Legislative Assembly of Alberta

The 28th Legislature
Third Session

Standing Committee on Public Accounts

Alberta College of Pharmacists, Alberta Medical Association, Alberta Pharmacists' Association, College and Association of Registered Nurses of Alberta, College of Physicians & Surgeons of Alberta, Health Quality Council of Alberta

Tuesday, December 2, 2014
8:32 a.m.

Transcript No. 28-3-3

Legislative Assembly of Alberta
The 28th Legislature
Third Session

Standing Committee on Public Accounts

Anderson, Rob, Airdrie (W), Chair
Young, Steve, Edmonton-Riverview (PC), Deputy Chair

Allen, Mike, Fort McMurray-Wood Buffalo (PC)
Barnes, Drew, Cypress-Medicine Hat (W)
Bilous, Deron, Edmonton-Beverly-Clareview (ND)
Donovan, Ian, Little Bow (PC)
Hehr, Kent, Calgary-Buffalo (AL)
Horne, Fred, Edmonton-Rutherford (PC)
Jansen, Sandra, Calgary-North West (PC)
Jeneroux, Matt, Edmonton-South West (PC)
Luan, Jason, Calgary-Hawkwood (PC)
McAllister, Bruce, Chestermere-Rocky View (W)
Pastoor, Bridget Brennan, Lethbridge-East (PC)
Sandhu, Peter, Edmonton-Manning (PC)
Sarich, Janice, Edmonton-Decore (PC)
Swann, Dr. David, Calgary-Mountain View (AL)*

* substitution for Kent Hehr

Also in Attendance

Anglin, Joe, Rimbey-Rocky Mountain House-Sundre (Ind)
Forsyth, Heather, Calgary-Fish Creek (W)
Pedersen, Blake, Medicine Hat (W)
Towle, Kerry, Innisfail-Sylvan Lake (PC)

Office of the Auditor General Participants

Merwan Saher	Auditor General
Doug McKenzie	Principal

Support Staff

W.J. David McNeil	Clerk
Robert H. Reynolds, QC	Law Clerk/Director of Interparliamentary Relations
Shannon Dean	Senior Parliamentary Counsel/ Director of House Services
Philip Massolin	Manager of Research Services
Stephanie LeBlanc	Legal Research Officer
Sarah Amato	Research Officer
Nancy Robert	Research Officer
Corinne Dacyshyn	Committee Clerk
Jody Rempel	Committee Clerk
Karen Sawchuk	Committee Clerk
Christopher Tyrell	Committee Clerk
Rhonda Sorensen	Manager of Corporate Communications and Broadcast Services
Jeanette Dotimas	Communications Consultant
Tracey Sales	Communications Consultant
Janet Schwegel	Managing Editor of *Alberta Hansard*

Transcript produced by *Alberta Hansard*

Standing Committee on Public Accounts

Participants

Health Quality Council of Alberta
Andrew Neuner, Chief Executive Officer

College of Physicians & Surgeons of Alberta
Trevor Theman, Registrar

Alberta Medical Association
Carl Nohr, President-elect

Alberta Pharmacists' Association
Margaret Wing, Chief Executive Officer

College and Association of Registered Nurses of Alberta
Shannon Spenceley, President

Alberta College of Pharmacists
Greg Eberhart, Registrar

8:32 a.m. Tuesday, December 2, 2014

[Mr. Anderson in the chair]

The Chair: All right. We're going to get started. Good morning. I would like to call this meeting of the Standing Committee on Public Accounts to order.

If we can maybe bring the volume down a little bit guys.

I'm Rob Anderson, committee chair and MLA for Airdrie, and I would like to welcome everyone here in attendance.

We will go around the table to introduce ourselves, starting on my right with the deputy chair. Please indicate if you are sitting in on the committee as a substitute for another member.

Mr. Young: Good morning. Thank you for being here. Steve Young, MLA for Edmonton-Riverview.

Mr. Horne: Good morning. Fred Horne, Edmonton-Rutherford.

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

Mr. Donovan: Good morning. Ian Donovan, Little Bow.

Mr. Bilous: Good morning. Deron Bilous, MLA, Edmonton-Beverly-Clareview.

Ms Jansen: Sandra Jansen, Calgary-North West.

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

Mrs. Towle: Kerry Towle, MLA, Innisfail-Sylvan Lake.

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

Mr. Allen: Good morning. Mike Allen, MLA for Fort McMurray-Wood Buffalo.

Mr. Neuner: Good morning. Andrew Neuner, chief executive officer, Health Quality Council of Alberta.

Dr. Theman: Good morning. Trevor Theman. I'm the registrar of the College of Physicians & Surgeons of Alberta.

Dr. Nohr: Good morning. Carl Nohr, president-elect of the Alberta Medical Association.

Ms Wing: Good morning. Margaret Wing. I'm the CEO for the Alberta Pharmacists' Association.

Dr. Spenceley: Good morning. Dr. Shannon Spenceley, president of the College and Association of Registered Nurses of Alberta.

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

Mr. Saher: Good morning. Merwan Saher, Auditor General.

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

Mr. Barnes: Good morning. Drew Barnes, MLA, Cypress-Medicine Hat.

Mr. McAllister: Good morning. Bruce McAllister, MLA, Chestermere-Rocky View.

Dr. Swann: Good morning, everyone, and welcome. David Swann, Calgary-Mountain View.

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

Mr. Pedersen: Good morning. Blake Pedersen, MLA, Medicine Hat.

Mrs. Forsyth: Hi. I'm Heather Forsyth, Calgary-Fish Creek. Thanks for coming.

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

The Chair: We have Peter Sandhu on the phone. Is that right, Peter?

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

The Chair: Good morning, Peter.

And we have . . .

Ms Pastoor: Bridget Pastoor, Lethbridge-East.

The Chair: All right. Before we begin, the microphones are of course operated by *Hansard* staff. Audio of committee proceedings is streamed live on the Internet and recorded by *Alberta Hansard*. Audio access and meeting transcripts are obtained via the Legislative Assembly website. Please make sure to speak directly towards the microphones, and don't lean back in your chairs because it's difficult for the *Hansard* recorders to pick that up. Please do your best to keep your cellphones away from microphones and on vibrate or silent.

We have circulated the agenda. Do we have a mover to move that the agenda for the December 2, 2014, Standing Committee on Public Accounts meeting be approved as distributed? Ms Jansen. Those in favour? Any opposed? Carried.

We've also circulated the meeting minutes from the last meeting, and we would need a mover that the minutes for the November 25, 2014, Standing Committee on Public Accounts be approved as distributed. Nobody wants to admit to that? Mrs. Sarich. Those in favour? Any opposed? Carried.

Today, of course, we are meeting with the College of Physicians & Surgeons of Alberta, the Alberta Medical Association, the College and Association of Registered Nurses of Alberta, the Alberta College of Pharmacists, the Alberta Pharmacists' Association, and the Health Quality Council of Alberta. Members should all have a copy of the briefing documents prepared by committee research services and the office of the Auditor General, which we went over at the 8 o'clock meeting.

Of course, joining us today are representatives from the groups I just mentioned. We've invited you all here today to get your perspectives on what is needed to improve chronic disease management in this province as well as your thoughts relating to the Auditor General's September 2014 report, which dealt with this topic. We'll begin by having each of our guests make an opening statement of no more than five minutes – even fewer minutes would be better because we'll have a lot of questions and there are a lot of you – and then the remaining time will be for the committee to ask questions. Usually we have the Auditor General say a few words after that, but he wants to free up as much time as possible for questions, so he'll be forgoing that today.

I do want to let a gentleman who just sat down a second ago introduce himself as well.

Mr. Eberhart: Thank you. Greg Eberhart. I'm the registrar of the Alberta College of Pharmacists. My apologies, Mr. Chair.

