalab facility. Now, there's been so much confusion and secrets on this matter that I'm sure members of the committee would love to know some answers. If you could clarify: what exactly are the plans and the status of the privatization of labs and lab services in the province?

The Chair: This is, again, not dealing with the last report. Please try to frame future questions about the report.

If you'd like to answer that, go ahead, Mr. Trimp or Dr. Cowell.

Dr. Cowell: I'm personally a late arriver to this file, but I've been briefed pretty thoroughly on it, so I'll share with you what I can. The process of upgrading the lab services for Edmonton has been going on for certainly more than a year in its planning and communication stages.

As I am led to believe and I truly do believe, the DynaLife model that has been operating here successfully over many, many years has come to its natural end of life, if you will, in that the building that it's housed in is going to be redeployed by its current owner. That and several other reasons have led to the work that has gone on to determine that the Edmonton population and surrounding areas are assured of continuing access to incredibly high-quality and even better services than we are currently enjoying. In other words, lab tests that currently have to leave the province would now be able to be provided here.

By January 1, 2017, the studies have shown, if we don't move quickly on implementing a new approach, which means, really, using the same model that we've used in the past with the DynaLife model – if we don't get that moving, we're going to run into a bit of a wall on January 1, 2017, in providing some 16 million lab tests that Edmontonians and the surrounding area absolutely need to have access to.

There's been lots of discussion out there and concern, and I think the simple answer is that we are going to issue an RFP in the very near future to get an expression of interest from those organizations that have the capacity to step up to the plate and work with us on providing these vitally needed lab services. Time is of the essence, so we're going to be moving very, very shortly on this.

The Chair: Thanks for that update, Dr. Cowell.

Let's get back to the annual statements of past years.

Mr. Bilous: Sure. I just have one follow-up. We'll see if you allow this, Mr. Chair.

According to the process the province follows when issuing major RFPs and P3 projects, three companies are preselected to

place bids. AHS confirmed to my staff that a preselection process did occur in this case already. Will you tell us which three companies are preselected on the bid for the RFP?

The Chair: Sorry. As much as I'd love to hear that in question period today – that is a fabulous question for question period – let's go back to the annual reports.

Mr. Bilous: Sure. I would like to know, though, if you have the numbers on hand as far as how many dollars have been injected into upgrading and updating our equipment in lab services.

Mr. Trimp: We would love to get back to you in writing on that.

Mr. Bilous: Okay. If possible, if you could, I'd love to know, specifically on the equipment end of the capital side as far as when equipment has been updated. I'm curious to know how many dollars are directed toward lab services and if that's gone up or down in the last five years.

Mr. Trimp: Like a five-year historical?

Mr. Bilous: If you wouldn't mind, please.

Mr. Trimp: Absolutely.

Mr. Bilous: How much time do I have, Mr. Chair?

The Chair: Three minutes.

Mr. Bilous: Never enough.

In 2006 the AG made 10 recommendations related to food safety in Alberta. By the time the second follow-up audit occurred in October of this year, the AG found two outstanding recommendations. One of these was repeated a third time. The AG recommended that Health "develop a strategic plan to demonstrate the effectiveness of its food safety program" and that Health and Agriculture work together to "integrate their strategies to ensure a coordinated and effective approach to food safety." This is on page 59.

I also note that one of the earlier recommendations included greater information-producing capability for the minister. For what kinds of information does the minister still need greater production capacity and access?

Ms Davidson: We'll get back to you on that question.

Mr. Bilous: Wonderful. Then maybe I'll just read in the other ones. I'm sure my time is running short.

Considering the numerous overlaps between the two departments when it comes to food safety, what are priority areas for moving toward a fully integrated system? I don't know if you want to field that right now.

Ms Davidson: I think we'll get back to you on that as well.

Mr. Bilous: Sure. Okay. I'll just read in the other two.

What kinds of information or programs are currently integrated or being shared or co-managed by the two departments at the moment?

