

Legislative Assembly of Alberta

The 31st Legislature
Second Session

Standing Committee on Public Accounts

Ministry of Hospital and Surgical Health Services

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Standing Committee on Public Accounts

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Evan Romanow, Deputy Minister
Will Sawchyn, Assistant Deputy Minister, Finance and Capital Planning, and Senior Financial Officer
Sayeh Zielke, Interim Chief Executive Officer, Acute Care Alberta

9 a.m. Tuesday, November 17, 2026

[Mr. Sabir in the chair]

The Chair: Good morning, everyone. I would like to call this meeting of the Public Accounts Committee to order and welcome everyone in attendance.

My name is Irfan Sabir, MLA for Calgary-Bhullar-McCall and chair of the committee. As we begin this morning, I would like to invite members, guests, and LAO staff at the table to introduce themselves. We will start to my right.

Mr. van Dijken: Good morning. Glenn van Dijken, the MLA for Athabasca-Barrhead-Westlock.

Mr. Cyr: Good morning. Scott Cyr, MLA for Bonnyville-Cold Lake-St. Paul.

Mr. Bouchard: Good morning, everyone. Eric Bouchard, MLA for Calgary-Lougheed.

Ms Lovely: Good morning, everyone. MLA Jackie Lovely for the Camrose constituency.

Mr. Dyck: MLA Nolan Dyck for Grande Prairie.

Ms Joseph: Kindy Joseph with Hospital and Surgical Health Services.

Mr. Sawchyn: Will Sawchyn, senior financial officer for Hospital and Surgical Health Services.

Mr. Romanow: Evan Romanow, Deputy Minister of Hospital and Surgical Health Services.

Mr. Nickerson: Good morning. Chris Nickerson, assistant deputy minister, acute-care division in the Ministry of Hospital and Surgical Health Services.

Dr. Zielke: Good morning. Dr. Sayeh Zielke, interim CEO of Acute Care Alberta.

Mr. Peters: Good morning. Phil Peters, Auditor General.

Mr. Leonty: Good morning. Eric Leonty, Assistant Auditor General.

Mr. Schmidt: Marlin Schmidt, Edmonton-Gold Bar.

Ms Renaud: Marie Renaud, St. Albert.

Member Eremenko: Good morning. Janet Eremenko, Calgary-Currie.

Ms Robert: Good morning. Nancy Robert, clerk of *Journals* and committees.

Mr. Huffman: Good morning. Warren Huffman, committee clerk.

The Chair: Thank you.

MLA Sinclair, are you able to introduce yourself?

Mr. Sinclair: MLA Scott Sinclair for Lesser Slave Lake.

The Chair: Thank you.

Purpose statement. The Standing Committee on Public Accounts is mandated to review the public accounts of the government of Alberta and reports of the Auditor General. The committee examines the administration of government policy, not the merits of it, with the objective of enhancing transparency and accountability in government spending of public funds. The committee operates best when it maintains a nonpartisan approach in carrying out its responsibilities on behalf of all Albertans.

A few housekeeping items to address before we turn to the business at hand. The microphones are operated by legislative office staff. Committee proceedings are live streamed on the Internet and broadcast on Alberta Assembly TV. The audio- and videostream and transcripts of the meeting can be accessed via the Legislative Assembly website. Please set your cellphone and other devices to silent for the duration of the meeting, and comments should flow through the chair at all times.

Approval of the agenda. Members, are there any changes or additions to the agenda? If not, would a member like to move that the Standing Committee on Public Accounts approve the proposed agenda as distributed for its November 17, 2026, meeting?

Ms Lovely: So moved.

The Chair: Thank you.

Any discussion on the motion? Seeing none, all in favour? Any opposed? Thank you. The motion is carried.

We also have minutes from the November 3, 2026, meeting of the committee. Do members have any errors or omissions to note? If not, would a member like to move that the Standing Committee on Public Accounts approve the minutes as distributed of its meeting held on November 3, 2026?

Mr. van Dijken: So moved.

The Chair: Thank you.

Any discussion on the motion? All in favour? Any opposed? Thank you. The motion is carried.

I would like to welcome our guests from the Ministry of Hospital and Surgical Health Services and the office of the Auditor General who are here to address the ministry's annual report 2025-26, responsibilities under their purview during that reporting period, and relevant reports and outstanding recommendations of the Auditor General. I invite officials from the ministry to provide opening remarks not exceeding 10 minutes.

Mr. Romanow: Thank you, Mr. Chair, and good morning. My name is Evan Romanow. I'm the Deputy Minister of Hospital and Surgical Health Services. Thank you very much for the opportunity to appear before this committee to discuss the ministry's 2025-26 annual report and the outstanding recommendations of the Auditor General. Joining me today are senior officials from the department, Acute Care Alberta, and our provincial health corporations who can assist in answering the committee's questions.

Along with the tens of thousands of incredibly talented and dedicated health care professionals, we are working hard to build an acute-care system with greater capacity to help Albertans receive timely, high-quality care. Today I will outline tangible progress we achieved last year. We are pleased to outline how our acute-care system is responding and responding well to intense pressures facing our and other health systems across Canada.

Across the country every province is managing an aging demographic, which creates compounding health care demands, and the prolonged effects of the pandemic both on patient health and front-line health care workforces. Alberta faces these same national realities and is also dealing with historic population growth. In just over five years our population grew 17 per cent, surpassing 5 million residents. That means 736,000 additional people and nearly 100,000 this last year alone now also rely on our acute-care system in their times of need. An added dimension to this growth is the seniors population, which expanded by 42 per cent. This means there are now 231,000 more seniors requiring

higher levels of care from our system. This has created what health economists identify as Alberta's population paradox. On the surface, we have a younger median population than the Canadian average, yet our population is aging faster than the rest of Canada.

The 2025-26 winter was also one of the worst and more deadly respiratory virus seasons on record in Alberta, driven by a severe influenza surge. We faced and continue to face significant pressures in our acute system associated with these trends, but we are rising to that challenge. To meet this demand, we are increasing resources. In fact, recent national health and CIHI data show that Alberta is expanding health resources at per capita rates which outpace national benchmarks. We now provide more hospital care per person than the Canadian average, delivering 7,911 hospital admissions and 52,200 patient days for every 100,000 residents.

Our system delivered record clinical outputs last year. Front-line teams completed a record 332,800 surgeries last year, including record numbers of cancer surgeries. This surpassed our annual target and represented a 4.4 per cent increase year over year. CIHI data also showed we led the country in surgical growth, expanding surgeries by 15 per cent since 2019, tied for the best performance in Canada. We also performed more surgical procedures, more hip replacements, more knee replacements than the national average.

As our population grows and ages, cancer rates, unfortunately, are also rising. Last year Cancer Care Alberta delivered over 11,200 radiation treatments, an 8 per cent increase, with 97 per cent of patients starting radiation within the clinically recommended 28 days. Again, better than the national average.

The same is true for diagnostic imaging. We completed almost 700,000 CT scans last year, an 8.4 per cent increase, along with over 280,000 MRIs. Both of those are provincial records. And we delivered a record 104 million laboratory tests.

To deliver this volume of care, we took decisive action to recruit, retain, and support front-line staff. Last year Alberta's acute-care system added approximately 1,100 physicians, 3,300 nurses, and 140 nurse practitioners. Licensed specialist doctor registrations increased by 14 per cent, reaching a record 7,042 doctors. This was driven by double-digit gains in acute disciplines, including emergency medicine, medical oncology, and anaesthesiology. Similarly, EHS Alberta expanded its practising paramedic headcount to 3,151, up 27 per cent in five years. Work to modernize emergency services and ambulance drop-offs have also delivered positive results. Paramedics spent an average of 1.6 hours waiting at hospital in 2025, down from roughly 3.1 hours in late 2022, returning crews to communities faster. And red alerts have radically declined, if not completely disappeared, across the system.

Of course, improving patient flow requires action beyond hospitals. Last year on an average day more than 1,500 alternative level of care patients occupied acute-care beds, representing about 17 per cent of provincial acute-care capacity. These patients no longer required the intensity of acute care, but they could not be safely discharged until the appropriate care was available in another setting. This reflects broader pressures across the system where other health ministries led and supported joint augmentations in continuing care, supportive living, addiction and mental health, and other nonacute supports and services to improve transitions so that patients can move out of hospitals and be supported more appropriately in community settings. This included implementing enhanced discharge processes, temporary accommodation supports, and targeted initiatives such as the Royal Alexandra hospital task force for diversion and discharge.

9:10

Obviously, beyond improving more efficient flow, overall bed capacity absolutely matters. Over the past year we expanded short-, medium-, and long-term capacity across the acute system. To help immediately, we added 239 net new acute beds, bringing our baseline to a record 9,003 staff bed level. We integrated 336 surge beds into permanent operations and added 50 permanent adult critical care beds, expanding baseline ICU capacity by 29 per cent. More than 200 surge beds were also converted to permanent capacity. All of this is incredibly positive. Over the next four years we are on track to add 300 more acute-care beds, and over the next decade we are planning capital projects to add even more beds across Alberta. Major bed tower projects in Red Deer, Edmonton, and Calgary will deliver upwards of 1,200 beds alone alongside the new stand-alone Stollery children's hospital.

We are proud of the work that was done last year and that continues today, but we also are clear that there is a lot more work to do. Our acute-care system remains under intense pressure. Patient demand does continue to rise, which means that record volume and rate increases for many acute services are well above just the population rate increases. People are using more services, like emergency health services, where 911 events were up more than a third in six years. This means, unfortunately, in some areas our major investments are not immediately leading to reduced wait-lists or quicker access to care.

While we are proud Alberta performs in line with or better in many cases than national averages, make no mistake. We are not satisfied, and we must do better. As an example, admitted patients in Alberta spent four hours less in emergency departments than national averages before being transferred to an in-patient bed, and discharged patients went home over an hour sooner. That is very positive news, but it is not good enough. The other three health ministries and ours, working in partnership as one health system, are laser focused on strengthening the system and, importantly, making it cost-effective and sustainable.

In summary, the 2025-26 fiscal year demonstrated the resilience and remarkable capacity of Alberta's acute-care system and the dedicated people working within. When faced with unprecedented demographic challenges, severe winter respiratory illness pressures, and more, our acute-care system delivered record surgical volumes, added more acute beds, expanded adult ICU capacity, and grew our clinical workforce by thousands of professionals. We recognize the significant access, wait time, and patient flow challenges that remain, but by working together in the refocused health system, expanding front-line capacity, unblocking downstream community transitions, and investing in infrastructure across the province, we are stepping up to meet this challenge and building a health care system that continues to deliver for Albertans.