The Chair: Welcome. Thanks for coming today.

Okay. Well, why don't we just go right to left, my right to left, and start with Andrew there, Mr. Neuner.

Mr. Neuner: Great. Thanks very much for the opportunity to present today. As some may or may not know, I'm one of the newest members to the Alberta system, not yet having completed my 90 days here. This is a new process for me, so forgive me if I don't quite do this the way it is customary in these proceedings.

I'm pleased to be here on behalf of the HQCA. We're an organization that measures, monitors, and assesses patient safety and health quality in Alberta. We identify practices and make recommendations for the improvement of patient safety. And we do assist in the implementation and evaluation of those activities. Periodically we survey Albertans on their experience and satisfaction with patient safety and health service quality.

In reading the Auditor General's report, we certainly agree with patient engagement, we agree with the notion of patient attachment to physicians, and we agree with a unified IM/IT system. In terms of patient engagement we see that broader, as citizenry engagement. It's not just patients that need to have a voice but the general public as well. We also understand that there are many other providers in the system where the first point of contact may not always be physicians. In terms of a unified IM/IT system it's not just physicians in Alberta Health Services; there are many systems in play out there that need to be connected.

Patient access to records. We definitely support that and would encourage the development of an appropriate province-wide portal for engaging patients to access their own information.

8:40

What is described in the report as not being in place, I believe, is the barrier to accomplishing the majority of recommendations in the time frames identified. From my perspective what is needed is a public conversation to create a culture shift that fosters an emotional attachment to primary care and chronic disease management rather than the emotional attachment we see to hospitals and emergency rooms, a conversation on health services and health practices that do not achieve meaningful improvements in health and how we move that off the agenda, and an understanding perhaps of the current relationship with physicians and the awareness that a prescriptive approach that is targeted at specific system changes will not engage physicians. Any perceived threat to professional autonomy of any health discipline will not be well received.

Application and sharing of standardized data that begins the process of reducing variations is the gateway towards moving best practice as the clinical data, just creating good knowledge about what is and isn't working, will start shifting outcomes.

I support a change in language that moves the conversation from purely holding the system accountable to holding the system able. I hear the word "accountability" a lot. I'm not sure that those who are charged with being accountable always have the resources, the tools, the skills, and the supports that are needed to achieve that accountability.

I think this is more about relationships between providers and patients and funders and deliverers. If the time frame is reasonable and there is an alignment between outcomes and incentives at all levels, then change is achievable, but the change must be scalable. I've seen incredible good work done in this province by a variety of providers, but it exists in pockets, and it's not connected. I think also that for the most part there needs to be an appreciation that savings achieved through an improved primary health care chronic disease management process cannot immediately be harvested from other sectors of the system.

In terms of how the Health Quality Council can help support a change, we have an interest in improving quality; we have an expertise in collecting, analyzing, evaluating, and reporting the data that's needed; and we understand the Alberta context and are passionate about system improvement. Our continuity of care report demonstrates our commitment to making services better.

Thank you.

The Chair: Thank you.

Dr. Theman.

Dr. Theman: Yes. Thanks very much, Mr. Chair, and thanks for the opportunity to speak about the Auditor General's report with respect to chronic disease management on behalf of the College of Physicians & Surgeons. I believe you have a copy of *The Messenger*, the college's newsletter, and the article I published in there a couple of weeks ago with respect to this report.

In brief, the Auditor General correctly identified the issues with respect to chronic disease management in Alberta, and I believe his recommendations logically follow. Appendix A to that report nicely contrasts our system in Alberta as compared to generally accepted attributes of high-performing health systems. Without belabouring this, a few things are pretty clear to me from looking at that table as well as the report as a whole.

The first is that we do not have a fully integrated health system in this province as primary care, which properly delivers most chronic disease management, is only closely linked with the rest of the health system, largely being Alberta Health Services. In my mind, this is really an issue of governance. Nobody owns primary care or chronic disease management. Secondly, our information systems are woefully inadequate. While we have administrative data, it is a poor substitute for high-quality process and outcome data. Finally, while we have invested substantial resources in the form of money to computerize medical offices, the resources available to primary care, or to chronic disease management specifically, in terms of support is really very small. If the goal is team-based care and the goal is team-based care because it leads to better results, then we need to invest to allow that to happen.

I'd just like to share a quote from Steven Lewis, a health policy analyst from Saskatchewan. I'm sure many of you know Steven. He says: autonomy without accountability is a recipe for poor quality and high cost.

I think the questions that come from this report are the following: who will be responsible to make the necessary changes; when will that happen; and who will be responsible to track and ensure progress is being made?

I'd like you to know that the report and the recommendations align very nicely with the college's strategic plan and the goals of our organization. So we're onside with the recommendations in this report, and we'll continue to play our part.

Thank you very much.

The Chair: Thank you.

Dr. Nohr.

Dr. Nohr: Great. Thank you, Mr. Chair and members. The Alberta Medical Association commends the Auditor General for addressing chronic disease management. The report brings together many important issues in one place, and that is very timely. There are three themes in the report that the AMA would particularly like to reinforce. The first is patient engagement, which means

empowering patients to self-manage their conditions and to work with health care professionals to share responsibility for better outcomes and better quality. One of the ways we can do that is through an integrated health information system, and that is my second theme. We must give patients access to their own health information in order for them to participate actively in their own care plans. We need all the members of the health care team to be able to communicate efficiently and securely about chronic care patients as they move around the system. The data we generate with this information exchange will also help us track what we are doing and measure our results.

When we talk about our integrated health information system, we're talking about eventually seeing one comprehensive record for every patient that covers all the care received, from community to hospital settings. There are different ways a system like that could be built. No matter which way it's done, it will take time and investment. The AMA believes that in the short term we can leverage some of the technology that we have in place today to get some results sooner rather than later and make use of some of the significant investment that's already been made.

The third theme is the need for an overarching strategy for chronic disease management and co-ordinated, team-based care. Mr. Saher wrote about innovation that is emerging in what the report calls "clusters of excellence" in some primary care networks, or PCNs. But the improvement is not consistent across all PCNs. The committee should be aware that there is a structured PCN evolution framework that has been developed by the AMA and adopted by government. There is a plan to provide every Albertan, particularly our chronic disease patients, with a medical home for co-ordinated, integrated, team-based care. If properly resourced, PCN evolution will also deliver the accountability and measurement requirements that the Auditor General has found lacking so far.

When it comes to encouraging more team-based care, this could include moving away from traditional physician payment mechanisms like fee-for-service for some patient populations. Fee-for-service will still serve many Albertans well, but in areas like complex chronic care we could change the way physicians are paid by linking it to the way they deliver care and the things they do. Work is being done on a new payment model for primary care physicians as part of a movement toward the medical home. This is a joint AMA-Alberta Health committee established by our agreement called the Physician Compensation Committee that has the ability to explore this approach.

My last comment is this. It's time to get started. Let's get moving on those ideas that will bring the best value for patients and help the system see the outcomes and affordability that are needed. There are practical things we can do in the near future. Focusing on chronic care patients and their special requirements is a win-win opportunity for all concerned. We will need many cumulative changes, some quick and some over time. We can't wait for the perfect set of solutions to appear on the horizon. We have to expect some failure and disappointment, but we also can expect that some things will perform or succeed better than we might have anticipated. We won't know until we try, and it's just time to get started.

Thank you.

The Chair: Thank you very much.

Now we'll go to Ms Margaret Wing, the CEO of the Alberta Pharmacists' Association.