The other outstanding recommendation is for consistency in the application of meat facility standards and inspection of food establishments. How do the standards between Health and Agriculture differ?

The Chair: Great questions. Are you sure you don't want the last minute and 15 seconds?

Mr. Bilous: Oh. Yeah. Absolutely.

I just wanted to ask a question about PCNs. The funding that you had stated was $62 per patient per PCN. Where do PCNs derive their lists from?

Mr. Monteith: Great question. One of the challenges we have in our health care system is that we don't have what's called formal enrolment or formal attachment. You may view a physician as your physician, and in the everyday course of your care that's how it's treated. But people will go to different physicians at different times, so we have a sexy term called the four cut method. What we do is a time series analysis of the number of visits that that individual makes to the number of physicians that they actually see for primary care services. On that basis we determine that that patient, for the purposes of allocating the $62 for that individual, will go to this particular physician. That's how it's done, and it's refreshed on an annual basis.

Mr. Bilous: Just a last question before the chair cuts me off. What I found fascinating was that the majority of Albertans are actually on the list for PCNs, yet the majority of Albertans have no clue that they're on the list. I had no idea that I belonged to a PCN, yet the PCN was receiving $62 for me to be on that list. I'm just wondering how we justify dollars going to PCNs for people that don't even know that they belong to a PCN.

The Chair: Very good. Point taken. Excellent. I had no idea that I was on a list either. I guess I am. That's fantastic.

All right. Let's move back to the PCs.

Mr. Dorward: Thanks very much. Just a comment, firstly, and maybe even speaking to our Auditor General. I'm going to choose my words carefully here. Within a publicly funded health care system there are all kinds of private businesses. Now, sometimes the wording is changed to indicate that when something is done by a private business, it's not part of a public health care system. Indeed, as a chartered account I well know that the list of vendors, indeed the very doctors, run as businesses. I'd just throw it out to anybody who wanted to comment very briefly. Am I right in this? Private business absolutely backs up a publicly funded health care system, and that's an absolute mainstay in our system of health care delivery. Any comments there, Mr. Auditor General?

Mr. Saher: Well, there's been a lot of discussion. Dr. Cowell has talked about Dynacare today. To the best of my knowledge, Dynacare is a private corporation. It's involved in the delivery of health care.

Mr. Dorward: Thank you. That's all I wanted.

We'll move on to Mrs. Sarich, then MLA Jeneroux and MLA Pastoor, who has her own connection to the health care system.

Mrs. Sarich: Thank you very much. I really appreciate your presentation thus far. Just a couple of quick comments. I've heard in some of the answers that you've been trying to give this morning the words "significant improvements." I'd just like to remind you that our level of inquiry at Public Accounts is that it is evidence based, so on your responses that will require a written answer, it would be greatly appreciated that you would provide the evidence to support the details that you're going to provide to the committee. It would be most helpful.

9:40

On that note of trying to provide some evidence and to help Albertans understand some of the directions that you're going in or achievements that you're making – and I am very grateful for

that and all of the front-line workers and everybody in the complex organization. They're trying to provide a top-notch health care system, management, and also an experience in the system itself.

The Auditor General has also pointed out in the area of infection prevention and control at Alberta hospitals a number of recommendations. One was directed to the Department of Health and three of the recommendations to Alberta Health Services. I'm just wondering. For example, in the line of inquiry for recommendation 2 on the cleaning, disinfection, and sterilization of medical devices it was pointed out that there was no single line of oversight in this area at the corporate level, that it was very important to make improvements along the lines of implementation of compliance reviews, that there were inadequate systems to direct and co-ordinate the work of individual reprocessing sites at the operational level, and that strategic direction was lacking from the structure process implementation. I'm very curious as to your response and evidence that you would put forward that you're making what you say are significant improvements, if there are any in this area. I'm just going to hold there because I'd like to get a couple of other questions in as well.