Thank you very much, Mr. Chair. My colleagues and I here today very much look forward to the discussion and answering questions of the committee, and I can hand it back to you.

The Chair: Thank you, Deputy Minister.

I would now invite the Auditor General for his comments. Mr. Peters, you have five minutes.

Mr. Peters: Thank you, Mr. Chair. Good morning, hon. committee members and officials from the Department of Hospital and Surgical Health Services. Thank you for including our office in these proceedings and the opportunity to provide an overview of our reports related to the department and its reporting entity, Acute Care Alberta. The ministry has a total of five outstanding recommendations, two to the department and three to Acute Care Alberta. I'm pleased to note that two of the recommendations are ready for assessment.

Before speaking to our performance audit or examination reports, I would advise the committee that we have completed our fiscal

’25-26 financial statement audit work for this department and Acute Care Alberta as set out in the Auditor General Act. Any findings will be reported to the members of the Legislative Assembly in the coming months as part of our annual audit of the province’s consolidated financial statements and our annual summary of ministry audit work.

I will now move to the outstanding recommendations. Our An Examination of Community Laboratory Services (Contract with DynaLife) was released in November 2025. Two recommendations were made and were directed jointly to what is now this department and the Department of Primary and Preventative Health Services. We recommended that the departments ensure that their procurement processes and those of their reporting entities are followed, specifically that an analysis is conducted and retained to support the expenditure of public money prior to proceeding with major procurements and, secondly, ensure that their record management processes document all key decisions, directions, and recommendations, including those who made them and rationale. The department should ensure that the same standards are met for their various reporting entities. Sound procurement and record management practices are essential to transparency, accountability, and effective stewardship of public resources.

Of particular note, a business case is a cornerstone of responsible procurement. It typically includes an analysis of projected cost savings, impacts on quality care, risks to service continuity, and alignment with user needs and strategic goals. It helps decision-makers evaluate alternatives, justify the preferred option, and ensure transparency and accountability.

Turning to Acute Care Alberta, we released a performance audit on the Alberta Health Services’ public performance reporting in December 2025. The report made one recommendation, that Acute Care Alberta formalize its public performance reporting processes as written policy and procedures and ensure that these procedures resolve process weaknesses noted throughout our audit. We issued our report entitled Use of Publicly Funded CT and MRI Services in April 2021 in which two recommendations were made: one, improve the outpatient CT and MRI intake and scheduling processes, and secondly, measure and report on performance to identify areas of improvement and best practice. We inform that these two recommendations are ready for assessment.

Thank you to the departments both past and present for their co-operation and assistance throughout our audit work. Thank you, Chair. I’d be pleased to answer any questions from the committee.

The Chair: Thank you.

We will now hear questions from the committee members, and we will begin with the Official Opposition caucus. You will have 15 minutes. MLA Eremenko.

Member Eremenko: Thank you. Thank you, Mr. Chair. Thanks everybody for being here. The ministry on page 22 includes information on surgery volumes for chartered surgical facilities but doesn’t include the same information for hospitals. Can the ministry provide year-over-year surgery volume numbers for hospitals as it does for chartered surgical facilities?

Mr. Romanow: Great. Thank you very much for the question and the comment. Certainly, as noted, we’re proud that over 332,000 surgeries were completed overall. We do have robust measurement and outcomes on where surgeries are being performed and those overall volumes, which are highlighted.

It’s important to note that we did see an increase of 4.4 per cent, and that absolutely outlines the performance in chartered surgical facilities. Those performed more than 68,000 publicly funded procedures, and that provides 20 per cent roughly of scheduled surgeries without out-of-pocket costs to patients. That number is noted and listed, again, at 68,000.

Member Eremenko: Thank you. So again, for hospitals, can I simply take 332,000 and subtract 68?

Mr. Romanow: That’s correct. There was a question about the chartered surgical facilities, and yes, that is the total overall with 332,000.

Member Eremenko: Okay, but I was asking specifically about hospitals. Do you have year-over-year growth from hospitals from – let’s see. The chartered surgical facilities reported by the department are from 2021 to ’25-26. I wonder if the growth has been more significant in chartered surgical facilities than in hospitals.

Mr. Romanow: Yeah. Correct. The specific numbers that are listed there in hospitals in 2023-2024 list the three years. In 2023-24 we saw 242,195 growing to 254,129 and then growing again in the year 2025-26 to 264,822. That collectively was an increase of 61,865.

9:20

Member Eremenko: The 4.4 per cent increase in chartered surgical facilities: is that increase a result of more facilities coming online or changes in efficient – I don’t know. Is it more spaces coming online or something else?

Mr. Romanow: Collectively it’s a 4.4 per cent increase with surgeries writ large. What this collectively points to – and I’ll invite in a moment Dr. Zielke, who can elaborate on where we’re continuing to see growth – is significant investments that government has made to expand the resources available to deliver surgeries. It’s working on multiple levels. It includes net new investments to add more surgical capacity, including through the Alberta surgical initiative. It’s looking at process enhancements to be able to streamline how surgical spaces are critically being used and making sure that the right utilization of surgical space, including in chartered surgical settings, is being utilized, so it’s a combination of multiple entities.

Dr. Zielke, would you care to add some additional details to elaborate just on the different types of enhancements we’re seeing to why we’re collectively receiving a 4.4 per cent increase?

Dr. Zielke: Yeah, absolutely. We continue to work within Acute Care Alberta with our partners to bring on as many surgical chartered facilities as possible, so that is rolling, active work that we’re undertaking to add to our CSFs over time.

Member Eremenko: Okay, so I’m hearing that the investment is in the chartered surgical facilities to – that is the response to the growth. Do agreements with chartered surgical facilities have minimum requirements for the number of surgeries to be provided in a given year or in a given period of time?

Mr. Romanow: Yeah. Thank you for the question. Absolutely, the contract requirements for chartered surgical facilities and where we’re looking at the allocation of resources: it is based on the output. It’s based on the number of patients being served, and it is absolutely targeted to be able to support and drive that performance in numbers. There are clear expectations on what is required for performance.

Member Eremenko: What happens when those numbers aren’t achieved?

Mr. Romanow: There first absolutely is an assessment of all of our performance from any providers, including looking at hospitals, and it's leveraging the strength of performance. This is where initiatives where we're targeting where dollars are following the patient, where we are being much more targeted to look at the outcomes, the quality, and the performance from all providers and certainly our ability – I would even suggest the reason for creating a dedicated Ministry of Hospital and Surgical Health Services, a dedicated provincial health agency in Acute Care Alberta, is specifically to be able to lean in to measure performance and progress and make adjustments based off performance.

Member Eremenko: Are there consequences when the minimum number of surgeries are not met by chartered surgical facilities?

Mr. Romanow: Absolutely, there are.

Member Eremenko: What are they?

Mr. Romanow: Including looking at opportunities to redirect and enhance performance and spending in other parts of the system, all tools would be on the table for Alberta to make sure that the dollars and the investments that are going into surgeries and different providers and different hospitals and different settings all across the province, to make sure that we've got that high-quality performance . . .

Member Eremenko: One can imagine that if the inputs are finite – physicians, surgeons, anaesthetists, anaesthesiologists – and they have to determine whether or not they're going to perform a surgery in a chartered surgical facility that has minimum agreement numbers versus participating in a hospital or in a surgery elsewhere that may not have the same kinds of consequences, that they will choose the chartered surgical facilities. How do you speak to or reconcile the finite resources, labour, in one versus the other system?

Mr. Romanow: To be very clear, these are publicly funded, publicly available surgical facilities and so are readily available at no cost to Albertans. In the oversight of where resources are going and with the finite resources operating between different sites, that's where we look at the optimal utilization of staffing, physicians, anaesthesiologists, nursing capacity, and make adjustments according to the right setting, be it in a rural site, be it in an urban setting, a chartered surgical site. So adjustments and evaluation are absolutely the reason that there's strong oversight and leveraging the collective public health system. I'll invite the interim CEO of Acute Care Alberta just to elaborate on your question.

Member Eremenko: Actually, thank you for that, but I'm going to move on because I do have a lot of questions. On page 23, therefore, the department reports that "to further address surgical wait times, [the ministry] continues to work . . . to improve operating room utilization." What is our current operating room utilization rate in hospitals and in chartered surgical facilities?

Mr. Romanow: Thank you for that question, the detailed one. I'll just take a moment to make sure I get the right specifics. I might actually just need a moment to get back to you on that one if that's okay.

Member Eremenko: Would you like another question in that case, while you're looking?

Mr. Romanow: Sure. If that's possible, and I will get back to you. Thank you for that question, through the chair.

Member Eremenko: You've already spoken to a high level of monitoring in terms of the outputs, outcomes, particularly the patient outcomes. What is the percentage of patients who received follow-up care as a result of postsurgical adverse events from chartered surgical facilities specifically?

Mr. Romanow: As you would know, Alberta has one of the most robust, probably in the country if not beyond, connections through our Connect Care system. Our integrated health system has the most robust evaluation mechanisms to look at patient outcomes to be able to track. That's precisely the work of a dedicated ministry, a dedicated Acute Care Alberta, to be able to zero in. It takes a moment because it's important to zero in on the outcomes and the broader well-being, including through surgical interventions and others. There is a robust ability to be able to monitor patient outcomes, including assessments through surveying, postsurgeries, and post any interaction with our health system.

Member Eremenko: Great. We've established that you have the process, so the numbers should be readily available to say what the secondary admission or adverse events are from surgeries performed in chartered surgical facilities versus those performed in hospitals. Specifically, please.

Mr. Romanow: Yeah. I think what is really important to highlight, again: all activities in any surgical facilities are delivered through the same CPSA-accredited facilities and contractual arrangements, so there is not a difference between the different sites or locations . . .

Member Eremenko: So you don't . . .

Mr. Romanow: The tracking will continue to be the same. Really important to highlight that the consistent evaluation and outcomes and performance – it doesn't matter which site individuals are in. There is the same robust tracking for Albertans across the province.