Ms Wing: Thank you very much for the invitation to be here this morning. Just a few words on the Alberta Pharmacists' Association. It's also known as RxA, and it's the provincial organization whose focus is to promote the value of pharmacists in supporting and advancing the health of Albertans. Through its leadership the association endeavours to create opportunities in which Albertans can benefit from the expertise of pharmacists in meeting their chronic disease management goals. RxA is also Alberta's largest provider of professional development for pharmacists, much of it with a focus on assisting pharmacists in supporting patients with chronic disease.

On pharmacists' connection to chronic disease, more than 80 per cent of seniors have at least one chronic disease, and nearly two-thirds of seniors had claims for five or more drugs from different drug classes in the previous year. As the use of medications by both seniors and those living with chronic diseases is understandably common, the potential role of the pharmacist as a community-based knowledge resource in assisting Albertans with chronic diseases is tremendous. Pharmacists are viewed as medication experts and are the most accessible health care professional. Since the start of the annual influenza immunization campaign on October 20, pharmacists have immunized more than 422,000 Albertans, the highest of any health care provider group, primarily due to the fact that they are so accessible.

8:50

Until recently pharmacists have been viewed as dispensers of medication. However, changes in the pharmacists' scope of practice that were implemented in 2007 and the approval of a practice model in 2012 that reimbursed pharmacists for assuming a greater role with patients have started to shift this paradigm. The result is a more patient-centric model where our pharmacists can play an important role in helping patients achieve their own optimal health therapy outcomes.

As for pharmacists within this, they are embracing their role to assist Albertans with chronic disease, and many have sought additional designations such as certified diabetes educators. Through the care plan process pharmacists have been conducting comprehensive medication management reviews that focus on performing an assessment, identifying any problems with drug therapy, creating a plan, communicating that plan to other health professionals, and following up with the patient on their progress. When performing this role for patients, pharmacists can improve medication use, reduce service utilization, and improve patient health outcomes.

A few thoughts on the Auditor General's report. Although many things are working well in the care of those Albertans living with chronic disease, the Auditor General's report demonstrated that there is room for improvement. Specifically, the report focused in a significant way on the delivery of chronic care through AHS, PCNs, and physicians. Accordingly, the recommendations of the report and the definitions of a high-performing health system tend to be viewed through a government reimbursement lens that focuses on these three providers.

However, it is important to recognize that a significant component of primary care takes place outside of AHS and PCNs. Specifically, more than 85 per cent of pharmacists practise outside of these environments. However, all of the government-funded pharmacists care plans are completed by community pharmacists. Although pharmacists play an important role in meeting the primary care needs of patients, the report only highlights their role in the care plan process that is government funded. Therefore, in order to provide Albertans with integrated care, we need to carefully consider where care occurs outside of government-funded environments, that are highlighted in the report.

Further, by proactively working with Albertans, pharmacists represent an opportunity, an important opportunity, to prevent chronic disease before it occurs.

Thank you.

The Chair: Thank you very much.

We could go on to Dr. Shannon Spenceley, who is the president of the College and Association of Registered Nurses. Go ahead.

Dr. Spenceley: Thank you. I'd like to start by thanking the committee for the opportunity to present before you today and to thank the Auditor General for his report. We believe that the report is a strong call to action for the Alberta government and the health delivery system to implement a comprehensive strategy for CDM. We suggest that the solution resides within the government of Alberta's primary health strategy, yet to be implemented. CARNA would like to respond to three particular issues raised in the Auditor General's report, and they are around payment structures and accountability as well as care planning.

First, we need to recognize that the fee-for-service compensation model is one of the most significant barriers to team-based chronic disease management. We urge renewed efforts to develop alternative compensation models that more appropriately remunerate team-based care. The Auditor General's report recognizes that patients with chronic disease need a care team of professionals such as nurse practitioners, nurses, dieticians, therapists, mental health counsellors, and pharmacists. The absence of this care team is evident in the majority of Alberta's current primary care delivery. High-performing health systems have recognized that fee-for-service environments don't provide the right incentives and, ultimately, the desired outcomes or return on investment in primary care.

The evidence supports mixed models of remuneration, and a variety have been evaluated. Although none are perfect, there are mixed models in use that do align incentives, encourage focus on a population, and support the achievement of desired outcomes.

The Auditor General's report is also a clear reflection of the current imbalance in the development of delivery models for CDM. The report's recommendations, funding, and care models are provider-centric rather than about a patient-centred care team. We need to focus on the outcomes of service delivery models for patients rather than for providers. After all, the patient is a member of the team. Actually, the patient should lead the team. Patients don't exist to provide an income for health care practitioners or for the health system.

Alberta's primary health care strategy requires clear expectations for care delivery, a health home for every Albertan, integration and co-ordination of services, and involving the community in their health care services. Improvements in the health of Albertans and effective CDM services will not be achievable if decision-makers do not include representatives of the public, registered nurses, nurse practitioners, and other health care professionals.

The report notes an ideal ratio of 3 regulated health professionals to every family physician as a proven and effective team mix, yet in Alberta we know that our current ratio of 0.2 of a regulated health professional to every family doctor is what is currently existing. We know where this has gotten us. Our current model is costly and achieves mediocre results. The evidence clearly demonstrates return on investment through improved population and patient outcomes in primary care when that care is based on the patient having timely access to the most appropriate member of the team. It's time to develop, monitor, and enforce standards; expect and demand accountability; and move ahead on implementing the necessary team approaches to continuously improve patient and population outcomes.

Alberta is currently recognized for its leadership in the introduction of the family care centre model, primary care models that set minimum team composition requirements with team composition varying based on community need. These have been identified as very successful where they have been implemented. A family physician or nurse practitioner can lead a team in primary care within a governance structure that represents the community's needs. This type of CDM and primary care delivery is providing positive patient and population results in places like Ontario.

Finally, I would like to discuss care plans. It seems to us that we seem now to be paying for the development of different care plans by different health care practitioners for the same patient. Both the Auditor General's report and other evidence indicate that a small percentage of people requiring CDM services now have a care plan, and a very low percentage of them are monitored. CARNA strongly recommends a collaborative, integrated team approach to this work, which would help ensure that people requiring assistance with CDM would actually have care plans that are not only initiated but followed up on and evaluated rather than a process that simply relies on whether or not a family physician or pharmacist chooses to create a care plan. CDM in Alberta would be more effective if a single integrated plan was expected and not tied to a fee-for-service model with different fee schedules for pharmacists and physicians. We know that continuity of care is an issue in Alberta, and this piecemeal approach actually discourages integration and continuity.

The Chair: Thank you so much. I can't wait to hear more.

If we could move on quickly to Mr. Greg Eberhart, who is the registrar at the Alberta College of Pharmacists.

Mr. Eberhart: Thank you, Mr. Chairman. The Alberta College of Pharmacists welcomes the report of the Auditor General on chronic disease management. Despite limitations in scope we support the recommendations presented.

ACP is responsible for governing the practice of pharmacists and pharmacy technicians in Alberta under the Health Professions Act. We also govern the operation of licensed pharmacies under the Pharmacy and Drug Act. Today there are 4,742 pharmacists practising in Alberta, and there are 1,104 licensed pharmacies, over 97 per cent of which are privately operated. In 2012 CIHI data reported 4,065 pharmacists in Alberta, 72 per cent of whom practised in community settings, 21 percent of whom practised in hospitals or other health care facilities, and less than 1 per cent who practised in other pharmacy group practices or clinics like PCNs. I suggest that those percentages have not changed.

Albertans are fortunate to have access to one of the broadest pharmacists' scopes of practice in the world. Today there are over 730 pharmacists, an increase of 68 per cent since February 28, 2014, who successfully completed a peer-reviewed process authorizing them to prescribe most prescription drugs, not including controlled substances, both at initial access and for the purpose of managing drug therapy for chronic diseases, and 3,152 pharmacists have completed training and are authorized to administer injections. These tools allow Alberta pharmacists to more effectively address the population health, primary health care, and chronic disease needs of Albertans.