I believe one of the members of the committee had talked about handwashing. I think it was the rate of 66 per cent. I'd like to draw your attention to a news release that Alberta Health Services put out on November 5. You did comment on this 66 per cent. You said that there was "a 33 per cent increase in hand washing compliance at health facilities over the past two years." So it measures up to the number that has been pointed out.

Also, you say:

> It is also important to note that [Alberta Health Services] meets all Accreditation Canada Infection Prevention and Control . . . standards, which are based on research and best practices in the field, as well as standards from the Canadian Standards Association, the Public Health Agency of Canada, and Alberta Health's own provincial IPC standards.

It's a bit of a contradiction that you're getting accreditation, yet you've got a long way to go in this protocol that has huge gaps from management, process, and structure. Do you have a comment?

Mr. Trimp: What I'll do is ask Dr. Mark Joffe to come forward. He is our head of infection prevention and control.

Dr. Joffe: Thank you, Rick. Thank you for those questions. There were at least two questions embedded in there, so first let me address the hand hygiene question. Our hand hygiene rates have improved. We have a lot of focus and attention on this particular issue, and we've improved from about 49 per cent to 66.4 per cent between 2011 and 2013. We have a long way to go. We acknowledge that. We need to get better. We're just like every other health system.

Mrs. Sarich: Can I just interject? One other thing. Here's the test. If I come into a hospital and I have the infection, one hospital's protocol is to red-flag me, and then I get discharged, but then I go to a different hospital. All those admission standards and those processes, all those admission things: would I be picked up as a red flag with an infection, you know, like, for disease control at another hospital? Have you bridged that Alberta-wide?

Dr. Joffe: We're addressing several different issues at once here. To switch over to that issue, if that's what you'd like to address, we have different computer and information systems around the province. Those have not yet been unified, so it's difficult if not impossible to flag an individual in one system and to be absolutely certain that a different system in a different part of the province will also pick that up because, again, we still work under different information systems.

However, the individuals who are colonized with a particular antibiotic-resistant organism, which is what you're referring to here, would generally know that and would be asked at the time of admission, or it could be apparent in some of their health records that that is the case. Then the health care workers . . .

Mrs. Sarich: I'm going to interject one more time. On the handwashing issue, or infection control, if I come into the hospital and am admitted and discharged, that communication, there's an interrelationship there. It also has a relationship, you know, to the standards based on research and best practices on your accreditation system, so it's a bit of a contradiction. Do you understand what I'm suggesting here?

Dr. Joffe: Not entirely, but let me emphasize that accreditation is a quality improvement process, and in fact we have been accredited, three years ago, and the Accreditation Canada team is coming through again in the spring. What they will look for is that they will look to ensure that we are monitoring our hand hygiene practices and that we are feeding that information back to health care workers so that they know how they're doing and so that they can improve and, at the same time, so that we have systems in place to help them improve.

Mrs. Sarich: I'm going to interject again. You can monitor really well, but what's the level of compliance? It has been pointed out by the Auditor General that you have gaps in your compliance and structure and systems. How are you bridging that?

Mr. Dorward: MLA Sarich, what I'd like to do here is just interject. This is all on *Hansard* so far. MLA Sarich, we're going to go on to two other MLAs, just because of time considerations. If you could frame a 30-second summary question at the end that we could get into *Hansard* as well for a follow-up in writing, that would be great.

We'll go to MLA Jeneroux and then MLA Pastoor.

Thank you.

Mr. Jeneroux: Okay. Great. I'll try to be quick here. I want to talk about executive compensation. I had two questions. I now have a third one. I'll just read them.

Mr. Dorward: In two minutes. That would be great.

Mr. Jeneroux: Less than two minutes.

You mentioned that there was $3 million in pay-at-risk that was paid out and that then $630,000-ish was paid back. I was under the assumption that there was possibly more that we were expecting to be paid back. Is that in the works? Is that something that, I guess, you guys are anticipating? That money: once it's paid back, where does that go? Does it go back into general revenue or what?