Member Eremenko: So these are publicly funded, privately operated facilities, and there are unique stand-alone agreements. Hopefully Albertans would expect that they should go through a very rigorous procurement process, but these are profit-making enterprises. One would hope that there would be very strong monitoring of the quality of the procedures and the outcomes of those procedures provided in that facility, particularly when, in the case of secondary admissions, those then have to be managed by acute care and in the hospital system. What is the department doing to monitor the quality of the service that is provided in these publicly funded, privately delivered facilities?

Mr. Romanow: Publicly funded, publicly available services at no cost to Albertans . . .

Member Eremenko: Privately delivered, sir.

Mr. Romanow: . . . are monitored and overseen all in a consistent way. To be very clear, hospitals continue to provide emergent, complex, higher acuity, and in-patient surgical care. Chartered surgical facilities complement hospital surgical services. By providing appropriate lower complexity and scheduled procedures they are all – and to be clear, all surgeries are overseen in robust measures to oversee the quality and safety, including CSFs. It's important to highlight that CPSA-accredited facilities and

contractual arrangements are all overseen in a robust and consistent way through Acute Care Alberta.

Member Eremenko: Okay. Thank you. The ministry has established that the agreements monitor quantity, the volume of surgeries performed in a period of time. What about quality?

Mr. Romanow: Quality, as mentioned – it is not just the quantity, although quantity is huge where we've seen a 4.4 per cent increase, but it is important to highlight that the quality is absolutely being measured as we measure and assess the overall health outcomes.

I'll invite Dr. Zielke, the interim CEO of Acute Care Alberta, to elaborate, but absolutely, the quality of care is very much overseen by Acute Care Alberta. Dr. Zielke.

Dr. Zielke: Thank you, Deputy. Just to reassure you that we have a very robust contracting and procurement process. As part of the contracting, to your earlier question, if the surgery is not performed, the provider does not get paid, but also quality is woven into that contracting and the outcomes. We also very closely track who presents at the emergency department and for what reason and the readmission rates as well.

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I also wanted to clarify that the chartered surgical facilities are only for low-acuity surgeries. We have spent quite a bit of effort in AHS and Covenant to increase surgical capacity for more complex surgeries like cardiac oncology, and because of that, we have had to recruit adequate staff. For example, we expanded our anaesthesiologists in the province and have aggressively been recruiting to be able to do more surgeries in those settings as well.

Member Eremenko: Do chartered surgical facilities have access to Alberta Netcare?

Dr. Zielke: Every provider, clinician has private access to Netcare. They all use different EMRs, depending on which surgical facility it is.

Member Eremenko: So the practitioner but not the facility?

Dr. Zielke: I would have to confirm that with the team. I will get that answer for you.

Member Eremenko: Okay. So in the case of secondary admissions would all of the information be available to a hospital about the procedure and any complications that occurred during that procedure in a chartered surgical facility? How are the two speaking to one another?

Dr. Zielke: I will confirm that.

Member Eremenko: Can I get that in writing after the meeting?

Dr. Zielke: We will. We can do that, yes.

Member Eremenko: Thank you.

Any progress on the utilization rates?

Mr. Romanow: Thank you, Chair. We'll be able to provide a follow-up to those two questions, hopefully, during this session because we would absolutely like to give a timely response. But tracking down that very specific figure that you were asking is important.

Member Eremenko: How does the ministry determine the cost of procedures in each of the respective chartered surgical facilities?

Mr. Romanow: I think what's very important and so much of the reason for establishing Hospital and Surgical Health Services and Acute Care Alberta was to exactly dig into that, and it has been many years, actually – many, many years – to dig into the exact cost for what surgeries are costing through Alberta Health Services. It was a very difficult number. I know seeing that first-hand from years past. Incredibly challenging to pull that apart. But the interest is, again, looking at where there is an opportunity for more of the scheduled, more of the routine lower acuity needs.

The Chair: Thank you.

We will now hear questions from the government caucus members. MLA Sinclair will start.

Mr. Sinclair: Thank you, Mr. Chair. Thank you, Deputy Minister Romanow and the rest of your team, for all of your guys' hard work. I was looking at page 9 of the HSHS '25-26 annual report, and I see that a key component of the refocused health system is the establishment of Acute Care Alberta, or ACA, the provincial health agency responsible for co-ordinating and overseeing the delivery of acute-care services. Can you explain the responsibilities and strategic oversight that ACA has with the department and the health system?

Mr. Romanow: Thank you for the question, Chair. I think it is incredibly important to highlight that very direct oversight and accountability to oversee the delivery of acute-care services and, actually, building on earlier questions from other members, to be able to drill in very specifically. What is the cost? What is the quality? What are the outcomes? There was not that ability previously. The department in its role provides the strategic leadership and oversight of the acute-care system – that includes establishing legislation and public policy and the funding and the resource allocation – and then Acute Care Alberta is responsible for the system planning, the performance monitoring, and accountability and co-ordination of acute-care priorities across the province.

Why it is so important, again, is exactly that, the questions that this committee has already asked of our department. How can we have the responsibility for monitoring, for tracking and reporting on the sector the number of individuals who are accessing care, the number of surgeries being performed, the cost of those surgeries, the longer term outcomes? That's exactly where there was a need for a dedicated, accountable set of bodies: the department, a dedicated minister overseeing that, Acute Care Alberta very specifically to lead and oversee.

What is important, because previously under a stand-alone Alberta Health Services and a comprehensive Alberta health ministry, where one much broader health business plan, annual report – it didn't have the level of detail that you're seeing in front of you today. Even the business plan from '25 going into '26 did not have the level of specificity that outlines the types of services that are being performed and the quality that is being overseen in the acute-care system in Alberta.

Mr. Sinclair: Appreciate that. Thank you.

Just a follow-up if I may, Mr. Chair. What are the different provincial health corporations that acute services are delivered through, and what system responsibilities do each of them have? I know we touched briefly on them, but I was just wondering if you can get maybe a little more specific.

Mr. Romanow: Thanks very much for the question. I am joined here in the room with leadership from the various corporations that are supporting and leading the incredible services that our acute-

care system delivers to Albertans. Front-line acute care is delivered through four specialized provincial health corporations, or PHCs, as you noted, that operate under the purview of Acute Care Alberta. They are Cancer Care Alberta, Give Life Alberta, Emergency Health Services Alberta, and Alberta Health Services. In addition, certainly, and joining here in the room is Covenant Health and leadership, which provides incredible services in their settings. Each of these dedicated corporations is accountable to their individual mandated objectives to ensure the highest quality of care in key areas that are essential to a high-functioning acute-care system.

I'll give you, as you had asked, through the chair, a brief summary of what each of them provide. Cancer Care Alberta delivers and co-ordinates specialized cancer services across the province, including cancer treatment and supportive care. They work within and alongside Primary Care Alberta and other health system partners to support prevention, screening, diagnosis, and care across the cancer continuum. It supports equitable access to high-quality cancer care. I think we should be incredibly proud. In terms of cancer care over 24,895 cancer surgeries. That represents a 6 per cent increase. Very importantly, 95.7 per cent of radiation treatment patients were seen within clinically recommended windows. That's all overseen by Cancer Care Alberta. Very importantly and robustly, Cancer Care Alberta, under the amazing leadership of their managing director, who's in the room with us today, has launched Alberta's strategic plan for cancer to 2036. In collaboration with other ministries it supports the implementation of the strategic plan and priorities through annual cycle and clinical operational planning, service delivery, and decision-making.

Next is Give Life Alberta. They have all the oversight for organ and tissue donations and transplantations across the province. Give Life Alberta is focused on improving access to life-saving transplantations.

Next Emergency Health Services Alberta is accountable for the planning, delivery, co-ordination, and continuous improvement of Alberta's emergency health services system. It's responsible for ground ambulance operations, air ambulance services, emergency dispatch and medical communications, medical first responder programs, and the management of service delivery arrangements with contracted providers throughout the province.

Alberta Health Services is a provincial health corporation under the purview of Acute Care Alberta and with a focus on the operations of its 97 acute-care hospitals and facilities with a renewed mandate of shorter emergency and surgical wait times, increased system capacity, improved patient flow, and better overall experience and outcomes for patients and health care workers. AHS ensures their facilities provide Albertans with access to quality health services such as emergency departments, surgeries, and critical care.

Acute Care Alberta also, importantly, does commission and collaborate with Covenant Health and Lamont health as hospital service providers to prioritize efforts to better serve Albertans. Importantly, as mentioned but to reinforce, Acute Care Alberta also oversees the contracts with chartered surgical facilities to provide publicly funded, no-cost surgical services to further augment the staff and resources and increase access to surgical care.

9:40

What's really important across that broader spectrum is the ability to manage resources, to help prioritize, to shift precious resources. As was noted, we do have finite resources both financially and the incredible people resources, and overseeing in very direct line-of-sight areas on these various corporations and entities is incredibly important to be able to manage the best flow and the best access for Albertans all across the province.

Mr. Sinclair: Thank you. I appreciate the answers.

Mr. Chair, if it's okay, I'd like to cede the rest of my time over to my colleague from Calgary-Lougheed.

The Chair: Go ahead.

Mr. Bouchard: Thank you, Mr. Chair. Turning to the issue of performance measurement, on page 18 and 19 of the HSHS annual report there are a number of data points on increasing ED volumes. Would the deputy minister please outline the initiatives and enhancements being done on-site to lower ED wait times and increase capacity and patient flow?

Mr. Romanow: Yeah. Thank you very much. Absolutely and obviously, that's a question of deep importance to Albertans. Our emergency departments, as mentioned at the onset, are experiencing record volumes, just like the rest of our emergency systems across all of Canada. Alberta's emergency departments do remain under significant pressure. Volumes have increased each of the past three years, starting with 2.26 million visits in 2023-24, rising to 2.3 million visits in 2024-25, and up again in '25-26, which we saw last year, to 2.33 million.

What Alberta does experience: it continues to have one of the highest ED utilization rates in Canada at approximately 463 visits per 100,000 compared with 431 nationally. It's important to note, you know, those numbers we see in neighbouring British Columbia. They have 424 visits per 100,000 – so Alberta is seeing considerably higher and disproportionately higher rates than B.C. – and 406 in Ontario. It's a trend that is concerning and one that is actively being managed and monitored.

Higher acuity patients are also adding pressure to the system. Importantly and of concern, in 2025-26 more than 1.21 million discharged ED visits involved CTAS 1 through 3 patients, and those are assessed as resuscitation, emergent, or urgent. At the 90th percentile these patients spend 10.2 hours in the ED before discharge, nearly four hours longer than CTAS 4 and 5 patients at 6.3 hours.