Pharmacists have the most education and training in drug therapy amongst Alberta's regulated health professionals. ACP supported expansion of pharmacists' scope of practice to better avail this knowledge and these skills to Albertans and Alberta's

health system. Our college's goal has always been to improve access to safe and effective drug therapy for Albertans through pharmacists, whose expertise and services are co-ordinated with that of other members of individuals' health teams. Therefore, when implementing these new roles, we established standards of practice that recognize the interdependency of pharmacists with other members of individuals' health teams, requiring the sharing of information when pharmacists made decisions about drug therapy. Our standards require that pharmacists who prescribe a drug must document their decision, the rationale for it, provide a follow-up plan, and, as soon as reasonably possible, notify any regulated health professionals whose care of the patient may be affected by that prescribing decision.

9:00

Since 2007 pharmacists have been uploading and dispensing data to Alberta Netcare. The quantity and quality of this data continues to improve; however, it is not real time and has no context.

In 2013 our college led the development of national standards requiring pharmacy practice management systems to have the ability to create records of assessment, care planning, interventions, and monitoring and to update jurisdictional drug information system records and/or electronic health records of assessment, care planning, interventions, and monitoring conducted by pharmacists. Pharmacists' practices and their ability to co-ordinate care with other members of patients' teams have been impeded by system deficiencies that fail to collect and share personal health information in a timely and effective manner.

In supporting the Auditor General's recommendations, we believe that the following four themes are most critical to success. Number one, chronic disease management must be patient centred. Patients require easy and unimpeded access to their personal health information in a format that informs and empowers them to be actively involved in their health and health care decisions.

Number two, electronic medical records systems must be strengthened; however, these must not be medically or PCN-centric. Investment in EMRs must address the practice requirements of all health professionals contributing to CDM. In the absence of a single solution systems must be integrated to support the uploading and sharing of contextualized, comprehensive personal health information. Data sets are no longer adequate. Patients and all members of their health team require access to and to have the ability to enter information on a single real-time personal health record that supports care plans, monitoring records, clinical decisions, and other information important to patients' health.

Number three, common decision support tools must be accessible and usable by pharmacists and all other regulated health professionals contributing to chronic disease management. The efforts of strategic clinical networks must be communicated and made accessible to all health professionals contributing to CDM across Alberta regardless of their place of practice.

Lastly, initiatives to standardize and improve the quality of care plans will make them more usable and valuable to patients and their health teams. Our college supports quality assurance through quality improvement, and it already proposed an initiative to improve the quality of pharmacist care plans prior to publication of this report.

The Auditor General's report does have limitations. Unfortunately, the report on chronic disease management fails to adequately recognize or consider the scope and breadth of services provided by pharmacists practising in privately operated community-based pharmacies. These practices are privately operated . . .

The Chair: Excuse me. Sorry. We have to move on here. That was five minutes.

By the way, thank you very much for all of those reports. We may need more than one session. There's a lot of meat on the bones there. That's fantastic.

Let's move on to the PC caucus. You have the first 12 and a half minutes.

Mr. Young: Okay. Jason Luan, please.

Mr. Luan: Thank you, Mr. Chair and Deputy Chair. Good morning, everybody. I just want to commend all of you by saying how much I really appreciate your feedback report. I'm getting this overwhelming sense that what the Auditor General pointed out – the team approach, the outcome-based, shared responsibility, those best practices – that, it looks to me, you all support it one way or another. Some have even suggested more to that. I want to commend you for that, and that's how I want to begin.

I want to share with you a story very briefly. I personally at one time had a physician that was part of a PCN network but was really operating solely as a fee-for-service kind of provider. As I was door-knocking during the last election, there were so many constituents telling me: Jason, you should visit the Crowfoot Village family practice. We were talking about how to improve the system and so on and so forth, and there were so many people saying that it was a great example: you should do that; you should do that. So I followed up right after the election and, let me tell you, what a world of difference. The best practices we've been talking about here: I personally experienced that.

That begs the question: why are other parts of the system in our province not providing services in such a way? My first question to all of you is this. Several of you talk about fee for service as a barrier to enabling this team approach. Given the spirit that one of you already mentioned, let's try to work together to enable all of us to do well versus pointing fingers as to who is accountable, who didn't do whose job. In that spirit, what's your thought as to how we approach this, giving a specific reference to that Crowfoot model, which is a shared practice? It's not fee for service, all of that stuff. How do we move forward on that?

The Chair: Jason, who are you directing this to?

Mr. Luan: I'm going to ask Dr. Nohr to start because he was the one talking about the enabling approach, which really intrigued me, and I'd welcome any comment from additional experts here.

Dr. Nohr: Thank you. There is active consideration for alternative payment compensation mechanisms, particularly in the care of chronic disease management, which is a big part of primary care. It's an ongoing subject of substantial interest for the AMA, and we believe we'll be part of the future solution to expand the centres of excellence that you described.

The Chair: That was excellent, a nice, short answer.

Mr. Eberhart: Mr. Chairman?

The Chair: Yes. Go ahead.

Mr. Eberhart: I would just comment that I believe leadership is key to success, and my understanding is that there was substantive leadership at Crowfoot by many of the practitioners there in advance of the advent of PCNs. I think that's one of the

limitations within the report is that it's not really spoken to; that is, the human factors that are important to creating change. We do work within a very historical and traditional system, and there's a substantive cultural shift that needs to occur. I think leadership is core to making that happen.

Dr. Spenceley: I think Greg has hit the nail on the head. Many of the family physicians that I have the great honour of working closely with would really like to have an alternate way to be paid in order to enable teamwork. If you talk about Crowfoot Village or you talk about the Taber primary care practice or you talk about Boyle McCauley health centre in Edmonton – I would encourage everyone that if you haven't visited Boyle McCauley, to visit Boyle McCauley as well. It sets up a different foundation. A family doc who is trying to practise and pay overhead and pay everyone else and trying to do it on a fee-for-service basis: it's a recipe for piecemeal medicine.

I've just been on the rural review. You talk to family docs in rural, and they are burning out on a fee-for-service model. They can't spend the time that they need to. So I think alternate remuneration structures that support team are desperately needed.

Dr. Theman: The issues of compensation and how physicians are compensated is completely the Alberta Medical Association's business and not that of the college. I'd just offer a personal opinion that this isn't about compensation or compensation models. Compensation models shouldn't be driving how we structure our system. I think what we need to do is to identify what the goal is, what it is we're trying to achieve, and in primary care chronic disease management I think it's very clear that team-based care is better care. Then the compensation model should follow naturally with the goal of the system. I see this as that it shouldn't be driven by compensation; it should be driven by a vision and a recognition that this is what we're trying to achieve.

Mr. Luan: That's wonderful. Can I have a follow-up question? We all acknowledge that the vision drives where we need to go, but I'm also wondering about a practical case. If we're going to achieve this, I'd rather not see our government lead this or tell you one way or another. My understanding of the Crowfoot model is that it was driven by a few doctors and practitioners, and they came together, and they think this makes sense for the community. On the broader provincial case I feel that folks like you are the most significant stakeholders and experts in this area. Is there any mechanism that you have currently established that you initiated as a collaborative, having government support you in the process? Whatever the outcome of the fee structure or compensation model or how we team up, how do you come up with a collaborative versus from government legislation, policies, and so forth? What's your comment on that?

9:10

Dr. Nohr: It is part of the current AMA government agreement that there be consultation on system-wide efficiencies, and I think this would fit under that category. There is an existing agreement that covers the opportunity for the AMA and government to consult with each other and determine the most effective way to compensate physicians for the work that they do in a variety of clinical settings.

Mr. Young: All right. Thank you very much.

We're going to jump to MLA Horne.