The other two questions are largely to do with the executive retirement plan. On page 96 of the report it shows that there are still 44 active members that are getting paid the executive retirement. Is this being phased out? Are we just waiting for this to kind of run its course? What's the timeline on that?

Also, there's a line item for supplemental pension plans, that you call SPPs here. This is in AHS. Is this just another version of the senior executive retirement plan? If you could explain that, too.

Thanks.

Mr. Trimp: Thank you for your questions. I'll ask my colleague.

Mr. Hawes: With respect to the pay-at-risk, what actually happened was that in total there was $3 million paid out relative to '12-13 for pay-at-risk to all individuals that were eligible. One individual waived their legal entitlement to that benefit, and $637,000, the number that you referred to, is what was actually paid to the executive, that are listed by individual on the third page of the schedule.

With respect to your second question . . .

Mr. Jeneroux: On the 44 active members.

Mr. Hawes: Sorry. Right.

. . . the supplemental executive retirement plan is a defined benefit plan for executive. It was inherited from the legacy health regions. On April 1, 2009, that was actually closed to new entrants. Those individuals from that point in time continue in that plan until they are terminated or, basically, leave the organization. That number has decreased significantly from I think 80 some-odd down to 44 at the end of March. What we have done also: we provided notice about a year ago to all individuals that were participating so that even though the plan was closed, they then would no longer accrue any benefits related to continuing service. That basically put an end to the benefit under the SERP.

The supplemental pension plan that you refer to, the SPP: that is a defined contribution pension plan, and that is a significantly lower cost plan to the organization.

9:50

Mr. Dorward: Thank you.

We're going to move on to MLA Pastoor.

Ms Pastoor: Thank you very much. Part of this is going to be comments, part of it's going to be questions, so I'll just keep moving along. I'll start off with that I'm an old nurse, and that's in more ways than one, trust me. Also, high-level answers are really great, but they're pretty useless on the ground. I really, really believe that health care is 24 hours, and that includes from physicians to the little person that delivers newspapers to the bedside.

Some of my questions. We've just heard that you've spent a significant amount of money on equipment. A couple of things relate to that. Our MRIs, CAT scans, angiograms, all of those: why are they not running 24 hours a day?

Again, on the equipment side of it: are we buying all of this special equipment for this lab? Are the taxpayers buying equipment for a private, for-profit lab?

My other question. The PCN and the FCC parts are starting to come together. Where the problem is is waiting for a specialist. It's unbelievable. Unbelievable. The wait times are just not acceptable. Just a quick story. It's sitting on my desk. A woman needs an MRI. Her physician got fed up and finally suggested and gave her a referral to a private clinic. The private clinic would not accept the referral unless she had $200 up front for the registration, and the wait was going to be six months for an MRI on her back. Like, what is that?

The other thing is that I would like to have someone tell me that they've actually walked through a hospital and it's clean. I've watched, physically watched, someone clean a floor with the same bucket of water, and it was the entire hall. Slop, slop, slop into the room. Slop, slop, slop. Like, what is that? That's the ground stuff that I'm interested in.

Thank you.

The Chair: Well, that's gross. That's what that is.

You don't have to answer the question about the private lab services issue. Again, it is a phenomenal question, and I would love for you to put that in question period, but I did cut off Mr. Bilous for the same question.

All the other questions are legitimate, so go ahead.

Mr. Dorward: I'm going to go to Mrs. Sarich to get a question on the record, and then we're out of time.

The Chair: Okay. Mrs. Sarich, do you want to end off? You've got 30 seconds.

Mrs. Sarich: Thank you very much, and my apologies for the cut-off, but you were informed about how compressed our time is today.

Just going back to the recommendations that were directed by the Auditor General to the Department of Health and three to Alberta Health Services on the area of infection prevention and control at Alberta hospitals, I would appreciate a detailed response to those things that were pointed out. Please, if you could focus on the oversight that's provided at the corporate and management levels; the management systems that are in place to ensure the level and evaluation of compliance; risk management and the evaluation of risk management; the use of data; and the evidence that you're going to provide in your detailed written response back to show progress.