Last year we did take action across the health system to respond to these types of pressures where there is a higher acuity to improve access to timely emergency care. Importantly, advanced triage protocols, direct admissions, and patient flow innovations are helping to reduce delays and accelerate hospital intake. Emergency departments have also expanded multidisciplinary teams, including nurse practitioners, physician assistants, associate physicians, and social workers to support earlier assessment and care. At really high-pressure sites – and we're unfortunately seeing these including in Edmonton, where we are today, the Royal Alexandra hospital being a notable site – additional registered nursing coverage and waiting rooms are also strengthening patient monitoring, enabling earlier intervention and helping prevent deterioration.

I'll talk a little bit more about some exciting new announcements that we're continuing to see and building on these successes. If Dr. Zielke would like to add some additional details on some of the innovations we're seeing in emergency departments, I'd invite her to answer as well. But what we're seeing with these expanded nurse-initiated clinical protocols as well as initiating some early clinical pathways: this allows for assessment and treatment to begin while patients are actually waiting for physician care, so starting that procedure far earlier, which is incredibly important.

The newest piece, and Dr. Zielke can elaborate: in January, building on some of this earlier work, we've announced the triage liaison physicians, or TLPs, which are strengthening physician support at triaging in some of Alberta's busiest emergency departments. While there were some recruitment challenges and

stakeholder engagement impacted the pace of the implementation several weeks slower than we were originally hoping, work did continue to advance this initiative, and we're excited.

This model is very much intended, as the question, Chair, had noted, to support earlier clinical assessment, to be able to expedite diagnosis and testing and treatment, to identify patients whose conditions may be deteriorating and support more effective patient flow through the emergency department or in some cases – importantly, roughly 1 in 5 people who show up to an emergency department might not even need to be treated in the hospital setting – to very rapidly be able to roll out to the appropriate directionality for those individuals presenting in emergency departments. I'll conclude and then hand it over to Dr. Zielke. The triage liaison physicians are beginning to be phased into our busiest urban settings in Edmonton and Calgary.

Dr. Zielke, would you care to elaborate a little bit more on some of the initiatives we're seeing on that side?

Dr. Zielke: Yeah. Thank you, Deputy.

We are working towards standing up TLPs, triage liaison physicians, across the top 16 sites in acute care in the hospitals in the province. The reason for that is to be able to provide care right in the emergency department waiting room, especially when we have increased visits and wait times. We do have really good evidence here, actually, from studies that were done in Alberta at the U of A a few years ago, that providing care and intervening directly in the emergency department helps reduce the number of patients that are left being unseen and also reduces the length of time for waiting in emergency departments. The TLP is able to order the tests, the diagnosis, and, very importantly, can identify the very sick patients that need care right away or assess patients as their status changes. That's really important and part of being able to save lives rapidly by rapidly responding.

As part of this we are also standing up broader clinical triage teams to support the TLPs. These teams are made of social workers, mental health and addiction recovery workers, as well as NPs and nurses to be able to provide that front-line care in the emergency department and at times, if it is appropriate, divert the patients to the appropriate place in the community for the care that they need. Not always does the care need to be provided in a hospital.

So that is a program we're standing up. We have had great success so far, and we hope to finish standing it up over the next few weeks.

The Chair: Thank you.

We will now hear a question from the Official Opposition. Member Marlin Schmidt.

Mr. Schmidt: Thank you. I have a few questions for the Auditor General. In July 2026 the Auditor General told the Canadian Press that he expected his investigation into AHS procurement practices would be completed by the end of this year. Can the Auditor General provide the committee with an update on the expected completion date for this report?

Mr. Peters: Thank you, Mr. Chair, and thank you to the member. We don't have a specific date that we can communicate as of yet. What I can tell you is that we are getting close, and all the resources of our organization are focused on getting this out as quickly as possible.

Mr. Schmidt: Is the end of the year still your goal for releasing this report?

Mr. Peters: I can't provide a particular date at this point.

Mr. Schmidt: Okay. In July of 2026 the Auditor General seemed to be pretty confident in meeting the end of 2026 deadline. What delays has the Auditor General encountered since July of 2026 that make it sound like you might not be able to make that deadline now?

Mr. Peters: Thank you to the member, through the chair. I would respond by saying that the business of audit is complex and fluid. You know, we have continued throughout the year to interview many people and gain further documentation. As we are exploring and obtaining information, we have follow-up questions which require additional work, and we take great care in really developing the most useful recommendations from the findings we are coming across. We're really focused on creating that value, and that takes our time and focus.

9:50

Mr. Schmidt: Has this investigation been delayed in any way because of the appointment of the new Auditor General?

Mr. Peters: Thank you to the member, through the chair. I guess the short answer is no. Like, you know, we continue to – I've been part of the team for the duration of the entire investigation, and we've got a dedicated team of quite a few members of our office focused on it.

Mr. Schmidt: Thank you.

There were a number of concerns that were related to the Auditor General's investigation with relation to the DynaLife contract. Have any health officials claimed legal or cabinet privilege over documents related to the procurement investigation without providing rationale or evidence of why those documents are deemed privileged?

Mr. Peters: Thank you to the member, through the chair. There are always privilege issues of different kinds involved in the examination, and we work through the nature of the claims and obtain the appropriate evidence. I think if you're asking the question, "Is this a significant issue?" you know, I would say that there have been conversations, but I don't want to get ahead of the reporting that we will be making in our report when it goes public.

Mr. Schmidt: Is the issue of dealing with privilege delaying the investigation?

Mr. Peters: Thank you for the question. I wouldn't say, you know, a significant delay. It takes time to have conversations around privilege.

Mr. Schmidt: Okay. Have health officials engaged lawyers to review all of the documents related to the procurement investigation line by line before providing them to you?

Mr. Cyr: Point of order. Mr. Chair, I've given a lot of latitude, but I'd like to see this get back to the scope that it's in. I would like to do a point of order for 23(b). I also think point 23(c). He continues to ask the same question over and over again even though he's been answered. I would say that when it comes to the Auditor General in his current investigation, that is an important question for question period if he wishes to bring that up, but we're here for the annual report, so I would hope that as chair you would bring this back to the material at hand, sir.

Mr. Schmidt: Thank you, Mr. Chair. Well, first of all, I want to deal with the assertion that we can bring this up in – I don't know what question period Member Cyr attends, but the one that I attend

doesn't actually have the Auditor General present, so he can't answer questions in question period. For him to suggest that is completely ridiculous, and I think his constituents should maybe be asking him when he goes home where the heck he is when he's attending question period.

Now, with relation to the matters of standing orders, first of all, the Auditor General's investigations are always the purview of this committee. We know this investigation is under way. This is a significant issue of public interest, and I should be allowed to continue these questions. With respect to repeating the questions, of course, Member Cyr appears not to be listening to the questions that I've been asking. Each question has been separate and different.

For all of those reasons, Mr. Chair, I ask that you overrule the member and allow me to continue this line of questioning.

The Chair: Thank you, members.

I do not find this to be a point of order because Auditor General work insofar as it relates to the ministry is within the purview, and questions can be asked from the Auditor General, as the member points out. "Persists in needless repetition or raises matters that have been decided during the current session": I did not find that that is the case for this question.

The member can continue.

Mr. Cyr: Point of order, 13(2), please.

The Chair: So 13(2) requires me to explain my ruling.

Mr. Cyr: Yes.

The Chair: Okay. Member, you raised two points under 23(b) and under 23(c). Let me deal with 23(c) first, which reads, "persists in needless repetition or raises matters that have been decided during the current session." The latter part doesn't have any relevance here, so you must have relied on persistent, needless repetition. No two questions were the same. I do not know what was intended and you didn't explain, when you raised the point of order, what you found was needless repetition. That's why I ruled that out of order.

Then you said that we should be only talking about the annual report. That is not the case in this committee. You can talk about anything that's within the purview of the ministry in the reporting year, and you can also talk about the Auditor General's work, recommendations insofar as they relate to that ministry. That's why I ruled you out of order.

Mr. Cyr: May I respond, sir?

The Chair: Not under 13(2). That was for me to explain the ruling. If you have any other point, you can still raise a point of order.

The member may continue.

Mr. Schmidt: Thank you. My question was: have health officials engaged lawyers to review documents related to the procurement investigation line by line before providing them to you?

Mr. Peters: Thank you, Member, through the chair. Lawyers have been engaged, as you might expect in discussions around privilege. I can't really speak to the approach that they are following. I think there are particular documents that there are privileged discussions about.

Mr. Schmidt: Thank you. Has the department fully complied with the provision of all documents that you've requested for this investigation?

Mr. Peters: Thank you, Member, through the chair. Again, I don't want to get ahead of what we are going to be reporting in our written report. We do have a statutory obligation to inform the Assembly where we have been denied access to information, so we'll be reporting as appropriate when we table that report.

Mr. Schmidt: It's telling, I think, that the answer wasn't an immediate yes. That's definitely concerning.

Have any officials refused to be interviewed for this investigation?

Mr. Peters: Thank you, Member, through the chair. I do not think there are any – to my recollection, there are no department officials current or past that have refused.

Mr. Schmidt: Thank you very much.

Now, the media has reported that the RCMP are investigating Alberta health and Alberta Health Services for fraud, breach of trust, and money laundering. Can the deputy minister tell the committee which transactions are under investigation for fraud?

Mr. Romanow: Thank you, Chair, for the question. I'd have to ask the member to elaborate based on that question and specifically related to our budget. I'm not sure what he's referring to, and I certainly don't know what matters police are investigating.

Mr. Schmidt: So the deputy minister has no idea what transactions are being investigated that concern Alberta health and Alberta Health Services for fraud?

Mr. Romanow: Thank you, Chair, for the question. I'm absolutely aware of broader exploration the Auditor General is undertaking. I read newspapers, but I certainly won't speculate on what the RCMP or police or others are investigating.

Mr. Schmidt: The RCMP requested that documents be turned over. Who is responsible for making sure that those documents – is it not the deputy minister?

Mr. Romanow: If the ministry was asked by any law authority or other to provide documents, we absolutely would, but I certainly can't speculate on what law enforcement . . .

Mr. Schmidt: Whoa, whoa, whoa.

Mr. Romanow: . . . or RCMP investigations . . .