Mr. Horne: Thank you. Good morning. There may not be enough time for you to give a full answer to this, but I'd just like to put a couple of things on the record. First of all, I think it's important that everyone understands that all of the groups represented here today were very involved in the development of the primary health care strategy, and I believe most, if not all, of the organizations are actually signatories to the primary health care strategy. Collectively you have taken ownership of that vision for primary health care for Alberta, that includes much of what's been discussed with respect to chronic disease management in the Auditor General's report, albeit without perhaps as much detail as we would like to see.

The second thing is that the PCN evolution report that Dr. Nohr referred to is, again, a product of about 18 months' work that sets out a future vision for PCNs that features more standardization in the services that will be delivered, a greater level of accountability, and a real focus on putting the patient at the centre.

In the last meeting and starting today again, we've explored some of the incentives in the health care system that are not aligned with the goals of the primary health care strategies. Fee for service is an example, but it's only one example, and the examples are to be found in all professions, not just the practice of medicine.

I'd like to ask Mr. Neuner. You talked about relationships and the culture within the system. I'd like to get your thoughts on what, if any, role you might see for the Health Quality Council in facilitating that change in culture among the professions using the tools that we already have available, which include the most per capita funding in the country for health care and a lot of other resources in IM, IT, and other areas that other provinces don't have. What do you think the Health Quality Council can do?

Mr. Neuner: Thank you for the question. In my view, the Health Quality Council can provide a lot of different avenues to get the right people together to create some sense of the system that currently exists here in Alberta. Certainly, one of our interests is the information systems and how those come together. I've listened to a lot of examples of where there are good practices in the province that provide exceptional services to patients, and I know of some of those. Pincher Creek is another one that I could add to that list.

But I can tell you that as great as it is to be a patient in those, a good percentage of the activity that goes on in those high-performing areas is different. Should Albertans have to choose about where access is best and how they get the best services, or should the access to those services be common across the province? I think the Health Quality Council can provide a role in having a look at that. The relationships, as I said earlier, are key. We have a specific interest in working with physicians at the practice level, helping them to measure exactly what is going on in their practices and how that supports good patient care.

Then the bigger question will become: what is the outcome that you're wanting to achieve? That's a conversation that will require a lot of in-depth understanding and knowledge. The way it's portrayed currently, we're talking about CDM as being this big piece of work. There has to be a place to start. You don't solve it by starting at CDM. There are other places, entry points, to engage with others and form something that is collaborative, not consultative but collaborative. Those are very different ways of approaching and creating good relationships with all the professions.

Mr. Young: Okay. We have one minute here, so I'm going to sneak in a quick question. I heard that we want to have a patient-centred approach, and those are the patient's records. So if the records belong to the patient and everybody is a participant or at

that table, why are we having so many barriers in terms of moving forward, in terms of recognizing that it's the patient's record and that we are simply part of it and sharing information? I'm not sure who should answer that.

Dr. Theman: I'm happy to try, Mr. Young. We have electronic medical records from physician offices. We have an electronic health record, Netcare, and Netcare, I'm told by my clinical colleagues, is great. We have not made it available to every practitioner in the province, so it's not, clearly, shared. I don't know why. I keep advocating for that. Absolutely, patients should have a right to access their own information. The Auditor General pointed that out, and we agree totally. I think all my colleagues at the table believe there should be a single patient record that everybody involved in that circle of care should have access to.

Mr. Young: I think our time is up, but the ownership of that is important, too. I think that point hasn't really been brought up in anything I've read. Who owns that information?

Dr. Theman: The Supreme Court of Canada has made it clear that the information in the record belongs to the patient. However, if I'm the doctor and I created the record, I have a duty to maintain that record.

Mr. Young: Okay. Thank you.

The Chair: Excellent. We'll move over to the Wildrose Health advocate, Mrs. Forsyth.

Mrs. Forsyth: Thank you so much for coming. Many of you I've met with on occasion.

I'd like to start off by following up on a comment that Mr. Neuner of the Health Quality Council mentioned in his opening remarks about moving from a hospital-based system. I'm going to be referencing the Alberta Health Services annual report, where it talks about acute-care beds and it gives a breakdown on all the zones, and referencing the recent comments of today from the AMA, Dr. Johnston, about the frustration with the infrastructure, specifically our hospitals. I'd like a quick comment, if I could, from the AMA and also the college of nurses about how that's affecting patient safety and their quality of care, both, if I may, for the patients and the staff.

Dr. Nohr: Thank you. Access is foundational to safety, and access is dependent on infrastructure, so therefore infrastructure drives safety.

Mrs. Forsyth: Thank you.

Dr. Spenceley: Thank you. I'm happy to respond. First of all, I'd like to pick up on the theme; we very much have a hospital-centric system. That culture truly does need to shift.

My comment around infrastructure. I've toured a number of the facilities in Alberta, and we have some state-of-the-art, wonderful places, and we have others that are – for example, in some of our rural communities – funded for serving 700 souls now serving shadow populations of 2,000 and 3,000 people with crumbling infrastructure. So there's a real disparity across the province in terms of infrastructure.

The other comment that I would make is that we are putting processes in place to deal with overstuffed hospitals and making announcements around new beds when, really, a large part – I'm certainly not the first person to say this – of the demand crunch in our acute-care facilities across Alberta are people who would really rather be elsewhere and need care elsewhere and are in the system in the wrong place and using up acute-care resources.

One of the things that concerns me, that I hear a lot about, is these contingency plans for when hospitals are overcapacity. Those were intended to be sort of a pressure release valve, and it seems like in many parts of the province those have now become standard operating procedure for capacity protocols everywhere. That, of course, has an effect on patient safety. It has an effect on the ability of staff to properly care for people within that structure.

So those would be my general comments.

9:20

Mrs. Forsyth: Well, thank you very much for, I guess, what I can consider being honest about what's happening in our infrastructure.

I want to follow up on something that, as the Health critic, has been very frustrating for me over the last four years. It goes back to a meeting that I had some time ago with Dr. Cowell from the Health Quality Council. The fine work that you do on direction that you're giving the government in regard to reports and findings – and it goes to the Auditor General on the work that he does. Continuously recommendation upon recommendation upon recommendation to the government for the acceptance by the government of those recommendations, yet there's no ability to make sure that those recommendations are taken.

I had a frank conversation with Dr. Cowell a couple of years ago, and he said that he wishes there was some sort of legislation or mandate that could make those recommendations be implemented by the government. I'm wondering if the Health Quality Council, maybe the Auditor General could make a comment. It's unbelievable to me, quite frankly, that I go through the Auditor General's comments about recommendations from 2008 and they're still not implemented, many of them on our seniors. So if you could.

Mr. Saher: Yes. I think I understand the frustration that the member is expressing with respect to implementation of recommendations. The comment I can make is that from the audit office's point of view, once we've made a recommendation, we're not finished until we do what we call a follow-up audit. Our experience has been that the recommendations that are the oldest outstanding deal with complex matters. Some of them were delivered to environments that are no longer the environment in which the implementation has to take place.

Whereas I understand the premise of the question, for me the important thing, if I use chronic disease management as an example, is to focus on the recommendations that are being made now. I think one member expressed a sense of willingness of people to co-operate and move forward, but the thing that will truly make the difference in the implementation is a simple action plan.

I'm looking at the first recommendation we've made on chronic disease management, page 7. It's directed to the Department of Health. We've decided, because the Department of Health on behalf of Albertans is the funder, that the funder has the primary leadership responsibility. We're not implying that the Department of Health can fix everything. Going to this question that leadership is needed, we can all say that leadership is needed, but somebody has to step up and actually exercise that leadership. Somebody has to do something profoundly different.