Thank you.

The Chair: Okay. Thank you to our guests for coming today. You've got lots of homework to take home with you. I'm sure you'll be busy doing that. That said, it does very much help us to do our jobs and give us assurances that the health system is moving forward, so we appreciate your standing in the line of fire here and answering the questions. We really do. To our guests: certainly feel free to leave if you would wish. Thanks again.

We have a couple more issues to deal with here. The working group met with the Auditor General this morning regarding the schedule of invitees in the new year. We already have Alberta Agriculture and Rural Development on deck for next week. Now, of course, we're probably not going to be here next week, so we're going to move that meeting, as we discussed previously, into when we get back in February.

Also, working group members would like to recommend that we schedule Alberta Tourism, Parks and Rec and Alberta Executive Council as we haven't heard from either of them since 2008. That's five years for both of them. Those are the ones that have been the longest without being looked at. The working group was also recommending calling Alberta Infrastructure as they haven't been here since 2010, and the Auditor General thought there were some interesting issues to be looked at there as well.

Also, Mrs. Sarich reminded us that on a go-forward basis we're going to try to do a meeting with the Auditor General kind of summarizing for a couple of hours what was in his last report. Now, we've already kind of gone through this report and the departments that have been involved with it, but I think that after the release of the February report, we should schedule an 8 to 10 block to just go over the Auditor General's report from February, as we talked about. So we'll wait for his report. His report will be roughly sometime in late February-ish. Then we'll go from there and schedule that meeting with the working group.

Could we have a mover that

> the following groups be called before the Standing Committee on Public Accounts in the order listed subject to scheduling availability – Alberta Tourism, Parks and Recreation; Alberta

> Executive Council; and Alberta Infrastructure – and that any necessary scheduling changes to this list be made at the discretion of the informal working group.

Could we get a mover for that motion? Mr. Stier. Those in favour? Any opposed? Carried.

Is there any other business from the members? Yes, Mrs. Sarich.

Mrs. Sarich: Thank you. Just to clarify, you had said that after the release in 2014 of the Auditor General's report we would – your words were "the working group." We're not part of the working group. The intent was to schedule a meeting with the Auditor General to review the most recently released report to allow the committee an opportunity to ask questions, you know, to further understand those details. That would help us with the other departments that we are calling to the committee. Maybe it would help us in formulating more succinct questions. We'll have to try it and see what the outcome will be. So my understanding is correct?

The Chair: Yes. As soon as that report comes out, when we meet as an informal working group, we will make a point of scheduling that exact meeting in as soon as possible before we meet with any of the departments that are mentioned in his report, if that makes sense.

Mrs. Sarich: Yes.

The Chair: All right. Fantastic.

Mr. Dorward: I would like to see that be a formal kind of a thing, in a more formal way, that once the Auditor releases a report, it goes to the Assembly, and then we have a formal meeting whereby we accept it, the Auditor General presents it to us, and then he gives us a briefing on it, maybe an hour-and-a-half meeting, one-hour meeting, or whatever it is. I think that's probably a good idea.

Mrs. Sarich: We've talked about that before. So whether it's an hour and a half, two hours, whatever, it depends on the size of the report.

The Chair: I think we can get that done, Mrs. Sarich. Thank you for pushing that initiative. It's a good one.

If the House continues to sit next week, the date of the next meeting will be Wednesday, December 11, with Ag and Rural Development. That's very unlikely, I think. Otherwise, our committee clerk will contact members in the new year with the date of the next committee meeting, which will likely be after we get back on February 12, 2014.

Would a member like to move that this meeting be adjourned? Mr. Rogers. Those in favour? Any opposed? Carried, barely, by one vote.

[The committee adjourned at 9:59 a.m.]

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