Mr. Cyr: Point of order.

Mr. Romanow: . . . are undertaking and trying to look into.

The Chair: A point of order has been called.

Mr. Cyr: Well, the last ruling that we had, the member across took a remarkable amount of latitude to insult this government member. I recognize that there's very little that we can do inside of these points of order discussions.

10:00

The Chair: Come to the point. You raised a point of order. Point me to the section that you're raising the point of order under.

Mr. Cyr: It's amazing that you, sir, are not doing that with the opposition.

The Chair: Listen to me. Point me to the section that you're raising the point of order under. Explain the reasoning so we can move forward with that.

Mr. Cyr: Well, we're clearly in an area where it's before the courts or investigation. I would say that this speaks to a matter that's other than the matters at hand, so it's under 23(b).

You're saying that he's not repeating himself, yet he continues to repeat his questions tactfully in a different way, but it's the same answer that the Auditor General gives, which is: I'm investigating this and can't comment on this. Then he goes to the ministers or the deputy ministers and starts asking the same questions, knowing that we need to be sticking to the annual reports in the current periods.

I did question your ruling last time, Mr. Chair. I believe that it was a poor ruling at that time, and I hope that you would bring this meeting back into what we're here for, which is getting answers from the ministry on the annual report from '25-26. Sorry; '24-25. I'm not sure which. It's '25-26.

Mr. Schmidt: You don't even know which report we're doing.

The Chair: Hang on, Member.

Mr. Cyr: We can't point of order inside a point of order.

Again, this is the insulting language that you continue to allow. This is terrible that you've allowed this meeting to degrade like this, sir. You allow him to take potshots in points of order, yet when it comes time for the government, you're right on top of this right away. Please get this meeting back in order, sir.

Mr. Schmidt: You want some tissues there, Scott?

Mr. Cyr: See? Look at this. How is this helpful?

The Chair: I think it's not helpful on either side, Member. I think, again, you raised a point of order that the question asked was not relevant. I didn't find any arguments why it was not relevant. Just because it was not about the annual report, that doesn't make it irrelevant.

You're saying that he is asking the same questions in different ways. I think repeating a question is not, as such, out of order to begin with. You have to explain. It needs to be to a point where it's persistent, needless repetition. That's a bit higher bar than you would suggest.

I would ask members to respond. I will rule then.

Mr. Schmidt: Thank you, Mr. Chair. I believe I have been allowed to continue to ask my questions.

Can the deputy minister tell us whether or not Alberta health has fully complied with the RCMP's request for documents?

Mr. Romanow: Thank you, Chair. The member would probably be aware that Alberta Justice manages all of the legal requests, including through law enforcement. They manage any responses, including any interaction with the RCMP or law enforcement bodies. Very importantly, Justice lawyers review the production order and search the warrant for legal validity, negotiate or engage with to clarify the scope of the request. I think, most importantly, they do review all compiled documents before they're handed over. Of course, that would be expected with ensuring the completeness and ensuring legal privilege, cabinet confidence, solicitor-client privilege, or others to make sure that we're fully complying with and supporting any law enforcement investigation. As a ministry which supports as requested, the minister and Ministry of Justice would respond to any of those, and that is where all the questions are directed.

Mr. Schmidt: Thank you.

Is the deputy minister involved in any way with the production of documents to the RCMP?

Mr. Romanow: Thank you, Chair. As mentioned, Alberta Justice manages the engagement with law enforcement.

Mr. Schmidt: No.

Mr. Romanow: Thank you. I'm trying to . . .

Mr. Schmidt: Let me ask the question directly so that the deputy minister can't wiggle out of answering it. Has the deputy minister seen the documents that Alberta Justice has turned over to the RCMP? Yes or no.

Mr. Romanow: I'm sorry. I was trying to answer before being interrupted.

Mr. Schmidt: I want a yes or no answer.

Mr. Sinclair: Point of order, 23(j).

Mr. Cyr: Do your job, sir.

The Chair: Be respectful.

Mr. Cyr: I'm trying to be.

The Chair: You're not.

Mr. Cyr: No. I am.

The Chair: You're not.

Mr. Cyr: You can't allow this to continue the way it's going.

Mr. Sinclair: Respect should be reciprocal.

Mr. Cyr: It should be.

It's sad how you've allowed this committee to degrade.

The Chair: You may not want to hear these questions. That's a different thing, but you need to behave.

Mr. Cyr: Me behave?

The Chair: Yes.

Mr. Cyr: That's absurd.

The Chair: That's not absurd. The way you're treating me: that's disrespectful. Reflect on that.

Sure, point of order.

Mr. Sinclair: Mr. Chair, I call point of order 23(j), "uses abusive or insulting language of a nature . . . to create disorder." The member opposite: he's what I would call a repeat offender when it comes to this kind of behaviour, not just including . . .

The Chair: I think that kind of language is also not helpful: "repeat offender."

Mr. Sinclair: I think what the member from Cold Lake here is trying to communicate is that the member has asked a question repeatedly, which falls under – right inside – repetition of the same question. He might not like the answers that the government's giving, but he continues to, I would say, badger the members of government. Also, he's not even allowing them to answer the question and continues to interrupt them, so I think that that's creating disorder. It's insulting. He's also using the arguments to be able to throw insults across in the middle of other people speaking uninterrupted, which I think is also creating disorder, which would

be a separate point of order. I think that's some of the clarity that perhaps my colleague is trying just to see, that the chair is holding everyone accountable in a fair way.

The Chair: Thank you.

Before I get to you, for both sides, I guess, I'll caution that when you're raising a point of order, state the provision and just state the facts instead of, I guess, engaging in conversation across with each other.

Go ahead, Member.

Mr. Schmidt: Thank you, Mr. Chair. I ask that you not find this a point of order. The member raised a point of order under 23(j) and then proceeded to make an argument under 23(c). So it looks like to me that the member is not even sure what the issue is here that's raising a point of order. He hasn't clearly matched his argument to the point of order that he's raised, so I ask that this be overruled and that I be allowed to continue with my questioning.

The Chair: Thank you.

I don't think that the language used was abusive or insulting. But when the question is asked, I would caution members that we should let the deputy answer the question the way he chooses to answer it.

You can continue with 29 seconds.

Mr. Schmidt: Thank you very much.

It was a yes or no question. Has the deputy minister seen the documents that have been handed over to the RCMP with respect to this investigation?

Mr. Romanow: In my three weeks that I have been here, no.

Mr. Schmidt: Thank you very much. Can the deputy minister tell the committee which transactions are under investigation for breach of trust?

Mr. Romanow: Again, it's important, Chair, to clarify that I can't speculate or specify which law enforcement investigations are ongoing.

The Chair: MLA Lovely, you will have 10 minutes in this block.

Ms Lovely: Thank you so much, Mr. Chair.

Deputy Minister, I have been looking forward to this meeting for many months because I wanted to share with you some feedback that I have received while I door-knocked through my community this summer. I have met so many people who have had hip surgeries, knee surgeries, cancer procedures. They were told that they were going to be on a wait-list for a year and they got in within months. So I'm seeing first-hand the improvements that you have spoken about at the beginning in your opening comments, and I just wanted to thank you. My community is reaping the benefits of the positive changes that your ministry has made, so thank you so much.

To get to my question on acute-care capacity and patient flow optimization on page 23: would the deputy minister please identify for this committee what are the plans for the new in-patient bed towers in Edmonton at the Grey Nuns and Misericordia community hospitals?

Mr. Romanow: Thank you, Chair, for the member's question. Related to the specific question, we greatly appreciate hearing the broader feedback on behalf of the constituents.

10:10

Specifically in Edmonton, Budget 2026 builds on and advances funding for the planning of new in-patient towers at the Grey Nuns and Misericordia community hospitals. Their CEO, who is in attendance here, continues to lead that work with our government and Alberta Infrastructure, helping ensure future capacity does continue to align with population growth. The patient demand that we absolutely noted is significant and a challenge to continue meeting. This will, very importantly, expand acute-care capacity in major urban centres and alleviate pressure more broadly across the province, including in the member's constituency neighbouring Edmonton, and invests through this budget an additional $7 million over the next two years to advance that important capital planning to add up to 700 new acute-care beds in Edmonton and advancing the new bed towers at Grey Nuns community hospital and Misericordia community hospital so that we can better meet and respond to those rising patient demands.

Ms Lovely: Okay. I think you may have answered my question here. What bed increases have been made in existing infrastructure, and has there been any planning dollars allocated for new sites?

Mr. Romanow: Additionally, perhaps, talking about planning dollars, Minister LaGrange recently gave enhancements building on the work from last year that was under way. There is also, importantly, the development of nine new urgent care centres across the province, including three in the greater Edmonton and surrounding area, that will also help expand capacity and reduce pressures.

Building off the 350 beds at Grey Nuns community hospital and the 350 beds being planned for Misericordia community hospital, these are just a few of the examples specific to Edmonton, though obviously the entire system is interconnected and building out capacity helps alleviate pressures elsewhere.

Ms Lovely: All right. Can the deputy minister share an update for this committee on the long-term acute care – there's a 50-year capital plan – alongside any highlights? For the benefit of this committee, would the deputy minister please outline what programs and partnerships exist within Indigenous communities?

Mr. Romanow: Yeah. Thank you very much, Chair, for the question. What is important to highlight with the long-term acute care, the 50-year plan, is that the ministry is working not only with Alberta Infrastructure but the various other health and social ministries to develop a more integrated and comprehensive capital planning process, which includes that 50-year acute-care capital plan component. Once complete, this initiative will be able to provide exactly, as the member noted, that long-term, evidence-based approach to forecasting acute-care needs, what the infrastructure requirements are to be able to support future capital investment decisions, and, very importantly, help ensure that Alberta's health facilities can meet the demands of a growing and aging population.

I think what is important to highlight: it's looking at a different type of infrastructure, including digital and virtual, which increasingly is important to highlight – a 50-year plan is a longer range plan, and we see rapid technological enhancements – and very much making sure that we're able to provide a forward-looking way of cost-effectively not only forecasting but planning future investments and why that is so important and in a large part how we can better support rural and remote and Indigenous communities, which was the second part of the member's question.

We are currently working very closely with our partners in Primary and Preventative Health Services and specifically their primary care capital program, which really on the front lines is an initiative that works at supporting the primary care services in many underserved rural, Indigenous as well as urban communities, but many Indigenous and rural communities, and Budget 2025 approved $20 million over three years to be able to support those initiatives.