The first recommendation that we have on page 7 is the one that I believe has the capacity to make the difference, and it has the capacity to deal with the issue of long-outstanding recommendations, because if the first recommendation on page 7 is not dealt with, this committee or its subsequent iterations will be coming

back three, four years from now, and the conversation will be exactly the same.

The Chair: Why don't you read that recommendation into the record, Mr. Auditor General.

Mr. Saher: The recommendation is to the Department of Health to

- set expectations for CDM services to be provided by physicians, AHS and Primary Care Networks
- strengthen CDM supports to family physicians
- facilitate secure sharing of patient healthcare information among providers
- support all family physicians in identifying who their patients are and which patients have chronic disease
- set expectations for care plan delivery and strengthen the administration of care plan billings
- support family physicians and care teams in implementing better electronic medical record systems

I'll just repeat. Unashamedly, it's the view of the audit office that the primary leader here is the Department of Health.

The Chair: Thank you. That's excellent.

Mrs. Forsyth: If I may, I know I'm going to ask some questions that the numbers aren't accessible for right now, so I'm going to ask if you wouldn't mind, through the chair, providing these. The first thing I'd like to know is that I'd like to get the numbers for overall family physicians currently working within the system plus specialists if I can, please, broken down by if it's an orthopaedic surgeon or if it's a kidney specialist.

If I may, from the college of nurses: how many nurses are currently employed in the province, and is that adequate? We keep hearing from the government that staffing is a problem, so if I can find out from the college, if I may, how many nurses are currently employed in the province, I would greatly appreciate that.

One of the AG's recommendations to the Department of Health on page 7 is to be achieved within one year. The AG referred to this: "Facilitate secure sharing of patient healthcare information among providers." Another recommendation to be achieved within a year is to "support family physicians and care teams in implementing better electronic medical record systems." Now, I understand that the government and the physicians have been working to deploy an electronic medical record system for a decade now, with very high costs, over a billion dollars. Does the AMA and the college of physicians believe that getting the EMR right is possible within a year? What supports are required to get that job done, and is it an issue of money or leadership?

The Chair: Dr. Theman, you can start.

Dr. Theman: Well, as has been made clear, the funding of EMRs for physicians was a contractual arrangement between government and the Alberta Medical Association. I think that probably when that was done, Alberta Health Services or its predecessors, the regional health authorities, were part of those negotiations. We have no role with respect to negotiations. The fact that there were allowed to be multiple vendors and that there was no consistency in terms of records or what they could do or the information that they would provide, I think, is a failure. We are currently in a state now where it appears there is unanimity that there should be a single system and that there has to be interoperability. It has to connect with the electronic health record.

So is it possible? I'd have to ask an IT person in terms of what it would take to change what we currently have. Frankly, I think it would cost a lot of money, but I have no idea what kind of number to put to that, Mrs. Forsyth.

Mrs. Forsyth: Okay. Thank you.

I'm told that I've got two minutes. I want to talk about the Health Quality Council of Alberta and the very, very sad case about Greg. Is that how you referred to him? I met with the family on this. I'd like, if I could, through the chair – there are several recommendations that have been made to the College of Physicians & Surgeons, the AMA, and the nurses. As this report was done just about a year ago, if you can provide through the chair where you are on the recommendations that the Health Quality Council has given, because time is short.

The Chair: You have about 45 seconds to answer that.

Mr. Neuner: The parties have been meeting, and I know there's another meeting scheduled for January 8. If the timeline for the end of January is to have a report on those recommendations, I'd be happy to bring it to that group.

In reference to your earlier question about when recommendations don't seem to get traction, it's not within the mandate of HQCA after recommendations have been approved and directions given to go back and re-evaluate or re-audit. We typically don't self-initiate that type of work but are happy to do so if requested by the appropriate parties to do that. But I can take that away and talk to the relevant stakeholders.

That report you referred to is at the heart of HQCA and the work we'd like to do, and we'd like to be more of an enabler to get those recommendations in a way that helps the system.

9:30

The Chair: Thank you very much.

We'll move on to the Liberal caucus. Dr. Swann, you have six minutes and 15 seconds.

Dr. Swann: Thank you. We'll cover it in six minutes.

We've heard lots of talk about integrated care plans and patient- and family-centred care plans. I believe that every one of our professional groups at the table is supportive of that from what I've heard. How often do you meet across professions and plan for integrated care plans?

The Chair: Go ahead, Dr. Spenceley.

Dr. Spenceley: I just want to make sure I understand the question. As organizations?

Dr. Swann: As organizations.

Dr. Spenceley: Since the report that Mrs. Forsyth recommended, we've had one very large meeting of our three boards to have a brainstorming session about concrete pieces that we can take away to work on to increase collaboration across the professions in terms of preserving continuity and integrating care. I don't have all of the pieces that came out of that particular day right in my mind. But we've had one large meeting of all of our three boards since the . . .

Dr. Swann: What three boards?

Dr. Spenceley: Actually, five organizations. There were the two pharmacist organizations, two medical organizations, and then our own, the registered nurses organization.

When I first heard your question about needing to integrate care plans, of course, I thought of care teams, and I thought of sitting

down and talking about the care plan as a team. As organizations we've had one full formal meeting, but our operational leads are meeting on a regular basis, and there's a plan to have the presidents get together much more frequently as well.

Mr. Eberhart: I think I would supplement that. I believe that the five organizations have been engaged in other ways to address the integration of care plans. For a year and a half many of us dedicated substantive time to the working group on the primary health care strategy, and the core of that was discussions around primary health care, chronic disease management, and how health professionals work together to meet the needs of patients.

If we look over the course of the past 15 years – I'll certainly speak for our organization – we've spent exhaustive hours working with the Alberta Netcare strategies. Those deliberations indeed are exhaustive. I think it's rather embarrassing that we're here in 2014 and we don't have the technology in place to integrate the care and to accommodate the co-ordination of care that we're all interested in. So we've spent a lot of time. I think that there are various environmental factors that have not allowed us to get to where we need to be.

Dr. Swann: Please, go ahead.

Dr. Nohr: The foundation for an integrated patient-centred care plan is going to be information management. Clearly, there must be an agreement on content, process, triggered evaluations, et cetera, et cetera, but the foundation is going to be information management. In order to do that, we must have a vision of what is required for patient-centred information management. What path to take to get there remains to be determined. The minister has established a task force on a clinical information system, which is to report in February, which, hopefully, will examine a variety of paths to that visionary goal of information management. But the foundation of integrated patient-centred care plans and any other aspect of chronic disease or any disease management will be information management.

Mr. Neuner: Could I add to that? There's so much discussion about the records and the information systems and time frames. Can I sort of put it out there boldly and suggest that the time frame is probably not less than five years for a strategy that clearly focuses on an outcome and a plan for migration of a variety of activities and sectors to move on to that platform? When you bring it right down to the provider level, there are lots of offices that don't even have an EMR. We're still using fax machines to communicate. Others are leading the industry by having fully integrated records and are ready to take the next step, yet there's a tentative feeling – like, is that the right step to take? – because that vision as described isn't there.

It's not a one-year time frame – and five years may be enormously aggressive – but the setting of a specific, targeted outcome for where we want to be and then defining what the system will be that will carry that load and a migration strategy to create enablers through a combination of both incentives and disincentives to start alignment. The early adopters will go quickly, and there will be a positive sense of peer pressure in the province, where others will want some of that as well. I think that it's really describing the end state and allowing the system to align itself and not putting the burden all on Alberta Health or Alberta Health Services. This requires everybody at the table.

Dr. Swann: That's why I am asking how often you're planning to meet and if there is a regular, scheduled meeting and if you are working together as the leadership of the various professions. If you are not working together to find some common ground and establish a plan for integrated care plans, it's unlikely that anybody else is going to be able to achieve that.

Did you want to say something?