It is important to highlight that the Ministry of Hospital and Surgical Health Services is a small ministry. Primary and Preventative Health Services does lead and has a very dedicated stand-alone Indigenous health division, incredible leadership, and people working within that team with direct experience working with Indigenous health providers and Indigenous leadership. They help guide the work across the broader system and very much inform and engage our ministry in that work. That ministry can provide additional details on some of those important steps, but it is important through that partnership that HSHS does support Indigenous and First Nation communities. We also have a very direct role, however, in supporting and strengthening emergency response capacity and building the emergency health services workforce through the emergency medical responder education grant as well as the medical first responder grant. I think, importantly, on the Indigenous community front, in 2025-26 20 Indigenous and First Nation communities received EMR education funding, and five received funding to establish new municipal first response programs. Some fairly significant initiatives that are under way to be able to support.

I think it's important, and just to reinforce that, through our partnership with Primary and Preventative Health Services we're taking additional steps, at their lead, to be able to support initiatives such as Indigenous signage, visibility, and culturally appropriate spaces; to be able to support and responding to, which we see and take very seriously, unfortunately, responding to racism with antiracism to enhance the patient experience and the overall system accountability.

Again, very importantly, tying back in with our direct work, acute-care planning and Indigenous community engagement and, for example, work related to the Cardston health centre had and continues to have ongoing engagement with the Blood Tribe and the Blood Tribe Department of Health regarding culturally appropriate care, potential service alignment, cultural components, and opportunities to strengthen Indigenous participation and planning. That's just one of many examples that could be highlighted that reinforces that close set of programs and partnerships with Indigenous communities, which also support rural communities across the province.

Ms Lovely: Thank you so much.

Now, turning to page 24, I note that there are a number of challenges with seasonal and surge-related bed pressures as well as ALC pressures alongside any highlights. What is the department doing in response to these pressures that are impacting health systems across Canada?

Mr. Romanow: Thank you, Chair. Certainly, as noted at the top, we have continued to take very direct action responding to the pressures that all provinces across the country have faced to deal with these seasonal surges, the worst of which we saw last year, the worst in a number of years, and really to address – we're looking at optimizing patient flow and, importantly, to ease the alternative level of care, the ALC, pressures across our overall system. That's just an area we all the time need to be focusing on but especially when we're seeing those seasonal and surge-related pressures. Ahead of the 2025-26 respiratory virus season Alberta Health Services repurposed 336 existing surge beds and, actually, very impressively, converted 206 into permanent year-round capacity and maintained 130 beds specifically for seasonal demand.

These proactive measures built vital resilience into our acute-care system. They protected scheduled surgical procedures. I think what's really important to highlight: in our last year only nine surgeries across the entire province had to be rescheduled due to respiratory pressures. I think it demonstrates the strength not only with Alberta Health Services and Covenant but across our whole system, how we were able to balance and juggle collective pressures to make sure services were not being disrupted for Albertans. At the same time, and really important to highlight not only with surge pressures, we are tackling the alternative level of care pressures very head-on.

The Chair: Thank you, Deputy Minister.

We will now move back to the members of the Official Opposition for 10 minutes.

Member Eremenko: Thank you, Mr. Chair. I'd like to start my next block with some questions to the Auditor General. On page 2 of the DynaLife procurement report that was submitted December 2025, the AG writes that "our access to information was restricted by [Alberta Health Services] and this restriction was supported by the Department of Health." Is this being repeated, in your opinion?

Mr. Peters: Thank you to the member, through the chair. The direct answer is that we are not seeing the same dynamics of access to information as we did in regard to the DynaLife report. The privilege, however, does continue always to be an issue, so we're working through that.

Member Eremenko: Where the office also writes that Alberta Health Services "created a process where a team of lawyers conducted a line-by-line review of the over ten thousand documents prior to being provided to" the office of the Auditor General, can the office tell us, like, who held the pen when it comes to employing that legal support to redact such an incredible volume of information from your investigation?

10:20

Mr. Peters: Thank you to the member, through the chair. I guess my direct response to that would be, you know, that the legal services in the DynaLife matter were engaged by Alberta Health Services. Is that the question you're asking?

Member Eremenko: Sure, or to what extent was the department of health involved in that process? It seems like throughout the report, the AG report, you know, kind of confirms that the department of health was intimately involved in decisions with Alberta Health Services. So was the office able to make a distinction where Alberta Health Services was making some of those decisions around privilege and submission of documents for investigation and where it was department of health?

Mr. Peters: I think most of our conversations were with Alberta Health Services. There was a lot of back and forth about the particulars, specific documents, and details to assess the legitimacy of claims of privilege on documents, so I think that was the focus of our . . .

Member Eremenko: In the office's opinion, can the Auditor General tell us if the many new layers of bureaucracy across multiple ministries in regard to the activities and the accountability

of Alberta Health Services has in fact improved accountability or made it worse?

Mr. Peters: Thank you for the question. I guess I would respond by segregating a couple of different issues. The most direct way I can answer that question, I think, is that we are seeing kind of an improved responsiveness to our questions and discussions around privilege. The . . .

Member Eremenko: Okay. I'm sorry. I apologize. I do have to move on, but it sounds like that was a tricky question to answer. One would certainly hope that Albertans can count on increased accountability given the expense and given the time and the incredible investment in the restructure, and it doesn't sound like the Auditor General can necessarily speak to that.

I'm going to go back to the deputy minister, please, and return to my questions around the cost of surgeries in chartered surgical facilities versus hospitals, and we'll just, please, have a very specific conversation here. Let's start with: what is the cost of a knee replacement surgery in hospitals?

Mr. Romanow: Thank you for the question. If I could take a moment to answer the earlier questions that you had, we can concisely provide responses . . .

Member Eremenko: No. That's okay. We've heard from the AG. I'd like to hear about the cost, please.

Mr. Romanow: Sure. It was to elaborate on the utilization of volume questions that you specifically asked.

Member Eremenko: Oh, okay; from my previous block. Sure. Shoot.

Mr. Romanow: I could invite assistant deputy minister Chris Nickerson to answer a couple of questions, and then Dr. Zielke can elaborate on the Netcare, following.

Mr. Nickerson: Thank you, Chair and the member through the chair. Just to point out, there were a couple of questions about surgical volumes and utilization specific to hospitals. I just wanted to point out that, in supplement to the metrics around volumes and utilization, one of the key metrics that is also used is what's called case time hours, the number of hours that surgeries are performed. In '25-26 that was just over 495,000 case hours, and that involves both emergency and elective surgeries in acute-care hospitals. To be clear, that excludes chartered surgical facilities. That's up just over 16,000 hours from '24-25.

Member Eremenko: I'm sorry. Can you repeat the number of case time hours again in '25-26? I missed the number.

Mr. Nickerson: In '25-26 it was just under 496,000 hours.

Member Eremenko: How many case time hours would the full complement of operating rooms be if they were fully operational?

Mr. Nickerson: I would have to get that number.

Member Eremenko: Okay. The number doesn't really mean anything when we're talking about the rate. If full utilization is 100 per cent, 496,000 is how much per cent?

Mr. Nickerson: It's important to note that 100 per cent utilization is not actually the goal.

Now I will pass it over to my colleague Dr. Zielke to talk about OR utilization.

Dr. Zielke: Yes. The utilization rate number that we were able to provide to you for the top 16 hospitals is 91 per cent utilization rate of the ORs. The reason why it can't be 100 per cent is because if you operate the ORs at 100 per cent, then you have no room for incoming trauma or available surgical room for emergencies.

And, to answer your earlier question, I did confirm with the team that the CSFs are required to upload information on the patient's chart to the EMR so that it would be available, and we do track all visits to the emergency department resulting from a CSF intervention or surgery.

Member Eremenko: Are there time requirements in terms of how quickly that information needs to be uploaded to Netcare?

Dr. Zielke: I will look into that and just confirm that with you, but typically it's routine medical practice to do it the same day. It gets uploaded, EMRs usually get uploaded to Netcare at a given time once or twice a day, but it should be happening the same day.

Member Eremenko: Can the deputy minister confirm what the average upload time is to Netcare from CSFs?

Mr. Romanow: The very specific question: we'd be happy to respond back.

Member Eremenko: Thank you.

You provided a 91 per cent utilization rate across the top 16 hospitals. What about all hospitals, all operating rooms in all hospitals?

Dr. Zielke: I will look to see if we can get that number to you right now.

Member Eremenko: Okay.

Dr. Zielke: Yeah. Thank you.

Member Eremenko: Back to my question about cost. What is the cost to do a knee replacement surgery in a hospital?

Mr. Romanow: On specifically with a knee replacement?

Member Eremenko: Sure.

Mr. Romanow: We will get you that very specific number shortly.

Member Eremenko: Can I get that very specific number for chartered surgical facilities, please?

Mr. Romanow: We're happy to bring those numbers back to be able to talk. Again, really important to highlight that hospitals by purpose deal with the high complexity related surgeries, so chartered surgical facilities very specifically are upping the capacity to be able to deal with lower acuity types of surgeries. Yes; happy to bring that back.

Thank you.

Member Eremenko: At the very top of this meeting the Auditor General highlighted just how critical the business case is when we're talking about procurement. I would certainly expect that those numbers would be readily available because they would be fundamental to the business case, I would expect. Can the deputy minister also include what is actually included so that we can be very clear that this is an apples-to-apples comparison – lab and diagnostics, imaging, the actual hardware required for the replacement, postop overnight stays – so that we can in fact be very clear that we're talking apples to apples, that when we're looking

at the cost of the chartered surgical facility versus a hospital, we are in fact comparing the same bucket of goods and activities? Does the cost for a knee surgery vary from chartered surgical facility to chartered surgical facility?

Mr. Romanow: What is important to highlight, and I do have the figure in front of me: on average an in-patient unilateral knee replacement costs approximately $8,227 in hospital . . .

The Chair: Thank you, Deputy.

We will now move to government members for 10 minutes. Member Cyr.

Mr. Cyr: Thank you. Would you like to finish your response to that last question?

Mr. Romanow: We'd be happy to elaborate. There are some other elements that certainly can carry on on that side. What is critical to highlight and the oversight: it is making sure that more expensive hospital spaces are going to where hospitals are best supporting Albertans with higher acuity needs. Obviously, the broader wraparound costs in a hospital are far greater. It has taken years to quantify those numbers. Again, that's the importance of zeroing in and actually being precise what the costs of given procedures are. It has taken and it's continuing to take years to unravel the costs going into our acute health system. It's important, but the specific details: we're happy to share more because the interest of our ministry, Acute Care Alberta is about the quality and making sure that there's the accountability as well as that clarity for Albertans about the costs going into the system and the outcomes and the quality coming out. So happy to share more of those details in greater form afterwards.

Thank you.

10:30

Mr. Cyr: Well, thank you for that. Again, I would like to thank the deputy minister and all of his team for being here today as well as the Auditor General and the Auditor General's office.

Now, I'd like to talk about acute care, specifically about rural. I will say that it was really remarkable to see former minister Jones come out to all of our hospitals and take a look at all of our challenges. What happens here is that learning about the concerns regarding acute care when it comes to the front-line staff is something that I know our government gets the lead on. We then had Minister Long come out, the Infrastructure minister, to take a look, at least, at the Bonnyville emergency room and the work that's being done there. I will say that when it comes to acute-care capacity and efficiency for my constituency, we've seen the emergency room in St. Paul done – so thank you for that good work done in '25-26 – we see the good work being done for the Bonnyville health centre – and that one there is moving on – I also will say that the announcement and the moving forward of the urgent care facilities within Cold Lake: I see the impacts of your ministry, sir, in my constituency of Bonnyville-Cold Lake-St. Paul. It doesn't happen overnight, and I recognize that these challenges are there.

To get to the annual report, where we should be, our constituencies cover rural Alberta. Page 26 drives into stabilization of rural acute-care services. Would the deputy minister explain the efforts that are being taken to stabilize acute-care services in rural communities?

Mr. Romanow: Thank you, Chair and to the member for the question. For the broader context and I think what is important to highlight, as is noted, acute-care stabilization and the services also are reliant on the broader system of care. I had past experience with a member related to mental health and addiction needs in the community. That's a critical component, to alleviate the pressures even before reaching the acute-care setting. Certainly, in supportive housing, assisted living, and very much in the primary care environments it is critical, and I think that's important where resources are so precious. Expected specialization cannot be consistently spread across the entire province. We need to use those resources as judiciously as possible, and that's reliant on that broader system of care.

You know, one important element, looking at options to allow rural Albertans to get timely care without having to visit an emergency room when that level of hospital care is not required or, in some cases, is a longer distance to travel, options like 24/7 access to health advice from experienced nurses with Health Link 811 as well as virtual care options to connect patients directly with physicians or phone or video, are critical, and they're accessible, again, 24/7 readily across the province. It's really important that we're actively strengthening the front-line recruitment and retention, because that oftentimes is a challenge with the existing facilities that are there, so that we can maintain that access to local emergency and hospital services to be able to improve that patient flow. And working, again, very closely and through our ministry with emergency health services so that we can utilize the resources that are going out into community and into people's homes to be able to support them there and, again, not reliant on that physical infrastructure or facility always. There are many other options.

Some other key pillars supporting our rural and northern emergency departments – this is quite important – is through the virtual emergency physician program. Through this model off-site emergency doctors are able to work alongside local health care teams. In real time they're able to assess patients, order diagnostics and tests and medications, and determine whether a patient can be safely treated locally or requires transfer and transportation to a tertiary facility. This virtual support provides essential relief to local clinicians and, most importantly, keeps emergency doors open in communities experiencing acute physician coverage pressures.

Finally, and maybe last piece on that question, mandatory acute-care accreditation ensures that rural patients and remote and Indigenous communities receive the exact same high standards of quality, safety, and clinical excellence as those treated in major urban centres. That is, of course, critical in communities like the member's to give families that complete confidence in the care that's being delivered closer to home.

Mr. Cyr: Well, thank you for that response. I know that from my area we are seeing results from the good work that Minister Wright and the deputy minister and his entire ministry have put forward. When it comes to moving health care forward in rural, I can see the impacts clearly in Bonnyville-Cold Lake-St. Paul.

I would like to also start talking about: on page 30 we see a number of items related to the strengthening performance monitoring and quality oversight along with the launch of Alberta's hospital-based leadership model and patient-focused funding. I've got three questions here. I'll read them out really quick. What is being done to support and strengthen the quality and safety oversight? Can you update us on the health system dashboard? And what can be shared with us so far about patient-focused funding?

Mr. Romanow: Yeah. Perfect. Thank you, Chair. The department does support the quality and safety oversight through its work with Acute Care Alberta on the accreditation, the standards, and quality improvement. This helps ensure that health care organizations meet

established standards and maintain appropriate safeguards for safe, effective, and high-quality care.

Acute-care accreditation is specifically mandated under ministerial directive D1-2026, which requires all provincial health corporations and acute service providers to participate in a standardized accreditation process. This directive establishes Acute Care Alberta as the provincial oversight body responsible for selecting suitable accrediting bodies, for monitoring accreditation status across all facilities, ensuring consistent reporting, and providing that assurance back to the minister regarding the clinical outcomes.

The department does continue to strengthen, as the member asked, performance monitoring using common indicators and more consistent reporting practices across the system. Monitoring does focus on key performance areas such as surgical and cancer volumes and wait times, EHS response times, and emergency department wait times. Ultimately, performance monitoring quality and accreditation processes do drive that continuous improvement, and through our entire acute-care system that's how we focus that ongoing commitment for the highest clinical quality and patient safety.

Now, with respect to the patient-focused funding part of the member's question, the patient-focused funding improves transparency, accountability, and efficiency in how public resources are allocated across our acute-care system. Instead of relying solely on fixed global buckets, this model ensures that funding directly follows the patient. In simple terms, hospitals that treat more patients receive more funding, creating . . .

The Chair: Thank you, Deputy.

We will move back to the Official Opposition for 10 minutes of questions.

Mr. Schmidt: Thank you, Mr. Chair. Back to the RCMP investigation of Alberta health and Alberta Health Services for fraud, breach of trust, and money laundering. The deputy minister apparently has no idea what transactions are under investigation for those charges, but can the deputy minister tell the committee who is being investigated for fraud?

Mr. Romanow: Thank you, Chair, for the question. I'm not sure the question framed my prior comments accurately, but I will clarify. I can't speculate what law enforcement is specifically investigating or who they are comprehensively investigating. We're the Ministry of Hospital and Surgical Health Services, not a police service.

10:40

Mr. Schmidt: Thank you very much.

I assume, then, that the deputy minister also doesn't know who is being investigated for breach of trust or money laundering. Yes or no?

Mr. Romanow: Not to my knowledge.

Mr. Schmidt: Okay. Thank you very much.

If people in the department are accused of committing crimes, what steps has the ministry taken to remove those people under investigation so that they can't continue to commit crimes?

Mr. Romanow: Certainly, there's a very extensive process through our code of conduct as the Alberta public service.

Mr. Schmidt: In this particular case what has the department done to ensure that those people under investigation are not able to commit further crimes?

Mr. Romanow: As I was outlining, the Alberta public service has a robust . . .

Mr. Schmidt: I don't care about the hypothetical processes. Be specific about what processes this deputy minister has taken to ensure that people under investigation for fraud, breach of trust, and money laundering cannot commit further crimes.

The Chair: We will hear from the deputy minister now.

Mr. Romanow: Thank you. For starters, the allegations being made that there is a crime are not founded, and any instances of crime are dealt with incredibly seriously. There is a robust process across the Alberta public service to deal with the highest quality and performance . . .

Mr. Schmidt: Has the deputy . . .

Some Hon. Members: Through the chair.

Mr. Schmidt: Okay. Has the department taken any steps to put anybody on administrative leave or put anybody who is under investigation out of positions of responsibilities while they're under investigation?

Mr. Romanow: Again, Chair, the challenge is that the allegations being made that people have directly been identified by law enforcement, have committed crimes, is unfounded . . .

Mr. Schmidt: So can the deputy . . .

The Chair: Let the deputy finish.

Mr. Romanow: . . . and there are robust steps to deal with anybody identified in my department or across the Alberta public service. There are robust processes to deal and deal appropriately through robust HR processes and absolute confidence. Anybody . . .

Mr. Schmidt: So . . .

The Chair: Member Schmidt, let the deputy finish.

Mr. Schmidt: No. I'm sorry, Mr. Chair.

The Chair: No. Let the deputy finish. The deputy was . . .

Mr. Schmidt: The deputy minister has answered my question.

The Chair: The deputy is answering the question. We may not like the answer, but . . .

Mr. Schmidt: I have the answer that I want, Mr. Chair. I want to move on.

How does the deputy minister know that nobody has been under investigation if he has no idea who's under investigation? What triggers the processes that the deputy minister has said are under investigation?

Mr. Romanow: Through Alberta Justice, the Public Service Commission, and Executive Council there are robust processes to deal with any identified individuals. The allegation being made that . . .

Mr. Schmidt: Thank you very much, Deputy Minister.

The Chair: Member Schmidt, let the deputy finish.

Mr. Schmidt: No. The deputy minister has answered my question.

The Chair: Member Schmidt, he's still answering it. He's entitled to answer this question.

Mr. Schmidt: He's wasting the committee's time.

The Chair: Member Schmidt, let the deputy finish.

Deputy, are you done with answering this question?

Mr. Romanow: I was proceeding to complete the very important part of the question. If anybody – and the allegation made by the member, I would suggest, is false; individuals have not been identified – if any individual was identified, the appropriate steps would be taken so that they were not engaged in work and certainly not related to any matters under investigation.

Mr. Schmidt: So no staff members of either Alberta health or Alberta Health Services have been identified as being under investigation from Justice to trigger any of the allegedly robust processes that the deputy minister claims the public service has?

Mr. Romanow: Chair, just a clarification. Investigations: is the reference to law enforcement investigations? There are many investigations that we continue to support, but I would like clarification, please.

Mr. Schmidt: Thank you very much. Have any new contracts or payments been made with respect to any of the suppliers who are being investigated by the RCMP?

Mr. Romanow: Again, Chair, if the member could confirm the allegations being made and allusions to companies. It's not clear what he is asking about and . . .

Mr. Schmidt: Thank you very much.

The Chair: Member Schmidt, clarify whether it's an Auditor General investigation, RCMP investigations. Be specific.

Mr. Schmidt: It's been alleged that MHCare continues to bid on health contracts. How many health contracts did MHCare bid on in the '25-26 fiscal year?