Dr. Spenceley: Just a follow-up comment, quickly. Leaders in this work, in integrated care, will tell you: don't wait for the perfect system to appear and for the clouds to open and the angels to sing; instead, get on with the business of integration, get on with establishing the relationships around the care, involve the patient, and get on with it. If we are going to wait forever for an integrated – I want the system too, and I want information to travel seamlessly, but if we wait for that, we're going to have a lot more grave crises on our hands.

The Chair: Thank you very much.

Mr. Bilous, NDP.

Mr. Bilous: Yes. Six minutes of heaven. I'm going to ask a few different questions here. Again, going with this theme or at least a theme today is a couple of different things. Most of you recognize in your organizations that the current fee-for-service model is not conducive, whether it's to an integrated care plan or to providing the level of care that each of your organizations truly hopes to get to. Then we talked about data systems, and you've just mentioned the information management vision. So it sounds like for the most part your different organizations are on the same page.

What I'd like to get to, if possible in six minutes, is: what are the actual obstacles and roadblocks? We're talking about a lot of high-level things and having a vision and moving toward it, but the fact is that we are in 2014, and it shocks me to learn that people are communicating via fax machines to each other, that we're still very much bound to paper and pen for our patient files or whatever you call them. I'd like to know, and I may have to get written responses: number one, for each of your organizations how do you propose we move away from a fee-for-service model to maybe a couple of different ways of doing it or towards a team-based model if that's the best result for what we're looking for, the best avenue to get to where we want to go?

Again, the amount of dollars that we've spent on trying to update or to get our medical records system electronic completely floors me. We're still nowhere near the left hand knowing what the right hand is doing. So how do we get there? What should we be pushing the Department of Health and the government to do to get there? I mean, sitting around just talking about, "We're not there yet" – everybody is waiting for someone else to take the first step. Maybe that's a little unfair as a comment because maybe it is happening in certain pockets, but I'd like to know from your organizations: what do you need? What are the roadblocks? What are you doing to move us ahead?

Ms Wing: Hi. I wonder if I could start with a response. I know a lot of the conversation has been around formalized, recognized team-based care in primary care settings in Alberta Health Services, but I have to point out that, you know, there is that care going on in community-based pharmacy, and some of those team-based care situations that occur are less recognized because they're driven by the patients selecting their care team members. As a result of that, we do have care provided through community pharmacy that has been fundamentally resourced and an infrastructure that's been created around private-sector funding, not formally through recognized public funding, as these other team environments have created. As a result of that, there are solutions, I think, that can be recognized in what's going on in the private sector.

Certainly, with regard to information sharing, as Mr. Eberhart pointed out, pharmacists since 2007 have been sharing dispense record information with the provincial electronic health record. Is it a perfect solution? No. But it certainly points out that pharmacists have a lot of opportunity and ability to share information once there's a form or a recognized process of how that would look. That's not a little bit of work; that is currently 40 million dispense records in this province alone that are shared with that system. Pharmacists are prepared. They're ready to share care plans, but what we need is to understand what works best for everybody and what that platform would look like. As has been suggested by my other colleagues, there has to be leadership around what some of those solutions would look like before it can happen.

9:40

Mr. Eberhart: If I could just complement Ms Wing's comments, that is why I led a task force nationally to develop standards around pharmacy practice management systems with a very specific focus on the collection of information around care planning, monitoring patient care, addressing decisions around appropriate drug therapy, and, within those, ensuring that the ability of those systems could upload that information to other systems such as the electronic health record. I think that pharmacy is fully committed to the sharing of information, and we've demonstrated that both through the actions that Ms Wing has spoken about and the standards that we've led across Canada.

Mr. Bilous: I think I only have about a minute left. Forgive me, I know that you want to answer – this is the challenge with the structure of how much time the smaller opposition parties get – something that I just want to read in and ask for your written response to, because there may be a reason that we're not talking about this.

I want to talk briefly about family care clinics. Now, we're also concerned about the ways in which the cancelling of the promised family care clinics will impact the broader capacity of Alberta's health care system to cope with the greater demands that are being placed on it. Three quick questions I'll read in: in your opinion has the retraction of FCCs had a negative impact on our health system's ability to provide a complete, multidisciplinary approach to care? Have these cancelled clinics impacted your organizations' planning for the future of care in Alberta, if at all? In what ways does this cancellation impact prospects for improving the management of chronic disease in our province? I'm just trying to get a sense of: is it something that we had that was great, that was moving us on the right path, and since they've been pulled, is that part of the impediment to what we were discussing today?

The Chair: All right. Well, thank you for that.

If you could provide those answers through the chair. I know that one of the downsides of coming to this committee is that you always go home with homework, so my apologies to our guests in that regard.

We'll move over, for the last 11 minutes, to the governing caucus.

Mr. Young: Thank you.

MLA Sarich.

Mrs. Sarich: Thank you very much. I was very interested in the information provided and some of the comments made, and I would like to tackle one particular area. Dr. Theman, you had made a comment, something to the effect that the system as we know it today is not fully integrated, and your view was that it was an issue of governance.

All of you are representatives of your organizations, and governance entails oversight and monitoring. On that note, the Auditor General's report on page 46 provided a number of details. I'm just going to read right out what it says. It says:

> The department expects all physicians will use electronic medical records, but less than 80 per cent of family physicians currently do. At least 12 different electronic medical record systems are currently used by family physicians in Alberta.

From a governance perspective of the organization that you represent, is this something that you are monitoring, that you have oversight for, or do you look to, you know, Alberta Health Services or Alberta Health for the monitoring, in terms of compliance, of where we are today?

There were lots of comments that the IT systems are inadequate, that they're not integrated. I appreciate the ones that are trying to integrate with the system. A theme that has arisen is that you all are basically also saying that these recommendations of the Auditor General are a call to action. I was wondering, from the College of Physicians & Surgeons and AMA, if you would have a comment on that.

The second thing I'd like to address is that we were given at table here from the College of Physicians & Surgeons *The Messenger*, and you had pointed out in here that the report of the Auditor General does not – you refer to ". . . chronic disease management primarily because most CDM is (appropriately) provided by family physicians, and family physicians – whether in PCNs or not – are only loosely connected with the Ministry of Health and Alberta Health Services." I'd like to get on your record: are you fully supportive of an integrated approach where allied health professionals are in fact viewed and there's an equitable participation in the chronic disease management system? I don't get a sense by this comment. It says: appropriately provided by physicians. But it makes no comment about allied health professionals in a chronic disease management system that is integrated, fully respected, and equitable.

Dr. Theman: I should correct that, then, to make it clearer that, absolutely, I fully support and the college fully supports integrated health care teams providing primary care and chronic disease management. I mean, team-based care isn't a panacea for everything, but in chronic disease management I think there's lots of good evidence. There's really good evidence that the best chronic disease management happens in primary care communities, a practice. It's better quality at lower cost with better results. I think there's lots of evidence around the world to support that.

With respect to the first question, it's a real challenge. The simple answer is: we don't monitor that. This was a negotiated agreement between government and the Alberta Medical Association. The fact that government did not say, "This is what we require in exchange for the money that we're giving," is astounding to me as a taxpayer and as an Albertan. Family doctors took the money; other physicians took the money. Doesn't mean necessarily that they have a well-functioning electronic medical record. They'd certainly use it for billing purposes because they have to, but in terms of the other things, in terms of being able to monitor their patient panels or identify who has diabetes or who has chronic obstructive pulmonary disease, it's not necessarily part of what was part of that negotiated agreement.

Mrs. Sarich: Okay. Maybe from the Alberta Medical Association perspective.

Thank you.