Mr. Romanow: I can't confirm what specific bids come in. Again, through our very open and transparent bidding processes any number of firms can bid on any number of publicly posted opportunities. I can't confirm what there might have been specific bidding on. I can tell you that, absolutely, steps have been taken to respond to considerations related to that entity with matters that are being alleged by the member, but I'm not aware of any contracts that are in place. I couldn't comment if they have bidden on different processes anywhere across government.

Mr. Schmidt: So just to summarize what the deputy minister has said, it's a very open and transparent process that allows anybody to bid, but he has no idea who's bidding on this. Is it normal practice to allow people who are under investigation for fraud, breach of trust, and money laundering to continue to bid on health care contracts, or are there no provisions whatsoever to prevent those who are accused of crimes from bidding on contracts?

Mr. Romanow: Thank you. Just an important clarification that it is Health Shared Services. It is not me specifically or our department that oversees the health system and leads the procurement and contracting of supply chain management. It is really important to highlight that the agencies and provincial health corporation experts are the ones that are working directly and ensuring the highest standards are being met. They're the ones directly interfacing with various companies, so that is a reason why our ministry and certainly I specifically are not directly involved in those procurements. It is Health Shared Services, and I think it's really important to highlight that that is an important distinction related to the accountability that is built into our system so we can ensure that quality and oversight.

Mr. Schmidt: So much accountability.

Member Eremenko: In regard to that, was it the department's decision to cancel the negotiations for the Red Deer and Lethbridge chartered surgical facilities in this fiscal year?

Mr. Romanow: Again, it is Health Shared Services which continues to lead that process.

Member Eremenko: No, I don't believe Health Shared Services actually had been stood up when the minister announced in the Legislature that the contracts were cancelled.

Mr. Romanow: I'll be able to clarify that point. I'm not aware of that process, and I wasn't directly involved, nor was my office in that. I would be able to clarify, but I can speak confidently that I'm not aware, nor was I involved in that process.

Member Eremenko: So just to clarify, then, what we're asking for the department, Mr. Chair, is that they provide the rationale for the cancellation of negotiations. MHCare, Alberta Surgical Group rather, was pursuing conversations with Red Deer and Lethbridge chartered surgical facilities. The minister announced – I believe it was November 28 – that those negotiations were cancelled. Health Shared Services under an entirely different ministry, by the way, is making decisions around procurement for Alberta Health Services, but they were not in existence at that time. So who made the decisions, and what was the rationale for cancelling it? Was it, in fact, the concerning allegations that were made in regard to conflict of interest and totally inflated contracts that the department wanted to see pushed through?

Mr. Romanow: That certainly predates me, but I would be happy to outline or reiterate what has been publicly communicated related to that process.

Member Eremenko: Perhaps the fact that it predates really shouldn't be of concern. The continuity of the role of deputy minister is critical. Whether the deputy minister started three years ago or three weeks ago, there is a degree of accountability to Albertans that there is continuity there in the decision-making.

Mr. Romanow: Absolutely, there is direct accountability with my team, with the department, but as the member had outlined in the question, the minister has communicated on that side very publicly about steps taken.

The Chair: Thank you.

We will now hear from government members for 10 minutes.

Mr. Dyck: Excellent. Thank you, Chair. Greatly appreciate that. I got a few questions here. Thanks for coming in. I do want to just follow up on implementation plans and procurement governance. I believe your – well, I know that your report indicates that a joint implementation plan was addressing procurement governance and also oversight. This was submitted to the Auditor General as well in July earlier this year, and then implementation early next year.

I've got a couple of questions here. I believe the Auditor General already answered this question, but I do want to make sure that I'm

understanding the pathway here. Has the ministry received the Auditor General's feedback that was expected in September of 2026?

10:50

Mr. Romanow: No. Thank you for the question. At this point, though I recognize it was just a few weeks ago, feedback has not been received from the Auditor General's office. The ministries are proceeding with their proposed plans. We're not sitting and waiting, but the process and the ongoing engagement includes our colleagues meeting tomorrow with the Auditor General's office on various factors and initiatives that are under way. Work proceeds, but we very much look forward to receiving and engaging with the Auditor General's office on these matters to support that process and really strengthen that accountability for Albertans.

Mr. Dyck: Thank you for that.

Just following up on that, what changes have been made to your business cases, to your due diligence, and approval requirements for major health care procurements?

Mr. Romanow: Thank you. Absolutely, we are implementing several of the changes in response to the recommendations. One notable as such is establishing a formal process to collect, review, and submit records to Health Shared Services for procurements initiated by the ministry but intended for implementation by a provincial health agency or corporation. I think precisely, even building on the questions from members earlier, these process enhancements are absolutely going to make sure that there is stronger accountability and transparency and role clarity from people leading the procurement, which is separate from our ministry directly.

Mr. Dyck: I appreciate that. I think there's a question of accountability here as well. I think it's really important as you create and craft these approval requirements for procurement. I just want to know from your stance and in that fiscal year: how will the ministry ensure that these requirements are consistently followed across Acute Care Alberta and its reporting entities? I do want to see: how are you going to hold the entities accountable to these requirements?

Mr. Romanow: Yeah. Thank you. It does build on the earlier comments. Absolutely, as a newer deputy it builds on and continues the robust processes that were in place before me. There are formal policies and processes that have been and continue to be established between the ministry with Acute Care Alberta and Health Shared Services to align procurement practices and strengthen that compliance.

I can tell you in my earlier weeks in this role that that is absolutely a top issue to continue digging into to make sure that we follow the appropriate procedures, current and past, and current policies, centralized procurement, and contracting functions within Health Shared Services. That is purposeful. That's intentional. That requires Acute Care Alberta and its reporting corporations to use Health Shared Services infrastructure and processes to manage these contracts, process payments, and engagement directly with vendors.

Again, there is that clear accountability that's been in. These are enhancements, and we look forward to strengthening that transparency and accountability to Albertans.

Member Eremenko: Mr. Chair, point of order. I'd like to call a point of order under Standing Order 23(j), uses abusive or insulting language of a nature likely to create disorder. A few minutes ago one of the members opposite – I don't know – perhaps got a little carried away and chose to show the middle finger to my colleague from St. Albert. We made eye contact. I think that there is very clear recognition that this was something that was unbecoming of a member in committee, and I would like to seek an apology, please. Specifically, the Member for Camrose, if they would like to issue an apology.

Ms Lovely: If you thought I was giving you the middle finger, I'm sorry. I was not. I was scratching my hand like this. There have been a lot of sensitivities today.

The Chair: Do you want to add something?

Mr. Cyr: Again, I respect this committee. I believe that I've never seen that kind of conduct by the Member for Camrose. I would be shocked to see that. I believe that, again, when these meetings become highly polarized, things can be read into, I guess, scratching your face that aren't there, so I would ask the chair to rule this point of order out of order, sir.

The Chair: Do you have anything to add, Member?

Well, as such, I didn't see it. I will take the member on her word and won't rule this out of order. I didn't see it, and the member maintains that she didn't do it.

Also, while I have the floor, there were points of order. We do not have enough time to finish our agenda today. I can ask members for their unanimous consent if they want to go beyond 11. I can ask one question. Do the members agree to go beyond 11?

An Hon. Member: No.

The Chair: Unanimous consent denied, so we will end at our scheduled time.

Go ahead, Member.

Mr. Dyck: Excellent. Thank you, Chair. Just for clarity how much time do I have left? This is the time on the clock? About three minutes?

The Chair: Yeah.

Mr. Dyck: Okay. Thank you. I appreciate that, Chair.

The Chair: I will stop you at 30 seconds.

Mr. Dyck: Sounds great. Okay.

I do want to talk just about the hospital-based leadership. There were some pilot projects that were launched – this is page 34 of the annual report – and that was beginning in January 2026, I believe, to give local leaders greater authority over staffing, over hiring, and access to resources as well. I'm very, very intrigued. What sites participated in the pilot, as well as how were they selected?

Mr. Romanow: Thank you, Chair, for the question. The site-based leadership is such a critical step. We, obviously, for the broader procurement initiatives want Health Shared Services leading that, but that's not to tie the hands of local decision-making on smaller initiatives, buying a jug of bleach, that we routinely hear and in a very alarming way continue to hear and to strengthen site-based leadership to have that ability so that they're able to take those local steps to engage with local providers where it makes sense. Obviously, we want to make sure that we've got the economies of scale that are in place, but we'll want to make sure in an increasing way in the days ahead that we have good consistency but also the ability and adaptability and agile action.

There are a number of sites that were engaged in this process, and I'm just wanting to not misspeak, so we'll clarify which

specific sites in a moment with you, but I think it is really important to highlight that we're trying to untie the hands of the front lines. That is the whole benefit of the health system refocusing. It's to be able to bring closer connectivity and engagement between a minister who's setting the frameworks, the legal frameworks, allocating resources, but at the same time unleashing the expertise and the potential of people on the front lines who are experts in their domains, experts and incredibly knowledgeable and connected in their communities, so that we are able to work as a cohesive team.

There were questions about multiple layers of bureaucracy. I would suggest that it's quite the opposite. It's working as a cohesive, co-ordinated unit as part of this refocusing to be able to shrink that space between the front lines, between the health care providers, between site-based leadership, and people working in Acute Care Alberta under Dr. Zielke and her team and with our ministry. If a barrier for procurement gets in the way, if a law or a budgetary consideration needs to be adjusted, we'll take the steps as a team to do things differently.

Mr. Dyck: Excellent. I do want to ask in this last moment: what measurable changes have occurred in the timeliness of local decision-making? Leadership is important. They need to be able to make those decisions. How have we seen those changes in this budget year?

Mr. Romanow: Sure. I think it's incredibly important to highlight some of these. I might actually call upon, if it's possible, my colleague Andre Tremblay, the president and CEO of . . .

An Hon. Member: He just walked out of the room.

Mr. Romanow: Untimely.

Those steps weren't taken because we're actually supporting our colleagues across the health system and working lockstep with them despite what comments were. Very specific actions have been taken at the local level. Hearing about basic stuff like sites being able to purchase a couch in a visitor lounge, basic small stuff that would have been caught up in red tape in the past: we've taken those barriers away so we can support the front lines.

The Chair: Thank you.

Seeing that the time is now 11, the meeting stands adjourned.

[The committee adjourned at 11 a.m.]

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