Dr. Nohr: Historically physicians were given the opportunity and encouraged and perhaps even required to make a choice as to how

they would maintain their patient records. That led in the enterprise model in Alberta at that time to a choice of office-based EMRs that physicians could use to maintain their records. Physicians contribute to the provincial electronic health record, current iteration being Netcare, by way of providing reports, et cetera, but that data set is incomplete. Netcare can't accommodate all the data that physicians generate.

Mrs. Sarich: Okay. So you're identifying that there is problem. I have to move on here, so if there's anything further that you would like to provide, you're welcome to provide it in writing to the committee on the questions that I asked.

Last week in the Public Accounts Mr. Monteith commented about high-performing chronic disease management systems, and he cited France, Scotland, Kaiser Permanente, Geisinger. In those systems physicians actually are not paid in a fee-for-service environment. I would like to understand: what is your commitment to move away from a fee-for-service model or some other abridged version of that, and how long do you expect that Albertans would be looking at something a little bit different provided by your leadership of the two organizations, the College of Physicians & Surgeons and the Alberta Medical Association?

Dr. Theman: Really quickly, we have absolutely nothing to do with physician compensation, and the act says that we cannot.

Dr. Nohr: But we do.

Mrs. Sarich: Yes. Good.

Dr. Nohr: I appreciate the great interest from my friends at this end of the table and from the committee members and the public at large in how physicians are compensated. Physicians themselves are interested in how they're compensated. There is an active engagement by the AMA in understanding how physicians work and in tying compensation to how they work. As the physician work model transforms into a chronic disease management model, then how they get compensated should match that, and we are working on that.

9:50

Mrs. Sarich: Okay. My last question is going to focus on – and there have been many studies, many papers written – that in Alberta it is a medical model, and less than 3 per cent of the budget overall is spent on health promotion and wellness. I would like to understand, and I'm asking on behalf of Albertans. To really tackle chronic disease management as an overall issue, and it touches on many, many aspects of health, what is your commitment from your organization about – the medical model has its place – moving more into the health promotion and wellness area so that there will be a broader integration for chronic disease management by allied professionals, not atypical to what you would find in a medical model? Go ahead.

Mr. Eberhart: Maybe I'll just provide a brief comment. Again I reflect back to the primary health care strategy. I remember in the very earliest of the meetings the debate about whether this was a primary care strategy or a primary health care strategy, and the consensus amongst the working group that was contributing to it was that this was clearly about primary health care, that we needed to consider those aspects of healthy living and get traction on them as a means to ever getting out of the rut that we're currently in. Again, I would plead that we get some traction and that we ensure that the recommendations within the primary health care strategy continue to live and that they are appropriately resourced so that we can see the efforts that were put into it come to fruition.

Dr. Theman: Really quickly, the comments read into the record by the Auditor General with respect to the recommendations would go a long way to getting us there. It's clear that until we have some expectations and a strategy and a vision in terms of what we want to achieve, it's going to be hard to get there, and we need to have information systems that track that. We currently do not. It takes an enormous effort by primary care networks, for example, to get information for those who are really interested about how well they're doing in meeting such targets. They set their own targets. There is no overarching system that looks at the targets. That's what I mean by the fact that we do not have a system. They're not integrated. They're not part of the system writ large.

Dr. Spenceley: Thank you for the question.

The Chair: Really quickly.

Dr. Spenceley: Yes. Very quickly, I would reiterate the comments of my colleague Greg Eberhart from the pharmacists. The primary health care strategy needs to get some wheels underneath it, and one of the fundamental misunderstandings is that primary health care only happens out in the community. Primary health care, as a health-promotive, illness-prevention strategy, happens in hospitals. It happens everywhere across the system if we want to make a difference.

Mr. Young: Thank you.

Mrs. Sarich: Deputy Chair, I would just like my last question answered by the remaining representatives here. Could you provide the committee a written response?

Thank you.

Mr. Young: Okay. We have a minute left. I'm just going through a brief list that I wrote here. We have pharmacists, physicians, physios, dieticians, hospitals, diagnostic organizations, PCNs. Then to Dr. Theman's point, we spent $300 million or more on EMRs for physicians and really got nothing more than electronic isolated file systems. Do we realize that we need to have data exchange standards before we start adding systems? We need systems to talk. Do we realize that? There is no panacea of one system and the government coming with a billion dollar cheque to write for this massive health system. There needs to be systems. Each of you have fingers in parts of them that need to talk. We went down this road without any kind of data exchange standards, and there are lots of them out there: HL7, NIEM, XML. I mean, it blows my mind.

The Chair: Well, thank you very much, and thank you to our guests for being here today. There's a lot to chew on, obviously. We might have to have you back. I just say, going back to kind of a theme that I've heard from all, that you really should be meeting on a regular basis and providing us lawmakers, you know, some recommendations, specifically around the way that – compensation is one thing that we talked about a lot today but also this electronic health record. We need you guys to come up with a solution and then get us to line up behind your parade or get in front of the parade as politicians like to do. It's very difficult with all six of you not talking to each other on a regular basis. This was just excellent. It seems like you all want the same thing but, you

know, we need to know what we need to do as lawmakers. So, please, please, please, help us out in that regard.

So that's it for today.

There's just one quick piece of business, and it does apply to some of the take-home work for our guests today. Last week Mrs. Sarich brought up a topic of the responses follow-up template she created and submitted to the committee back in May. Now, it was posted to the internal website this week for members to take a look at and to make some remarks if they need to. Essentially, what this would do is that all those questions that are read into the record by various members, it kind of puts it into a template, provides it to our guests after they've left, and then they can answer those questions. Then we can decide as a committee whether the answers to the questions were, in fact, answers, and they usually are.

Dr. Swann: Unlike in the Legislature.

The Chair: Yeah. This isn't question period; it's answer period.

After viewing the template, I certainly saw no issues with it. I thought it was very well done. I know it was done in consultation with the Auditor General as well. But are there any comments or questions or things that you'd like to see improved in the template?

Mr. Young: I have one comment. It just seemed to me – and I've expressed this to Mrs. Sarich as well – very subjective and broad on whether the question was answered to satisfaction. I know that's difficult, but how do we wrap our heads around qualifying an answer? I mean, you may not like the answer, but it may have been reasonably answered. So in a form like that how do we deal with that?

The Chair: Go ahead, Mrs. Sarich, real quick.

Mrs. Sarich: Yeah. I believe the Auditor General could help answer your particular question at this time.

Mr. Saher: Well, I would submit that it's as simple as: someone asks a question, gets an answer, and is asked to exercise their judgment. Is the answer satisfactory? If it's not satisfactory, I think that would require some mechanism to seek further information or a revised answer. But I think the subjectivity is in the hands of the person who asks the question. It's that person, not the committee as a whole, who has to decide: am I satisfied?

Mr. Young: I think what I'm taking from that is that we also have to articulate why it's unsatisfactory, and that can't be around: I didn't like the answer. I think my point has been made.

The Chair: Very good points. If it becomes a problem in that we have a member that is essentially having a disagreement with regard to whether they're getting an answer, maybe we can talk about that as a committee and decide whether the question has actually been answered, but I think I trust the judgment of members around the table to be reasonable. You know, once they get answers, if they don't like them, they don't like them, but at least they got answers.

Do we have a mover to accept this template and put it into implementation? Ms. Pastoor. Those in favour? Any opposed? Carried.

All right. I guess we'll use that on our guests. You'll be getting that shortly.

The date of the next meeting is scheduled for Tuesday, December 9, with Alberta Seniors, Alberta Health, and Alberta Health Services. Obviously, a very important meeting, so please be there. Again we'll start at 8 o'clock with a briefing from the Auditor General and our research.

Do we have a member that would like to move that the meeting be adjourned? Mr. Bilous. Those in favour? Any opposed? Carried.

Thank you very much.

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

Published under the Authority of the Speaker
of the Legislative Assembly of Alberta